WALTHAM FOREST SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CHILD B

19.01.12

Contents

1 BACKGROUND & REVIEW PROCESS

BACKGROUND

Family

1.1.1 Child B was the third child of a White British couple whose first language is English. The family, which is wholly dependent on Benefits, is nominally Christian but does not belong to any particular denomination. The family has lived in a one bedroom flat in Waltham Forest since 2007 and both parents' respective families of origin are also long time residents of the borough. Child B's mother had lived in Haringey for a brief period in 2006/07.

1.1.2 At the age of eleven, mother (now aged twenty three) had been assessed as a 'child in need' and was accommodated by the local authority on more than occasion. Throughout mother's adolescence, there had been professional concerns about her mental health. Child B's father (now aged twenty seven) was known only to universal services and more recently as a result of domestic violence allegations by the mother of child B, to the Police.

1.1.3 The couples' first child (sister 1) was born in 2007; a second (sister 2) in 2009. Concerns about neglect of both daughters and mother's mental health led to several episodes of involvement by Children's Social Care.

Circumstances in which child B died

1.1.4 According to her parents, child B (aged eight weeks) was awake and fed at 1am and found unresponsive in her cot next morning at 10.30am. She was taken to a local hospital and pronounced dead. The death was unexpected and there were no underlying health issues known to local professionals. The parents' initial account of the two days before child B died was disputed by the medical staff who had examined her within the previous week.

1.1.5 The initial cause of death ascribed by the pathologist was 'dehydration due to gastroenteritis' and included observations that '…at 8 weeks of age, baby measures 57cm in length (50th centile) and weighed 3,810gms (2nd centile) indicating she was underweight for her height. The presence of dirt beneath finger nails and in skin creases as well as the nappy rash might be taken as evidence of sub-optimal care'. To ensure the accuracy of post mortem details cited by individual management review authors, the pathologist's report was sought and provided for the purposes of the serious case review.

1.1.6 The Metropolitan Police Service commissioned a paediatric expert to review the case and offer an opinion about parental care and whether neglect was a contributory factor to the death. On legal advice, the results of the medical review could not be shared with the panel prior to completion of the review, though a briefing provided to the overview author suggested its conclusions were unlikely to impact upon the recommendations in the serious case review. The panel therefore took the decision that the completion of the serious case review should not be delayed.

REVIEW PROCESS

Purpose

1.1.7 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires Local Safeguarding Children Boards to undertake reviews of serious cases in accordance with procedures set out in chapter 8 of *Working Together to Safeguard Children* HM Government 2010. A Serious Case Review 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 can 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 on, and what is expected to change as a result and
- As a consequence, improve intra and inter-agency working and better safeguard and promote the welfare of children'

1.1.8 The then chairperson of the Local Safeguarding Children Board (Mark Benbow) determined the case satisfied the criteria of *Working Together 2010* and that a serious case review would be completed. Ofsted was notified of that decision and the following agencies were identified as likely to have information and opinions of relevance to the SCR:

- London Ambulance Service (emergency response)
- Outer North East London NHS Community Services (health visiting)
- NHS Waltham Forest (GP services)
- Waltham Forest Children's Social Care
- North Middlesex University Hospital (midwifery and A&E)
- Whipps Cross University Hospital Trust (midwifery & medical)
- North East London Foundation NHS Trust (children and adolescent and adult mental health services)
- Ascham Homes (providing housing for the family)
- Metropolitan Police Service (investigation of reported crimes)
- A Children's Centre and three local schools (early years services)
- Haringey (where briefly, police, midwifery, ante natal care, health visiting, GP, children's social care, adult mental health and substance misuse services were provided)
- Waltham Forest Environmental Health (pest control, animal warden and noise services)
- Royal Society for the Prevention of Cruelty to Animals (allegations of mistreatment of dog/s owned by child B's family)

Panel membership

1.1.9 Members of the panel set up to consider the case were as follows:

- Steve Liddicott (Independent Chairperson)
- Principal Lawyer London Borough of Waltham Forest
- Detective Superintendent Metropolitan Police Service
- Metropolitan Police Service individual management review author
- Detective Chief Inspector and Detective Superintendent Metropolitan Police Service Waltham Forest Command Unit
- Interim Divisional Director London Borough of Waltham Forest Children & Families Services
- Group Manager London Borough of Waltham Forest Child Protection, Planning and Partnership
- Group Manager London Borough of Waltham Forest Extended Services
- Designated Doctor for Child Protection (Outer North East London Community Services)
- Interim Designated Nurse NHS Waltham Forest
- Individual management review author North East London Foundation Trust

Independence & quality assurance

1.1.10 Panel members had no prior involvement with child B or her family; the panel was chaired by a suitably experienced independent person and the overview report was drafted by a suitably experienced author Fergus Smith (CAE Ltd www.caeuk.org) who has no connection with the agencies or professionals involved in this case.

1.1.11 Each agency's individual management review was drafted by a suitably qualified individual with no line management or supervisory responsibility for the case. An independent health overview report was also provided .

1.1.12 Mother, father and the maternal and paternal grandmothers were invited to and contributed directly to the serious case review. Relevant staff were also interviewed and others who were in any way affected by child B's death were provided with opportunities for support.

1.1.13 Initial terms of reference were extended to include mother's receipt of child and adolescent mental health services. The review was completed in the period June – December 2011 and following acceptance by Waltham Forest's Safeguarding Children Board, submitted to Ofsted in January 2012.

1.1.14 The terms of reference and advice provided at panels made it clear that each agency drafting its individual management review should quality assure it and have it signed off at a senior level before submitting it.

1.1.15 Panel members are to be commended for their additional scrutiny of incoming reports and a clear determination to ensure effective reports e.g. all were returned to their respective agencies for further information, a more rigorous analysis and/or to develop more accessible contents so as to fully address what became the enhanced terms of reference.

1.1.16 In the author's view this serious case review benefited from:

- A very rapid recognition by the Local Safeguarding Children Board that although (upon initial consideration of the case), it was not mandatory, a serious case review *was* likely to generate opportunities for improved practice
- Speedy identification of relevant agencies and comprehensive terms of reference corrected and enhanced as required
- An independent chairperson and overview author
- A clear determination to ensure the quality of agency chronology and individual management reviews and subsequently the overview report
- Interviews with family members and professionals so as to obtain wider perspectives and seek to understand *why* judgments were formed and actions taken

Feedback of results to family

1.1.17 Though the timing will need to be sensitive to other current legal processes (criminal investigation and Care Proceedings), the panel has committed to providing, upon completion of this serious case review, feedback to respective family members.

Publication

1.1.18 It is current government policy to make such reports public and this version is identical in most respects to the version submitted to Ofsted *but* (on legal advice) excludes unnecessary medical or personal information and omits any details that would enable the identification of individual service users, professionals or smaller workplaces.

1.1.19 Waltham Forest's Safeguarding Children Board has also made available a brief executive summary that highlights the conclusions, lessons learnt and the recommendations for improvements arising from the serious case review.

2 AGENCIES' CONTACT

PERIOD 1: EARLY CHILDHOOD TO AWARENESS OF MOTHER'S FIRST FULL TERM PREGNANCY

MOTHER

2.1.1 Mother's early and middle childhood included some very significant events and circumstances that impacted adversely on how she grew up, her educational achievements and the way in which she later responded to the demands of being an adult and a parent.

2.1.2 Though a detailed exploration of her available historical records added significantly to panel members' understanding, the need to safeguard her right to confidentiality with respect to medical, psychiatric and other personal information mean that such details have not been reproduced in this published version of an otherwise complete serious case review report.

2.1.3 Instead, a number of 'developmental influences' have been summarised below.

Early childhood behaviour patterns

2.1.4 The maternal grandmother has reported that from the age of two, mother was a challenging and often aggressive child e.g. pulling her hair out and biting herself, who rapidly established a record of extremely poor school attendance and behaviour.

Maternal grandfather's prolonged extra-marital affair & premature death

2.1.5 Mother's behaviours in her very early school years may have been made worse by the expectation of her father, with whom she enjoyed a reportedly close relationship, that she keep secret from her mother (child B's maternal grandmother) his lengthy extra-marital affair with a neighbour.

2.1.6 The maternal grandfather died as a result of a cancer when mother was about ten years of age and her behaviours at this time e.g. thefts from home and physical aggression are attributed by the maternal grandmother to the loss of her father.

Maternal grandmother's illness & new partner

2.1.7 A further source of anxiety for mother in her mid childhood was the potential loss of the maternal grandmother who also contracted cancer when mother was about eleven years of age.

2.1.8 Fortunately, the treatment provided to the maternal grandmother was successful. However, she went on to form a new partnership with a man whom mother (then a young adolescent) strongly disliked.

Care episodes, self harming & in-patient psychiatric services

2.1.9 As she entered adolescence, mother's relationship with child B's maternal grandmother became increasingly conflictual. She made allegations of physical abuse by both the maternal grandmother and her partner (step-father to child B's mother) though neither were substantiated. The maternal grandmother's ability to assert control was anyway considered limited and may well have been further reduced because she suffered at times from clinical depression.

2.1.10 Mother spent three relatively brief periods in substitute care (foster homes) provided by Waltham Forest Children's Social Care.

2.1.11 Mother's general emotional distress was made visible when she began to self-harm in a variety of ways e.g. she is believed to have taken significant overdoses of prescribed anti-psychotic medication on three or possibly four occasions as well as other physically risky behaviours such as jumping from upstairs windows and recklessly running into the road at major road junctions.

2.1.12 During her early adolescence, mother had also been provided with some community based and in-patient 'Child and Adolescent Mental Health Services', though their usefulness was limited by a low level of co-operation

2.1.13 No educational records were available to the serious case review, although family members and some agencies' records confirm a very low rate of attendance and achievement at a number of different schools.

Sexual assaults

2.1.14 Though no conviction was secured, it is thought likely that mother at the age of twelve was sexually assaulted by one of the foster carers with whom she was placed. A recommendation associated with this possibility is included in section 5.

2.1.15 Mother was also the victim of other sexual assaults referred to below. By thirteen she was sufficiently sexually active to seek and be given by her GP a contraceptive prescription.

Mental health status

2.1.16 In the opinion of a consultant psychiatrist who assessed mother when she was about sixteen years of age, there was no evidence of mental illness but he described mother as having a 'borderline personality disorder'. In spite of that expert view as to her mental state, a variety of misleading psychiatric descriptions appeared in professional records held by health and by social care agencies.

2.1.17 As she approached adulthood mother once again sought support from the Child and Adolescent Mental Health Service. A subsequent lack of co-operation prompted this service to close her case.

Proposal that mother move out of home, & further self harm

2.1.18 In early 2005, the maternal grandmother contacted Children's Social Care and relayed concerns about her daughter (then aged seventeen) and the fact that she wanted her to leave home. An appointment was arranged for a week later but as a result of the failure to attend, the 16+ team which had been dealing with the maternal grandmother, closed the case.

Fourth overdose & further reference to sexual assault

2.1.19 A month later mother claimed she had taken a further overdose of seventy tablets following an argument with her boyfriend. The history taken included a reference to the possibility she was 'manic-depressive with psychotic symptoms' (a further variant on other descriptions seen by the author).

2.1.20 Mother referred to her 'rape' 'two months ago' which *may* have been a reference to an (apparently un-investigated) event mentioned to other professionals earlier that year.

2.1.21 As a result of the latest events, there was liaison between the hospital, and Child & Family Consultation Service and then between Children's Social Care's First Response Team and 16+ team. The latter appeared reluctant to become involved.

2.1.22 Mother failed to attend an urgent appointment offered her by Child & Family Consultation Service in November 2005. The Child & Family Consultation Service seem to have had no further contact and the case was formally closed in mid April 2006 after three more failures of mother to attend appointments offered her.

Leaving home & financial support from Children's Social Care

2.1.23 In early 2006, it would seem that at the request of the maternal grandmother mother had left home and was living with a friend and/or on the streets with a boyfriend with whom, it was claimed, she had been breaking into cabs to sleep.

2.1.24 The response of Children's Social Care 16+ team was to organise a family meeting and complete an assessment which painted a picture of a highly vulnerable young woman whose difficulties had begun at a very young age.

2.1.25 Mother and the maternal grandmother in their interviews with the 16+ worker, referred mother's 'schizophrenia'. Mother also indicated that she might be pregnant. The conclusion drawn by the 16+ worker was that mother needed to be provided with housing together with her partner and on that basis she initiated a referral to the Homeless Persons Unit.

Comment: Mother's needs (pregnant or not) were far more complex than just a need for somewhere to live. A core assessment was required and (though she might not have accepted it) she could and should have been offered accommodation via s.20 Children Act 1989.

2.1.26 During the early part of 2006 mother maintained contact with the 16+ team primarily because it subsidised her living expenses pending resolution of her longer term Benefits claim. By April, mother and her partner (who was to become father of all of her three children) had moved into a temporary address 2 in Haringey.

2.1.27 By mid June mother's pregnancy was confirmed by Whipps Cross Hospital.

FATHER

2.1.28 Father's personal and medical history was also explored for the purposes of the serious case review and was unremarkable. It included some common childhood accidents but offered nothing that could be linked to his parenting of child B or her sisters.

EARLY EXPERIENCES AS A COUPLE

2.1.29 Mother at interview confirmed she and father first become a couple when she was 'about sixteen'. Mother had attributed her overdose in May 2005 to 'an argument with her boyfriend'. He was not named but it seems probable that it was the father of her three children.

2.1.30 Though not confirmed in any records supplied, it seems even more certain that in very early 2006 when the maternal grandmother required mother to leave home, she was still in (or back in – they parted frequently) a relationship with father.

First 'domestic' dispute

2.1.31 In mid January 2006, mother called Police to the maternal grandmother's address saying she had had a row with her boyfriend who had left the premises and now all was well. This was the first Police record of mother and father as a couple. Mother gave her date of birth as XX making her appear over eighteen years old to the officers.

2.1.32 Mother informed the officer who attended that she suffered with a mental health problem that caused her to lose her temper but did not elaborate.

Comment: One assumes mother's motivation is falsifying her age was to avoid probable notification to Children's Social Care. It is unclear where the maternal grandmother was at the time of the row.

Second 'domestic' incident

2.1.33 Only a week after the first domestic dispute police officers again attended the maternal grandmother's address. Mother and maternal grandmother said that an ex-boyfriend of mother had come to the address and during an argument kicked a glass table top, smashing it. They had no details of the boyfriend and the allegation was not investigated further.

Comment: It is thought likely the 'ex boyfriend' referred was father.

Third ‘domestic’ incident

2.1.34 In mid May 2006 mother once again called Police this time to her temporary address 2 where she claimed to fear that her ‘ex-boyfriend’, whom she had thrown out, might return with others to cause trouble. The view of the Police is that the ex-boyfriend was ‘father’. Advice was offered but officers were not called back. This incident was notified to the relevant borough’s Children’s Social Care.

Comment: In spite of these regular domestic crises, a GP’s observations of mother at this period noted that she was calmer and looked well.

PERIOD 2: FIRST FULL TERM PREGNANCY TO AGENCIES’ INITIAL AWARENESS OF PREGNANCY WITH CHILD B: AUGUST 2006 – AUGUST 2010

Ante natal period: ‘sister 1’

2.1.35 When GP5 referred mother to the North Middlesex University Hospital in early August 2006, he cited ‘psychotic depression’ as amongst the issues to be taken into account.

Comment: The term employed by this GP is just one of many inaccurate labels that became currency amongst non-psychiatrically trained professionals, sometimes prompted by mother.

2.1.36 When mother attended this hospital in the middle of August 2006 she was seen by midwife 1. The history she shared with staff included ‘a family history of learning disability including her’ - an issue not mentioned previously by her or found in any professional records. As surprising was that mother apparently made no mention of her mental health history, though she had hitherto shown little reluctance to acknowledge it.

2.1.37 During this consultation mother reported a previous obstetric history of two early miscarriages in 2005 at home. Other medical details were discussed and those of potential relevance to this serious case review were that she smoked ten cigarettes a day. Mother acknowledged she used marijuana and also reported that she had left care at fifteen years old and was known to Children’s Social Care.

2.1.38 The North Middlesex University Hospital individual management review found no evidence that a ‘LINK’ form was completed (a LINK form is an internal maternity form completed by midwives at booking and is used to communicate a care plan for client with medical, social or psychological concerns). Though the midwife’s written intention was to refer to Children’s Social Care, it seems that she failed to do so.

Comment: Thus, an early opportunity to recognise and mobilise the professional network to mitigate the risks to the yet to be born sister 1 was missed.

2.1.39 In early September 2006 mother was due to see the consultant obstetrician for antenatal follow up at the clinic. She did not attend this or a majority of subsequent obstetric and other appointments for her and/or her children.

2.1.40 In mid September 2006 mother visited the 16+ office asking for support with finance as her Benefit claim had not gone through. She was interviewed by her allocated '16+ worker' to whom she explained her recent scan had been fine. A similar encounter took place on later that month when mother was given cash and vouchers and several more appointments followed during 2006.

Comment: Thus, several further opportunities to initiate a pre birth risk assessment were overlooked within Children's Social Care.

2.1.41 Having missed a consultant ante natal appointment the week before, mother (then twenty three weeks pregnant) attended an appointment in early October at the community midwifery clinic with 'midwife 2'. Although mother named her '16+ worker', no liaison was initiated by the midwife, who did however refer mother to a Sure Start facility. It is not known whether mother ever accessed that source of support.

Comment: Thus, a further opportunity to exchange information and assess risks was overlooked by health staff.

2.1.42 About a week later, having been hospitalised for pregnancy related complications, mother discharged herself against medical advice because it was not possible for her partner to remain overnight with her in the hospital. She then failed to attend a pre-booked consultant appointment two days later.

2.1.43 She subsequently attended a minority of scheduled ante natal appointments.

2.1.44 In early November a supervision note written by the '16+ team manager (TM 1) summarised mother's status as 'mother having financial trouble due to the delays in her benefits claim being processed; social worker working on an appeal regarding incapacity benefit and income support due as the case notes describe an inability to work as she has been having mental health issues; decision made to support her for three weeks only due to recent allegations of abuse against ex-foster carer and news received about the carer in court for other allegations of similar nature'.

2.1.45 The team manager decided the case was to be 'referred to the Family Support team - as 'young woman pregnant and faced with large arrears'. He noted she was not 'a former relevant young person' under the 2000 Act and therefore the 16+ team has no remit to support her. The focus of concern remained mother's material needs, not how she might cope with a baby.

Comment: Assuming records of care episodes are accurate, it is true that mother had never become 'eligible' nor therefore 'relevant' under the Children (Leaving Care) Act 2000 but the response given indicates confusion about the role of that (since disbanded) team.

2.1.46 The reasons for the change of perspective are not apparent from records seen, but the 16+ service in Waltham Forest made a referral to the Children's Social Care of the other borough stating that mother was due to give birth in two weeks, was vulnerable and in need of support and guidance in caring for a baby.

2.1.47 The other borough's records indicated that mother had mental health problems, mood swings and difficulty controlling her temper. The referrer noted her care history and sexual abuse while in foster care; that she was living in temporary accommodation in that borough and was on incapacity + disability living allowance. The referrer further that 'it will be difficult for mother to cope with her baby due to her mental health problems'.

Comment: The referral though appropriate was very belated and left the Children's Social Care little time.

2.1.48 Next day the other borough confirmed orally to the midwife 1 and later confirmed by fax that it had accepted case responsibility. The Children's Social Care acted promptly and made checks with the Whipps Cross University Hospital where mother had initially attended for ante natal care and the GP with whom she had previously been registered. Mother was now registered with GP 6 at a different Health Centre.

2.1.49 On the same day, the other borough's allocated senior practitioner initiated a referral for psychiatric assessment of mother who was by then thirty eight weeks pregnant.

2.1.50 Next day the senior practitioner completed a home visit. Mother was not present and father indicated she had gone to Waltham Forest's Housing Dept as they were due to be moved back to Waltham Forest. Father denied any intention of splitting up, particularly since mother was about to have a baby. He said she had stopped taking her medication because she was pregnant and had not had any mental health services since being in the other borough because mental health services had not yet referred her.

2.1.51 The flat was noted to be small, messy, smelling of smoke and of a dog that also lived with the couple. Mother and father slept on a mattress on the floor.

2.1.52 Three days later, the senior practitioner from the other borough made telephone contact with Waltham Forest's 16+ service and with the borough's 'Support & Resettlement' team and learned that accommodation was to be provided back in Waltham Forest in two days time (which would be three days before mother's estimated date of delivery).

2.1.53 On the justifiable basis that mother was about to move to permanent accommodation back in her borough of origin, the other borough initiated transfer of case responsibility to Waltham Forest.

2.1.54 The senior practitioner first sought an opinion from the consultant at the Child & Family Consultation Service (psych.1) who had previously assessed mother. His response was that ‘she is 'immature' and he would have 'serious worries about her ability to care for a baby'. Mother was also described as a 'very disturbed girl'.

2.1.55 Psych.1 did not believe ‘that Children’s Social Care need to rush in and remove the baby immediately but there were going to be 'chronic worries' about her caring for a baby long term’.

2.1.56 The immediate response by Waltham Forest’s First Response Team on the day of referral was to initiate an initial assessment and allocate the case to SW 1. The level of risk was quickly seen to be high and a core assessment was begun next day.

2.1.57 Waltham Forest Children’s Social Care sought to convene a strategy meeting but was told by its local Child Abuse Investigation Team (CAIT) that no officer was available. The other borough’s CAIT formed the view such a meeting was not needed. Police did agree to alert the London Ambulance Service once Children’s Social Care could provide a new address.

Comment: the London Child Protection Procedures make it clear that in circumstances such as these, a strategy meeting should be held. Alerting the Ambulance Service could not offer as comprehensive a strategy as might have emerged from an urgent strategy meeting. In addition, the ‘alert’ relates to an address not to a named individual and loses its value as soon as the person moves home.

2.1.58 Further to a high level of information exchange, a professionals’ meeting was convened. Represented at that meeting were Children’s Social Care from the other borough, Waltham Forest Children’s Social Care, Connexions (with whom mother had had limited contacts), North Middlesex University Hospital' midwifery and Waltham Forest’s Support & Resettlement team.

2.1.59 The 16+ worker sent apologies but her initial assessment was quoted and included the misleading reference to mother’s admission that she was ‘schizophrenic’. No agreement was reached about someone actually talking to the parents about professionals’ concerns, the identified risks or about working with them

Comment: Whilst information about the immediate circumstances was shared there was no recommendation about undertaking a pre-birth assessment (to encompass mother and father) which, given the history and high risk level, might well have lead to an initial child protection conference and protection plan.

2.1.60 Practical precautions were agreed to cover the possibility that mother might give birth at either North Middlesex or Whipps Cross hospital. The former was to be contacted to see if it would be possible to keep the baby in for a period when s/he was born to get a preliminary assessment of mother and baby

Comment: The idea that mother and baby might remain longer than was medically necessary was not well thought through. It ignored not only pressure on resources but more importantly that it required mother's consent if the arrangement was to be lawful. As explained below, this consent was not provided and tension was created.

2.1.61 It is uncertain how the conclusions of the professionals' meeting were shared with mother but, given the lack of preparation coupled with the proximity to her estimated date of delivery, it may well have added to the levels of stress she was already experiencing.

Birth of sister 1

2.1.62 Following a 'false alarm' mother returned to either their address in the other borough or the new Waltham Forest address and actually moved into their flat (address 3) on a confirmed date.

2.1.63 Mother re-presented to the North Middlesex Hospital two days later where she give birth to a healthy baby girl.

2.1.64 Only on one occasion while in hospital did mother's care give any cause for concern when the baby was left on top of instead of underneath, a blanket.

2.1.65 A midwife phoned the other borough to notify Children's Social Care of the birth. Later that day the ward was informed that Waltham Forest had accepted case responsibility.

Comment: Midwives should have been notified of case accountability transferring to Waltham Forest after the 'professionals' meeting'. Speed of events may have prevented this.

2.1.66 On the day of sister 1's birth Waltham Forest's allocated SW1 and a 'referral & support officer' met the parents and their new baby on the ward. The social worker was given a misleadingly positive description of the family and its sources of support. She indicated to the parents that she would be initiating a core assessment and that there would be a strategy meeting. Father expressed the view that this was unnecessary.

2.1.67 Notes indicate that mother was to re-register back with the family practice of GP 7 back in Waltham Forest.

2.1.68 In the early evening of the day of her baby's birth mother was beginning to say she wished to leave hospital. A paediatrician advised the parents that a continued stay was to ensure mother was able to care for her baby and there was no problem with her.

Comment: Though not explicitly recorded, it does appear as though some professionals e.g. the manager in First Response Team may have believed or anyway assumed that mother and baby could be prevented from leaving the hospital. Clearly, without an Emergency Protection Order or use of Police Powers of Protection, this was not so and, though preferable that they remained in a place of safety, whether they did so was entirely mother's choice.

2.1.69 During exchanges with Children's Social Care mother confirmed that she was unable to read or write and that father also had difficulties in this regard.

2.1.70 SW1 set up (subject to funding) an observed parenting session (misleadingly referred to as 'contact') via a local agency and sought to organise a strategy meeting.

2.1.71 Early on the day after sister 1's birth SW1 undertook a home visit and recorded her observations of a one bed room flat on the first floor in a shared house. The flat was noted to be clean, carpeted and furnished. Gas and electricity were metered. The kitchen was seen and there was food in cupboards although the fridge was empty. Shopping had not been done as mother was in hospital. Items for the baby were seen including a high chair, steriliser, nappies and baby wipes.

2.1.72 The social worker was given what transpired to be false reassurances about a pet dog (a long legged Irish Staffordshire), the presence of which was anyway in breach of the couple's tenancy agreement. Father indicated the animal was to be cared for by a family member but in fact the dog was still present three weeks later and by August, there were two or more present.

Comment: As suggested by the Children's Social Care individual management review author, it is unclear whether there was sufficient effort made to sit down with parents and talk through Children's Social Care's concerns, potential risks and what might happen next.

2.1.73 Later on the day after the birth of sister 1, what was to be the first of several 'working agreements' was discussed and read to the parents. Mother was at first agitated, and walked away stating no-one would take her baby from her. Father remained calm. Both parents signed the document, copies of which have been found on file and include:

- 'Partnership working' [it seems unlikely this term would have meant much to this couple]
- Mother to go to GP to seek mental health support
- Parents will act to protect baby [how and when unclear]
- Parents to allow the selected local agency offering contact and other services, to assess parenting, and
- Local authority to provide parenting advice and guidance

Comment: One suspects that parents in these circumstances might sign anything; in addition being barely literate; they may have had little understanding of that to which they had 'agreed'.

2.1.74 There appeared to be some variation of understanding about the status of the proposed meeting. The hospital regarded it as a pre-discharge or professionals' meeting, Children's Social Care had wanted a 'strategy meeting' but settled in the end for a 'strategy discussion' next day when it was agreed that a core assessment should be completed in the context of s.47 enquiries.

2.1.75 Later on the day after sister 1's birth mother did, as expected, discharge herself and her baby. An unspecified individual in Children's Social Care completed a 'record of outcome of s.47 enquiries document as follows 'decision & reasons: concerns are substantiated and child judged at continuing risk of harm'. The agreed actions were to convene a child protection conference, monitor child's welfare, complete a core assessment and provision of s.17 services'.

Comment: There seems to be no indication that legal advice was sought in order to explore options.

2.1.76 The day after mother had self discharged, the social worker sought from the hospital and was provided promptly with a generally reassuring account of how mother had cared for her baby whilst an in patient. The ward manager reported only one incident in which the baby was insufficiently covered and two in which mother was verbally abusive toward professionals, both related to her wish to self discharge.

2.1.77 In the early afternoon of the day following sister 1 being taken home SW1 undertook an unannounced home visit so as to establish that the baby was safe, arrangements for her care were sufficient and to negotiate with parents a schedule of observation visits by a member of staff from a local contact centre.

2.1.78 Mother reassured the social worker that she would be registering with a local GP practice and the social worker undertook to re-refer mother to psych.1 who had previously psychiatrically assessed her.

2.1.79 Next day Children's Social Care commissioned thrice weekly observed parenting sessions by a worker from the selected local agency and sister 1 was seen on each of twenty four occasions over ten weeks.

2.1.80 Sensibly, the emergency duty team was briefed about a potential need to remove sister 1 should there be a crisis.

2.1.81 A further home visit was undertake by SW1 when she advised mother of the dates of the parenting assessment, in mid February and her now scheduled mental health assessment.

2.1.82 Sister 1 appeared well and mother said she accepted the times set for the supervision of parenting sessions and would attend the conference. Mother indicated that she had attended the Waltham Forest clinic yesterday and had an appointment to register with GP7 whom she said knew the family well.

2.1.83 Commendably, a joint home visit was completed in the first week of February by SW1 and the duty mental health worker from the mental health duty team.

2.1.84 No signs of severe mental illness were elicited. An out-patient appointment with a psychiatrist was to be arranged so as to clarify diagnosis and psychological support from a local counselling service was suggested.

2.1.85 Within a week of the birth of sister 1, the named midwife 3 offered a reassuring description of how the parents were coping and indicated that further home visits would be made prior the upcoming conference.

2.1.86 Later that same day SW1 was able to elicit by phone from psych.1 his diagnosis of mother as having 'a borderline personality disorder. He indicated that he had not seen her for a year and a half and described her as a 'difficult character' and 'not a responsible girl'. He confirmed though, that her decision not to take medication during pregnancy was a sensible one.

2.1.87 About a week after the birth of sister 1 the deputy team manager in supervision of SW 1 captured actions taken and those required to be taken. Whilst the care of the baby was described as good, the worker observing parenting was visiting three days a week and unannounced visits by social worker and the referral and support officer were being completed on the other three days. A discussion had been held with psych. 1 from the Child & Family Consultation Service. The mother was due to register with a GP.

Comment: Mother had claimed she would register with GP7 the day before, It seems this was not confirmed.

2.1.88 Required actions were to send a chronology to the Legal Department and request a legal planning meeting and to complete a request for a family group conference.

2.1.89 Later the same day, SW1 emailed a request for a legal planning meeting to the Legal Department. Confirmation was received two days later that the case had been allocated but for reasons explained below the request for a legal planning meeting was later withdrawn.

2.1.90 From this point what transpires to be a lengthy delay prior to the parents registering sister 1 with a GP ensued. The initial reason given was that the GPs required a birth certificate which the parents had not yet obtained.

2.1.91 Two days later, Children's Social Care received useful written confirmation from psych.1 at Child & Family Consultation Service of diagnosis / advice:

- 'Child & Family Consultation Service involved since October 2004 mother as 'very dramatic…can be quite immature… lifestyle is chaotic and characterised by rages, anxieties and frustrations which erupt into harming herself and occasionally her boyfriend'
- Diagnosis: 'closest approximation is borderline personality disorder characterised by erratic behaviour, self-harm, volatility and abuse of drugs at different times'.
- Mother is outside remit of Child & Family Consultation Service and review of mental health would need to be done by adult mental health team.
- Tremendous reservations in respect of parenting ability but qualified by stating he hasn't seen her for over a year - recommended a parenting assessment'

Comment: It is significant that this psychiatrist who knew mother better than most identified her as being the aggressor as opposed to her partner (child B's father).

2.1.92 The observation sessions by workers from the local contact centre proceeded as planned and parents were co-operative and showed that they could (whilst observed) provide adequate care.

First initial child protection conference & follow up

2.1.93 About two weeks after the birth of sister 1 the first initial child protection conference was held. Feedback from the visiting support worker observing parenting was very positive - parenting and keeping routines was good and mother and father were working well together and with the baby.

2.1.94 It was noted that mother had co-operated with mental health services and the First Response Team and the details of psych.1's report were shared. An attending Connexions worker arranged to meet the parents within the next three weeks to offer advice on education and Benefits. An agreed priority was for sister 1's birth to be registered.

Comment: If mother's account was accurate the failure to register sister 1's birth was preventing her registration with a GP.

2.1.95 The midwife reported no concerns and the police officer reported only the incident in May 2006 when mother had broken up with her partner. The chairperson sought views and there was unanimous agreement sister 1 did not need to be made subject of a child protection plan and a 'child in need' plan should instead be introduced to ensure:

- Regular monitoring by midwife and transfer to health visitor
- Midwife would organise testing of baby required for possible effects of cannabis use during mother's pregnancy
- Parents ensure baby attends all appointments
- Parents register birth and with local GP
- Connexions offer benefits advice
- SW1 complete a core assessment
- The review / assessment required by adult mental health
- Review of family support work three day / week frequency
- A referral was completed for a family group conference.

Comment: In the light of experience parental co-operation and performance, the decision sister 1 did not need to be subject of a child protection plan was justifiable. Which toxicology tests were being contemplated and whether they were to test for mother's use in pregnancy of hard drugs and/or impact on the baby is unclear.

2.1.96 About three weeks following the birth of sister 1 when mother failed to present her for weighing, there began what was to become a characteristic non attendance at a variety of health related appointments for mother and/or her children. Mother claimed she had left a message but none was found.

2.1.97 It is a matter of concern and commented upon further in the analysis section of this report that the minutes of this conference reached psych.1 at Child & Family Consultation Service only in May and were filed there rather than being forwarded to the mental health consultant for adults or the mental health duty team.

2.1.98 By a date in late February the registration of the baby's birth was confirmed by sight of her birth certificate. The midwife alerted a health visitor in the other borough to the need for a new birth visit and provided a mixture of accurate information about mother's psychiatric history - self harm, suicidal tendencies and drug use coupled with some less accurate information about mother having been in care 'all her life' and indeed the maternal grandmother also having been in care.

Comment: It remains unknown whether the maternal grandmother really had been in care. The inaccurate references to mother are subsequently carried forward.

2.1.99 A further joint visit was completed by SW1 and a mental health worker. It seems that mother had still failed to register herself at a GP. At a visit next day, the social worker is offered some questionable reassurances e.g:

- 'The dog is going to the maternal grandmother' (a similar reassurance had been given this social worker in late January)
- Mother was going to register herself with a GP 'tomorrow' (a repeat of the same assurance given in early February)
- Parents 'did not smoke near sister 1' (though the social worker had observed full ashtrays in the shared bedroom at her first visit to the flat)

Comment: These individual issues offered a proxy indicator of parents' capacity to organise and/or their honesty.

2.1.100 It is not clear from records whether mother's assertion that she had at least registered sister 1 with a GP had been confirmed. Though it is not known whether they did so, the parent's declared intention to visit a town in the North of England for three days without the baby, is curious not only because sister 1 was so young but also because they were at this time telling involved professionals that they had no money.

2.1.101 In late February, the Housing Association indicated to Children's Social Care that although its involvement with the family was limited, it had no concerns.

2.1.102 Also in late February and somewhat belatedly the midwife 3 followed up her allocated task of establishing whether there were any results of testing sister 1 for possible effects of cannabis use during mother's pregnancy. Unsurprisingly the response to this line of enquiry when it emerged in mid March was that there had been no clinical signs in sister 1 of drug withdrawal (though no specific tests had been arranged at the time).

Comment: One might have expected the midwife to know which toxicology tests could have been or indeed were done at the time of sister 1's birth.

2.1.103 At an unannounced visit by SW1 a month after birth of sister 1 she was told that the parents were due to take sister 1 to an (unnamed) health centre that afternoon. Nothing in the material provided confirms that they did so, though it is possible that the baby was taken for weighing at a centre / site that has not contributed to this serious case review.

2.1.104 Plans for a family group conference were progressed though considerable delay ensues before it was convened (as described below) in June 2007.

2.1.105 Throughout the first six months of sister 1's life parents often sought and were usually given cash and/or nappies by Children's Social Care's First Response Team or its 16+ team as well as by the Connexions service. When SW1 discovered that the parents has extracted cash from Connexions she challenged them and obtained a promise of a £20 reimbursement from father who claimed he had not realised his partner had been given cash as well as vouchers.

Comment: Records are not sufficiently detailed to be sure the money was reimbursed but the social worker is to be commended for her assertiveness in this context.

2.1.106 Mother failed to attend her appointment with the psychiatrist in late February 2007 and when later questioned claimed that she 'had forgotten'; she 'had no money' and that XX February was the anniversary of her father's death.

Comment: The maternal grandmother indicated at interview that her husband died on YY July 1997 so 1997 was the tenth year since his death but February was not the month nor was XX the correct date. This behaviour (possibly confabulation) illustrates a characteristic response of mother when challenged.

Completion of core assessment 1

2.1.107 In late February 2007 SW1 completed a thorough core assessment and recorded her observations of secure and positive attachments and that sister 1 was well presented. She noted First Response Team's high level of monitoring and support as a means of safeguarding sister 1. The social worker concluded that both parents were meeting the baby's basic care needs and responding and engaging well with sister 1.

2.1.108 Presciently though, the social worker concluded that the 'parents are young and inexperienced and baby will need continued support from Children's Social Care as a child in need'.

Comment: The conclusion that the parents would need ongoing support was an accurate one but that clarity of thinking was lost in the ensuing months. The inclusion of a response from the hospital paediatrician dated mid March renders the 'completion' date of late February for the core assessment doubtful and perhaps a function of the then required timescale of thirty five working days. Similarly, sister 1 (in spite of many promises to so do) was only registered with a GP well after the 'write up' indicating that this task had been completed by parents.

2.1.109 The individual management review covering GP contacts does not offer confirmation that mother did (as she said to the worker that she would) take sister 1 to a GP as a result of a 'thick white layer' on the baby's tongue.

2.1.110 Parents were at this stage expressing more resentment at what they considered the unnecessary involvement of Children's Social Care.

2.1.111 In mid March the midwife alerted HV 1 to the fact that, apparently on the advice of the maternal grandmother, sister 1 was being given solids i.e. eighteen weeks before the recommended six months of age.

Comment: It is unclear when the midwife learned of this fact. The social worker perhaps without realising its adverse health impact had noted it on her visit in mid March but there is no record of a midwife visit at this time.

2.1.112 HV 1 followed up with a home visit and, in the face of some hostility from mother sought to dissuade the parents from weaning sister 1. Her paper records apparently refer to the dog still being there so the promises made from late January onwards to pass it over to the maternal grandmother had come to nothing.

2.1.113 In late March and contrary to the instruction from the psychiatrist to offer a second appointment after mother failed to attend a late February appointment, a discharge letter was sent to mother's then GP 8.

2.1.114 Events seem to take a turn for the worse at about this time. Midwife 3 had 'serious concerns and not discharging' to the care of the health visitor. The midwife reported that mother was not on medication, was in conflict with social worker and refusing to see her. She also recorded that the dog 'went for social worker' who was advising parents to 'get rid' of it.

Comment: If the dog (which was to have been disposed of in late January) did indeed attack the social worker (and there is no Children's Social Care record of such an incident) it would have had serious implications for the safety of sister 1. Mother reported to the health visitor in late March that she was 'attached' to the dog giving no indication that she was planning to get rid of it.

2.1.115 The midwife also reported parents were giving contradictory reports of how they were coping and she felt mother was 'on the edge'.

2.1.116 The midwife obtained details of the family's social worker and spoke with her by phone when, aside from relaying her observations and concerns she confirmed HV 1 was now the allocated health visitor.

2.1.117 Toward the end of March there had been an exchange between HV1 and SW1. The health visitor indicated she would continue to have monthly contact at home and that there would be clinic attendance every one to two weeks.

2.1.118 Parents claimed at a scheduled visit by the contact worker in early April that sister 1 had been presented to an unspecified hospital and flu / cold diagnosed. Neither North Middlesex nor Whipps Cross Hospital confirm contact so it remains uncertain if the story was true and if not, what the purpose of inventing it might have been.

2.1.119 About a week later, according to the parents they and sister 1 were the victims of an incident at a retail outlet involving firearms. The incident does not appear in the Police report leaving the possibility in spite of its seriousness as described, it had not been reported.

2.1.120 In mid April and, according to the parents because of the maternal grandfather's funeral the day before, the flat was observed by the visiting SW1 to be untidy and unclean; the kitchen spread with unwashed plates and soiled nappies, dirty clothes and used milk bottles on the bedroom floor.

2.1.121 Later the same day the social worker tried to expedite resolution of continuing delays in payments of Benefits and succeeded in getting a mental health assessment with psych. 6 brought forward to mid April 2007**.** Given mother's unreliability, the social worker sensibly took the precaution of offering to take her to that appointment.

2.1.122 During a phone conversation between SW1 and the mental health worker, the former reported that she has seen mother today and that she was better than the previous visit when she was 'shouting and screaming at SW1 appeared extremely angry and was quite aggressive towards her baby'.

Comment: There was no Children's Social Care record of such hostility. At interview mother recalled this social worker (SW1) was not intimidated by her and would suggest mother went and cooled off when she had angry outbursts. An unintended consequence of this skill or resilience could be a level of tolerance in excess of what should be considered acceptable by an average professional or a vulnerable baby. The instrumental use of mother's aggression is considered later.

2.1.123 A supervision session in mid April confirmed that the intention was to transfer the case to Children's Social Care's 'Family Support Team'. An account by the observed parenting worker of a session was received on the same day though whether it was available before the supervision session or indeed the mental health assessment is unclear.

2.1.124 The worker reported having met both parents and sister 1. Mother had been on her phone, upset and asking someone to borrow money. Though positive interactions had been observed between father (calm and caring) and his daughter, 'mother's behaviour towards her daughter was appalling' - shouting loudly and demonstrating mood swings. The worker further reported …'I am of the view that without…high level of support…, mother will be unable to parent sister 1' …mother cannot control her emotions'.

2.1.125 In the view of the psychiatrist by whom mother was seen in mid April (psych.6) her mental state was 'stable' and though it was discussed, mother did not require medication. The psychiatrist sought further clinical records

(assessments and medication) from the adolescent unit to which mother had been briefly admitted and from the Child & Family Consultation Service's psych.1.

2.1.126 A hearing test for sister 1, delayed because parents failed to take her to the original appointment in early April was passed later that month.

2.1.127 Having been told that it would anyway be the last, mother offered an excuse and avoided the 'observed parenting' session.

Referral by paternal grandmother / observations of neglect

2.1.128 At the end of April and apparently prompted by concern from father's own mother i.e. the paternal grandmother of child B, there was a case discussion between team manager and the deputy team manager who supervised the case accountable social worker (then on annual leave).

2.1.129 The paternal grandmother had apparently alleged parental drug and alcohol misuse, that the home was unkempt and that sister 1 had a rash on her. Additionally she reported the parents were selling milk tokens and that sister 2 had been given Calpol when not needed, which makes her sleepy and that the parents were planning to sell a recently provided tumble dryer.

2.1.130 The response was prompt and included an unannounced visit that day, a strategy meeting to be booked to explore the highlighted concerns, and liaison with Housing and Benefit services.

2.1.131 On arrival mother answered via the intercom and was shouting. Father came down and when asked brought sister 1 down. Father initially refused entry though the baby was observed to be 'fine, content, clean and appropriately dressed, albeit with signs of a rash on her neck with a white cream having been applied. Mother asserted this was Sudocream and that she had taken her baby to the GP the week before because of an ear infection'.

Comment: Aside from the likelihood that an ear infection would be in the middle or inner ear, or even if superficial would not be 'on the neck', the fact is that there is no record of a presentation of sister 1 to the GP the week before. The use of Sudocream might have been benign or (as per use of chocolate 'Child B' Haringey LSCB 2007 aka Baby Peter), it could have disguised more significant marks.

2.1.132 The maternal grandmother claimed that the paternal grandmother's referral was a result of a feud over the weekend and father got angry and wanted to go to his mother's house. Maternal grandmother persuaded him not to do so and after persuasion, the parents allowed workers into the flat to see where the child was sleeping.

2.1.133 The bedroom was described as chaotic and unkempt and a full ashtray of cigarette butts indicated that in spite of frequent parental denials, the parents smoked in the bedroom while the baby was there.

Comment: This episode typifies the functioning of the family and it is probably not coincidence the crisis arose when what was an attentive social worker was on leave.

2.1.134 There is no record that the alleged misuse of Calpol or sale of milk tokens were explored nor that the observations made and their analysis were shared with a manager to establish if she was in agreement.

2.1.135 No strategy meeting was subsequently arranged nor was an explanation for its cancellation located, and there is no record to confirm that the paternal grandmother received feedback about the results.

2.1.136 In mid May mother spoke with her allocated social worker and indicated that she would be unable to attend the finally scheduled family group conference because it clashed with her follow up appointment with a psychiatrist and because her mother and sister in law would be away.

Comment: In analysing mother's excuses for non compliance it becomes apparent that she usually uses more than one excuse for any given event. In this instance the appointment which she anyway failed to attend was three days before the family group conference which she together with the maternal grandmother did in fact attend.

Family Group Conference

2.1.137 At the family group conference in early June at which only members of the immediate and extended maternal family the following plan was agreed:

- The maternal grandmother to offer child care, as shift work allows
- Maternal sister to offer help when needed
- Father to work towards reconciliation with paternal family
- Mother to change GP and hand in sick notes
- Mother to visit 16+ for financial advice / support
- Father to visit housing benefit office re arrears
- Maternal grandmother and mother to visit the Citizens' Advice Bureau / its local equivalent

Comment: The objectives agreed at the above meeting may have been justified but with no means established of monitoring compliance or effectiveness, the event served little purpose. The person recorded as being a 'maternal sister' here (and elsewhere a sister in law) is now believed to be a cousin.

2.1.138 According to its records the mental health clinic wrote to mother and phoned as a result of her previous non attendance However, the individual management review author was unable to locate documentary evidence of either action.

2.1.139 A record of a phone call by the health visitor in mid June 2007 refers to two failed appointments for immunisations though on which dates these may have fallen is unclear. Mother assured the health visitor that she would bring

sister 1 to clinic next day and actually did so. Records indicate a large weight gain for sister 1 which was attributed to sugary biscuits.

Supervision & case transfer

2.1.140 A pivotal supervision session in mid June recorded that the local agency that had provided observed parenting was no longer involved and that Children's Social Care visits had been reduced in number. Allegations of drug use made by the paternal grandmother were deemed to be unfounded. It was acknowledged that at times the home had been untidy but that the constant requests for money had not been an issue for about a month.

2.1.141 The family was noted to have been co-operative and concerns raised at the onset, not to have materialised. A core assessment had been completed and a family group conference held. The social worker was tasked with extracting an update from the health visitor. It was agreed that the case should be (as it subsequently was) transferred to the Community Safeguarding and Intervention team.

Comment: The parents had admitted cannabis use so allegations were clearly not 'unfounded'. The concerns of midwife and other worker seem to have been marginalised or overlooked and there is no confirmation agreed actions emerging from the family group conference were checked for compliance. Given the service provided hitherto by an attentive and cautious social worker, one wonders if the attraction of transferring case accountability to another team outweighed a more balanced risk assessment.

2.1.142 Sister 1 did receive her immunisations during June and July. In late June the parents were informed at a home visit that they would be having a new social worker and following a case transfer meeting, an introductory letter was sent to the family. By this stage sister 1 is, according to health visiting records nearly at the 91st centile for weight

Comment: The relatively large weight of the baby is not something that emerges clearly from agencies' records though it is known to have significant life long consequences.

2.1.143 A student social worker accompanied the Community Safeguarding & Intervention team manager on a first visit to the family and was tasked with updating a case chronology. The student later visited the family at what was to become, three days afterwards 'address 4'. He addressed a variety of practical issues though made no reference to sister 1.

2.1.144 Children's Social Care subsidised the family's transfer to its new address and (it is thought before the family even moved in) a complaint about loud music was lodged with the borough's Environmental Health Service.

Father seriously assaulted

2.1.145 In early August mother reported to her health visitor that she has separated from father. She also indicated that she had relinquished the dog.

Comment: Events next day suggested that the dog/s may never have left and that this may have been a further example of maternal confabulation.

2.1.146 The day after the above contact, mother dialled 999 to report that her 'ex boyfriend' was trying to break in and was armed with a knife. Police attended the flat where a friend of mother's had knocked father out with a spanner. Father was taken to Whipps Cross Hospital and detained for treatment. Both he and mother's friend were arrested and interviewed.

2.1.147 Father admitted damaging the door to gain entry and accepted an 'adult caution' for the offence of causing criminal damage. Mother's friend admitted hitting father but claimed it was in self-defence. This case was considered by the Crown Prosecution Service who advised no further action be taken.

2.1.148 Officers attending noted the room that the baby slept in was virtually empty of furniture and had a bare concrete floor.

2.1.149 Later the same morning the newly allocated social worker from the Community Safeguarding & Intervention team (SW3) was alerted by HV 1 to the incident (and given what is now known to be misinformation about father's transfer to an intensive care unit). In fact father was treated at hospital and discharged next day.

2.1.150 Mother failed in her attempt later that day to be given money by Children's Social Care and was instead advised to contact Women's Aid or a local domestic violence service.

2.1.151 At a home visit as a result of this incident the new social worker was told by mother that she had previously been the victim of physical abuse from father; that the paternal grandfather (paternal grandfather) had used cocaine and that father self harmed. She also alleged that father physically abused the dogs.

Comment: Mother's account revealed dogs [plural] though she had claimed to have got rid of the one that she owned only a day before.

2.1.152 There were no marks observed on sister 1 who appeared comfortable, and was interacting and smiling. Mother admitted that she sometimes smoked marijuana outside to relax but did not do so when in sole care of sister 1.

2.1.153 SW 3 had seen no bruises or received any complaints about domestic violence, nor when she was consulted, had HV1.

Comment: Mother was by then admitting to 'occasional' use of cannabis and to two dogs sharing this 1 bedroom flat.

2.1.154 Children's Social Care tried to organise a strategy meeting. Their attempts were frustrated when numbers for the Police domestic violence unit provided by the Child Abuse Investigation Team officer (who was pre-occupied by the assault on father), were repeatedly not answered. No case notes of the

efforts were located though some notes of further attempts by the deputy team manager were found.

Comment: Reports provided make no reference to this worrying experience being typical then or a current problem so no recommendation has been provided.

2.1.155 At the request of Children's Social Care, police officers undertook on a 'welfare visit' to an address of a friend at which mother stayed following the incident above.

2.1.156 Following a strategy discussion later that day, s.47 enquiries and a new core assessment are triggered.

2.1.157 At an office visit by mother and her friend she is advised to seek a 'non-molestation order'. Mother stated that the worker was making her angry, kicked the desk and began slapping the table with her hand and shouting. The deputy team manager initially left the room and on her return the friend kicked the door and both she and mother followed the manager out of the room yelling, with mother threatening to 'petrol bomb the building'.

Comment: Whilst the response of the deputy team manager defused the immediate situation, mother was able to make such threats with no consequence and the implication of her temper for parenting was not picked up.

2.1.158 In mid August, coinciding with mother's temporary re-location to the home of her friend in another area, health records are transferred to a new Health Centre and a new health visitor HV2 is allocated. On the same day the recently allocated SW3 visited mother and sister 1 at her friend's home and also met the man who had assaulted father whom mother described as her boyfriend. The new relationship proves short lived, though their plans at this time included 'going to Australia for three months'.

2.1.159 The social worker noted that sister 1, who was by implication used to such behaviour, did not react at all to her mother shouting and screaming at the social worker when the need to convene a child protection conference was explained to her.

Comment: The then boyfriend boasted of his involvement with several families and having up to nine children by local women. It is unclear what checks were completed by Children's Social Care.

2.1.160 Following further unsuccessful attempts to arrange a strategy meeting, a date for an initial conference was set for about a week later.

Comment: the deputy team manager's attempts to locate relevant professionals for a strategy meeting revealed that the 16+ team had 'closed the case in February'. It remains unclear what the specific contribution of that service had been. The accuracy of the statement is anyway dubious since later records indicate case closure on a different date.

2.1.161 The rationale for convening a conference included concerns about domestic violence, mother's ability to protect sister 1, drug use and mental health. It also referred to allegations that father was using drugs and 'has self-harmed in front of his daughter including spraying her with his blood'. The origins of the latter suggestions are un-attributed though seem likely to be from mother. The risk level was (reasonably) described as 'high'.

2.1.162 On a date later that month mother having refused to attend the Children's Social Care office, was visited at the address of her friend with whom she was staying, by a duty social worker and a trainee. Sister 1 was seen and no obvious problems noted. Mother's loud and hostile response to the presentation of a written 'working agreement' was such that the Children's Social Care staff felt obliged to leave.

Comment: Again, the significance of mother's characteristic outbursts when challenged, to her parenting capacity seems to have been underestimated.

2.1.163 Two days later, in the late afternoon 'paternal aunt 1' had called Police to express concern for the safety of sister 1. Officers visited the maternal grandmother's home but found no cause for concern. On the same evening, the paternal aunt together with the paternal grandmother contacted Children's Social Care's emergency duty team and made a variety of unspecific allegations about mother's association with violent men and about drug use. The emergency duty team agreed to and presumably did pass this on to the allocated social worker (the paternal grandmother later initiated similar allegations the next month to Haringey's emergency duty team which were passed on to Waltham Forest).

A&E presentation of father

2.1.164 The day before the scheduled conference father arrived via ambulance to A&E following self-infliction of superficial cuts to his wrist and abdomen on. A psychiatric assessment next day by mental health nurses recorded father:

- 'Had been feeling 'paranoid and stressed out; for the past few weeks and was 'unable to get off the 'skunk'[1]; he said he had a constant fear of his girlfriend leaving him and was always accusing her of cheating on him'; they argued constantly since the baby as born and she does not feel safe around him' he pushed her against the wall that day when she told him she was leaving; he then shut himself away in order to cut his wrist and stab himself in the abdomen; his girlfriend had reportedly kicked the door open and called emergency service; he informed us Social Services are involved with the baby'

[1] Traditional 1960s herbal cannabis contained about 2-3 per cent of the active ingredient tetrahydrocannabinol (THC). Skunk varieties may contain 15 or 20 per cent THC and new resin preparations have up to 30 per cent [Professor Robin M Murray Institute of Psychiatry at the Maudsley Hospital London]

2.1.165 Father indicated that he had begun cutting four years ago when depressed because of family problems and being homeless and cuts when he does not have his girlfriend and baby around him and when he cannot get skunk.

2.1.166 Father showed nurses the tops of his legs both of which had multiple fresh cuts and also reported pulling out hair from his armpits and behind his ears.

2.1.167 Father further reported poor sleep and nightmares since a friend was shot and died in his arms in 2005. He admitted to smoking seven to eight spliffs of skunk a day and had been smoking since the age of twelve. He admitted also to using ecstasy, speed and cocaine in the past but stopped the latter because it was too expensive. He also described drinking a bottle of spirits or a crate of twenty four cans of beer every other day starting at eleven in the morning or noon.

2.1.168 Other personal medical information was captured and father was discharged with some short term palliative medication and a recommendation that he seek help from the Community Drug and Alcohol Team with whom the examining nurses immediately liaised by phone and in writing.

Comment: Father failed to respond to the help available from this drug and alcohol team and the above account provides a graphic description of a man with significant and very expensive individual difficulties, some of which would inevitably impact upon parenting performance.

Second initial child protection conference

2.1.169 The unanimously supported conference decision was that sister 1 be made subject of a child protection plan for 'emotional abuse' and the outline plan:

- Regular monitoring by the health visitor.
- Mother to protect sister 1 from exposure to domestic violence
- Domestic violence support to be offered to mother
- Family support to improve parenting to be offered to mother
- Core assessment to be completed to include risk assessment of mother's new boyfriend
- A risk assessment of father
- Parents to seek legal advice re contact
- Adult social work services to be offered to mother
- Mother to advise Children's Social Care of any change in circumstances
- A family group conference to be considered
- Sister 1 not to be left in care of adults other than mother / maternal grandmother
- Social worker to assist with housing
- Social worker to inform the relevant local authority that sister 1 is now subject of a protection plan [presumably a reference to her temporary stay in another area]

Comment: Only the maternal family was represented and issues and perspectives considered were limited by that. Plans were based on what turned out to be a very temporary absence of father and transient involvement of mother's new boyfriend.

2.1.170 A week later when a duty social worker was dispatched to complete a home visit at address 4, sister 1 appeared physically well, clean and in appropriate clothing. The home was described as clean and tidy and mother as sad and withdrawn. Mother reported that was currently living between her own and the maternal grandmother's address. She also indicated that her relationship with the new boyfriend was over though had had no further contact with sister 1's father or his family.

2.1.171 Mother refused to sign the working agreement which the social worker read out to her though why was not recorded.

Comment: It was less than a week since mother had presumably agreed to the outline plan at the conference so her refusal did not augur well. A retrospective examination of records suggests that both parents were back at address 4 by then and possibly even a few days earlier when Police called there and noted [unnamed] occupants shouting at dogs]. Hence mother may have been economical with the truth when she denied during this social worker's visit, any contact with father.

Complaint about mistreatment of dog/s

2.1.172 In early September Environmental Health received a complaint that dogs were being locked out on the balcony of address 4 and beaten.

Comment: Though the details of this event are few, the correlation between abuse of animals and children is picked up later in this report.

Allegation of assault by paternal aunt

2.1.173 In mid September 'Paternal aunt 1' alleged that her brother was high on skunk and had assaulted her. After investigation, the Crown Prosecution Service advised Police that that there was insufficient evidence to prosecute and no further action followed.

2.1.174 When the deputy team manager 1 undertook a home visit next day and met both parents, there is no indication he explored the meaning to them or the implication to their child of the reconciliation e.g. to what extent if any, were mother's descriptions of domestic violence accurate?

2.1.175 Supervision of deputy team manager 1 on the same day as the above visit correctly identified the need to explore drinking and cannabis use though did not explicitly refer to cocaine or the allegation of father's self harm in front of the baby.

Comment: The requirement that a revised working agreement is drawn up, that a family group conference is convened confuse process with action. The first such conference added nothing to the safeguards for sister 1 and (even if parents signed it) they had shown little ability to comply with agreements so far reached.

2.1.176 At a home visit a week later mother was admitting to the use of marijuana though at this stage father was denying it. Both agree to testing though this was never achieved.

Comment: Avoidance of testing for various drugs was achieved by a mixture of parental 'disguised compliance' (about which more is said later) coupled with exploitation of organisational inefficiency.

2.1.177 At this visit, mother stated she had lied about father and was now afraid of her recent boyfriend. It may be that the report she made to the Police later that day of harassment by an ' boyfriend' referred to that man (the Police are clear that it was *not* about father) but she failed to follow it up so her report led to no further action.

2.1.178 Mother's wholly unnecessary refusal to provide her changed address to the health visitor from the other area, who had sought it was a typical example of her oppositional conduct.

Core group 1

2.1.179 For reasons that remain unexplained, the first scheduled core group on was aborted, possibly because health staff in the other area had not seen the child at that point. It would appear anyway that Children's Social Care then failed to inform the local health visiting service that the family was back in the borough and at address 4.

2.1.180 A core group was eventually held on some five weeks after the conference and father with sister 1 (but not mother) was in attendance. A curious reference to 'father to seek a Residence Order' leaves unclear whether this was a statement of intent from father or advice from an unspecified professional. Nor, unless he was contemplating a separation from mother, is it clear why such an order would be of any advantage (the issue was though discussed again with both parents at a later home visit). Social work visits were reaffirmed as weekly by the core group members.

Comment: As highlighted in the Children's Social Care individual management review, this first core group was significantly delayed.

2.1.181 Notes of supervision of the allocated SW3 by the deputy team manager suggest that there was a recognition of the damaging impact of parental discord and a belief that updating the core assessment and referring mother via her GP to Adult Services would (in an unspecified manner) help.

Dilution of child protection plan

2.1.182 At a visit in early April what had been seen as an important element of the protection plan (drug testing) has become something that parents were 'advised to see their GPs about'.

Comment: Predictably, neither parent sought drug testing nor was the follow up at the review conference sufficiently rigorous to recognise and take action about this avoidant conduct.

2.1.183 At a home visit in mid October mother, after a lot of angry shouting (reportedly ignored by sister 1) agreed to a re-evaluation by the mental health team of her mental health status.

2.1.184 An incident a few days later in which mother suffered a bruised foot was subsequently described by her as 'the worst A&E had ever seen'.

Comment: Though in itself unimportant (e.g. there was no suggestion this was a function of domestic abuse) mother's exaggeration was illustrative of a tendency seen later when she considered sister 1's minor motor difficulties to be more serious than they were considered by relevant professionals.

2.1.185 At the home visit on the same day as mother's presentation to A&E the SW3 completed her risk assessment of father and concluded that 'he has been seen with sister 1 on multiple occasions and there are no concerns about his ability to care for his daughter. It is the opinion of Children's Social Care at present that father is fully capable of caring and providing for his daughter'.

Comment: Though his immediate and physical care of sister 1 indicated nothing of concern, it is uncertain whether this 'risk assessment' actually explored or challenged father about his alleged and at times acknowledged alcohol and drug misuse, self-harm or (previously alleged by others) domestic violence?

2.1.186 By the end of October 2007 SW3 in a letter to parents providing a schedule of future visits, indicated that due to noted improvement visits will be reduced to three weekly, announced and unannounced

Comment: It is unclear by whom this was authorised or what justified it. Mother's mental health had not been re-assessed; there had been no drug testing and a number of appointments had been failed.

Core group 2

2.1.187 Sister 1 was by the date of the second core group meeting in mid October on the 91st centile for weight but was otherwise thriving. Father was undertaking the majority of care for the couple's daughter.

2.1.188 About a week after the core group Police were called to an argument (it appears about money) between mother and the maternal grandmother. Sister 1 was reportedly undisturbed and the maternal grandmother had left by the time officers arrived.

Comment: At interview with the author and health colleague, the maternal grandmother confirmed that the parents have always sought and continue to seek money from her as well as from Children's Social Care and other agencies. The presumption of the author is that it has been required for purchase of alcohol and skunk (£10 per spliff is understood to be the local market price)

First review child protection conference

2.1.189 At the review conference in early November, mother claimed that she had only just received the minutes of the initial conference which (if true) would have represented an unacceptable two month delay.

Comment: More credible accounts from partner agencies of failures with respect to circulation of such minutes are referred to elsewhere.

2.1.190 The reports to this conference identify ongoing risk but overlooked father's self harm, drug use and the still unresolved issue of domestic violence.

2.1.191 'Weekly visits' are cited not 'three weekly' as per the social worker's letter of late October. The conference is informed that parents have 'refused drug and alcohol assessment' though no record of refusal has been found, just a (probably calculated) failure to comply.

2.1.192 A cautious and appropriate decision to maintain sister 1's child protection plan under the category of emotional abuse was made.

2.1.193 A core assessment was said to be in need of completion though it *had* been completed according to records. An update might have been a more precise description of the required task.

2.1.194 Other actions in outline plan repeated previous unfulfilled objectives e.g.

- Parents to undertake substance misuse assessment
- Mother to follow up mental health need
- Parents to sign written agreement
- Family group conference to be convened

2.1.195 Some objectives were new:

- Health visitor to refer sister 1 to Child & Family Consultation Service
- Mother to be referred to Parent & Infant Mental Health Assessment for assessment [it is unclear how this differs from 'mother to follow up mental health need']
- Support sister 1 to attend parent and baby activities
- Parents to be given a written account of concerns

2.1.196 Other recorded objectives e.g. for the health visitor to monitor sister 1's health appear self evident or 'extended family to support the protection plan' no more than aspirational.

Comment: These plans remained process not needs-driven.

Core group 3

2.1.197 A third meeting was scheduled but parents failed to attend leaving the health visitor and social worker to exchange recent and unremarkable observations of the family.

2.1.198 At a visit by father to the GP in mid November 2007 he reported that he had had no further fits, was off alcohol and skunk was now sorted. It is unclear when he had experienced 'fits' or what 'skunk sorted' meant.

2.1.199 Parents were out for a planned Children's Social Care visit in late November so the home had not at that point been seen by the social worker for six weeks. Police had attended the property on a date in late October but officers had not entered it. The health visitor with an outreach worker did see the flat in late November and recorded no adverse comments about its appearance. Mother agreed to a referral to the peri-natal mental health service, though predictably failed to use the service offered.

2.1.200 The next time the social worker accessed the flat was some eight weeks since her previous visit.

Comment: It is a matter of speculation whether the parents reduced by manipulation the level of oversight or whether it was a matter of organisational inefficiency.

2.1.201 By the end of November father having failed to attend either of two drug and alcohol appointments, was discharged from that service, thus leaving unresolved the issue of his level of misuse and of which drugs.

Presentation of sister 1 to A&E

2.1.202 In the early evening of a day some two weeks later mother brought sister 1 to the North Middlesex Hospital A&E. complaining that her daughter had had 'a cough and flu for three days'. Staff noted that sister 1 was not in distress and was playful.

2.1.203 Sister 1 was diagnosed as having an upper respiratory tract infection and was prescribed antibiotics and analgesia. Mother was reassured and her daughter discharged home with her.

Comment: Presumably the commendable check on 'register status' which proved negative was because it covered only children in the local borough i.e. Enfield. This experience reinforces the need to develop a cross borough system for identifying those who are subject of a child protection plan of any London borough and a recommendation has been added to the others emerging from this case review.

2.1.204 Mother next day relayed the misinformation to her social worker that sister 1 was diagnosed with tonsillitis and bronchitis. At this encounter, the parents explicitly declined to be tested for misuse of drugs.

Comment: Prior to this, their resistance has been passive, i.e. agreeing then just not seeking testing.

Need for legal advice ?

2.1.205 A planned visit to the home was postponed when mother convinced the social worker that her daughter was still unwell. Mother undertook to take sister 1 to the GP next day but there is nothing in the GP records supplied to confirm that she did, nor anything in Children's Social Care records to indicate that her so doing, was checked.

2.1.206 At a supervision session in late December 2007 The deputy team manager and SW3 recognised that parents were non compliant about key aspects of the protection plan. It was agreed that a letter indicating those concerns was to be sent with reference to legal action if there is no improvement.

2.1.207 The agreed letter was sent next day, it is thought *after* an uneventful home visit at which a (to the social worker's mind) healthy looking sister 1 was described by mother as 'still having bronchitis'.

2.1.208 An opportunistic home visit was completed in early January 2008 and from the record of it by the social worker, it would appear that she learned for the first time and from mother of her historical diagnosis of a 'personality disorder'.

Comment: This may mean that the allocated worker did not read available background information when accepting the case.

2.1.209 In early January the social worker provided the family with her schedule of visits through to the review conference.

Comment: The value of unannounced visits should have been apparent and material supplied does not make it clear whether they continued in addition to planned visits.

2.1.210 When visited in mid January 2008 mother asserted that they had attended Whipps Cross Hospital (though 'could not recall exact date') because of sister 1's conjunctivitis and bronchitis. She indicated they were not impressed with the service received and that sister 1 was given eye drops and Amoxycillin. Hospital records do not confirm any such presentation.

2.1.211 The social worker's notes indicate that mother had by this time missed her first peri-natal mental health appointment (a reference in her core assessment confirmed the date but that mother cited her toddler's 'bronchitis' as an excuse for not going out to attend. Mother certainly did fail to attend a second appointment and the service closed her case a few days later.

Comment: It should be recalled that sister 1 had not been diagnosed with bronchitis prior to Xmas; that even if she had she was likely to have recovered by the time of this visit and even if she had not done so, mother had a mobile phone from which she could have alerted the psychologist to her non attendance.

Core group 3

2.1.212 In mid January the core group meeting was attended only by parents and social worker and, although the lack of compliance with the plan was noted, the prospect of legal action as implied by the letter sent before Xmas seems to have disappeared. Mother was asserting sister 1 still had bronchitis which (if true) would have been serious.

Comment: In reflecting on why the parental perception of illness / events was not more effectively challenged, it may be that the social worker was 'acclimatising' to mother's exaggerated perceptions and in so doing losing some objectivity.

2.1.213 The account of the 'completed core assessment' is at odds with levels of concern and contains some phrases that had been written (more clearly) by the previous SW1 from the First Response Team as well as some unhelpful jargon e.g. 'parents needed empowering'.

2.1.214 By late January the parents finally sign a 'working agreement' though do not thereafter abide by it e.g. by early February mother is declining to attend the peri-natal mental health service. Mother also offered an implausible excuse about her failure to be seen at the mental health service

Comment: Mother's disguised compliance was proving successful and her excuse about attendance was not checked out.

2.1.215 The next recorded supervision session was in some respects a re-run of its predecessor in late December i.e. alerting parents to the possibility of legal action if they did not comply with the child protection plan, but inexplicably referring to case closure once respective grandmothers had been alerted to the failure of mother and father to co-operate in drug testing.

Core group 4

2.1.216 A fourth meeting was convened in early March 2008 and parents, maternal grandmother, health visitor (according to her notes though not Children's Social Care's) and social worker attended.

2.1.217 It is difficult to reconcile the positive picture implied by the following record with the early warnings sent of legal action (itself *justified* by parental non compliance with the protection plan):

- 'Parents have been generally cooperative
- Flat been generally OK
- No recent police reports
- Sister 1 is generally in good health
- Maternal grandmother says sees child nearly every day; feels mother has significantly improved
- Parents feel things are going well
- Parents have not accessed playgroup

- Mother wants to quit smoking cigarettes and marijuana
- Drug testing outstanding; parents state attended a named drugs project but were informed testing can only be done if under court order
- Mother states she attended the peri-natal mental health service; they have lost her records from aged fourteen +; have records from seven to fourteen though; mother feels her mental health is stable - doesn't want any further assistance'

Comment: In reflecting upon why there is such a contrast, it may be that the optimism apparent here is influenced by the engagement only of the maternal grandmother who has a good relationship with the parents, ignoring concerns raised by the paternal grandmother and overlooking parental failure to comply with the child protection plan - unfulfilled elements of which had been made explicit at the previous review conference.

2.1.218 Sister 1 (having been weighed on the day of the core group) was known to be on 99th centile. Obesity alone should have been a source of concern and raised questions about the parents' knowledge of and/or interest in their daughter's health needs.

2.1.219 There are no records to indicate that parental assertions about a need for a court order or indeed the visit to the drugs project were checked out.

2.1.220 Parents continued to fail to comply with key aspects of the protection plan. At the health visitor's supervision in early March, it was agreed the proportion of 'did not attends' at health appointments should be monitored so as to inform the child protection review conference in April. In contrast and only a month later, the Children's Social Care supervisor and social worker were debating the possibility of recommending sister 1 no longer needed a protection plan.

Mother's self presentation for psychiatric help

2.1.221 The day after the fourth core group, mother self presented to the mental health service requesting help with (unexplained) 'protection Issues'. She claimed (inaccurately) that she had not been offered a follow-up appt. since seeing psych. 6 in April 2007**.**

2.1.222 It would appear as though mother then failed to attend an urgent appointment offered her for**.** Father also failed that day to attend his appointment with a neurologist (a follow up to his assault in August 2007 or a road traffic accident according to which source of information is employed), and also failed to turn up for a further appointment in mid May 2008.

Second review child protection conference

2.1.223 In early April 2008 with a different independent chairperson and on the recommendation of Children's Social Care and allocated health visitor, sister 1 was made subject of a 'child in need' rather than child protection' plan.

2.1.224 The health visitor noted that mother had not engaged with the peri-natal mental health service or attended toddler group with her daughter. Otherwise sister 1 was reported to be developing age appropriately and parents were confident and working well as a team. Her report included the words …'I do not have any child protection concerns'.

2.1.225 The summary by the conference chairperson suggested that a sense of volatility seems to have settled down; that parents were working well with professionals although have chosen not to engage with certain services. Parents were congratulated.

Comment: A more objective view is that the parents simply ignored those aspects of the child protection plan that did not suit them; that over time the professional network acclimatised and reframed the resistance as 'parental choice'. The implications of failing to recognise the disguised compliance was that it would be sustained and continue to have damaging consequences for sister 1 and future children.

2.1.226 The child in need plan that was then introduced contained the following elements:

- 'Child in need' meeting within next three weeks, then after further three months
- Social worker to visit three times within next three months, minimum six weekly
- Sister 1 to be seen by health
- Parents to attend baby groups
- Mother to visit her GP if she feels low to request referral for mental health assessment
- Parents not to care for sister 1 if drinking or taking drugs
- Extended family to offer support

Comment: A summary of the likely results of this 'child in need' plan would be 'no change'. It contained no incentive for mother and father to reconsider their failure to date to seek mental health / drug related treatment and was naïve in accepting assurances that if the parents were to use drugs / alcohol, they would ensure sister 1 had an alternative carer.

Child in need plan & case closure

2.1.227 Within only a day of the review conference, mother failed to bring sister 1 to an appointment with an orthoptist to assess a potential squint. A letter subsequently sent by that orthoptist and dated late May indicated that mother had by then failed four appointments.

2.1.228 Mother also failed to attend for her own mental health appointment on mid April.

Comments made to police officers when they were called by mother to a verbal altercation with a neighbour, indicate that she (and it is supposed father) had been

living with the maternal grandmother for some months. It is unclear from records if agencies had been aware of this or whether mother returned to her flat only when professionals made an announced visit.

2.1.229 A child in need review was held in mid June 2008 though records fail to clarify who was in attendance. Output notes portray a positive picture of progress.

2.1.230 When in late June mother registered with a new GP9 her new patient screening suggested she smoked twenty cigarettes a day as well as cannabis twice daily. Mother indicated that she was teetotal and took no exercise. Sister 1 was also registered with this GP Practice at some point in this period.

2.1.231 At this time, mother was in dispute with the housing provider about repairs and rent arrears and was often rude and aggressive to staff either in person or on the phone.

2.1.232 During a supervision session of the health visitor in early July the possibility of moving from the 'enhanced' to the 'universal' level of service delivery was contemplated, indicating a diminution in the levels of concern. HV2 actually expressed the view to the allocated social worker on at this time that Community Safeguarding and Intervention involvement was no longer required and in mid July received a phone call presumed to be from the same social worker to indicate the case was indeed to be closed.

2.1.233 The requirement to monitor 'did not attends' may have been overlooked. Mother had not brought her daughter for immunisations at the beginning of July and on the very day the case was closed by Children's Social Care failed to bring sister 1 to an appointment with the GP.

Further allegation of abuse of sister 1

2.1.234 Ten days after case closure a referral was received by Children's Social Care from a (named) neighbour of address 4. The referrer raised concerns about sister 1. She said she had observed the parents swearing and screaming at the baby and the couple arguing. They had also sworn at the neighbours and the referrer claimed she had seen father kick the dogs and also seen mother bite sister 1's arm.

2.1.235 No record has been found of an immediate response to this worrying set of allegations. Four days later, with no indication of management advice or oversight, a SW4 did undertake a home visit with the declared aim of completing an initial assessment.

2.1.236 At the social worker's visit, she shared the allegations with father who denied all except that he had kicked one of the dogs. The final draft of the Children's Social Care individual management review offered a worrying quote from the referrer i.e. 'when mother screams at the toddler she bites her arms'. Neither mother nor, (critically) sister 1 were seen and no explanation was recorded about their whereabouts or when the social worker could see them.

Comment: Even though this initial assessment was completed within time scales, in overall terms, it was a belated and poorly planned response which should have prompted enquiries under s.47 and a medical examination.

Pregnancy 2

2.1.237 By mid August mother thought she might be pregnant but a test undertaken at the GP was negative. A subsequent test at Whipps Cross Hospital toward the end of the month proved positive. In fact SW3 had undertaken a visit the day before and been told that mother was expecting a second child.

2.1.238 In early September at a consultation with GP 9 mother acknowledged that previously her mother (child B's grandmother) and now her partner bears the brunt of her outbursts and made no reference to being a victim of abuse.

Comment: Mother had tended to be more open with medical staff than others e.g. acknowledging drug misuse which adds credibility to these assertions.

2.1.239 At a subsequent consultation this time with GP10 in mid September to smoking three joints daily as well as still smoking seven cigarettes. The doctor noted that 'mother very wary of social services'. Mother acknowledged on this occasion, her tendency to aggression but 'only toward her partner'.

Comment: Three spliffs per day is more than the two admitted to in late May.

2.1.240 An initial booking letter received at Whipps Cross Hospital Maternity Unit from mother's GP11 requested a midwife to contact mother about her pregnancy. This letter was marked as urgent for an early booking as mother had a psychiatric history of depression, aggression, behavioural disorder, and overdoses as a teenager. Mother's estimated date of delivery at this stage was mid April 2009.

2.1.241 GP 11 also made telephone contact with the Mental Health Access team requesting assessment / urgent support for mother and discussed issues with the (unnamed) person with whom he spoke.

Comment: GP 11 was alert to the significance (beyond medical) of mother's second pregnancy.

2.1.242 The initial booking letter additionally noted that mother had been using cannabis daily, but stated (contrary to her statement to GP10 in mid September) that she had stopped.

Comment: It is difficult to reconcile 'three spliffs a day' as recorded by GP 10 earlier in the month with his initial booking letter.

2.1.243 Only two days after mother's consultation with her GP she was phoned by the Mental Health Access service and offered an appointment in early October which (predictably) she failed to attend.

2.1.244 Later in September mother was seen by the named midwife who took a comprehensive medical and social history. Mother's account was reasonably accurate (though included 'borderline schizophrenic) and she confirmed that she was taking specified doses of two legal drugs daily (presumed to be prescribed by a GP).

2.1.245 When asked about alcohol and illegal substance mis-use, mother claimed she did not take any drugs or drink. Curiously, when asked about mental health status she stated she had 'no history of mental health problems'.

Comment: Mother's readiness to apply labels such as schizophrenic (indeed 'split personality when seen by the overview author) is at odds with her contention that she had no mental health history.

2.1.246 Mother was informed by midwife 4 that she was 'on the Vulnerable Family Criteria' and that Children's Social Care would be contacted, as well as the health visitor. Mother verbally agreed to this.

Comment: At interview midwife 4 acknowledged that she intended but failed to alert Children's Social Care at this point. She did alert Children's Social Care and the relevant health visitor by phone in mid October.

2.1.247 An opportunistic visit by the health visitor in late September had revealed the flat to be 'sparsely furnished and unkempt'. Next day the parents again failed to bring sister 1 for her immunisations.

2.1.248 In mid October an officer from Ascham Housing described an 'abusive' mother whilst making a visit. It was not noted whether a child was present.

2.1.249 A meeting was held in late October with the named midwife 4 at Whipps Cross Hospital SW3 and the 'midwifery advisor for safeguarding'. This *may* have been regarded as a child in need review meeting. No records have been made available but it is understood that the social worker confirmed that the case was closed.

2.1.250 On a date in late October, the health visitor received a letter from Children's Social Care to confirm that the case had been closed.

Comment: Presumably the case having been closed in July, had been re-opened whilst the new allegations were 'investigated' in late July and was now (at a very inopportune time) being closed again. No record of management support for this decision was found.

2.1.251 Although she had mentioned to her midwife in mid November that she had an appointment later that month with psych.5, mother failed to attend it and was subsequently discharged from that service.

2.1.252 At the beginning of December the health visitor was informed that sister 1 had not been at her play group for several weeks. There is no indication that this information was relayed to Children's Social Care.

2.1.253 During the first two weeks of December 2008 Environmental Health received complaints about dogs at the home address being mistreated. These were followed by a call from mother when she asked about a 'Staff x Mastiff' cross (a further referral in January 2009 petered out when the complainant could not be contacted).

Comment: The breed and temperament of other dogs seen had never been definitely recorded; but without regard to its breed, a one bedroom second storey flat with children was unsuitable.

Further allegation of abuse of sister 1

2.1.254 During the second week of December 2008 Children's Social Care received an anonymous referral stating that the caller was very concerned about sister 1 'she is smacked and beaten regularly by her mother; seen last Friday, dragging her daughter by the arm and yelling at her, swearing'.

2.1.255 A strategy discussion was initiated and it was agreed that the allegations satisfied s.47 Children Act 1989 criteria and that a core assessment would be initiated. The social worker would visit and feedback to the Police if there were any concerns.

2.1.256 Police had completed checks and found no new entries on their system. A MERLIN record referred to a previous malicious allegation in August but the individual management review author could find no trace of it in any other Police record and concluded that it might have come from the strategy discussion with Children's Social Care by the child abuse investigation team. A 'working agreement' was to be drawn up with parents and grandparents.

Comment: It is hard to see on what basis another 'working agreement' would safeguard sister 1.

2.1.257 There is no confirmation of any medical examination of sister 1 or that the parents were promptly informed of the allegations and allowed an opportunity to respond or of a substantive investigation.

2.1.258 The need to investigate properly may have been further undermined when a member of staff who wished to remain anonymous indicated that she had chanced to see sister 1 interact with the parents, apparently without fear.

Comment: Aside from the principle that a professional should openly acknowledge and be accountable for her/his view, this observation does not address, far less resolve, the question of whether sister 1 had been physically abused as alleged.

2.1.259 At a home visit the day after the allegation was received, sister 1 was seen running around in knickers and a T-shirt and no marks or bruises were visible, nor were signs of fear observed. The child was laughing, playing and smiling with parents and the flat was clean and adequate. The parents asserted that they were not using drugs at all and mother claimed to have been pretty stable with her mental health and to be feeling quite good.

2.1.260 Parents felt the referral was malicious and because sister 1 appeared to be thriving, the allegations were deemed to be unsubstantiated.

2.1.261 The health visitor's response to the social worker's enquiry that day was 'that she had not seen the family since September and that sister 1 no longer attended the Children's Centre' offered no reassurances.

Comment: The allegation may have been malicious but some direct interaction with sister 1, a medical examination and more challenge about the parents' claim to be drug free and exploration about how they controlled their daughter would have added credibility to the conclusion.

2.1.262 The social worker sought the paternal grandmother's views as well and was reassured by her statement that she saw sister 1 most days and 'trusted her son' (father). Her views of mother were either not sought or not recorded.

2.1.263 On the basis of what the social worker was told by family members, a core assessment was completed within a further day with the conclusion that no further action was required.

Pregnancy with sister 2

2.1.264 Two days after the conclusion of the core assessment, mother attended Whipps Cross Hospital for an ultrasound scan, but failed to attend a consultant's appointment. A new appointment was sent out as per Trust policy and it appears that mother did on that occasion, attend.

2.1.265 Mother also failed to attend a growth scan in mid January 2009 and next day, the social worker having completed a comprehensive closing summary, effectively left the monitoring of sister 1 and the as yet unborn sister 2 to the health services.

2.1.266 In early February 2009 the midwife contacted the allocated health visitor to inform her mother had been transferred to Whipps Cross Hospital due to her 'small for dates' status. The midwife passed on the fact mother had missed her appointment with the midwife today and she would check on attendance at hospital. She was able to report sister 1 appeared well cared for.

Comment: Possible reasons for a 'small for date' condition included smoking or poor nutrition.

2.1.267 In the second week of February mother again failed to attend for a community midwifery appointment; sister 1 was not brought to an appointment with GP 11 nor in mid February to her two year developmental check with the health visitor.

2.1.268 In early March mother failed to attend a booked ultra-sound scan and four days later her ante-natal appointment at Whipps Cross Hospital.

Birth of sister 2 & further referral/s

2.1.269 During the second week of March mother was admitted to the hospital for induction of labour and next day gave birth to sister 2 following an emergency Caesarean performed for 'failure to progress'. A live baby girl was delivered in good condition.

2.1.270 Ward staff observed mother appeared 'a little strange' and commendably contacted Children's Social Care's emergency duty team. The advice given was to contact the duty psychiatrist or initiate a child protection referral.

2.1.271 Emergency duty team staff checked next day and were informed that mother and baby had been discharged without consultation with a psychiatrist. An exchange some days later suggests that mother may have been agitated since father was reported 'to have calmed her down when … …she became more co-operative and compliant'.

Comment: It is presumed initial concerns about mother's presentation reduced, but by whom the decision not to consult a psychiatrist was made remains unknown.

2.1.272 Some confusion in either or both the emergency duty team and the ward existed because the former made a further enquiry the following day and, although mother and baby had been discharged the day before the caller was assured the ward staff were aware of mother's mental health history and *would* monitor her closely. Individual management reviews cast no light on this miscommunication.

2.1.273 Three days after birth of sister 2 an unnamed person described as a family friend rang Children's Social Care to 'check if her call re this family is being dealt with?' Children's Social Care individual management review makes no reference to this call and it is uncertain what the concerns had been, what response they elicited or whether the caller was offered any feedback.

2.1.274 The ward's original contact had been regarded as a formal referral and was passed to the First Response Team and allocated to a SW5 who was based at the hospital.

2.1.275 SW5 completed her initial assessment on sister 2 just outside of the then required timescales and sensibly recommended a core assessment which she duly completed in July, again outside of the required number of days.

2.1.276 The core assessment was sensitively written and some limited effort had been made by the social worker to seek from parents their experiences as children and young people.

Comment: The social worker did not seek advice or information from mental health or medical sources though did liaise with the health visitor and took mother at her word with respect to diagnosis and treatment received or to be sought. The assessment reflected tensions in the parents' relationship but not that (according to mother's comment in May to the GP) she and father had separated and that there was a new sexual partner or that mother suffered post natal depression after sister 2 was born.

2.1.277 During this period (mid April 2009 was the first occasion) mother presented sister 1 to the GP and complained that she had intermittent mobility difficulties and pain in her right leg. The child pointed to her left leg when the doctor asked about pain. On examination nothing of concern was seen. At a home visit by health visitor at the end of April, parents stated it was sister 1's left leg that kept collapsing.

2.1.278 HV2 noted at a visit in April that sister 2 was on 0.4th centile and that there is a dog present (it seems probable that the or anyway a dog was always part of the family).

2.1.279 The case was handed over from midwife 4 to HV2 in early May 2009 at which time mother was unable to locate and return the midwife's notes.

2.1.280 In mid May 2009 whilst undertaking a home visit HV 2 arranged for mother to bring sister 2 to the GP later that day for an examination and for registration. The absence of any record of that planned consultation indicates that this was another 'did not attend'.

2.1.281 Mother re-presented sister 1 in late May to the GP. Because of mother's assertion that her daughter's gait was wrong, that her use of speech was delayed and that the child was biting herself and others GP12 initiated a precautionary referral to the relevant child development centre.

Comment: Mother may have been acting in good faith, exaggerating symptoms for attention/ sympathy and/or anticipating a need to explain any future bite marks or injuries. Given the complex background the referral was a sensible response.

2.1.282 By the beginning of June HV 2 in making a referral to the Children's Centre referred to mother's 'post natal depression'. Some material help was provided and funding sought and later obtained for sister 1 to attend a day nursery part time.

2.1.283 A GP consultation later in June recorded (so it is presumed diagnosed) that mother had post natal depression but 'has bonded well with baby who is well cared for PHQ 9 score 27 no acute suicidal identification; single parent 2002 schizophrenia diagnosis; referred CMHT November 20th but defaulted; having weekly visits from HV and Social Services involved'.

Comment: 27 is the maximum score of the PHQ 9 instrument. Mis-diagnosis of schizophrenia was persistent (possibly because mother often referred to it). Why the GP thought the health visitor was visiting weekly (her plan was fortnightly) is uncertain.

2.1.284 During the second week of June 2009 the Perinatal Mental Health Service received a referral from GP4 that cited mother's post natal depression. When a week later the referral was considered, the need to liaise with the relevant adult mental health psychiatrist was recognised and by the end of June it was established that she was still nominally a patient of psych.4.

2.1.285 When Police contacted mother in mid June as a result of apparently false allegations by paternal sister 1 that mother was being harassed via texts by father, officers were told she and father were now back together. This information was unknown to Children's Social Care. In supervision next day outstanding tasks still reflected parental separation i.e. 'core assessment to be completed looking at mother's care; written agreement needs to be undertaken setting out issues for contact, finances and following parental separation'.

2.1.286 Unknown to either Children's Social Care or health visitors, a further complaint about noise was received in late June. It also emerged at a visit by the health visitor, sister 2 was being fed rice and was advised 'not to increase the amount'.

Comment: The premature use of solids was also a feature of the care of sister 1. The accepted best practice is 'not before 4-6 months'.

2.1.287 Police were re-involved in late June when mother reported text harassment by father from whom she was again separated. Father accepted a formal warning.

Alleged domestic abuse

2.1.288 After an apparent reconciliation with father in early / mid June followed by further arguments and subsequent harassment by texting later that month, it is thought father was not living at address 1 in early July when the front door was damaged in what Police regarded as an attempted burglary.

2.1.289 Mother, at this time living with the maternal grandmother suggested to officers than father was responsible for the damage but in the absence of corroborating evidence, that possibility was not further explored.

2.1.290 Mother, on the basis of 'fleeing domestic violence' approached Ascham Housing in early July to be advised she could approach other boroughs. Subsequent contact with the Homeless Persons Unit suggested mother had left the borough in May and was living in a location outside of London.

Comment: This curious information might (as mother claimed) have been the result of identity fraud. Indications from local agencies were that mother and children really were living in Waltham Forest. Given the uncertainty, Ascham should have assisted mother to overcome this obstacle to her being offered temporary accommodation.

2.1.291 Regrettably, mother's aggressive responses at the Housing office caused a glass door to shatter. Police were informed but concluded there was insufficient evidence for purposes of charging. Mother was placed on Ascham Housing's list of 'aggressive customers'.

Comment: The implications of observed aggression for her children were overlooked by housing and police officers and no contact made with Children's Social Care.

Referral to Children's Social Care by paternal grandmother

2.1.292 The day before the core assessment was completed a further referral was received. The paternal grandmother reported 'mother's behaviour is erratic; she is not on medication or in receipt of any mental health services; parents recently separated; last week mother seen slapping sister 1 round the face outside the Job Centre'. The referrer reported that was a frequent occurrence coupled with abusive language and mother once bit sister 1 on the arm. The grandmother was concerned about mother's smoking cannabis in front of the children and felt the children were suffering. She has not been allowed to see them and wants the social worker to visit urgently.

2.1.293 SW5 made an unannounced home visit on the same day and saw mother, father (who claimed just to be visiting) and both children. Mother denied all the allegations. The social worker noted that the home was 'in some disarray'. Sister 2 appeared well, alert and responsive, was playing with toys and appropriately dressed.

2.1.294 No medical or other checks were completed and the social worker advised mother to contact psych.7 whilst she would contact the peri-natal mental health service.

Comment: These allegations should have been taken more seriously. There is nothing to suggest that the grandmother was offered any feedback. The visit made no impact on commitment to the children's health since next day mother again failed to take sister 2 for her immunisations.

2.1.295 In mid July 2009 at the conclusion of the assessment begun in April, SW5 recommended the provision of 'child in need services', though did not specify what they should be. By this stage sister 2 was gaining weight and reportedly developing normally but parents had split up [at least twice] and mother had briefly gone to live with her mother. She was back home by early June when seen there with both maternal and paternal grandmothers.

2.1.296 At a discussion between team manager 1 and SW5 the following steps (most tried before) were agreed:

- Arrange a child in need meeting
- Refer to the Children's Centre for parenting support.
- Written agreement with both parents
- Referral for a family group conference
- Follow up with perinatal mental health
- Follow up sister 1's attendance at playgroup / nursery
- Follow up child in need review three months - if no change then child protection procedures will be implemented.

Comment: This was the first plan to include a contingency position but, like others that followed it, when parents failed to comply, the contingency option was not triggered. It is not clear whether the fact there had already been a family group conference and 'working agreements' was known to these staff.

2.1.297 A child in need review meeting was indeed convened in early August and was attended by mother, maternal grandmother, social worker and health visitor. A child in need plan was completed.

2.1.298 Prior to the child in need meeting, it was apparent that although the parents seemed to be reunited, tensions with the paternal grandmother were running high e.g. in late July, the outreach worker reported mother's assertion she could not enter the area in which the Children's' Centre was located because of an injunction (presumed to have been initiated by the paternal grandmother) forbidding her from so doing.

2.1.299 Similarly, in early August, the paternal grandmother phoned to tell the SW5 that she had received a summons to attend court in September for harassment of mother and treatment of her granddaughters. It is not known what the outcome of these proceedings may have been, though the grandmother became re-involved in the family at a later date thus suggesting a level of reconciliation.

2.1.300 A suggestion by the health visitor at a home visit in July that sister 2 be taken to the GP because of her sticky eye was ignored by the parents and the missed appointment next day with a GP offered yet another example of failure to award priority to the children's health.

Sister 1 offered pre-school place & other developments Summer / Autumn 2009

2.1.301 The Children's Centre panel agreed in early August to fund two sessions per week for sister 1 at Pre-School 1 (with a third session later agreed by Children's Social Care). All sessions were to begin in September and mother was reported to be happy with the offer.

2.1.302 Though no minutes were located, a child in need meeting was held in early August at the Health Centre and Outer North East London Community Services records indicate that the health visitor was to become the 'lead professional'.

2.1.303 In mid August sister 1 attended the Child Development Centre with mother, maternal grandmother and sister 2 for medical, speech and physiotherapy assessment. Future management of speech was planned (for mother's convenience) to be delivered via her local Health Centre.

2.1.304 A few days later the fourth complaint about the family's noise level was received by Environmental Health and next day mother again failed to present sister 1 at an appointment with GP9. It is not known if the events were connected e.g. a late night party? Later in August, mother did in fact present sister 1 to a paediatric clinic.

2.1.305 In late August mother attended accompanied by her mother her appointment with the peri-natal mental health service. Mother was assessed by psych.7 and a 'mental health worker 2'. She described feeling down during pregnancy and asked to re-start her medication.

2.1.306 Mother said she was experiencing frequent mood swings and becoming irritable quite easily; was finding it difficult to cope with children when stressed. She said she had no thoughts about harming them or significant feelings of frustration towards them. Mother reported 'occasional' cannabis use and confirmed she had resumed her relationship with father. Mother also persisted in her description of abnormalities in sister 1's bones which affects her walking.

2.1.307 Mother was prescribed anti-psychotic medication at night and it was agreed that the mental health worker 2 would undertake a home visit to assess mother's interaction with children and see the home environment. It was further agreed that the team would consider the optimal psychological support for mother and would write a letter to Housing in support of re-housing.

2.1.308 Mother failed to bring sister 1 to her introduction to Pre-School 1 in early September and non-attendance became a significant issue in the months to come.

2.1.309 A week later at a home visit by the mental health worker, mother requested an increase in medication dosage. She felt that her mental state was stable, but was low in mood due to problems with father's parents. Mother claimed (though this was unconfirmed) she had obtained an injunction prohibiting he paternal grandmother or paternal aunt from having contact with the children.

Comment: The impact on father of the tension between his family and mother does not seem to have been addressed by any professional so far.

2.1.310 The mental health worker 2 observed that the parents were interacting well with the children and recorded that the 'children appeared well taken care of'. The home visit was followed by a phone discussion with the psychiatrist about medication.

2.1.311 In mid September sister 1 was seen by a GP after what her mother described as a fall between two chairs a week previously The injury was presumably not thought to be suspicious as the doctor did not liaise with either health visitor or Children's Social Care.

2.1.312 The case was subsequently closed to Children's Social Care and closure letters sent out to parents and involved partner agencies accordingly. The reason for case closure was that the core assessment completed by mid July was generally positive, the children deemed to be developing appropriately, parents appeared to be meeting all their needs satisfactorily and mother was deemed to be well supported by her partner.

Comment: With the advantage of hindsight, parental performance does not seem to be as positive as was thought by social worker and health visitor.

2.1.313 In late September a typically false reassurance was given the health visitor by mother, indicating that sister 2 would complete her immunisations next day.

2.1.314 In early October a patently false allegation was made by mother about the paternal grandmother and she was subsequently warned for wasting Police time.

2.1.315 Later that month mother was bitten by her dog and voluntarily relinquished it to the animal warden.

Comment: If the dog attacked an adult, the risk to children was as great and perhaps greater. It was anyway replaced in February 2010 by a puppy.

2.1.316 In Autumn 2009 mother failed two more perinatal mental heath appointments and before Xmas was discharged from that service. Sister 1 continued to attend Pre School 1 and funding was agreed to meet the costs through to March 2010 when she was due to start Primary School 1.

Early 2010

2.1.317 In early January 2010 sister 1 was taken to Whipps Cross Hospital A&E with reported diarrhoea and vomiting for three days. Sister 2 also became ill at this time and at a consultation with the GP mother is recorded as saying with respect to sister 1 she '….refused breakfast but asking for drinks…not had a drink yet today'.

Comment: The accuracy of mother's reported statement is unknown, but it raises questions about understanding of a child's (especially an ill child's) need for hydration.

2.1.318 Later in January, GP10 referred sister 2 for a paediatric opinion about her being wheezy and having a persistent cough. Mother in fact failed to present her daughter for the appointment in February.

2.1.319 GP 10 initiated contact with the health visitor to share her concern about mother's failure to take up the offer of mental health and other services. Sister 2's final immunisations were much overdue and finally completed in late April.

2.1.320 The erratic attendance of sister 1 at Pre School 1 noted by mid February was disputed by mother. However, the explanation of the system for monitoring attendance confirms that it is a rigorous and reliable one.

Allegation against staff member

2.1.321 In mid March mother initiated an allegation against the Head of Pre-School 1 of physical abuse. The process of investigation was slow and completed only in late April when local authority and Ofsted (as regulator of such institutions) concluded that the allegations were 'unfounded' (according to the Early Years individual management review) and 'unsubstantiated' according to the Children's Social Care individual management review.

2.1.322 During this period, mother refused to allow sister 1 to return to Pre-School.

Comment: The distinction between' unsubstantiated' and 'unfounded' is an important one which should be clear to Children's Social Care. As a result of sister 1 not attending, she not only lost the benefit of socialisation but was also more exposed to a neglectful home environment.

2.1.323 At this period, though the family remained eligible for 'enhanced health visiting' the named HV2 had in fact left in late February. This meant that the oversight implicit in home visits was lost.

2.1.324 In mid March, mother reported on to her outreach worker that she was pregnant, though did not mention it to the GP10 whom she consulted next day about sister 2's week-long history of intestinal upsets and frequent upper respiratory tract infections.

Comment: If mother was pregnant at this time, she presumably miscarried.

Renewed concerns

2.1.325 It would seem as though GP10 was concerned about her observations of mother and her children. She rang the HV3 and indicated that mother ….'has been seen shouting at children, has defaulted for mental health appointments…and sister 2 has had repeated chest infections'.

Comment: It was actually mother who self-reported that she sometimes shouted at the children but it may be the GP was also referring to other (unrecorded) sources.

2.1.326 About a week later, the same GP made a renewed attempt to get sister 2 seen by a paediatrician but mother again failed to bring her child to the appointment. The excuses mother subsequently deployed were unconvincing. Mother also failed to bring sister 1 to an appointment at the Child Development Centre with community paediatrician 1 later in April.

2.1.327 An unannounced visit at this time by the new HV3 revealed a 'smelly dirty flat and miserable children'. Mother was not there and 'had forgotten the health visitor was coming'. The flat was tidy but floors and surfaces very unclean; there was an extremely unpleasant odour and sister 2's clothes were dirty.

Comment: These observations should have been shared with Children's Social Care as the children remained in need and in receipt of services.

2.1.328 A week later, HV3 was called by the Children's Centre outreach worker who had visited recently (the date was not provided) and been concerned about the level of cleanliness of the home. Pre-School 1 had also expressed concerns over sister 1's hygiene and level of attendance and the outreach worker recalled that mother had also had a number of arguments with staff

2.1.329 A new SW2 was appointed at the end of April it seems in order to progress the investigation of mother's allegations against the head teacher. His first (planned) visit was early May but no record of its completion has been seen.

2.1.330 A day later however, a second home visit by HV3 revealed sister 1 and sister 2 to be 'very dirty in body and clothes'. The flat was said to be reasonably tidy though the floor was very dirty. Mother successfully resisted a Children's Social Care proposal for a home visit to discuss the strategy being adopted for investigating her allegations about the head teacher.

2.1.331 This period seemed to be a difficult one for mother and in early May 2010 she was given a fixed penalty notice for shoplifting. Later in the month when arrested for theft, officers discerned sufficient vulnerability for an 'appropriate adult' to be appointed and for a special watch to be kept on her cell.

Assertion of dystonia in sister 1

2.1.332 By mid May by which time sister 1 had begun to attend Primary School 1, it became apparent that mother had applied to the Department of Work and Pensions for an allowance for sister 1 in respect of whom she had described …. 'muscoskeletal dystonia, very poor mobility, speech difficulties and being unable to walk or play unaided'.

2.1.333 Pre School 1 having not observed the symptoms described, quite properly declined in spite of considerable pressure, to support mother's application.

Comment: It is interesting to note that in spite of a lack of formal education and self reported dyslexia, mother was able to assert her case in writing and using technical terms such as dystonia.

Further concerns / referrals from health staff

2.1.334 A little later in May, within the health visitor's supervision, the potential need to refer to Children's Social Care was recognised and noted.

2.1.335 Unusually, mother phoned and offered an excuse (lack of money) for her failure to be able to bring sister 1 to a physiotherapy appointment. Later that same day, the physiotherapist in consultation with the community paediatrician 1 and HV 3 initiated a referral to Children's Social Care. She informed the parents of her actions and also offered a further physiotherapy appointment. Sister 1 was brought by father to that assessment with physiotherapist 1 and an assistant.

2.1.336 Next day, the GP practice administrator shared her concern about mother shouting at her children. Mother failed two further health appointments. When challenged about the latter she said initially that she had not received the appointment and then that she had forgotten.

2.1.337 In early June the GP4 asked the health visitor to 'keep an eye on sister 2' and in her letter shared her concerns about sister 2 failing to attend paediatric appointments or and for immunisations; and that mother has been referred to the psychiatric access team.

Comment: Concerns were legitimate. A direct referral to Children's Social Care from GP would have been helpful (a later account by GP10 of 'did not attends' was much understated).

2.1.338 Concerns emerging from health staff were further reinforced by community paediatrician 2 when in early June, having reported a further 'did not attend' to Children's Social Care, 'sister 1 did not attend her appointment today; mother said she couldn't afford the fares'.

2.1.339 Children's Social Care (belatedly - the first referral was some two weeks earlier) responded by allocating for an initial assessment. 'Deputy team manager 2' indicated in a phone conversation that a social worker would complete a home visit within twenty four hours to establish whether the child's needs are being met by parents, to establish reason for not engaging with services, complete agency checks and make clear concise recommendations.

2.1.340 Deputy team manager 2 indicated in a subsequent phone exchange with the health visitor that a strategy meeting would be convened after the allocated social (SW2) had visited. Later that same day, the health visitor supported the idea of what she described as a 'professionals' meeting'.

Comment: According to the Outer North East London Community Services individual management review, the deputy team manager indicated that 'both parents were reported to be violent and that, in consequence, two social workers would be visiting The origin of this inaccurate information remains unclear.

2.1.341 Whilst assembling available information SW2 was faxed information from the physiotherapy service that included a reference by father to sister 1 'having recently fallen down stairs'. This was not further explored nor had the information been shared across agencies and (assuming father's account to be accurate) there is no record of any medical treatment having been sought at the time.

2.1.342 On early June 2010 SW2 completed his initial assessment on sisters 1 and 2 – and observed good attachments. Sister 1 was observed to be clean and show no signs of distress or fear and to be developing appropriately. The social worker did note that 'accommodation and hygiene are a major concern…parents agree to address'.

Comment: What did 'agree to address' mean? The mental health appointment mother promised to attend may not have existed. If it had, attendance could have checked as a tangible indicator of reliability. The initial assessment needed to reflect a long running history of false reassurances, not just a snapshot of the present.

2.1.343 The social worker recommended a strategy meeting and a core assessment *only* if other professionals reported further concerns so that the commitment to a multi agency exchange of concerns implied by deputy team manager 2 when the earlier referral was received was placed was at risk. In supervision a week later this deputy team manager *did* require the convening of what was at that point (and as late as the end of June) called a strategy meeting

Comment: The initial assessment had been 'signed off' by the manager but the social worker continued to seek information from education and health sources. This may have been a means of adjusting practice to satisfy the then seven working day limit for initial assessments.

2.1.344 According to the Outer North East London Community Services individual management review, when the community paediatrician phoned SW2 to inform him of a further appointment later in June, she was told the assessment was 'currently taking place'. The records also indicate that the social worker was, according to this doctor 'not helpful in information sharing, had poor communication skills, was quite obstructive and rude'.

2.1.345 As a result of the doctor's experience she spoke with the duty manager who agreed to speak with SW2. The results of that promised follow up are unknown but a recommendation has been added to section 5.

2.1.346 A report received from sister 1's new school referred to a home visit completed in late March prior to the child starting school. The living room had been clean and tidy and sister 1 'happy and smiley'. There appeared to be a strong smell of cannabis in the flat and mother appeared drowsy though father was more alert.

Comment: The impact of prolonged passive smoking of 'skunk' was, in its own right a source of risk for both children.

2.1.347 Sister 1 was finally seen at the Child Development Centre in late June 2010 when she was accompanied by mother and maternal grandmother. Mother refused to allow HV3 to be apart of the assessment blaming her for the recent involvement of Children's Social Care. Mother's diagnosis was recorded on this occasion as 'paranoid schizophrenic' (even less accurate than all its predecessors).

Comment: While HV3 withdrawing on this occasion may have been a pragmatic step that enabled the long overdue assessment, mother's assumption that she could reject the more critical amongst the professional network needed to be challenged.

2.1.348 Because of her level of concern, the community paediatrician made further attempts to gather information and prompt action. Following the appointment she phoned an unnamed staff member in Mental Health Services to be told that mother had last been seen as an out-patient in 2009 and had been discharged from the service.

2.1.349 The paediatrician also rang team manager (TM3) in Children's Social Care and reiterated her concerns about mother's 'aggressive, paranoid and erratic behaviour'. She was invited to attend the strategy meeting planned for a date in mid July.

2.1.350 In early July following liaison between GPs and Mental Health Service, mother was offered an appointment for later that month.

2.1.351 Meanwhile, sister 1's attendance at Primary School 1 was poor and a check by the overview author on some of the excuses offered, such as a 'medical appointment' revealed (and *could* have revealed them then) to be fictitious.

Referral of 'dangerous' dog

2.1.352 In mid July Environmental Health received a further complaint about the dog at the family home. The animal warden 'spoke to owners re Pitbull-type dog and advised that it be inspected by the 'dog status unit' of the Police.

Comment: Given the warden was aware of this family and had already disposed of another dog in 2009, it is of concern that he apparently completed no risk assessment with respect to the two small children living in a one bedroom flat on the second floor, nor follow up to confirm that mother had sought advice from Police as to the legality of owning such a dog. The dog anyway continued to be the source of complaints and the borough's 'Anti Social Behaviour Unit' was involved in late July.

Strategy meeting

2.1.353 The meeting held in mid July agreed supportive measures only and noted that mother had a mental health assessment pending. The conclusion that if supportive measures failed, Children's Social Care would move toward child protection was a repeat of previous positions adopted

Comment: As on previous occasions, the contingency position was reached but not recognised as such because professionals dealt only with the immediate and failed to contextualise it.

2.1.354 Later in July the results of the paediatric assessment revealed that no medical reason had been found for the reported pain sister 1's feet and legs. The report also indicated that sister 1 had ingrained dirt under finger and toenails, dried crusted food on her chest and did not appear to be recently washed. In addition…..'mother's behaviour today was erratic, showing paranoia; was verbally aggressive. I am concerned about mother's mental health; will review development in six months' time'.

Comment: Even when the parents knew their child would be medically examined, they were unable to organise so that she was clean and presentable. The account of the child was tellingly similar to one of late April 2007 i.e. 3 years earlier and clear evidence of prolonged physical neglect. For reasons that are not apparent and in spite of the above formal assessment, sister 1 was fitted with orthotic boots later in the year which may have served to reinforce mother's belief that her daughter did have a pathological condition.

2.1.355 In late July two members of the Mental Health Service undertook a home visit and their report was in mid August shared with Children's Social Care.

2.1.356 A week later the parents informed the new health visitor that they had broken up on but were now back together. Records do not confirm whether the impact of such incidents on the children was discussed.

2.1.357 In early August a ‘working agreement’ was signed by social worker and parents but rendered redundant when a day later he triggered case closure.

2.1.358 The social worker had not completed a home visit since early June and was not in a position to know whether any positive changes had been made to the condition of the flat. Nor, as a result of case closure was there any established means of monitoring compliance with the ‘working agreement’.

2.1.359 This unjustified and optimistic management decision left the children exposed to further risks.

Comment: There is no documentary evidence to confirm that any partner agency or indeed even the family was informed of Children’s Social Care case closure. Mental Health Services later become aware from mother and the health visitor was told in a phone call by the social worker in late August.

PERIOD 3: INITIAL AWARENESS OF THIRD PREGNANCY (CHILD B) TO HER DEATH: AUGUST 2010 – MAY 2011

Recognition of third pregnancy in network

2.1.360 GP9 was the first to be made aware in late August 2010 of mother’s latter pregnancy. On examination, mother appeared to have no thought disorders or depressive features. Her estimated date of delivery was mid March 2011 and she was at that stage, refusing Children’s Social Care or Mental Health Service involvement. The fact these options were recorded indicates the doctor was properly considering and discussing with his patient, their possibility.

2.1.361 Mother acknowledged that this was an unplanned pregnancy but said she was happy to continue it and felt supported by her partner.

2.1.362 The GP’s records indicate that he evaluated the risks and benefits of involving other agencies. His judgment was that ‘there does not appear to be significant risk at present to self / others; plan is for follow up appointment with myself in few weeks –note – dysfunctional relationship when previously referred to Children’s Social Care without consent’.

2.1.363 By early September 2010 the midwifery service had received a booking letter from GP4 informing it that this was mother’s ‘third pregnancy; unsure of due date, previous use of cannabis, personality disorder, on no medication for past year mother had stopped this herself.’

Anti social behaviour meeting

2.1.364 In early September mother and the maternal grandmother were present when a meeting was held in response to further reports of anti social behaviour. The meeting also included the neighbourhood police officer and a police community support officer (PCSO).

2.1.365 Police records note that housing staff had reported that ‘due to the smell they did not want to enter the premises’ and that on a previous visit, ‘she [mother] was completely off her face on drugs’.

2.1.366 It was noted that the referrer (who *may* have been the PCSO; it is difficult to be sure from the records) visited the home today and that it was very messy and unkempt; the walls were dirty, child crawling on dirty floors with no clothes on’.

Comment: This meeting had no written output but seems to have triggered a formal referral to Children’s Social Care next day.

2.1.367 The Children’s Social Care response to the above referral was to allocate the same social worker SW2 who had in Summer 2010 assessed the family and to initiate a further initial assessment.

2.1.368 The wholly justifiable conclusion reached was that a core assessment was required and this (the sixth for this family**)** was commissioned in late September.

Comment: At the request of the overview author, a copy of this core assessment was made available and a critique is offered below.

2.1.369 When mother was seen (twelve weeks pregnant) by the same community midwife 4 as had dealt with her previous pregnancy, her history (including the mis-diagnosis of schizophrenia) was again captured. Mother was offered an appointment to attend the community clinic to see the same midwife in early October.

Results of final core assessment

2.1.370 The last core assessment to be completed during the period under review was completed at the end of October. The social worker had discussed the reported anti-social behaviour with mother who simply denied it. The social worker noted that *he* had not experienced such behaviour and that the parent had co-operated with the assessment. He considered the state of the flat and recorded that the walls were now freshly painted. Parents had stated that they had used alcohol and drugs in the past but ‘not now’.

2.1.371 No health concerns were raised by health visitor and the social worker felt that the parents were working hard to ensure that the children were well looked after.

2.1.372 The social worker saw the children who looked well and happy. The record indicated ‘mild concern re condition of paternal grandmother’s accommodation’, which the social worker visited in late October (though see below for a less favourable description from the same worker).

2.1.373 The social worker's recommendation was that:

- There should be no further action by Children's Social Care
- Health visitor and midwife to monitor the family and
- Report back to First Response Team if concerns arise

2.1.374 These recommendations were signed off by TM5, who indicated the assessment was thorough….'if the parents start to disengage with services following case closure, nursery and health need to convene a meeting with the family to attempt resolve matters before referring to First Response Team'.

Comment: The limited value of this last core assessment is discussed in more detail later. In essence it is poorly written and confusing.

2.1.375 An unexplained observation within the assessment was 'parents are temporarily living at maternal grandmother's and accommodation required deep cleaning and health and safety gates. There are three dogs in the property and their hair is all over the carpet'.

Comment: It remains unclear at which location the parents were actually living. The description of what appears to be the maternal grandmother's home is at odds with that seen by the author and perhaps should have read paternal grandmother or might actually refer to the family's home address?. The reference to three dogs was also relevant to the children's safety, though not explored.

2.1.376 Completion of the core assessment *prior* to the important perspective of the health visitor (who was 'not in' when rung in late October) was poor practice and may have reflected a wish to satisfy the then thirty five working day target.

2.1.377 Children's Social Care failed to set in place any mechanism for future monitoring of key issues e.g.: future school attendance, sister 1 attending physiotherapy appointments, mother's pre natal checks with the consultant etc.

Comment: Intrinsic weaknesses of this core assessment were enough to justify not signing it off. To leave partner agencies with the responsibility of identifying any future risks, meeting and alerting First Response Team only *if that approach failed was wholly unacceptable.*

2.1.378 This manager (TM5) did appropriately require a closure letter to be sent out to relevant agencies (which might at least have offered the opportunity of challenge). There is no evidence to confirm such a letter was sent.

Further allegation of physical abuse / neglect

2.1.379 Within days of the completion of the above core assessment a (named) neighbour phoned and alleged emotional / physical abuse of sister 1, illegal drug use, neglect and abuse of a dog.

2.1.380 The caller described how (that day) mother was allegedly dragging sister 1 …'the child was screaming and feet were not even touching the ground. Mother was also kicking the dog. Other neighbours were said to have heard mother screaming at the children. Mother is pregnant and allegedly smoking weed. The home stinks of weed. The home does not have gas or electricity'.

2.1.381 The call was discussed with the same manager, who had authorised case closure less than week before and who now reflected that there had been no welfare concerns about the children raised in the completed core assessment.

2.1.382 The referral and assessment officer was asked to advise the caller to contact the Police if she had concerns.

Comment: This was a wholly irresponsible decision. The allegations merited s.47 enquiries (and liaison with Environmental Health / RSPCA). The weakness of the response overlooked real risks to this family's children but would also act to deter responsible callers who were, in good faith alerting the appropriate authorities. It is understood that this manager no longer works for the borough and may no longer be in the UK. For these reasons, no disciplinary investigation has been recommended.

Growing level of school concerns

2.1.383 By late September sister 1's non attendance pattern was beginning to emerge and only 52% attendance had been achieved by the end of November. During this whole term it seems as though sister 1 was either absent or significantly late for nursery.

2.1.384 Though usually the less outspoken of the couple, father's hostile response at the school in mid November to sister 1's school photo ('she couldn't f******g smile, miserable cow') made in front of school staff offered an insight into his potential attitude / language, even in the presence of a professional witness.

2.1.385 In late November mother informed Primary School 1 that she and father were no longer together. This appeared to be so when, in early December she began to complain of sister 1 being bullied at school.

2.1.386 In early December the concerns at the school prompted a fax to Children's Social Care. The school was concerned about the numerous absences of sister 1 who had not attended at all since mid November. Mother had also missed a meeting with the school at the end of that month. The school asked what action Children's Social Care proposed. Next day, following a visit by father who appeared surprised that sister 1 was not in school, the school manager asked that a home visit be completed.

2.1.387 Only ten minutes after father's visit to the school mother appeared with sister 1 and claimed that she was being bullied by a child in her class. The interim head teacher met with mother and told her that this was not the case. Mother agreed to send sister 1 in tomorrow and to keep her physiotherapy appointment in school next day.

2.1.388 In the event, she failed that appointment and is so doing missed her daughter's Nativity play. Mother later claimed to have notified the Child Development Centre of her inability to keep the appointment which had actually been moved to the school for her convenience.

Comment: In explaining the absences, mother claimed that (as well as inclement weather and sister 1's reluctance) she (mother) had been ill but she had had no contact with GP or hospital services since late September and even if true, this would not have prevented her informing the school.

2.1.389 SW2 who had attempted to but been unable to reach family members by phone, indicated to the school that he would be consulting his manager (TM 4). In the event this meeting was postponed by the manager and not re-scheduled.

2.1.390 Near the end of term the school also emailed TM4 and followed this up with a formal letter next day. The school recognised that attendance was not compulsory but were concerned about the home environment – mother is pregnant, mentally unwell and dad may not be there to support the family. No response to that letter has been found and it must therefore be assumed that none was sent.

Comment: This failure to even respond to a formal expression of concern was very poor practice.

2.1.391 SW2 phoned and spoke with mother in mid December and included the fact that Children's Social Care was concerned about neglect and was considering a child protection conference. Father later rang the social worker and indicated, as well as his displeasure at the possibility of a child protection conference that he and mother were back together again.

2.1.392 Mother and father met the school next day and attributed sister 1's poor attendance to bullying though they named a boy considered by staff to be the *least* likely to act in that way.

2.1.393 Following his postponed discussion with the TM4, SW2 emailed the school and indicated that Children's Social Care was taking this seriously and if this (missed school & appointments) continued, a strategy meeting would be considered

Comment: The suggestion of decisive action 'if……'.had been seen in many previous exchanges with parents.

2.1.394 After two days of attendance sister 1 was once again not brought to school on what is thought to have been the last day of term.

Domestic abuse allegation

2.1.395 An allegation had been phoned in some two days before then the end of term by paternal aunt 2 that mother hit father whilst he had care of sister 2.The aunt referred to a threat by the maternal great aunt to 'phone social services to come and remove the children from their care'. There is nothing in Children's Social Care records to indicate this was responded to in its own right.

Delayed results of mental health assessment

2.1.396 A letter from the Mental Health Service to GP and Children's Social Care took discharging mother, took four months to be sent and anyway concluded that her mental health was stable and that she could access counselling if she wished to.

Audits of core assessment

2.1.397 In late December an audit was completed by a senior manager which in essence identified what proportion of the core assessment *process* had been followed.

Comment: Although, it might have spotted internal inconsistencies, what it could not do is to test the validity of what was recorded i.e. was it rooted in accurate observations of the right issues and what had been omitted or underestimated in judgments about aspects of the family's functioning. It was right to point out that the views / feelings of the children were absent, though sister 1 was of an age to be engaged at home or at school on a one to one basis.

2.1.398 A further audit (this time by TM4) noted the lack of evidence of supervision / reflective practice by the 'group manager' previously. Whether a second audit so soon after the first reflected recognition that there might be weaknesses within the first is unclear.

2.1.399 An appointment with a physiotherapist in early January 2011 was one of the few occasions when sister 1 was quoted directly. That professional noted that the child's socks were dirty and her feet smelly (the fronts of her knees were also bruised).

Comment: What significance is attributed to child being dirty / smelly? – the long term consequences for self esteem, acceptance by peers etc can be profound.

Poor risk assessment by Children's Social Care

2.1.400 Exchanges between TM4 and her deputy in early January indicate a concern on the part of the former and a (wholly misplaced) confidence on the part of the latter about the family's ability to provide good enough care of their two children and of the third expected in March.

2.1.401 The deputy team manager's response is inaccurate with respect to history and severity of concerns, makes no acknowledgement of the effort of the

school (with its advantage of seeing sister 1 and parents more often than any other professional agency) to highlight the child's needs.

Comment: The significance of missed sessions for sister 1 is what is indicates of the family's capacity to organise and offer a consistent and predictable life. The fact parents were not obliged by law to ensure this daughter was educated was irrelevant.

2.1.402 In the early part of the Spring term, the school commendably persisted in sending reports of sister 1's attendance rates to the social worker.

2.1.403 Mother with the support of the Children's Centre initiated applications for two alternative schools as the current Primary School 1 (a five minute walk from home address 4) was 'too difficult'.

Comment: The reference to 'too difficult' is presumed to refer to distance and might make sense if mother and children had been living with maternal grandmother in Chingford since the Autumn of 2010. It is significant that although sister 1 failed to attend at the beginning of the new term, the strategy meeting mooted by managers a month previously was not followed up.

2.1.404 Within four days of starting Primary School 2 mother sought and obtained agreement for sister 1 to return to Primary School 1 (apparently because the family had moved back into the flat). Sister 1 returned from mid February.

Family's location / anti social behaviour allegations

2.1.405 Information received from a neighbour that the family had vacated the property in October and returned only occasionally to collect the post prompted Ascham Homes in mid January to visit and serve an 'abandonment notice'.

2.1.406 Mother (by then nearly six months pregnant) responded to that notice and visited the housing office to explain that they had been in a (named) town for a month and since their return stayed with either maternal or paternal grandmother so as to avoid the stairs. Mother indicated that they had not been living at the home address 4 for some seven months.

Comment: If the above assertion was true (and nothing has been found to refute it) it may partially explain the difficulties of ensuring reliable attendance at Primary School 1. It would though, raise the question of why neither school nor Children's Social Care had been clear about re family's location.

2.1.407 Ascham Housing wrote to mother about an anti social behaviour review of loud music, swearing, shouting and kicking of the dog in early February. According to that agency's, the 'anti social behaviour investigating officer' took a career break in February and the only other information further to the follow up meeting where mother accused the neighbour of anti social behaviour) was some feed back from neighbours in mid April that indicated things were now 'quiet'.

Comment: Attack as a means of defence and diversion was often apparent in mother's responses to challenge.

Further concerns from school & birth of child B

2.1.408 By late March 2011 the attendance of sister 1 was again becoming inconsistent. She was noted to be wearing unwashed clothes and have an unwashed smell. Her hair was not brushed and parents' moods appear erratic and they appeared to be 'scruffy'.

2.1.409 Two days later mother started labour and was admitted to Whipps Cross Hospital and child B was born after a normal delivery. Mother declined offer of a perinatal mental health assessment and there is no record of any liaison between midwifery, health visitor and Children's Social Care around the time of this event.

2.1.410 After a routine check by a paediatrician when nothing abnormal was detected, mother and baby were discharged home. Next day mother and baby were seen at the home address by community midwife 5 when a next visit was arranged.

2.1.411 Five days post-delivery, the baby was undressed, checked and weighed by the midwife. Blood was also obtained from her and the 'newborn screening test' completed.

2.1.412 In early April the midwife noted in a conversation with a GP that the home was in disarray, though whether to a greater degree than might reasonably be expected of a family in a one bedroom flat and three under fives plus a dog is not made clear.

2.1.413 The baby was undressed checked, and weighed as per post-natal guidelines, and her next visit was arranged at a post-natal clinic. At this time child B was thirteen days old. Next day, at a further home visit by the same midwife, child B was weighed and nothing abnormal was noted

2.1.414 By the second week of April when agency HV4 undertook her first birth visit, child B weighed 2.9Kg and was 'visibly well and alert'. This health visitor was apparently unaware of any family history so explored no mental health issues. This health visitor noted dogs [plural] on the balcony, which may have been kept out there (as described to the RSPCA) when 'welfare' professionals called.

2.1.415 Child B's hearing test was completed and 'passed' some three days later. By late April HV5 had been allocated and undertook a home visit when nothing untoward was noted.

2.1.416 Next day midwife 4 who had seen mother (when she attended appointments) throughout pregnancy went to and saw them both at the maternal grandmother's home. Child B was undressed, checked and weighed and midwife recorded this in her work diary. She had no concerns for mother and both were transferred to the health visiting service.

2.1.417 Child B's weight was recorded at 4.000kgs, which was a significant increase from birth of 1.122kgs gained in total. At this time the baby was thirty five days old.

2.1.418 In early May, the parents failed, as they had so often with their other two children, to present child B for immunisations though she was apparently registered as a patient at this point.

2.1.419 Some five days later mother called the surgery to explain that she had missed her six week post natal check because of 'gastroenteritis' and had asked her boyfriend to cancel the appointment.

Last week of child B's life

2.1.420 Seven days before child B's death mother presented sister 1 to the surgery where symptoms recorded were scratching / early vesicles / probably pox. The advice offered was 'five days school exclusion; mum to report symptoms as no PH' Calamine lotion and Chlorphenamine oral solution'.

2.1.421 Later that same day child B was seen by GP10 when redness & blistering areas were noted: 'probable Candida; baby fine / nappy rash'. It is likely mother mentioned the other GP had surmised that sister 1 had chicken pox.

Comment: Mother mentioned that she was now 'off antidepressants'. Though not cited in the GP individual management review, the overview author has been informed that mother was last prescribed anti depressants in March 2010.

2.1.422 Five days before child B died, the last home visit by a professional prior to the death of child B was completed by the outreach worker. She saw all three children, noted 'children with chicken pox' but not which ones. Assuming this is the same outreach worker as had previously been involved she had previously proved sensitive to home conditions and willing to alert others when justified. She made no adverse comments on this occasion.

2.1.423 Two days prior to child B's death at 15.19 GP 9 examined child B for her six to eight week developmental check. He recorded a 'history of a formula-fed baby thriving; injections planned'.

2.1.424 According to the record of weight in the 'Red Book' child B weighed 4.30Kg and the GP characterised the baby's appearance as 'satisfactory'. This stands in stark contrast to the post mortem findings two days later when the pathologist observed that child B (then 3.810Kg) was 'underweight, de-hydrated, thin, under-nourished and had dirt in the creases of her skin'.

Comment: According to the record of the parents' initial account at the hospital, it was GP10 who had examined child B but it is clear from records that this was not the case and at their meeting with the overview author and health colleague, they seem to accept that it had been GP9.

2.1.425 Two days before child B's death at 17.54 a different doctor (GP7) examined sister 2 who had been brought to the surgery by one of her parents. The diagnosis was captured as follows: 'an upper respiratory tract infection; D & V vomited x 1 today; loose stool x 2; sister has chicken pox; examined alert, throat red lethargic, today drinking well & hungry'. Discussed with paediatric registrar re 'sats' reading [blood oxygen levels]; advised erroneous with adult monitor go by clinical condition and signs; treat as ROM' IMPRESSION; ROM & viral illness Paracetamol & Amoxicillin prescribed'.

Comment: The parents informed the overview author and health colleague that the children had had upset stomachs a week previously following a visit to London Zoo but had recovered. Following child B's developmental check, the parents are clear that she had not *had any diarrhoea or vomiting though had been unsettled at night requiring each parent to take turns in comforting her.*

Response by London Ambulance Service

2.1.426 On the days of child B's death a 999 call was received by Emergency Operating Centre at 10.49 to attend the family's home address. It was reported that a two month old female had stopped breathing. The caller cleared the line at 10:50 but on the second attempt contact was made by the Emergency Operating Centre. It was further reported that child B was cold and stiff and cardiopulmonary resuscitation had been stopped.

Comment: It is unclear whether ambulance staff advised the father about resuscitation or whether he / mother had anyway tried to resuscitate child B. Also given, that all members of the family shared 1 bedroom, how father apparently failed to notice for some twenty minutes that the baby was not breathing remains unexplained and presumably will be considered as part of the parallel criminal investigation.

2.1.427 The call was correctly designated as a 'Red' priority and the chief complaint identified as 'cardiac / respiratory Arrest' at 10.51. A Fast Response Unit and an ambulance were dispatched at 10.50, arriving at the address at 11.01 and 11.09 respectively.

2.1.428 On arrival child B was lying on a sofa, deceased. Child B's father explained he had found her in her cot cold and stiff. He reported the baby had been last seen at 01.00 when she was given a feed and put to bed and that he had not woken till approximately 10.30am.

2.1.429 On examination child B was white in colour, her pupils fixed and dilated, her jaw and arms were stiff, and there were no spontaneous respirations or heart sounds. An electrocardiogram indicated child B's heart was in asystole i.e. no electrical activity was present.

2.1.430 'Recognition of life extinct' was documented at 11.05 and child B was removed to the waiting ambulance and subsequently conveyed to Whipps Cross Hospital, the ambulance leaving the scene at 11.19, arriving at 11.25. Child B's father also travelled in the ambulance.

Comment: The ambulance crew noted the presence of the other children. It remains unexplained how parents (with three under fives) had not woken until mid morning.

2.1.431 At the hospital father is reported to have indicated that child B had been unwell with diarrhoea for three days, had been seen by GP 10 two days previously for a routine check and advised to give her fluids. Father said that the baby had been excessively sleepy the previous day.

Comment: In their meeting with the overview author and health colleague, the parents both asserted that child B had not had diarrhoea or vomiting between her developmental check two days prior to death and 01.00 on the day of her death when reportedly settled for bed (a maximum of forty three hours and probably nearer thirty seven as the extent of rigor mortis suggested death had occurred approximately six hours before the ambulance crew attended).

2.1.432 Assuming the weights captured at her developmental check (4.30Kg) and post mortem (3.81Kg) are correct, the critical issue appeared to be whether such a weight loss was *possible* without condition involving diarrhoea and/or vomiting and whether a reasonable parent could have failed to notice and seek medical advice about such a sudden and significant loss of weight. This issue is considered within the analysis below.

2.1.433 Child B was certified dead by the hospital consultant paediatrician and the 'rapid response process for child deaths' initiated including involvement of Police, Children's Social Care and Coroner. Support was offered to father and later to mother and their extended family.

2.1.434 That same evening the maternal grandmother contacted the out of hours medical service to leave a message as follows – 'patient has upset stomach, diarrhoea (recently had chicken pox). History: call from MGM [maternal grandmother], baby has had chicken pox since last week but today developed diarrhoea and abdominal pains just this afternoon, no temp, no vomiting, she has not been given any medication. Diarrhoea not mixed with blood or mucus'.

Comment: It is curious that the maternal grandmother apparently made no mention of the loss of child B earlier that day. Her use of the term baby might though *(consistent with her culture / use of English) have referred to sister 1 whom it may reasonably be assumed did have chicken pox.*

2.1.435 In the evening of the day after child B's death, GP11 examined sister 1 with respect to some symptoms associated with her chicken pox and noted nothing untoward.

2.1.436 Mother's own GP phoned and offered her an appointment next day to discuss how she was coping. Mother failed to attend.

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3 ANALYSIS

3.1 INTRODUCTION

3.1.1 A large number of italicised comments about specific events or issues have already been included in section 2. Section 3 offers further analysis of each agency's inputs with respect to those issues considered by the serious case review panel and overview author to be of relevance.

3.1.2 Sections 3.2 addresses, on an agency by agency basis, the generic issues contained in the guidance provided in *Working Together to Safeguard Children* 2010 (pages 245-246).

3.1.3 Section 3.3 addresses each element of the 'case-specific' terms of reference'. This attempt to address every subject of interest to the case review panel was rendered significantly more difficult by the fact that some individual management review authors had not examined them in accordance with the given terms of reference and that there was some overlap with the generic issues of *Working Together*, thus creating a level of repetition.

3.1.4 Section 3.4 offers a brief glimpse into the world as experienced by the children within child B's family and section 3.5 a summary of examples of best practice that emerged from this serious case review.

3.2 GENERIC TERMS OF REFERENCE

3.2.1 The general terms of reference are considered immediately below with respect to the involvement of each named agency. If the question is not relevant to or there is no evidence available from, a given agency**,** the words 'NOT APPLICABLE' have been added

WERE PRACTITIONERS SENSITIVE TO THE NEEDS OF THE CHILD IN THEIR WORK, KNOWLEDGEABLE ABOUT POTENTIAL INDICATORS OF ABUSE OR NEGLECT & ABOUT WHAT TO DO IF THEY HAD CONCERNS ABOUT A CHILD?

3.2.2 Unsurprisingly, levels of sensitivity, knowledge of indicators of abuse or neglect and of proper process varied across agencies as well as across time.

3.2.3 The extent to which each specified agency succeeded with respect to the above three issues (sensitivity, knowledge and process) is considered below across the period defined for purposes of this case review in section 2.

Children's Social Care

3.2.4 Though constrained by the passage of time and unavailability of records, it is possible to discern in hindsight premature sexualisation (and potentially sexual abuse) of mother from a very early age.

3.2.5 Mother's temperament (impulsive and aggressive) in combination with other unknown experiences but anyway including several dramatic 'self harming' episodes, placed her beyond parental control from an early age. The death of her father with whom she was 'close', the hostile relationship she developed (and retains) with her mother's partner and minimal schooling compounded her vulnerability.

3.2.6 Clearly, the decision of Children's Social Care in 1999 to accommodate mother indicated its recognition of a social need but it is unclear whether the possibility of physical or sexual abuse within the re-constituted family was being considered at that time.

3.2.7 The inability to locate records relating to mother's periods of accommodation under s.20 children Act 1989 (itself a breach of regulation 50 of the current Care Planning, Placement and Case Review Regulations 2010) renders it impossible to verify the assertion by mother and maternal grandmother that they *had* in 2000 reported the sexual abuse of mother (then aged eleven) by her foster carer.

3.2.8 According to one of the most recent pieces of research into the prevalence of abuse in foster care[2], evidence is limited and inconclusive. The literature review by York University's Social Research Unit identified one National Foster Care Association study that suggested that 4% of foster homes had been investigated as a result of allegations and that in 22% of those cases, the allegations were substantiated i.e. an overall maltreatment level of approximately 1%.

3.2.9 A larger and more recent web based survey also cited by the above Social Research Unit found that 35% of carers had experienced an allegation of abuse and another study from Australia suggests that allegations of some form of maltreatment have been made in relation to 32% of fostered children at some point during their care careers.

3.2.10 Thus, allegations are not unusual, and although rarely substantiated must be investigated on the facts of each case. The period during which mother alleged her abuse pre-dated the explicit statutory guidance now in appendix 5 of *Working Together* 2010 or even the first published edition of the London Child Protection Procedures. Nonetheless, the nature of the allegation (sexual abuse) should have triggered an immediate s.47 enquiry.

3.2.11 The later prosecution and imprisonment of the man for similar offences during the same period adds credibility to mother's story. *If* the family's allegation was refuted by a retort that 'foster carers are carefully vetted', it would have represented the earliest example of gross insensitivity toward the needs of a child, ignorance or unwillingness to recognise the small but genuine risk of such abuse and an apparent ignorance of, or failure to initiate, s.47 enquiries.

[2] Maltreatment and Allegations of Maltreatment in Foster Care: A review of the evidence
Biehal, N. and Parry, E. 2010 Social Policy Research Unit, University of York, York
56 pages ISBN: 978-1-907265-05-1

3.2.12 The strategy meeting convened in October 2000 in response to mother jumping from a second storey room suggests a level of sensitivity to the distress mother (then twelve) was experiencing and a referral to Child & Family Consultation Service was appropriate though perhaps not of itself sufficient. The lack of records of the strategy meeting that determined this action plan prevents further comment.

3.2.13 By June 2002, mother (rising fourteen) made a further allegation of assault, this time alleging her mother's partner (the maternal grandmother) had punched her (the first *recorded* allegation was that the maternal grandmother had in 1999 struck her with a dog lead – this was and remains denied by the maternal grandmother and was not proven). Mother subsequently withdrew her specific claim that she had been punched and maintained only that they had been arguing.

3.2.14 However, the contemporaneous accounts (reinforced by direct conversations with mother and the maternal grandmother) suggest that mother even at the age of eleven was intimidating her mother and her partner and, according to the maternal grandmother at interview, beat up some peers who mocked her because her father (child B's maternal grandfather) had died.

3.2.15 Most agency involvement during mother's teenage years was with GP and mental health services. There was a brief contact with Children's Social Care in February 2005 when mother reported to the emergency duty team that her mother was going to 'kick her out'. The absence of records render it impossible to evaluate the sensitivity of response since one cannot be sure what was done and whether mother was open about her having been previously accommodated.

3.2.16 An example of insensitivity was evident in April 2005 when the 16+ team which should have been aware of the substantial family history closed the case after mother and the maternal grandmother failed to attend for an appointment. This contrasted with the later and more determined efforts by a number of health agencies to follow up health appointments failed by mother or her children.

3.2.17 Only a month later, following mother's overdose, the 16+ team appeared reluctant to become involved and the First Response Team expressed the view that because mother had been 'looked after', she was not eligible for a response by them.

3.2.18 *If* the then criterion for service by the 16+ team was that a child needed to be 'eligible' as per the Children (Leaving Care) Act 2000, then mother had not accrued the necessary thirteen weeks between the ages of fourteen and seventeen inclusive and thus did not satisfy that access criterion.

3.2.19 *If*, on the other hand, the criterion was that a young person needed only to be sixteen or over (with or without some care history) and 'in need', then mother should have received services from that team (the Children's Social Care IMR indicated that the 16+ service was supposed to offer both 'care leaving' and 'child in need' services for those aged sixteen and over).

3.2.20 The result of what appeared to have been internal Children's Social Care confusion about roles or workloads, resulted by July in the least sensitive of outcomes when the 16+ manager closed the case 'because the First Response Team had closed it'.

3.2.21 Less than a year later in February 2006, the 16+ team *did* respond positively to the account by mother and the maternal grandmother of friction and the fact that the former had been asked to leave the home some two weeks previously.

3.2.22 At or around the time of the family meeting convened by the 16+ team, the description of mother as 'schizophrenic' was noted as was mother's revelation that she was pregnant.

3.2.23 Judging from the date of birth of sister 1, mother miscarried this first pregnancy but seems to have conceived again quite quickly.

3.2.24 In spite of the lengthy history of disturbed behaviours, including self harm, conflict with the maternal grandmother, absence of education and declared pregnancy, only an initial assessment was completed. Its conclusion was that mother and father (with whom it seems mother had been in a sexual relationship for about eighteen months) needed to be given independent accommodation.

3.2.25 'R (on the application of G(FC) (Appellant) v London borough of Southwark (Respondents) [2009] had not been determined at this time but its judgement that any lone, homeless child should by provided with accommodation under s.20 was unsurprising and reflected how (in the author's estimation) the Children Act 1989 was *intended* by Parliament to be applied.

3.2.26 The focus of the 16+ team in its subsequent dealings with mother during 2006 was exclusively on her income or accommodation. In June whilst being interviewed about the sexual abuse some six years before, mother indicated that she was two months pregnant and this information was passed to the 16+ team. There appears to have been little recognition within that team that the following factors suggested mother's capacity to provide safe and adequate parenting could *not* be taken for granted:

- What was thought by Child & Family Consultation Service staff to be a poor and insecure attachment with the maternal grandmother
- A substantial history of self harming from a very early age
- Impulsive, aggressive and destructive outbursts
- A self declared diagnosis of 'schizophrenia' (with a presumptive diagnosis from the Child & Family Consultation Service consultant psychiatrist of an 'anti social personality disorder')
- An apparently conflictual relationship with the father of sister 1
- Smoking (twenty cigarettes and four joints (possibly skunk) per day, ? binge drinking and possible use of other illegal substances

3.2.27 Several contacts with the pregnant mother offered the 16+ worker opportunities to recognise the need for and initiate a pre birth assessment. These were missed and a supervision session in November offers some understanding of why. A note of that session written by the then team manager was preoccupied with mother's status (not a 'former relevant child' thus did not fall within the remit of the team), and her material needs.

3.2.28 Given large rent arrears and what were described no more precisely than her 'mental health issues' the manager's decision was that the case should be referred to the family support team.

3.2.29 The manager did not address the specific question of how might such an individual manage the demands of a new baby? Mother and it appears, father, had at this point been living in the other borough for about seven months though (according to the Children's Social Care individual management review) were due back in the borough on a date toward the end of January 2007.

3.2.30 By mid January 2007 and only ten days prior to mother's 'expected date of delivery' , the 16+ team did fax a very belated pre birth referral to the other borough, the details of which indicated a clear awareness of indicators and how to respond to the identified potential risk to the then unborn sister 1.

3.2.31 The Children's Social Care of the other borough acted swiftly and efficiently to involve all relevant agencies including Waltham Forest's Support and Resettlement team from which confirmation was received of the couple's scheduled return to the borough.

3.2.32 Further and important intelligence was gathered from the consultant at Child & Family Consultation Service who confirmed, inter alia…..'he would have serious worries about her ability to care for a baby'. The psychiatrist did not believe that Children's Social Care needed to rush in and remove the baby immediately but he indicated (accurately as subsequent events showed) that there were going to be 'chronic worries' about her long term care.

3.2.33 In response to the referral from the other borough, Waltham Forest acted promptly, allocated a social worker with sufficient experience and as a result of her initial assessment of the risk level as 'high' commissioned the same worker to compete a core assessment.

3.2.34 An entirely proper wish to convene a strategy meeting was frustrated by the Police inability to provide an officer and the problem made worse by the mistaken Police view that no such meeting was anyway required. Further analysis of the position adopted by the Police is provided later.

3.2.35 The professionals' meeting that was held five days before the birth of sister 1 included the inaccurate information from the 16+ team that mother was schizophrenic yet failed to agree an urgent need for a comprehensive pre-birth assessment.

3.2.36 Some of the contingencies covered at this meeting were useful e.g. anticipating that mother might deliver at either Whipps Cross or North Middlesex Hospital but one element of the agreed approach and described below highlighted that within Children's Social Care (and elsewhere) there was insufficient clarity about what the law does and does not allow.

3.2.37 The plan agreed at the professionals' meeting, as well as subsequent contacts by Children's Social Care representatives after sister 1 was born seemed (intentionally or not is hard to determine) to obfuscate the fact that in order for mother and baby to remain in hospital beyond the time genuinely assessed as necessary for health related purposes, mother's consent or some form of court order was required.

3.2.38 Though well intentioned, the deputy team manager's attempt to persuade mother to remain in hospital with sister 1 showed insufficient awareness of or sensitivity to law and proper procedure. An unintended result was to add to mother's level of stress and in consequence that of her new baby.

3.2.39 SW1 who had been allocated to the case appeared efficient and confident and recognised the need for s.47 enquiries and a core assessment.

3.2.40 The intensity of the 'observed contact' and frequency of social work visits suggests that the social worker was sensitive to the risks to sister 1. The social worker was though (like many other professionals who later became involved) prone to confuse 'process' and 'progress' e.g. obtaining from a functionally illiterate couple an agreement to 'partnership working' and a promise to 'act to protect the baby' was not of itself protective.

3.2.41 Of greater potential value was the regime of observed contacts delivered until mid April, alerting the emergency duty team to the possibility of a crisis out of hours, the joint visit with a mental health worker and the briefing offered over the phone by the consultant child and adolescent psychiatrist who had last seen mother.

3.2.42 The arrangements being driven at this time by Children's Social Care were comprehensive, though early indications of 'disguised compliance'[3] were apparent e.g. mother's promises about GP registration of herself and sister 1, the failure to relinquish the dog and self-evidently false claims about not smoking near the baby.

3.2.43 'Disguised compliance' involves a parent or carer giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention. Its effect is to neutralise a professional's authority and return the relationship to closure and the previous status quo (Reder et al, 1993, pp 106-7). In the case of child B's family, evidence of disguised compliance, whilst insufficiently recognised, was more apparent over time.

[3] Reder,P., Duncan, S. and Gray, M. (1993) Beyond blame: child abuse tragedies revisited. London: Routledge.

3.2.44 However, on the basis of the *then* predominantly positive professional observations, the decision at the initial child protection conference in 2007 that a 'child in need' plan would suffice was reasonable and the potential legal planning meeting was no longer required.

3.2.45 Mother's poor take up of ante natal care might be argued to represent a personal choice (or an indicator of an irresponsible attitude toward her unborn child). Her failure to present sister 1 (by now subject of a 'child in need' and later a 'child protection plan') to a large number of health related appointments, the first only six days after the conference, offered a tangible and insufficiently acknowledged example of neglect.

3.2.46 SW1 to a greater extent than her successors, did offer some challenge to the family e.g. about money extracted from Connexions and about mother's failure to attend her appointment with the psychiatrist in late February.

3.2.47 The 'completed' core assessment rightly recognised the parents would require 'ongoing support'. In the ensuing months, this certainty was lost.

3.2.48 From late March 2007, the midwife was expressing a heightened level of concern about mother and referred to the dog 'going for' the social worker.

3.2.49 The social worker on a home visit at this time had noted an untidy and unclean flat and recorded in an exchange with the mental health worker with whom she had previously undertaken a home visit, that mother had been 'shouting and screaming at her, appeared extremely angry and was quite aggressive towards her baby'. No reference was made to being attacked by the dog (which should not anyway have still been there).

3.2.50 Coupled with the observations of one of the observed parenting workers …'mother's behaviour toward her daughter was appalling…shouting loudly and demonstrating mood swings…I am of the view that without a high level of support…mother will be unable to parent sister 1…mother cannot control her emotions', this deterioration merited more decisive action.

3.2.51 It may be the psychiatric opinion received in mid April that 'mother's mental health is stable' diverted attention from her behaviours and consideration of their likely impact on her baby. It might also be the case the social worker who had developed a good working relationship with the parents and did not seem to be made anxious by mother's outbursts, had adjusted her expectations with perhaps insufficient consideration of the impact in the longer term of mother's conduct.

3.2.52 The allocated social worker was on annual leave and the Children's Social Care response to the paternal grandmother's referral of late April, though prompt and well planned was poorly executed. No medical examination was arranged, not all allegations were explored and a 'chaotic and unkempt bedroom with ashtrays full of cigarette butts' triggered no challenge or further action. A potential strategy meeting was not held and it seems doubtful that the referrer was offered any feedback.

3.2.53 The much delayed family group conference in June offered little added value and in July 2007 the case was transferred to the Community Safeguarding and Intervention team. The significance of mother's observed behaviours and parents' acknowledged use of cannabis was lost.

3.2.54 The newly allocated SW3 undertook a home visit following notification by Police of the assault on father by mother's (very temporary) boyfriend. The social worker was told that mother had often been the victim of physical abuse by father who was also said to abuse the dogs.

3.2.55 Though subsequent events cast doubt on the veracity of mother's claims to have been the victim of abuse, their implications for the safety of sister 1 as well as the presence now of two dogs (rather than none as promised frequently since sister 1 was born) should have been seen as indicators of risk. Additionally, there is no documentary evidence to confirm that Children's Social Care was sensitive to the further implications of the new boyfriend and had completed checks on his identity and potential risk to a small child.

3.2.56 Children's Social Care proper attempts to convene a strategy meeting were frustrated but a core assessment (the second) was initiated.

3.2.57 The implication for mother's parenting of her baby was overlooked when mother, during an office visit (and at a subsequent visit to a friend's house where she was temporarily staying) was aggressive and threatening. The fact that sister 1 who showed no reaction, was becoming used to her mother's outbursts was noted by the social worker but its value as evidence of emotional abuse / neglect was not appreciated.

3.2.58 As a result of the early findings of the on-going core assessment, the Community Safeguarding and Intervention team justifiably assessed the risk level to sister 1 as 'high' and the decision at the initial child protection conference in August that sister 1 should become subject of a chid protection plan was justified.

3.2.59 That conference did not have the advantage of the (concerning) mental health assessment of father completed on the same day but did identify the need to complete a risk assessment of father. Some of the outputs of the conference appear tentative e.g. 'a family group conference to be considered' or naïve 'mother to advice Children's Social Care of any change in circumstances'.

3.2.60 The home visit by the deputy team manager in mid September 2007 offered an opportunity, unfortunately not taken, for an exploration by this more senior social worker of the implications for sister 1 of her father's return home. Supervision of that deputy team manager later the same day also failed to grasp all relevant sources of concern and to some extent confused 'ends and means' e.g. actions such as 'convene a family group conference' and 'draw up a new working agreement' were not of themselves protective.

3.2.61 By the end of October 2007 and with no evidence of authorisation, the social worker notified the family of a reduced visiting schedule. This dilution of the plan was unjustified.

3.2.62 Whilst the review conference in November 2007 recognised that sister 1 needed to remain subject of a child protection plan, it did not confront head-on the parental failure to comply and/or their disguised compliance with the original plan.

3.2.63 Children's Social Care did not appear to be sufficiently sensitive to the implications of father's failure to attend the drug and alcohol service appointments and his resulting discharge from that service or to the fact that the home was not seen by the social worker for a period of eight weeks.

3.2.64 A record of the then social worker's home visit in early January 2008 when it appears she learned for the first time of mother's historical diagnosis of 'borderline personality disorder' suggests that she had not understood or had not complied with the clear expectation that a new worker familiarise her/himself with available social history.

3.2.65 At a supervision session immediately before Xmas 2007 parental failure to comply with key aspects of the protection plan appears to have been recognised for the first time. The dispatch next day of a letter to the family that cited the possibility of legal action was though, at odds with the actions taken early the next year.

3.2.66 The protective value of the then plan was further diluted in February 2008 when in spite of further recognition of non-compliance, the possibility of case closure was discussed in supervision. Failure to comply with a child protection plan should have intensified Children's Social Care input not reduced it.

3.2.67 Although it appears that the health visitor and her supervisor were mindful of the many failures to attend health appointments, a core group in March recorded a very optimistic view of the progress of sister 1 (now on the 99th centile for weight) and of the extent to which parents were compliant.

3.2.68 The conference decision in April 2008 to substitute a child in need plan for the protection plan was, on the basis of evidence available to it, unjustified but reflected the stated recommendations of social worker and health visitor, both of whom manifested undue optimism.

3.2.69 Some of the professional optimism seen was a consequence of parental reassurances that were accepted at face value. Had assertions about attendance at various appointments been checked, the level of duplicity would have become more apparent.

3.2.70 It seems as though the professional network over time adjusted its expectations and reframed what was parental resistance as legitimate parental choice.

3.2.71 The potential value in monitoring ‘did not attends’ as a tangible indicator of neglect was lost and by mid July the case was closed.

3.2.72 The belated and inadequate response to the new allegations emerging only days after case closure suggests that, amongst the individuals involved (social worker and manager) there was insufficient knowledge of the process to be followed. Sister 1 was not seen or medically examined and the response was entirely insensitive to her immediate and ongoing needs.

3.2.73 Though Children’s Social Care was (belatedly) informed of mother’s pregnancy with sister 2, it anyway confirmed closure of the case. Given the history of mother’s functioning as a parent, this decision, which may not anyway have been authorised by a manager, was a poor one.

3.2.74 In spite of a further allegation in December of physical abuse of sister 1, the parents’ reassurances about misuse of drugs and mother’s mental health together with an absence of observable injuries on the toddler were taken as justification for no further action. It is unclear how the social worker explained the allegations but it may be that she simply accepted the parental contention that they had been made up.

3.2.75 Following the birth of sister 2 in April 2009, the hospital based social worker was sufficiently sensitive to the need for a core assessment and made some efforts to understand the origins of the parents’ difficulties. She failed though to understand the significance of mental health and (as those before her had) accepted at face value what mother said about hers.

3.2.76 In early July 2009, there was a further poor response to allegations made by the paternal grandmother of physical abuse of sister 1. Though the plan agreed between social worker and her team manager did at least include a contingency position, there was a subsequent failure to trigger it.

3.2.77 Though GP and health visitor recorded worrying observations in early to mid 2010, these remained unknown to Children’s Social Care. Further Children’s Social Care involvement was prompted when SW2 was allocated to investigate mother’s allegations against the head teacher at Pre-School 1.

3.2.78 In June 2010 an initial assessment was completed which seemed to provide little more than a snapshot of some direct observations and more parental promises to address the poor state of their home.

3.2.79 The meeting described as a ‘strategy meeting’ held in July essentially repeated the position adopted on previous occasions i.e. that Children’s Social Care would move toward protective steps ‘if supportive measures failed’. Those protective steps were justified but never triggered and indeed case closure within a day of signing off a ‘working agreement’ removed even the possibility of a rapid identification of a need to take decisive action.

3.2.80 It would appear that no partner agency or perhaps even the family was informed of this case closure.

3.2.81 In September 2010 Children's Social Care received a further referral, this time as a result of an 'anti social behaviour' meeting at which a police community support officer was present.

3.2.82 Whilst the recommendation and decision to undertake a further core assessment was justified its completion was poor and the recorded managerial comment that it was 'thorough' ill evidenced.

3.2.83 The core assessment offered a very optimistic, parent-led account; failed to distinguish the parents' capacity to present well with the substantial verified history of emotional abuse and physical neglect. The social worker seems to have been diverted by the characteristic 'attack as a means of defence' seen on other occasions.

3.2.84 His conclusion that 'parents have shown a commitment to change' was wholly without foundation and is perhaps why the parents spoke well of this worker when interviewed by the overview author. The view of the Children's Social Care individual management review author is that at the very least, a 'child in need' meeting needed to be convened.

3.2.85 Children's Social Care failed to put in place any mechanism for the future monitoring of key issues such as sister 1's school attendance or attendance at various health appointments.

3.2.86 The apparent 'completion' of the assessment before any input from the health visitor may have reflected the organisational need to satisfy the thirty five day performance indicator. Implementation of Professor Munro's[4] recommendation that such *arbitrary* time limits are abolished to which the government is committed, should resolve this unintended consequence. Self evidently all assessments must be thorough and timely but, in the light of the imminent shift of national policy, no recommendation has been made.

3.2.87 The failure to notify other agencies of the case closure and the presumption that they would accept responsibility seemed to reflect individual inefficiency as opposed to ignorance of due process since the manager did ask the social worker to take such action.

3.2.88 In early November 2010 the Children's Social Care failure by the same team manager who had signed off the latest core assessment to even commit her staff to a response was wholly irresponsible. It appears that in spite of her knowledge of the appropriate procedures, she merely asked the 'referral and assessment officer' to advise the caller to call the Police if she had concerns.

3.2.89 If this manager were still an employee (and the overview author has been informed that she is not and that her current whereabouts are unknown) a recommendation for a disciplinary investigation would have been included.

[4] The Munro Review of Child Protection**:** Final Report A child-centred system Professor Eileen Munro May 2010 The Stationery Office

3.2.90 During the Autumn term of 2010 the school continued to update Children's Social Care about attendance of sister 1 but the opportunity for staff to challenge or check up on the various excuses mother offered for failing to bring sister 1 to the pre school unit were not taken.

3.2.91 Worse, in that it suggests ignorance of or lack of respect for, established multi agency arrangements, was the failure in the last week of Xmas term to provide a formal response to the concerns expressed in a letter sent to Children's Social Care by the head teacher.

3.2.92 The social worker did later indicate to the school the agency's commitment that if health appointments and school attendance continued to be a problem, a strategy meeting 'would be considered'. The suggestion of decisive action *if* …. was by then a familiar response. The promised decisive action was brought no nearer by a new allegation from the paternal aunt of an attack by mother on father whilst he had care of sister 2.

3.2.93 The two core assessment audits completed in quick succession in late 2010 / early 2011 were limited in value by the fact that they evaluated only process and minimum standards as opposed to validity.

3.2.94 There was some indication (differing levels of) awareness of risk in exchanges between the then Children's Social Care team manager and her deputy in early 2011, with the latter insufficiently informed and unduly optimistic about the parents' ability and performance.

3.2.95 At the time of and following the birth of child B on 23.03.11, there was no Children's Social Care involvement and all support and surveillance was being provided by the wider network.

Metropolitan Police Service

3.2.96 The Police individual management review did not address these generic *Working Together* items of the terms of reference and because their involvement was limited (none related to child B) there is relatively little on which to base any comments.

3.2.97 In broad terms, on the occasions that officers attended, they showed an awareness of and sensitivity to the needs of sister 1 and/or sister 2 and initiated appropriate notifications.

GP Services

3.2.98 The value of commentary and analysis of GPs' professional practice has been constrained by the lengthy period covered and the fragmentation of medical responses across several doctors from the same Practice.

3.2.99 The independently authored GP IMR was able to offer a critique of a number of aspects of practice. The overview author agreed with some and in other specified instances, remains of the view that the professional practice required further scrutiny than that provided.

3.2.100 The (late) arrival of a third version of the individual management review provided a clearer but no more self critical account than its predecessors.

3.2.101 With respect to the general question of awareness and sensitivity, this unsurprisingly varied over time. Early GP records suggest nothing untoward about the family until mother was aged ten yet accounts by mother and maternal grandmother, brought together in a report provided by the first psychiatrist to assess mother, as well as in direct conversation with the overview author refer to significant difficulties from the age of two and shared with the then GPs. This cast doubt on whether there was a good enough level of awareness and sensitivity.

3.2.102 The individual management review author supplemented his search of records with a (joint) interview of more recent and current GPs and concludes that the GPs were knowledgeable about potential indicators of abuse and required action.

3.2.103 The overview author agrees that there were examples to support this contention e.g. the GP referral to Children's Social Care in March 2000 and a high level of attentiveness by GP10. Evidence that sensitivity and awareness were not across time, consistent features of GP care is seen by:

- Absence of any attempt to collate an overview or prompt proactive responses to the many and significant difficulties of a then ten / eleven year old smoker who was self harming, failing to attend school and experiencing a high level of conflict with the maternal grandmother
- An apparent failure to do more than record her injuries when in 2002 mother (aged less than fourteen) reported an assault
- The failure to assess the child's 'Fraser competence' and a prescription of contraceptive tablets to mother (aged thirteen and a half) apparently without knowledge of the maternal grandmother
- The erroneous ascription of the diagnosis of 'schizophrenia'
- Little evidence to indicate measures being put in place to reduce mother's ability to overdose on prescribed medication
- An apparent failure to monitor and discuss with mother prescribed use and discontinuation of prescribed medication in 2003
- An apparent failure to take action in early 2005, other than to refer her to a gynaecologist, in response to mother's claim of rape
- (In the clinical view of the independent GP) a lack of clarity in the records about the diagnosis that might have supported a GP's prescription of further prescribed medication in 2005
- Though reported to the GP practice in the psychiatric assessment of 2005 (mother then aged fifteen), GP records contained no information about mother's use of cannabis and alcohol
- An explanation about the benign (when compared to the initial post mortem report and its description of weight and cleanliness) conclusion of the final two clinical examinations of child B in the last week of her life by two different GPs

NMUH

3.2.104 Clinical practice was sensitive to the needs of sister 1 during the pregnancy and following her birth.

3.2.105 It had been identified at first contact by midwives that there were social risk factors that would impact on the unborn child so mother was referred for consultant led care. When mother failed to attend her consultant appointments these concerns appear not to have been addressed again at mother's subsequent appointment with practitioners.

3.2.106 Additionally, mother's mental health needs were not sufficiently assessed according to the hospital protocol at the time. This would have provided an opportunity to assess mother's current mental health status and potential impact on her baby. As soon as there was full awareness of the safeguarding concerns there was appropriate liaison and information sharing with Children's Social Care.

Whipps Cross Hospital (Midwifery)

3.2.107 At mother's initial presentation for ante natal care for sister 2, she was asked questions e.g. possibility of drug use and domestic violence, that indicated an awareness and sensitivity to the needs of the existing and unborn child and of potential indicators of abuse.

3.2.108 The GP's referral letter omitted reference to mother's history of overdosing.

3.2.109 In responding to mother's pregnancy with child B, the same midwife acting upon the information from GP and mother that the latter had ceased use of prescribed psychotropic drugs and was functioning well, omitted to alert health visitors, the perinatal mental health team or Children's Social Care.

Whipps Cross Hospital (Medical)

3.2.110 Though in retrospect, of marginal significance to child B or her family, the individual management review includes a commentary on father's 2002 presentation to A&E and highlights that *reasons* for a presenting injury should always be captured.

3.2.111 In addition at father's 2007 presentation had he been asked (as per the later introduced Care Quality Commission (2009)) expectations whether he had any children, a connection with sister 1 might have been established.

3.2.112 Mother (aged sixteen thus still a child) had two admissions in 2004 for self-harm and one for attempted self-harm (all close in time). She was seen by a psychiatrist on each occasion which was consistent with the National Institute for Clinical Excellence NICE (2004) guidelines but Children's Social Care was not apparently consulted or informed as per the London Child Protection Procedures ed. 2.

3.2.113 At her third alleged overdose in 2005, after a thorough history was taken, input from Child & Family Consultation Service and a referral to Children's Social Care was planned but there is no documented evidence that the referral to Children's Social Care was made, nor that a discussion took place between the psychiatrist and hospital staff to clarify who would make it.

3.2.114 When mother (still only seventeen) was seen at the Early Pregnancy Assessment Unit the misinformation about her 'schizophrenia' was captured but not further explored suggesting insufficient understanding of the risk of a deterioration in mental ill health during pregnancy.

3.2.115 The presentation of sister 1 at A&E for diarrhoea and vomiting in January 2010 raised no concerns among hospital staff and (reasonably) did not require contact with Children's Social Care to enquire if the child was or had been known to that service.

3.2.116 Sister 2 was never seen at Whipps Cross Hospital since she failed to attend two appointments. The consultant paediatrician, followed local procedure at that time for children who did not attend but the individual management review points out that since 2011 a new approach has been operational to manage the follow up of such children and incorporated into the 'safeguarding children policy and procedures and audit schedule'.

ONEL Community Services

3.2.117 The individual management review author found evidence that all staff interviewed in relation to the case were familiar with the current *Working Together to Safeguard Children* (2010), the London Child Protection Procedures (2011) and the Assessment Framework guiding safeguarding practice. The report provided details of the training received or scheduled for staff involved in this case.

3.2.118 They were aware of, and knowledgeable about, the potential indicators of abuse and what was required of them if they had concerns about the welfare of a child. At interview the staff were able to discuss the potential detrimental impact on parenting capacity in relation to the particular themes identified in this review.

3.2.119 There was though a delay in the necessary referral to Children's Social Care by the health visiting service following the home visit of April 2010 when a number of issues of concern had been observed and recorded.

NELFT

3.2.120 As acknowledged in the NELFT individual management review, the response of the Access Team just after birth of sister 1 in January 2007 did not explicitly address mother's relationship with her baby daughter or raise any issues about mother's capacity to parent. The response could therefore have been more sensitive to the needs of sister 1.

3.2.121 Practitioners also failed to evidence sensitivity to the needs of children when father presented at Whipps Cross Hospital in August 2007 and the assessing team did not alert Children's Social Care to the potential risks he might present to the baby and his partner.

3.2.122 The response to the concerns of the GP in July 2010 evidences that the practitioner concerned was not sensitive to the needs of the children. An interview with the person concerned suggested that she *had* considered the welfare of the children, but had not recorded her observations nor addressed the referrer's concerns about mother's verbal aggression towards the children.

3.2.123 The Access Team were aware of the process for registering concerns about the welfare of children but they were not then alert to looking for potential indicators of abuse and neglect.

Early Years

3.2.124 All the comments under 'Early Years' in section 3 relate to sister 1 since neither younger sibling was known to the Early Years Service.

3.2.125 It is clear that staff at Pre-School 1 were sensitive to the relative poverty in which the family lived and to mother's post natal depression following the birth of sister 2. Their awareness of the needs of a vulnerable child e.g. that she probably needed the snack trolley more than most was commendable.

3.2.126 Senior staff were observant of the appearance of sister 1 and sufficiently experienced to evaluate it against the local norm and to observe improvements and deterioration. Similarly, their observations of responses to and relationship with parents, was astute and convincing.

3.2.127 The best practice of staff would have been better informed if the health visitor had passed on to the outreach worker sister 1's history of being subject of a child protection plan and the fact that her mother had significant mental health / personality disorder difficulties.

3.2.128 The pre-school practice was informed by a child protection policy that was consistent with the London Child Protection Procedures (2007 edition).

3.2.129 The amount of information passed on to Primary School 1 in May 2010, though as much as was available was insufficient. It too has a robust child protection policy and up to date procedures consistent with 2007 and latterly 2010 edition of the London Child Protection Procedures.

3.2.130 The arrangements made for the physiotherapist to see sister 1 at school and for reminding mother were commendable

Ascham Housing

3.2.131 The independent management review provided did not address the general *Working Together* terms of reference and the unavailability of the most relevant officer throughout the period of this serious case review has rendered the task of both the individual management review and overview authors more difficult.

3.2.132 It would appear that Ascham officers never had the opportunity to see sister 1 or sister 2 in the period prior to birth of child B. Exchanges were exclusively with mother. Hence, judgments about knowledge and sensitivity can be evaluated only by consideration of the policies and procedures available to Asham staff.

3.2.133 Ascham Housing does have a safeguarding children policy and its individual management review confirms that staff involved in this case had undertaken a training course (which includes referrals to Children's Social Care), within the past two years. What remains uncertain is the robustness of the policy and procedures referred to and the extent to which recipients have gained knowledge, and confidence in reporting potential indicators of abuse.

3.2.134 A recommendation has been added to section to address the above uncertainties.

Environmental Health

3.2.135 From amongst the environmental health staff, only the animal warden actually met any members of child B's family. It seems as though his awareness of the needs of children in such circumstances may have been limited and no link was made between abuse of a dog and possible abuse of a child.

3.2.136 The links between animal abuse and child abuse are not clear, simple or yet sufficiently researched, but appear to have some foundation. A NSPCC briefing[5] considered the then recent research and observed that:

- About 80% of families identified in a UK study as a result of abuse of an animal were 'known to Social Services' and 60% to Probation, as result of neglect or physical abuse
- Of a cohort of families in the USA being treated for abuse of children, in nearly 90% animal abuse had also occurred
- In UK studies seeking to better understand the link, Bell (2001) cited in the NSPCC briefing note concluded that 'it might be an opportune time to consider the inclusion of animal abuse in risk assessment instruments'

[5] NSPCC Briefing 'Links Between Child Abuse & Animal Abuse Fiona Becker 2001

3.2.137 Edition 3 of the pan London Procedures issued by the London Safeguarding Children Board in 2007 included a reference to a joint working and information sharing protocol developed by that body and the RSPCA. Local Safeguarding Children Boards were urged to adopt the protocol to which a hyper link was provided.

3.2.138 With a view to increasing the likelihood of the recognition of a potential link and of confidence to initiate a referral to Children's Social Care, a recommendation is proved later.

WHEN, & IN WHAT WAY, WERE THE CHILD(REN)'S WISHES & FEELINGS ASCERTAINED & TAKEN ACCOUNT OF WHEN MAKING DECISIONS ABOUT THE PROVISION OF CHILDREN'S SERVICES? WAS THIS INFORMATION RECORDED?

Children's Social Care

3.2.139 Period 1 preceded the birth of children thus rendering the question irrelevant. In periods 2 & 3 the opportunities for ascertaining sister 1's wishes and feelings were constrained but not rendered impossible by her age.

3.2.140 The decision reached at the child protection conference in August 2007 that sister 1 should become subject of a child protection plan *did* indicate sensitivity to the emotional abuse she was experiencing, though whether the longer term impact of such an emotionally labile mother was considered is uncertain. No record has been seen to indicate that the *cumulative,* as distinct from the *immediate* impact of the children's experiences was identified.

3.2.141 The relatively modest amount of description of the personalities or behaviours of sister 1 (and later sister 2) suggests that attempts by Children's Social Care staff to relate directly to either child and see the world through their eyes were limited. For example, the inevitable impact of the frequent and usually acrimonious parental separations remained unexplored.

3.2.142 The last core assessment completed in Autumn 2010 includes useful descriptive material of both children but includes no indication that the social worker spent time engaging sister 1 in a direct conversation or in techniques such as drawing or perhaps projective techniques e.g. 'three wishes'. Certainly, as evidenced by the staff at the pre school unit, sister 1 would have been able to respond had she been offered such an opportunity.

3.2.143 Children's Social Care staff had no opportunity to relate to child B whose anyway limited contacts during her very short life were predominantly with health professionals.

Metropolitan Police Service

3.2.144 When officers were called to the domestic incident in August 2007, sister 1 (then only six months old) was noted to be safe and undisturbed by the events around her. Clearly she was too young for her wishes and feelings to be sought.

GP Services

3.2.145 The GP individual management review reports no record whatever of a doctor recording any direct verbal engagement with sister 1 (who has been sufficiently old for some time to enable such an approach) or with sister 2, whose affect and manner would be relevant to overall health and welfare.

North Middlesex Hospital

3.2.146 At the time of her birth and again at ten months when brought to A&E, sister 1 was pre verbal. There was though recorded evidence of staff being sensitive to the baby's feelings and their further actions being informed by their assessments e.g. in addition to the pre natal recognition of risk and (belated) involvement of the local Children's Social Care, mother's vulnerabilities were recognised and she was also referred to the local Sure Start Service.

3.2.147 There was an occasion noted and passed on to the social worker when the midwife noted that sister 1 was inappropriately dressed in a vest and a blanket, whilst mother was sleeping.

Whipps Cross Hospital (Midwifery)

3.2.148 Though neither the views of sister 2 nor child B could, by virtue of their age have been sought directly, the community midwife should have been more alert to the additional pressure on the existing children (and parents) consequent upon a third child being cared for in a one bedroom flat.

Whipps Cross Hospital (Medical)

3.2.149 Aside from the historical evidence that staff *had* listened to the wishes and feelings of mother (as a child) the individuals whose responses have been evaluated by this individual management review had little or no opportunity to seek the wishes and feelings of either child. Presentation of sister 1 in January 2010 because of her diarrhoea and vomiting was routine and sister 2 was not seen because the parents failed twice to present her.

North East London Foundation Trust

3.2.150 Whilst useful observations of mother, child and mother-child interactions were noted on each occasion and recorded, it would have been useful if on the latter occasion when sister 1 was nearly three years of age, she had been afforded an opportunity of some direct exploration of her feelings.

Outer North East London Community Services

3.2.151 Whilst records did not explicitly state that their wishes and feelings were ascertained in making decisions about the provision of children's services, the children were not of an age where it would have been developmentally appropriate to have been asked direct questions.

3.2.152 Records did consistently include an explicit account of which children were seen and present at contacts though observations of parent-child interactions were not always documented.

3.2.153 The individual management review includes several examples of appropriate observations and highlights the fact that in the case of families identified as vulnerable, such as that of child B, observations of interactions should not be limited only to those that cause concern.

Early Years Services

3.2.154 Descriptions of the environment at both Pre-School 1 and Primary School 1 make it clear that children's wishes and feeling are integral to their work with pupils and parents.

3.2.155 The original referral by the health visitor to the Children's Centre was prompted by a concern for the experiences sister 1 was likely to be experiencing. Attempts by nursery nurses / teachers to explore her family elicited no response from sister 1.

3.2.156 Records suggest that the Early Years staff may have been the only ones to have the opportunity to speak with sister 1 other than in the presence of one or other parent.

Ascham Housing

3.2.157 Because no Ascham Housing staff ever met the children, this question cannot be answered.

Environmental Health

3.2.158 According to the Environmental Health individual management review, officers may not have been aware that there were children in the household.

DID THE ORGANISATION HAVE IN PLACE POLICIES & PROCEDURES FOR SAFEGUARDING & PROMOTING THE WELFARE OF CHILDREN & ACTING UPON CONCERNS ABOUT THEIR WELFARE?

Children's Social Care

3.2.159 As spelt out clearly by the Children's Social Care individual management review, the London Child Protection Procedures (editions 2-4 being relevant to the period covered) were in place and supplemented by local complementary procedures for children in need. Copies of DfE guidance were available in offices.

3.2.160 The individual management review author also makes clear that the 'child protection co-ordinators' represented an additional source of advice and support.

3.2.161 The extent to which staff were supported or managed by means of reflective supervision is considered below.

Metropolitan Police Service

3.2.162 The Metropolitan Police Service has comprehensive internal 'standard operating procedures' as well as complying with the London Child Protection Procedures.

3.2.163 Officers involved with child B's family complied with procedural requirements.

GP Services

3.2.164 The GP individual management review confirms that relevant policies and procedures are in place though did not specify what these are and to what extent if any, they may have been accessed in this case.

North Middlesex Hospital

3.2.165 During the period of the review the hospital Trust child protection policy (2002) was in place and this included the antenatal management of cases and had a detailed flow chart of how to manage cases and with the process for referral to Children's Social Care.

3.2.166 The policy required that if there was a concern of significant harm, a referral should be made to Children's Social Care and discussion take place with the named midwife for child protection. The policy would also have required the practitioner to complete an internal 'LINK' form to ensure the case was able to be discussed at the fortnightly multidisciplinary LINK meeting.

3.2.167 As acknowledged in its individual management review, these processes were not followed, in consequence of a lack of awareness and understanding of individual responsibilities by a midwife. At the time of the review there was no specific guidance about mental health during pregnancy, though following a pilot period it is understood such guidance was introduced later in 2007.

Whipps Cross Hospital (Midwifery)

3.2.168 The individual management review includes a reference list that confirms the existence of relevant policies and procedures and confirms that the community midwife dealing with both pregnancies was familiar with the agency's expectations with respect to safeguarding.

Whipps Cross Hospital (Medical)

3.2.169 Though not made explicit in its individual management review, the medical services of the hospital were informed in the period covered by this review by NICE (2004) guidelines on self-harm, the London Child Protection Procedures ed.2 and later editions 3 and 4 and internal procedures which complement the London procedures and have been approved by the Waltham Forest Safeguarding Children Board

Outer North East London Community Services

3.2.170 The individual management review provided confirmation that staff work to national and local policies and procedures regarding including *Working Together to Safeguard Children* (2010), the London Child Protection Procedures (2011) (and predecessor editions) and the Assessment Framework.

3.2.171 Within services provided to Waltham Forest there are also two additional child safeguarding policies that staff are expected to follow – the Safeguarding Children Supervision Policy (2008) and the Safeguarding Children & Young People Guidelines (2009)

3.2.172 These policies complement and do not replace either of the above sources and are available to staff in paper and electronic format via the intranet. All of the policies and procedures have been circulated to all staff and their use and location is an integral part of the induction of staff.

3.2.173 There are systems in place to assure the organisation that all staff are aware of and have read the relevant policies and procedures.

North East London Foundation Trust

3.2.174 Since 2007 staff have had the benefit of a safeguarding children policy consistent with the then *Working Together* 2006 and *London Child Protection Procedures ed.2*.

3.2.175 Since 2009 each borough covered by the Trust has had a ‘safeguarding lead for children who attends the ‘mental health safeguarding group chaired by the Trust’s executive lead for safeguarding children. Operational directors attend their respective Local Safeguarding Children Board and report back to the safeguarding group and act as conduits between the two groups.

Early Years Services

3.2.176 Both settings had up to date policies and procedures that were consistent with the London Child Protection Procedures.

Ascham Housing

3.2.177 As previously indicated, Ascham Housing does have a safeguarding children policy and its individual management review confirms that staff involved in this case had undertaken a relevant training course within the past two years.

3.2.178 So as to cover off the possibility that the policy or arrangements for its monitoring or review require improvements a proportionate recommendation has been developed.

Environmental Health

3.2.179 Whilst the department had procedures for referring concerns about children, they were not based upon the London Child Protection Procedures of which senior managers were unaware. Nor (as explored above) was there any awareness of a potential association between cruelty to animals and abuse of children.

3.2.180 Relevant recommendations have been included.

KEY POINTS FOR ASSESSMENT & DECISION MAKING IN THE CASE

Children's Social Care

3.2.181 The Children's Social Care individual management review reasonably regarded each of the several core assessments as having been a key point for assessment and decision making.

3.2.182 However, the first missed opportunity arose when the 16+ team was told in February 2006 that mother was pregnant. Mother's history of and continuing mental health difficulties should have triggered an immediate realisation that the demands of parenting, an ambivalent relationship with a young man about whom so little was known, set in the context of conflict with the maternal grandmother justified a core assessment.

3.2.183 Whilst the well publicised Southwark Judgment (R (on the application of G) [2009] UKHL 26 had not at that time been reported, the use of accommodation under s.20 Children Act 1989 would have been justified.

3.2.184 The referral to the other borough by the 16+ team days before the birth of sister 1 was extremely tardy. Had it been initiated sooner, an opportunity for a thorough pre birth assessment would have existed.

3.2.185 Given the short notice, the other borough and, following sister 1's birth, Waltham Forest's First Response Team did co-ordinate to good effect and at the child protection conference in February judged reasonably on the basis of the then evidence base that a child in need plan was a proportionate response.

3.2.186 Because only the maternal side of the family was present, the family group conference in June 2007 could not fulfil its potential value and the next key point was the second initial child protection conference in August of that year when sister 1 was (justifiably) made subject of a protection plan.

3.2.187 Continuation of her protection plan at the review conference in November 2007 was justified but a key point for re-assessment and decision making was lost in late 2007 / early 2008 when the level of non compliance was recognised but not pursued via the promised legal advice / action route.

3.2.188 The second review conference in April 2008 failed to grasp the opportunity for the network to form an overview of the likely long term impact of the ongoing parental behaviour. Possibly by then acclimatised to the family norms, the social worker (and others) mistook non compliance or 'disguised compliance' as legitimate parental choice.

3.2.189 A final (again missed) opportunity for more informed and decisive action existed at the time of the last core assessment in late 2010. The Children's Social Care individual management review suggests that the then social worker's attempt to draw on historical records has been thwarted by a delay in their production and the fact that it has proved impossible to locate key case records for this serious case review certainly reinforces the conclusion that there is an urgent need to review archive arrangements.

3.2.190 The last core assessment was though, weak in other respects detailed in section 2. According to the Children's Social Care individual management review, the social worker had adopted a slightly more cautious line in his conclusions but was persuaded by his supervisor that the case might not meet the Community Safeguarding and Intervention threshold of intervention and that the team was anyway overloaded.

Metropolitan Police Service

3.2.191 The referral immediately prior to the birth of sister 1 represented the first key point for the Police to influence the assessment of need and risk. Although there was a full exchange of information and the London Ambulance Service was briefed in accordance with established protocol, the circumstances met the criteria for a pre-birth strategy meeting and it is unfortunate that it was not possible to deploy an officer.

GP Services

3.2.192 There have been across time, several key points / opportunities for decision making:

- Assessment of the child's 'Fraser competence' and a prescription of contraceptive medication to mother (aged thirteen and a half)
- The ascription dated 2002 of the diagnosis of 'schizophrenia'
- Monitoring and discussing with mother her prescribed use and discontinuation of prescribed medication in 2003
- A response to mother's claim in 2005 that she had been raped

- The GP's response to learning from mother in August 2010 that she was pregnant and did not want Children's Social Care involvement
- The two GPs' observations when seeing child B for nappy rash and a developmental check respectively on in May 2011

North Middlesex Hospital

3.2.193 Mother disclosed at the booking that she was previously involved with Children's Social Care and had left local authority care at the age of fifteen years old. Though clearly documented that this was a risk factor, the opportunity to refer to Children's Social Care for an assessment of parenting was missed. This oversight limited capacity for early assessment and planning in conjunction with Children's Social Care and was inconsistent with the hospital's then child protection policy (2002).

3.2.194 There was also a missed opportunity for internal multi agency discussion of the case at the LINK meeting because of a failure to complete a LINK form. Without regard to Children's Social Care involvement, such discussion could have helped assessment of need and risk to the then unborn child.

3.2.195 Involving both parents at an earlier stage would also have given greater opportunity to ascertain and assess their wishes and feelings.

3.2.196 At the professional meetings it was decided that Children's Social Care should be contacted as soon as mother delivered and that she should have an increased length of stay whilst a Children's Social Care assessment took place. The record of this proposed collaborative approach was not present in mother's hospital records so was not available at the time of sister 1's delivery which could have increased risk to the baby had a vigilant midwife not identified risk factors in mother's care and notified Children's Social Care.

Whipps Cross Hospital (Midwifery)

3.2.197 The key points for assessment and decision making were when:

- Mother booked in for maternity care of child B when familiarity with the family should have prompted a re-assessment of need (including associated with past post natal depression) and risk to the two existing and the unborn child B
- Mother's assertion that she had ceased cannabis use was accepted at face value and no consent sought (as per policy) for a urine sample to establish any use of other drugs
- The hospital clinic omitted to inform the community midwife when mother failed appointments
- In spite of records indicating previous poor attendance for ante natal care, no specific action was taken to explore or challenge mother's current failure to attend appointments offered

Whipps Cross Hospital (Medical)

3.2.198 With respect to key opportunities for decision making at A&E in the period of primary concern i.e. from May 2006, they were, for mother:

- Her presentation in June 2006 (aged seventeen) at A&E and reportedly eight weeks pregnant when she was fast tracked to the early pregnancy assessment unit and treated appropriately
- Further presentations in August and September 2008 when her further pregnancy was confirmed
- (Though irrelevant to the purpose of the serious case review) mother's self-referral in December 2009 for an injured foot when her treatment was appropriate but she failed to attend the follow up and was discharged to the care of her GP

3.2.199 With respect to the children, the opportunities were:

- Sister 1's presentation by mother in January 2010 for her daughter's diarrhoea and vomiting
- The failed appointments for sister 2 with the paediatrician in February and April 2010 in spite of the best efforts of GP and consultant

3.2.200 There were no further opportunities before the arrival by ambulance of a deceased child B.

Outer North East London Community Services

3.2.201 The individual management review provided an exhaustive list of the opportunities (within the context of thirty six face to face contacts) for assessments and decision making of which the following is a summary with some additional comments:

- The new birth visit in February 2007 when an opportunity to obtain the minutes of the recent child protection conference and explore some of the practitioner's observations or issues raised by parents was not taken – the results of this lack of professional curiosity meant that the subsequent health care plan was insufficiently rigorous
- The March 2007 alert from the midwife about premature weaning of sister 1 and her doubts about the family's capacity to cope when the immediate issue of weaning was resolved and (belated) contact was initiated with Children's Social Care
- The first visit by HV2 in October 2007 with some scope for more evidence for some (positive) conclusions drawn and more explicit observations in the follow up
- The review child protection conference in November 2007 for which no health visitor report nor any copy of the minutes was found

- The referral to the peri-natal mental health service in late 2007 which contained most but not all the relevant information available to the health visiting service
- During March 2010, liaison between the new HV3 the outreach worker, GP and the consultant paediatrician at Whipps Cross Hospital – when following a home visit, there was sudden but un-sustained improvement in the observed conditions of sisters 1 and 2 and the home – by May the observed deterioration would have justified a referral to Children's Social Care
- The verbal and written referral to Children's Social Care by the paediatrician in late May 2010 which led on to a multi-disciplinary developmental assessment in June, a (possibly un-minuted) 'strategy' meeting in July and a lack of sufficient multi agency co-ordination or even feedback to the referrer following it
- The closure of the case by Children's Social Care in August 2010 which was regrettably accepted by other agencies without a further multi agency meeting
- No contact or review (said by the individual to be a result of a high workload) by the newly allocated HV4 in the period from Children's Social Care case closure to the new birth visit for child B in early April 2011 undertaken by an agency HV5
- Essentially routine contacts at baby clinic and at home during April and into May 2011 when nothing of concern was noted about weight or development

North East London Foundation Trust

3.2.202 The first key point was shortly after sister 1's birth during a joint visit with SW 1 in February 2007. As indicated elsewhere, the remit was only to assess mother's mental state and the actions that followed were judged to be appropriate by the independent management review author.

3.2.203 A psychiatrist responded to the request of the Access Team for a medical review and mother was assessed in April and her mental state found to be stable. Because the doctor did not have access to the previous notes, this assessment was only partially informed. An attempt to obtain the prior history from Child & Family Consultation Service to appears to have elicited no response. Mother subsequently failed to attend ongoing psychiatric assessment.

3.2.204 The second opportunity for decision-making with regard to the family occurred when father presented to Whipps Cross Hospital in August 2007 and was assessed by the psychiatric liaison team in A&E.

3.2.205 His reporting of discord between himself and mother, his hostility towards her and problems adjusting to the birth of sister 1 were significant. Father also discussed his abuse of illicit substances and alcohol; this information in itself should have alerted staff to the need to refer the family to Children's Social Care.

3.2.206 Whilst staff did refer father to the drug and alcohol service this was not a sufficient response and resulted in a lost opportunity to signal the need for a more comprehensive assessment of father.

3.2.207 The third opportunity for assessment was when mother was referred to the 'perinatal service four months after sister 2 was born. The consultant psychiatrist undertook an assessment that provided, with the information she had available, an overview of history and a review of current mental health.

3.2.208 Crucially, the doctor did not have access to the prior paper notes from Child & Family Consultation Service as they had not been uploaded onto the current electronic patient recording system. In the circumstances, she was largely reliant on mother's testimony and she made a note to obtain the old notes. This was not followed up by the perinatal team and they thus only accessed incomplete information.

3.2.209 To ensure that the welfare of the children was checked, the psychiatrist asked her nurse to undertake a home visit. But she lacked prior information about mother's psychiatric history that might have alerted her to concerns about her parenting ability. Because mother subsequently disengaged, and the service did not have significant concerns about her mental state, there was no opportunity for the psychiatrist to undertake further assessments.

3.2.210 The final opportunity for the Trust to impact upon the decision-making process for the family took place in July 2010 when a home visit was undertaken at the request of mother's GP 14 due to concerns about her interaction (verbal aggression) with the children at the surgery.

3.2.211 The interview with the social worker from the Trust evidenced that she and the accompanying psychiatric nurse failed to address or challenge mother about her behaviour towards the children. Both staff failed to adhere to the Trust's 'safeguarding children policy' that requires keeping the children in mind, and their safety being paramount.

3.2.212 Whilst they did not observe any interaction that caused them to assess that the children were unsafe, they nevertheless focused on mother's mental state rather than her reported aggression towards the children.

Early Years

3.2.213 Worryingly, although Primary School 1 was represented at a strategy meeting in July 2010 no minutes from the meeting were received and (according to the Early Years individual management review) there was little communication from Children's Social Care after the meeting about the outcome of its work with the family.

3.2.214 The services offered to the family by the outreach worker from the Children's Centre were appropriate. But had she possessed more information about the family's history and previous child protection concerns it is likely that sister 1's poor presentation would have been considered as a more significant cause for concern.

Ascham Housing

3.2.215 Given the agency's record of mother's reports of domestic violence, and psych.7's supportive letter of September 2009, the agency should have considered a referral to its 'tenancy support / safeguarding child team' in accordance with the 'Safeguarding Vulnerable Adults and Children' procedures.

3.2.216 Further, the Ascham individual management review author concludes that the agency might also at this point have considered a referral to the local authority's social needs panel to address the question of whether mother's 'bidding status' merited higher priority which would have increased her chances of moving to larger accommodation.

3.2.217 A second key opportunity was only partially exploited following the referral in late July 2010 of the family for anti social behaviour and consequent office interview in September. The impact of the alleged behaviours on sister 1 and sister 2 was not apparently considered.

3.2.218 The response by Asham Housing to the SW2's request in late October for information did not include the information that the allegation against the parents had included mother's abusive behaviour toward her children, drug abuse or the issue of domestic violence.

Environmental Health

3.2.219 If practitioners have been aware of the links between abuse of animals and abuse of children a referral could have been considered. Other than this there was no opportunity to make a referral.

THE EXTENT TO WHICH ASSESSMENTS & DECISIONS WERE REACHED IN AN INFORMED WAY, ADHERING TO PROCEDURES

Children's Social Care

3.2.220 The Children's Social Care individual management review author has described that the initial and core assessments were completed within or very nearly within, the relevant time limits.

3.2.221 There is some evidence though that the pressure to 'complete' an assessment so as to satisfy the associated Department for Education performance indicator may have led to the value of information that was sought and/or arrived after 'sign off' being underestimated.

3.2.222 The more significant issue was the validity of (in particular) core assessments. The contribution of father (positive and negative) was under represented in all completed assessments.

3.2.223 Though the assessment undertaken by the hospital based social worker relied upon mother's description of her physical and mental health and her statements were not corroborated, subsequent assessments did seek from the local network, relevant information and opinions.

Metropolitan Police Service

3.2.224 Officers' response to mothers' allegation of domestic abuse in August 2007 was sensitive and compliant with procedures. Mother's refusal to move to a refuge was because she could not bring her the dog and new boyfriend.

3.2.225 When in October 2007 officers were called to an argument between mother and the maternal grandmother about money, officers noted that 'sister 1 was seemingly oblivious to the argument and was asleep as the time of reporting'. They also checked the child's living conditions and notified Children's Social Care in accordance with procedures.

GP Services

3.2.226 The overview author's view is that the following position was reached in an informed and professional way:

- The GP's response to learning from mother in August 2010 that she was pregnant and did not want Children's Social Care involvement

3.2.227 The following assessments / decisions (most historical) were *not* arrived at in an informed or professional way:

- Assessment of the child's 'Fraser competence' and a prescription of contraceptive medication to mother (aged thirteen and a half)
- The ascription dated 2002 of the diagnosis of 'schizophrenia'
- Monitoring and discussing with mother her prescribed use and discontinuation of prescribed medication in 2003
- The response to mother's claim in 2005 that she had been raped

3.2.228 The expert medical advice commissioned by Police for the purpose of its criminal investigation was not available in time to inform the serious case review. Of interest *would* have been:

- Any comment based upon post mortem examinations on how long-standing the indications of dirt and therefore physical neglect of child B were
- A comment on the possibility and mechanism for the apparent loss of about 0.5 Kg in the last thirty six hours of child B's life

3.2.229 Without such expert input, the author has been obliged to form his own view about the respective GPs' observations when seeing child B for nappy rash and a developmental check on the seventh and second days respectively before she died.

3.2.230 Neither the contemporaneous notes made by GP10 or her interview for the purposes of the GP individual management review indicated any lack of cleanliness of child B when she examined her seven days prior to her death. Thus, although (to a layperson) the pathologist's post mortem report viz: 'dirt beneath finger nails and in skin creases as well as the nappy rash might be taken as evidence of sub optimal care' suggests a chronic condition as opposed to one of sudden onset, it is reasonable to conclude on the balance of probabilities, that child B's appearance was (nappy rash aside) satisfactory seven days prior to death.

3.2.231 No comment was made about cleanliness in the notes of a comprehensive developmental examination by GP9 of a naked child B two days before death. Nor at interview, did he allude to the baby being dirty. Reconciling these facts with the report of the pathologist only two days later suggests one of three explanations a).child B was not dirty when examined by GP9, b). child B was dirty and GP9 failed to notice it or c). child B was somewhat dirty but to a degree considered acceptable to a family doctor who knew the family well and not acceptable from a pathologist knowing only that he was examining a dead child.

3.2.232 The author is of the view that explanation b). is unlikely to be accurate and that it remains impossible to determine which of explanations a) and c) may be correct.

3.2.233 The possibility of differing (and each reasonable and justifiable) clinical opinions must also be born in mind when considering the observation of child B by GP9 and the pathologist with respect to the general appearance of the baby. The former recorded that child B was 'thriving'. The latter, only two days later that the baby was 'underweight for her height'.

3.2.234 The apparently sudden weight loss over child B's last two days of life might appear to offer an insight into what occurred between her examination and death. However, for the reasons summarised below it would be unwise to rely upon that evidence.

3.2.235 A summary of research presented to the National Institute for Clinical Excellence (NICE) [6] highlighted a number of issues about the accuracy and consequently usefulness of weighing babies in various community settings.

3.2.236 Routine monitoring of the weight of infants and young children is intended to identify those whose growth pattern deviates from the norm i.e. individuals who have an increased risk of poor growth due to either pathology or sub-optimal feeding (Wright, 2000). Weights falling absolutely below the 0.4 centile on the UK90 chart are deemed to 'require immediate referral' while those between the 0.4th and 2nd centile merit 'close observation' (Freeman et al 1995, p23) and a change of 2 standard deviations or centile spaces meriting referral (Wright, 2000).

[6] Growth Monitoring of Infants and Young Children in the United Kingdom
Report to NICE, October, 2006 Magda Sachs, PhD, Breastfeeding Supporter The Breastfeeding Network, BA (Cantab) Fiona Dykes, PhD, MA, RM, RGN, ADM, Cert Ed

3.2.237 However, the majority of babies identified by such measures are likely, upon investigation, to be growing normally (that is, attaining their genetic growth potential, perhaps slowly) with no underlying pathology. Thus identification of weight gain patterns of concern is not in itself diagnostic (Wright, 2000).

3.2.238 In addition to the intrinsic limitations of absolute or relative weight gain, (i.e. validity) accuracy (reliability) of weighing has been highlighted as a significant ongoing challenge. Hall and Elliman (2003, p.173 in the NICE report) set out recommendations for weighing practice in the community which included using a digital scale (properly maintained and placed on a firm surface); weighing babies naked, toddlers in vest and pants; weighing babies at the same time of day as previous weights; weighing babies in consistent relation to feeding (before or after).

3.2.239 The net result of the above issues is that it would be unwise to assume that the weight finally recorded for child B i.e. 3.8Kg (nor those that preceded it) were necessarily accurate. If the final live weight is in doubt, then the apparent loss of 0.49Kg may be inaccurate.

North Middlesex Hospital

3.2.240 During mother's admission to North Middlesex Hospital she was treated appropriately and assessed by the appropriate level of medical staffing. In the assessments made following birth mother and daughter were observed to be medically fit for discharge and no concerns were noted regarding their health and wellbeing.

3.2.241 At her booking for maternity care mother had been appropriately referred to Sure Start so as to address the vulnerabilities that had been identified. Early communication and liaison with Children's Social Care prior to the professionals' meeting would have increased partnership working. Once the relevant services met, there was collaboration prior to the birth of sister 1 and a multi-agency plan agreed for the unborn child (though an earlier formal pre-birth plan would have been the usual and more appropriate approach).

Whipps Cross Hospital (Midwifery)

3.2.242 The failure by the community midwife to seek consent for urine testing has been commented on above.

Whipps Cross Hospital (Medical)

3.2.243 The failure at the early pregnancy assessment unit in 2006 to explore the self reported schizophrenia has been commented upon above and there seems also to have been no exploration of her account of three previous miscarriages. Mother mentioned at least one such pregnancy to other professionals thus reinforcing though not confirming its reality.

3.2.244 The observation by the ward manager in September 2008 of something 'not quite right' about mother's appearance and presentation was not followed up by any form of exploration of or referral about, her mental health.

Outer North East London Community Services

3.2.245 From amongst the larger number, the most significant of the assessments and decisions identified in response to the previous question were 'informed' and 'procedurally compliant' to the following extent:

- The new birth visit in February 2007 was insufficiently informed as a result of a failure to obtain the minutes of the recent child protection conference and explore some of the practitioner's observations or issues raised by parents was not taken
- The March 2007 alert from the midwife about premature weaning of sister 1 and her doubts about the family's capacity to cope was well informed though the belated contact with Children's Social Care was not wholly compliant with professional best practice
- Actions following the review child protection conference in November 2007 were under-informed in consequence of the absence of conference minutes
- During March 2010, liaison between the new HV3 the outreach worker GP and the consultant paediatrician at Whipps Cross Hospital was a well informed exchange but did not lead on to what would have been a justified referral to Children's Social Care
- The verbal and written referral to Children's Social Care by the paediatrician in late May 2010 which led on to a multi disciplinary developmental assessment in June, was well informed but the response to it including a failure to offer feedback or supply minutes a breach of relevant procedures
- Acceptance of the (unjustified) closure of the case by Children's Social Care in August 2010 without a further multi agency meeting was ill judged
- The failure to contact or review by the newly allocated HV6 in the period from Children's Social Care case closure to the new birth visit for child B in early April 2011 was not procedurally compliant

North East London Foundation Trust

3.2.246 With the exception of the failure in August 2007 to refer father to Children's Social Care and the final home visit in July 2010, Trust staff did follow through with appropriate assessments and decisions.

3.2.247 In retrospect, because mother's mental state was unremarkable and did not raise any concern, each time she was assessed by a psychiatrist, she became lost to mental health services because of her persistent failure to attend follow-up appointments.

3.2.248 Had she been of any significant concern, Trust would probably have taken a more pro-active approach, but there was no indication at the time that this was necessary.

Early Years

3.2.249 The letter written to the TM4 by the acting head teacher and the school's regular communication with the social worker about sister 1's non-attendance and poor punctuality appear from the school records not to have triggered further assessment or follow up of the family's situation and there appeared to be an acceptance of the parents' stated intentions to send their daughter to school regularly.

3.2.250 The report of the assessment undertaken by the consultant community paediatrician highlighted a number of concerns about the care of sister 1 and possible risks linked to her mother's mental health which the school staff held in mind during their work with her.

Ascham Housing

3.2.251 The failure in Autumn 2010 to share information with Children's Social Care about alleged abuse of children and of drugs was non compliant with procedures. As the individual management review author notes, if SW2 had been more explicit about his reasons for seeking information, more might have been offered.

3.2.252 In other respects and mindful that the key member of staff has not been interviewed, there are no obvious examples of decisions or assessments that were not professionally justified.

3.2.253 The reported presence of bed bugs in December 2010 might usefully have been seen as a sign of physical neglect but there had been little other adverse comment about the state of the home so it was reasonable to infer that it was an isolated occurrence.

Environmental Health

3.2.254 If practitioners have been aware of links between abuse of animal and of children a referral could have been considered.

THE COHERENCE OF ACTIONS & DECISIONS WITHIN ASSESSMENTS, WHETHER APPROPRIATE SERVICES WERE OFFERED / PROVIDED, OR RELEVANT ENQUIRIES MADE, IN THE LIGHT OF ASSESSMENTS

Children's Social Care

3.2.255 There was a significant level of inter agency co-operation in periods 1 and 2, chiefly between Children's Social Care and health professionals. Child protection and child in need plans were formulated and implemented as one might have expected, albeit there was a significant degree of repetition of approaches e.g. 'working agreements' , trusting mother's promises to attend mental health appointments, which records show had failed.

3.2.256 As indicated elsewhere, all formal assessments ascribed to much weight to parental and especially mother's assertions. 'Respectful uncertainty' identified as necessary in Lord Laming's inquiry into the death of Victoria Climbie[7] (para. 6.602) would have prompted social workers to seek confirmation of matters claimed to be 'facts' or to check on whether promises had been honoured. Had they done so, the level of confabulation or perhaps at times plain deceit would have been more obvious.

3.2.257 In reflecting on the question of how coherent Children's Social Care assessments and actions were, it is apparent that certain issues remained insufficiently explored throughout the whole period considered by the serious case review i.e. the:

- Level and nature of drug misuse
- Number, nature and risk posed by the dogs
- Source and significance of 'domestic abuse'

3.2.258 An issue that stands out is the perceived value within Children's Social Care of a 'working agreement'. The potential value of clarity and reciprocity in a child protection or child in need plan between service users and agencies is a 'given'. However, putting aside the relevance in *this* case of mother's illiteracy, there was no logic to the decision in early August 2010 after the social worker signed the latest of several such agreements, of immediate case closure.

3.2.259 As became apparent from examination of the integrated chronology, the home had not been visited by the social worker for some eight or more weeks, the parents had just split up again and no mechanism for monitoring compliance with the latest working agreement had been established.

3.2.260 The fact that partner agencies were not apparently informed of the decision to close the case compounded the anyway unwise decision to terminate the level of monitoring that had prevailed.

Metropolitan Police Service

3.2.261 All the reported actions and assessments of police officers appeared coherent and reasonable.

GP Services

3.2.262 Latterly, as described by the GP individual management review, actions accorded with completed assessments.

[7] The Victoria Climbie Inquiry HMSO 2003

North Middlesex Hospital

3.2.263 As already reported above, whilst the vulnerability of mother and her then unborn baby was recognised and immediate steps taken with respect to their health, the midwife did not follow through and comply with the policy and procedural implications of her assessment for safeguarding either in terms of internal or external processes.

Whipps Cross Hospital (Midwifery)

3.2.264 The actions that followed assessment of need were all coherent and appropriate midwifery services were provided to mother e.g. her discharge home was properly planned.

Whipps Cross Hospital (Medical)

3.2.265 The failure at the early pregnancy assessment unit in 2006 to explore the self reported schizophrenia or the later account of three previous miscarriages as well as the ward manager's note in 2008 of something 'not quite right' about mother's appearance and presentation has already been covered.

Outer North East London Community Services

3.2.266 This question has been covered by the responses to the previous two and to avoid repetition, they are not reproduced here.

North East London Foundation Trust

3.2.267 As indicated in response to the previous question, with the exception of the failure in August 2007 to refer father to Children's Social Care and the final home visit in July 2010, Trust staff did follow through with appropriate assessments and decisions.

Early Years: NOT APPLICABLE

Ascham Housing

3.2.268 Even with the benefit of the information provided in September 2009 by psych.7, Ascham Housing staff did not initiate a referral to the agency's 'tenancy support team', create a 'system flag' to indicate vulnerability or consider a safeguarding child referral.

3.2.269 Aside from the missed opportunities for fuller information exchange referred to elsewhere, there could have been a more helpful response when in July 2009 mother was refused temporary accommodation because of apparently erroneous 'Department of Work and Pensions' information.

Environmental Health

3.2.270 If practitioners had been aware of the links between abuse of animals and abuse of children a referral could have been considered.

WHERE RELEVANT, WHETHER APPROPRIATE PLANS WERE IN PLACE, & CHILD PROTECTION PROCESSES COMPLIED WITH

Children's Social Care

3.2.271 As acknowledged elsewhere, the arrangements made between the other borough and Waltham Forest at the time of the birth of sister 1 were efficient and the decision arrived at the first child protection conference justifiable on the basis of the then situation.

3.2.272 Subsequent conferences were held within required times limits though core groups were at times poorly supported or late e.g. there was a five week delay in convening the first core group after the August 2007 initial conference.

3.2.273 There remains considerable doubt about the speed and efficiency with which minutes of conferences were circulated to other relevant agencies e.g. the Police individual management review indicates that no minutes were found of the review conferences of November 2008 or April 2009.

Metropolitan Police Service: NOT APPLICABLE

GP Services

3.2.274 The primary accountability for organising conferences, formulation and implementation of child protection plans and circulation of minutes rests with Children's Social Care and it is clear that there were weaknesses with respect to the latter. This does not entirely explain how GPs seem to have remained unaware (in spite of possession of at least some conference minutes) of significant aspects of the functioning of child B's family.

North Middlesex Hospital

3.2.275 Neither mother or sister 1 were subject to any child protection plan or care plan at the time of hospital involvement. Hospital records contain a copy of a core assessment completed by Waltham Forest Children's Social Care, which did not contain any information which indicated there was awareness that mother was pregnant, though did conclude that there were a number of risk factors and current behaviour such as self-harming and criminal behaviour (breaking into cars). It remains unclear when or whether the midwife was made aware of this information.

Whipps Cross Hospital (Midwifery): NOT APPLICABLE

Whipps Cross Hospital (Medical): NOT APPLICABLE

Outer North East London Community Services

3.2.276 Primary responsibility for the decision to add and later remove sister 1's name form the list of those subject of a child protection plan rested with Children's Social Care.

3.2.277 In terms of plans and processes, there is no documentary evidence that HV 2 provided a report to the review conference in November 2007 nor (though these should have been sent to her anyway) that she had chased the minutes of that conference or the child in need plan emerging from the first conference in mid February 2007.

North East London Foundation Trust

3.2.278 Child B was unknown to this Trust as there had been no referral to the perinatal team. The Trust responded to all requests from Children's Social Care for information or advice but, as indicated previously should have alerted Children's Social Care following the revelations of father at Whipps Cross Hospital in August 2007.

Early Years: NOT APPLICABLE

Ascham Housing

3.2.279 Without the benefit of an interview with the relevant tenancy services officer, it is not possible to be certain, but it appears the only example of explicit non-compliance may have been the failure to pass to Children's Social Care in Autumn 2010 allegations of abuse of the children and (commented upon below) the failure to follow up the issue of unauthorised pet/s in the home.

Environmental Health: NOT APPLICABLE

THE EXTENT TO WHICH PRACTICE WAS SENSITIVE TO THE RACIAL, CULTURAL, LINGUISTIC & RELIGIOUS IDENTITY OF THE CHILD AND FAMILY & HOW THESE NEEDS WERE MET

Children's Social Care

3.2.280 The parents are members of the dominant local culture – White British whose first language is English. The describe themselves as non practicing Church of England and mother had indicated in the course of the last core assessment she would like to take the children to church to learn about their religion and cultural heritage but felt that they were too young at that time.

3.2.281 Whilst mother, father and the then three children might have appeared to be a traditional nuclear family, the impact of innumerable parental separations on the children's sense of security and identity, remained largely unexplored. Given mother's impulsivity, hostility and aggression, it can reasonably be assumed that each such separation would have been accompanied by a good deal of noisy and probably aggressive argument. The observations of school teachers suggest that sister 1 anyway had acclimatised to the dynamics at home by withdrawal.

3.2.282 Whilst the family claimed they enjoyed support from the extended family, it was clear that there were significant tensions. Mother's almost incidental references to injunctions against and by the paternal grandmother reflect what remained unexplored issues of real relevance to the children e.g. there is no indication that any social worker sought to find out what explanation had been offered sister 1 for not being able to see the paternal grandmother and how she might have reacted?

3.2.283 The maternal grandmother's support, though not entirely unconditional appears to have been the more consistent and events such as the family group conferences were skewed toward the maternal family perspective. It is not clear whether staff recognised that the maternal grandmother having been wholly unable to control her daughter as a young child was likely to remain dominated by her.

3.2.284 As well as the social disadvantage associated with the family's relative poverty and limited accommodation, alleged anti-social behaviours alienated them from what might otherwise have been sources of support such as good neighbours. Whilst practitioners at times raised questions about the allegations of anti-social conduct, denials seemed to have been accepted at face value rather than pursued on the basis that local tensions would impact on the children's welfare.

Metropolitan Police Service

3.2.285 Police were aware of the ethnicity and nationality of all family members. Its individual management review confirms no information or inference in Police records to indicate any actions or decisions were motivated or aggravated by ethnicity, faith, sexual orientation, gender, linguistic or other diversity factors.

3.2.286 Where the family had contact with Police, or in any of the joint working that took place, there is nothing to infer that any of these factors were relevant in the decision-making or how they were treated.

3.2.287 Mother's mental health vulnerability was recognised when she was arrested and use was made when she was interviewed, of an appropriate adult.

GP Services

3.2.288 The GP records were apparently silent with respect to any issues of race, culture, language or religious affiliation, although in this instance the family was an example of the *dominant* local culture.

North Middlesex Hospital

3.2.289 Mother's ethnicity and religious affiliation had been captured at the point she booked in for maternity care. Mother disclosed that she had a family history of learning difficulties (her brother and father) which was information (accurate or not) that did not emerge from other agencies. No specific or additional responses to meet cultural needs emerged during hospital involvement.

3.2.290 Though not required for this family, the hospital individual management review included confirmation of the agency's approach to and facilities for meeting the diverse needs associated with ethnicity, language, or religious beliefs.

Whipps Cross Hospital (Midwifery)

3.2.291 The individual management review offers no commentary on this issue and, aside from a clear sensitivity to what was perceived as the family's overcrowding, no other reference to their personal environment, culture, religious beliefs or links within the local community was made. The service provided appeared 'colour / culture' blind, which as the family were of the dominant local culture (White, English, 'C of E') may have had little impact but which could, if they were of a minority group have disadvantaged them.

Whipps Cross Hospital (Medical)

3.2.292 This issue arose in practice only after the 'life pronounced extinct' decision on child B when father was offered and declined support from a religious representative within the hospital.

Outer North East London Community Services

3.2.293 The individual management review identified no unmet needs in respect of race, culture, language disability, religion, gender or sexuality. As well as noting these details, the health visiting service had captured the employment and Benefit status of the family as had actions by the health visitor (seeking support from charities) and the child development centre (offering to provide a taxi) evidenced a sensitivity to scarcity of funds.

North East London Foundation Trust

3.2.294 The Trust's individual management review makes no references to issues arising from the family's race, culture, language or religious identity, though the author notes that mother and father were assessed by an ethnically diverse range of doctors, nurses and social workers.

Early Years

3.2.295 Sister 1 (who has no disability) is a White child whose parents described themselves on the pre-school's admission forms as 'White U.K.' The parents wrote 'Church of England' on the application form but were not known to be practicing Christians. In terms of 'cultural' identity little was known by the pre-school and nursery about their individual family culture other than that they were poor and had very limited resources and this was recorded by the health visitor on the initial referral form.

3.2.296 Awareness of these issues and of mother's depression did not prevent the staff at Primary School 1 from being clear that sister 1 needed to be in the nursery consistently and they sought to create a positive relationship with the parents to encourage them to bring their daughter in regularly.

Ascham Housing

3.2.297 The fact that staff met only one member of child B's immediate family (mother) severely restricted the opportunities to demonstrate sensitivity to racial, cultural, linguistic and religious identity. Nothing seen raises doubt about the agency's capacity or performance in this respect.

Environmental Health

3.2.298 The very limited contacts in this case offered insufficient opportunities to demonstrate it but the individual management review author confirms that the service and all its officers are aware of and sensitive to racial, cultural, linguistic, religious and disability issues.

THE INVOLVEMENT OF SENIOR MANAGERS OR OTHER ORGANISATIONS & PROFESSIONALS AT POINTS WHERE THIS WAS INDICATED AS APPROPRIATE

Children's Social Care

3.2.299 Throughout the history of the case, there was a high level of involvement of other relevant professionals and there were only two serious examples of a failure to engage effectively with partner agencies:

- The reported rudeness and reluctance / inability to communicate of the then allocated social worker when invited to share information with the community paediatrician in June 2010
- An apparently more systemic reluctance within the First Response Team to respond to oral and written expressions of concern from sister 1's school in late 2010 / early 2011

3.2.300 Though the most senior manager to have been involved was the person who completed an audit of the final core assessment, there had, throughout the period covered by this serious case review been a high level of local management support.

3.2.301 Supervision was provided at the following frequencies:

- Three times in the six months the case was allocated to SW 1 (which at two month intervals, was consistent with the departmental policy)
- For SW3, seven times in the period June 2007 – June 2008 (i.e. also at intervals of two months) but on *no* occasions for the remainder of her involvement until case closure on January 2009
- For SW5 for her five month long involvement April – September 2009, three times (also consistent with departmental policy)
- For SW2 in his five months from June – October 2010, only two occasions, the latter being on the day of case closure

3.2.302 Of the above staff, SW2 was newly qualified and needed and deserved the highest level of support which in departmental policy terms would have meant at minimum monthly supervision.

3.2.303 It is worth noting the above minimum standards are lower than some seen elsewhere by the overview author. It is more typical to offer newly qualified staff fortnightly and the more experienced, monthly supervision.

3.2.304 The Children's Social Care individual management review rightly regrets the decision taken by the deputy team manager in the First Response Team in late 2010 that because she thought the Community Safeguarding and Intervention team would struggle to resource the case, SW2 should amend his recommendation.

3.2.305 The above decision subverted the assessment process, undermined the social worker's status and was likely to have increased the level of risk to the children in the family. As indicated in the individual management review, the proper response would have been, in the event that her fears about allocation were realised, to escalate the case and involve a more senior manager.

3.2.306 Though the frequency of supervision offers a measurable means of evaluating aspects of management support and direction, it does not address its quality. The perception of the individual management review author and the managers who completed the core assessment audits of late 2010 and early 2011 is that supervision had been insufficiently reflective.

3.2.307 The Munro report (2011) emphasised the centrality of supervision to the social work task and the often critical value of having opportunities to stand back and reconsider a case from a different perspective. Whilst this serious case review has provided an opportunity to transcend individual events and discern patterns of behaviours, some comparable thinking could have been applied via supervision e.g. what proportion of health appointments were being missed, or the veracity of reasons given for not progressing aspects of child protection plans.

Metropolitan Police Service

3.2.308 Available records indicate that senior officers were involved as / when required during the period under review.

GP Services

3.2.309 GPs have no 'senior managers' and are essentially autonomous. Wide variations in levels of awareness of and involvement in safeguarding seen within this serious case review pose issues for commissioners of GP services about how expectations may be defined, monitored and (if unfulfilled) responded to.

North Middlesex Hospital

3.2.310 There was an appropriate level of management involvement as the named midwife was also managing the community midwifery service at the time of mother's presentation. However she was only aware of the situation after the birth of sister 1 when all the services had collaborated

3.2.311 The midwife involved should have contacted the named midwife when she needed, at the time of mother's booking for maternity care, to make a decision about the level of perceived risk.

3.2.312 *If* the named midwife had been involved following the booking appointment and risks identified her advice was likely to have been an immediate referral Children's Social Care in line with Trust child protection policy (2002)

3.2.313 When mother was threatening to self discharge, the 'antenatal / postnatal ward manager' contacted the named midwife for child protection and discussed the issue. They both then met with the parents to try to encourage them to remain with sister 1 in the hospital.

3.2.314 This attempt was made despite the hospital not having any legal grounds to prevent the parents from leaving. These actions, which it seems were supported, perhaps suggested by Children's Social Care were well intentioned though a comment is made elsewhere about the doubtful justification within Children's Social Care for such an approach.

Whipps Cross Hospital (Midwifery)

3.2.315 Community midwives are expected to discuss all child protection cases with the midwifery adviser for safeguarding or named midwife for safeguarding children which opportunity exists at eight weekly supervision sessions. Additional advice can be sought in between those sessions. In this instance, the midwife did not discuss the family during her supervision because she had not fully appreciated its vulnerability.

Whipps Cross Hospital (Medical)

3.2.316 Nothing in the material seen suggests that there was a need to involve more senior managers in any clinical decisions made.

Outer North East London Community Services

3.2.317 More effective child protection supervision in this case could have enabled a better understanding of the enduring concerns evident from this serious case review. This is explored in the Trust's Community Services individual management review.

3.2.318 The management of this case was escalated to the named doctor for child protection in April 2010 by the physiotherapist team lead who then escalated her concerns to the Children's Social Care deputy team manager. Following this escalation, a strategy meeting was eventually convened in July.

3.2.319 The referring doctor who was unable to attend the strategy meeting received no formal feedback regarding the decisions of that meeting (an issue identified by the individual management review as a recurring problem also identified in a recently completed serious case review). Receipt of the minutes would have triggered oversight of the case by the named doctor.

3.2.320 There was no recording in the health visiting records about disagreement with the outcome or plan emerging from the strategy meeting or confirmation of a feedback discussion with the named doctor. The agency's individual management review does describe a recent strengthening of the reporting of safeguarding incidents and governance within the agency.

3.2.321 The individual management review author identified a potential conflict of interest in the arrangements that existed during the period covered by this serious case review viz: the health visitor team leader was also the child protection supervisor. The author did not though find evidence that decision making was influenced by managerial priorities.

North East London Foundation Trust

3.2.322 The only occasion on which a more senior member of staff should have been involved was in August 2007 when father was assessed at Whipps Cross Hospital and no referral initiated to Children's Social Care.

Early Years

3.2.323 The assistant head and designated member of staff for safeguarding and child protection and interim head teacher from May 2010 until September 2010) was involved in liaising with Children's Social Care and communicating with nursery staff throughout sister 1's time at the nursery.

3.2.324 The assistant head rightly attempted to escalate her concerns by writing to the TM 4 when she felt that her concerns about the child's attendance were not being acted upon.

3.2.325 She did not receive a response from the manager and it is at this point that further escalation should have been considered.

3.2.326 Worryingly, the Early Years individual management review described this experience as a common difficulty for schools and a recommendation is included in section 5.

Ascham Housing

3.2.327 This agency's individual management review confirms an agency policy of six weekly supervision. Though it is silent with respect to the period prior to Autumn 2010, it confirms there was such oversight of the response to the allegations of anti-social behaviour. The report acknowledges the question of the unauthorised pet was overlooked in spite of this level of case supervision and raises but does not answer the question of whether the supervisor was fully aware of the information provided the previous year by psych.7

Environmental Health

3.2.328 Senior managers were not involved at any point in what were (justifiably) regarded by officers as routine responses.

WHETHER THE WORK IN THE CASE WAS CONSISTENT WITH THE POLICY & PROCEDURES FOR SAFEGUARDING & PROMOTING THE WELFARE OF CHILDREN IN EACH ORGANISATION, FOR THE WFSCB & WITH WIDER PROFESSIONAL STANDARDS

Children's Social Care

3.2.329 As indicated above, the organising of initial and review child protection conferences as well as associated core groups was in general managed in a timely manner (with the exception of the lengthy delay in convening the first core group in 2007).

3.2.330 There were occasions on which the agreed visiting schedule was not complied with because the family (by chance or design) was not in or in October 2007, the social worker, on the basis of 'noted improvements' [it was unclear what improvements] and without any recorded authorisation reduced her visits to three weekly.

Metropolitan Police Service

3.2.331 The records confirm that all work was completed in accordance with the MPS standard operating procedures in the context of the London Child Protection Procedures and in the broader context of *Working Together to Safeguard Children* 2006 and later 2010.

GP Services

3.2.332 The view formed by the independent GP individual management review author (whether rooted in an examination of the commissioner's contractual requirements is un-stated) is that the work of the GPs was consistent with the ONEL Community Services and Waltham Forest Safeguarding Children Board policies and procedures. (In fact advice from panel members corrected this comment and confirmed that GPs operate to the London Child Protection Procedures, not ONEL Community Services).

North Middlesex Hospital

3.2.333 Though there was an overall compliance with policy following the birth of sister 1, a number of exceptions have been identified.

3.2.334 There was some lack of awareness by practitioners in the antenatal period about child protection practice and policy. Practice following delivery of sister 1 was consistent with policy and procedures i.e. the midwife contacted Children's Social Care immediately and notified it of the birth of sister 1. In addition when mother asked to be discharged and not wait to be assessed by Children's Social Care, the named midwife and antenatal / postnatal ward manager made a well intentioned attempt to encourage her to stay.

3.2.335 Children's Social Care was also promptly informed when mother self discharged.

Whipps Cross Hospital (Midwifery)

3.2.336 The failure to seek consent for provision of a urine sample was contrary to agreed policy whereas not raising the family at a supervision session as discussed above reflected the midwife's underestimate of vulnerability.

Whipps Cross Hospital (Medical)

3.2.337 The extent to which clinical decisions accorded with national guidelines, regional or local procedure or accepted best practice has already been commented upon above.

Outer North East London Community Services

3.2.338 The individual management review author expresses the view (with which the overview author concurs) that staff were committed to delivering a high standard of care and sought to act in a way that was consistent with policy and procedure. There were though, deficits in practice (specified in the responses to all the other elements of the terms of reference) that obstructed a full appreciation of need and formulation of optimal multi agency plans.

North East London Foundation Trust

3.2.339 With the exception of the occasion in 2007 on which Children's Social Care was not alerted to father's revelations and when the joint visit in July 2010 failed to address the impact on the children of mother's conduct, policies and procedures were complied with.

Early Years

3.2.340 Staff at Primary School 1 responded swiftly and appropriately to requests for information about sister 1 and attended meetings when invited. They regularly shared information with Children's Social Care and the assistant (then interim) head teacher escalated the matter when she judged the school's concerns were not being given sufficient weight.

3.2.341 When Children's Social Care closed the case in February 2011 the school continued to try to manage the poor attendance internally. Practice was good and in line with its own child protection policy but their struggle to have concerns acknowledged highlights the need for schools to be able to access on-going support and advice when they are faced with these difficult situations.

Ascham Housing

3.2.342 Service provided was consistent with policy and procedure with the exceptions described above of a failure to follow up the unauthorised pet issue, and insufficient information being shared with SW2 in late 2010.

Environmental Health

3.2.343 It became clear in the development of the Environmental Health individual management review that there was insufficient awareness within this department of the Local Safeguarding Children Board policy and procedures for safeguarding children. A recommendation to address this deficit is provided in section 5.

THE EXTENT TO WHICH DECISION MAKING WAS AFFECTED BY OTHER ORGANISATIONAL CONSIDERATIONS FOR EXAMPLE WORKLOAD PRESSURES OR ORGANISATIONAL CHANGE

3.2.344 Current work being undertaken by the Social Care Institute for Excellence seeks to identify which factors in the work environment support good practice and which create unsafe conditions in which poor practice is more likely. The Social Care Institute for Excellence 2008 publication [8] summarised the proposed approach and its framework of 6 key influences. Government has announced three pilot serious case reviews to be completed using the 'systems approach'. Meanwhile and mindful of the *current* required methodology, the following analysis addressed the more obvious issues of workload, organisation and policy constraints.

Children's Social Care

3.2.345 Across the four years considered, there had been a number of organisational changes e.g. the 16+ service has been disbanded and the First Response Team was re-badged as a Referral and Assessment Service though still with the remit of being the first point of contact for the public and professionals with concerns about a child.

3.2.346 No evidence has been provided to suggest that the above changes impacted adversely on child B's family. However, as described elsewhere, the anticipation (whether justified or not cannot be certain) that the Community Safeguarding & Intervention team would struggle to meet the demands if the case was transferred to it in late 2010 served to create a problem where none may have existed.

Metropolitan Police Service

3.2.347 The only occasion on which a decision was constrained by resource issues was when it was not possible to provide an officer to attend the proposed pre -birth strategy meeting in January 2007.

3.2.348 There is no evidence that any organisational change adversely impacted upon services delivered.

[8] Learning Together to Safeguard Children: Developing a multi- agency systems approach for case reviews SCIE (2008)

GP Services

3.2.349 Though there were some communication difficulties between GPs and Children's Social Care (referred to elsewhere), there is no evidence that GP performance was in any way related to insufficiency of resources or reorganisation.

North Middlesex Hospital

3.2.350 The number born from April 2006 to March 2007 was 3456 and the 'midwife to birth' ratio was 1:36 which was above the London average and above the national recommendation of 1:28.

3.2.351 The North Middlesex Hospital individual management review concludes that this did not appear to have any significant impact on the clinical care and management of mother and sister 1.

3.2.352 The individual management review indicates that it is difficult to conclude whether this had an impact on the operational child protection practice, but the overview author's interpretation is that the oversights or examples of procedural non- compliance appear to be primarily, a function of individual performance.

3.2.353 With respect to the question of management accountability, as soon at the named midwife became aware of the case relevant advice and support was given to midwifery team and she also intervened when mother was threatening discharge.

Whipps Cross Hospital (Midwifery)

3.2.354 At the time of the midwife's work with mother and child B, there was a review of community services and a number of vacancies the result of which was an enlarged caseload for community midwives. This was, according to the midwife one of the reasons why mother and child B were invited to the post natal clinic at the health centre rather than being seen at their home.

3.2.355 The consequences of this unintended aspect of reorganisation cannot easily be quantified but transitional results of otherwise sound strategic plans should be acknowledged and factored in by senior managers and practitioners.

Whipps Cross Hospital (Medical)

3.2.356 There is no indication that any organisational factors such as staffing levels, or re-structuring impacted upon service delivery.

Outer North East London Community Services

3.2.357 Though the circulation of conference minutes remains a concern for the overview author, the authors of this agency's individual management review did not identify any organisational difficulties between agencies in the management of this case and instead attributed difficulties in interagency working to individual practice.

3.2.358 The family was in receipt of enhanced health visiting services from March 2007 until the death of child B (and beyond). HV6 did report that her workload prior to and at the time of child B's birth required the new birth visit to be completed by another practitioner (fortunately a very experienced agency health visitor).

3.2.359 Beyond this particular organisational consideration, there were no other suggestions that agency capacity impacted on the management of this case.

North East London Foundation Trust

3.2.360 Nothing in material supplied suggests that organisational difficulties impacted upon the efficiency or effectiveness of professional responses or that a lack of management support had an adverse effect.

Early Years

3.2.361 The Early Years individual management review confirmed that there were no organisational difficulties being experienced during sister 1's time at either early years facilities, both of which had sufficient staff in post and both of which had staff with designated responsibility for safeguarding.

Ascham Housing

3.2.362 At the time Ascham homes did not have access to the local authority's client database and thus to any reference therein to mother's mental health history or historical child protection history.

3.2.363 During the course of this serious case review, access has been agreed and all relevant staff are trained in use of the system.

3.2.364 No other workload pressure or organisational change was recorded as having impacted upon assessments or service delivery.

Environmental Health

3.2.365 No concerns about or evidence to suggest organisational considerations such as workload pressures or organisational change emerged from the agency's individual management review or panel discussion.

3.3 CASE SPECIFIC QUESTIONS

DID PROFESSIONALS HAVE A CLEAR UNDERSTANDING OF CHILD B'S EXPERIENCE IN THE FAMILY & HOW DID THIS INFORM INTERVENTION & SUPPORT FOR HER

Children's Social Care

3.3.1 Children's Social Care staff had no opportunity during her seven weeks of life to form any direct understanding of child B's experience within the family. This was a consequence of the absence of a pre or post birth referral.

3.3.2 If the question above were to be broadened to address the experience of either sister 1 or sister 2, then it is worth noting that *none* of the records seen describe the everyday experience of the children e.g. at what time does each wake up or get up; do they have large appetites?; what do they like doing?, at what time do the children go to bed?; do they sleep easily or have bad dreams ?; are they easy or difficult to manage etc.

3.3.3 An account of the 'child's world' would have added value to all the core assessments seen.

Metropolitan Police Service

3.3.4 Police had no contact with child B or her family from her birth until her death. Officers' previous contacts with the family showed sensitivity to the needs of the children they observed.

GP Services

3.3.5 GPs were cognisant of the family dynamics but had little knowledge beyond sister 1's school related issues or of the family's accommodation (the latter an inevitable consequence of the policy of not undertaking home visits).

North Middlesex Hospital

3.3.6 Hospital staff were not engaged with the family during child B's life.

Whipps Cross Hospital (Midwifery)

3.3.7 The midwife at her first post natal home visit was clear about what was to become child B's living environment i.e. a one bedroom flat where all parents and children would be sharing a bedroom. She had noted the home to be untidy but not dirty and had seen no dog hair or mess.

3.3.8 Perhaps because during the ante natal period, she had formed a relatively benign view of the family's capacity to cope, and was coping with a higher than desirable case load (hence further contacts were to be at the clinic), the midwife did not explore further the issue of mother's mental health post partum, drug misuse or the additional pressures a third child would bring.

WXUH (Medical): NOT APPLICABLE

Outer North Easy London Community Services

3.3.9 Child B's (presumed to be accurate) birth weight was 2.87Kg (> 9th centile). During the very few weeks of child B's life, the professionals from this organisation who saw her and/or her family were:

- The agency health visitor HV5 who completed the new birth visit on behalf of the allocated health visitor (when child B then two weeks old was recorded as weighing 2.9Kg (9th centile))
- The health care support worker who weighed her at three weeks of age and recorded 3.33Kg (25th centile)
- An unidentified person when (aged four weeks) child B was weighed and recorded as being 3.86Kg (> 25th centile) [parents can elect to present to any clinic where weights are recorded in handheld records but not uploaded to the agency's Rio database]
- In late April, a community midwife 4 at a home visit – child B was not weighed but 'all was well with mother and baby')
- HV6 who completed a subsequent home visit when no weight was recorded but, in spite of being on treatment for oral thrush, 'child B appeared well'
- The same health support worker as above, who at the medical centre two days before her death, recorded child B's weight as 4.3Kg and initially mis-recorded the baby's age as twelve (not the actual seven weeks + five days) and
- GP9 whom it is believed, corrected the above mis-recorded age

3.3.10 Thus, snapshots of how child B was developing were disseminated amongst several individuals. None however, had reason to be concerned in terms of the baby's recorded weights, development or issues related to parents.

North East London Foundation Trust

3.3.11 This organisation's staff were not engaged with the family during child B's life.

Early Years

3.3.12 Because Early Years staff had no direct contact with sister 2 or with child B, they were not positioned to form a view of the 'lived experience' of either child. However, their close involvement and attentiveness over time with sister 1 gave teaching staff valuable insights into the family's functioning and it is regrettable that these observations did not impact more on Children's Social Care responses.

Ascham Housing: NOT APPLICABLE

Environmental Health

3.3.13 Environmental Health officers had no contact whatever with child B and only indirect knowledge of either of the other two children.

DID PROFESSIONALS HAVE A CLEAR UNDERSTANDING OF MOTHER'S MENTAL HEALTH NEEDS & WHETHER ASSESSMENTS OF THE MENTAL HEALTH NEEDS OF THE MOTHER TOOK ACCOUNT OF HOW THESE AFFECTED HER ABILITY TO PARENT & WHAT WEIGHT WAS THIS GIVEN TO THIS IN ASSESSMENTS

Children's Social Care

3.3.14 Efforts were made from the outset to learn more about mother's mental health and the joint approach adopted by the then social worker and mental health worker in early 2007 was commendable. The Children's Social Care individual management review author, having interviewed the first two allocated social workers helpfully confirms that those individuals were clear that although mother's mental health might be described as 'stable' in its own right, that this did not mean that it was sufficiently robust to cope with the demands of parenting one, two and later three under fives.

3.3.15 The above social workers indicated that their level of concern about mother's mental health was (correctly in the view of the overview author) greater when father was not present to support his partner i.e. they appreciated that he had a calming influence.

3.3.16 There could have been (as indicated elsewhere) more robust challenges of mother's repeated failure to honour various promises to complete a mental health reviews. Children's Social Care staff were left in the uncomfortable position of acknowledging a diagnosis of borderline personality disorder but in practice being able only to monitor her presentation and parenting performance.

Metropolitan Police Service

3.3.17 Police contacts with mother did not, in all but one instance reveal anything which reached the threshold for action, the exercise of 'police powers' [s.46 Children Act 1989] or the specific reporting of mental health issues.

3.3.18 The one incident when specific measures were taken was after mother's arrest in May 2010. During the risk assessment at the police station it was considered her presenting behaviours justified examination by the Police 'Forensic Medical Examiner' whose view was that mother needed an appropriate adult present at interview and was placed on more frequent watch whilst in a cell. No other measures were considered necessary.

GP Services

3.3.19 At interview the current GPs asserted they had a clear understanding of mother's mental health issues. This is at odds with the written evidence seen by the overview author e.g. in the absence of a definitive diagnosis by a psychiatrist of mother's mental health status, GPs had referred variously to 'schizophrenia' (erroneously ascribed in 2002), 'psychotic depression' (inaccurately included in the August 2006 referral to North Middlesex Hospital) as well as other more nuanced descriptions.

3.3.20 The muddle about mother's mental health status, to which she, the maternal grandmother or father at times added, prevailed throughout the period under review. In relation to eligibility for Disability Living Allowance, it may have suited to mother to exaggerate her mental health difficulties e.g. she informed the overview author that she had a 'split personality'.

3.3.21 The referral in 2008 for ante natal care and mental health assessment by GP 4 contained a more balanced account of mother's mental health and showed an awareness of the potential impact on parenting of mother's mental health.

3.3.22 A further referral by GP10 in 2010 to HV2 when (inter alia) she was concerned about the way that mother and her children were interacting showed a welcome awareness of the impact on those children of mother's mental health.

3.3.23 A recommendation that (with her consent) mother's psychiatric condition is formally reviewed and the erroneous ascription of the term 'schizophrenia' is expunged from medical records is included in section 5.

North Middlesex Hospital

3.3.24 The GP's referral for maternity care had highlighted mental health issues though mother did not share this fact with the midwife who booked her in for maternity care. Thus, risks associated with mother's history were not identified in the booking and not included in the plan for sister 1's birth.

3.3.25 The hospital 'antenatal care guideline' (2004) indicates that a client with significant mental health issue should be managed by the consultant with liaison with the psychiatric team and internally a 'LINK' form should be completed with support services involved with a plan of action developed. Mother *was* referred to the consultant obstetrician immediately following booking but did not attend any of the three scheduled appointments arranged and there was no follow up of these (as opposed to the midwife) 'did not attends'.

3.3.26 During this period there were no specific agency guidance on the management of mental health issue in the antenatal and postnatal period, although a pilot of mental health screening in pregnancy was being introduced which included the recommendation of National Institute for Clinical Excellence (NICE) antenatal and postnatal mental health (2007).

Whipps Cross Hospital (Midwifery)

3.3.27 The midwife allocated to mother was aware of some though not all her history of mental health including that she had stopped taking prescribed medication before her pregnancy with child B. Mother's assertion that she was coping well without medication was supported by her GP's referral letter although that letter referred also to mother's previous post natal depression which the midwife cannot recall discussing with mother. The GP's letter did not include a reference to a history of overdosing so the midwife remained unaware of that risk factor.

3.3.28 When she took the booking history, the midwife followed the relevant NICE (2007) guidelines in asking questions about mother's mental health. Certainty about the post natal period is limited by the fact that post natal records have been lost by mother, but, from the midwife's exploration of her diary and her personal memories, there is no indication that mental health or its potential impact on parenting was explored following the birth of child B.

Whipps Cross Hospital (Medical)

3.3.29 Mother was seen by a psychiatrist on each occasion of her three presentations in 2004 which was good practice and consistent with NICE (2004) guidelines for the management of people who self-harm. Despite the information available from 'Triage' and from psychiatrist's history-taking indicating that mother was a very vulnerable young girl with possible behaviour / mental health problems no one seems to have considered the risk of significant harm to her, which potentially increases with each episode.

3.3.30 Good practice would have been for staff, as part of their assessment process, to check if the young person was known to Children's Social Care. In addition, the London Child Protection Procedures (ed.2 2003) recommended that, following psychiatric assessment, discussion should take place between the psychiatrist and hospital staff to consider if child protection concerns exist and if a referral should be made to children's social care. There is no evidence in the notes that this took place.

3.3.31 At mother's next presentation in May 2005 the psychiatric history taking was thorough and input from Child & Family Consultation Service and a referral to Children's Social Care was planned. There is no documented evidence that this referral was made and there is no evidence that a discussion took place between the psychiatrist and hospital staff to clarify who would make the referral.

3.3.32 Although the assessments at all the subsequent attendances / admissions note each prior attendance for self-harm, practitioners' responses do not indicate an awareness that repeated self-harm could be a potential indicator of abuse or neglect. As a consequence, Trust guidance and the London Child Protection Procedures (2003) were not implemented. Nor is there evidence of communication with the named nurse for safeguarding children. Each single admission represents a missed opportunity to consider child protection and provide an opportunity for additional child and family support via Children's Social Care and joint inter-agency plans of care.

3.3.33 A referral to Child & Family Consultation Service appears to be the extent of the partnership working initiated by A&E. Lack of communication between the services following the Child & Family Consultation Service assessment of mother indicated a limited view of partnership working and represents a missed opportunity for professional sharing of expertise and joint consideration of the safeguarding of the child.

3.3.34 At the first 'early pregnancy assessment unit' attendance in 2006 when she was seventeen years old, the casualty card indicated that she had a history of schizophrenia but there is no evidence that this was further explored by the nursing and obstetric and gynaecology staff. This represents a missed opportunity to explore mother's mental health and any medication she may have been taking. The limited assessment also precluded referral to other agencies, such as mental health, who could have supported a positive outcome to the pregnancy and the parenting of the baby once born.

3.3.35 No exploration with mother appears to have occurred in relation to the reported miscarriages e.g. had she visited her GP or sought any medical attention? The agency's individual management review points out that previous miscarriages can negatively impact on a woman's well-being during a pregnancy and can lead to anxieties about how the present pregnancy will progress (Cumming, GP et al, 2007). An opportunity was therefore missed to undertake a comprehensive assessment that would inform plans to maintain the physical and psychological health of this woman during pregnancy and after the birth of the baby.

3.3.36 Mother's pregnancy with sister 2 was confirmed in 2008 and the relevant ward manager remembered her because there was 'something not quite right about her'. This did not prompt an exploration of mental health with the patient which represents another missed opportunity to explore her mental health, its potential impact on pregnancy and subsequently parenting.

3.3.37 The limited assessment for both early pregnancy assessment unit presentations did not provide for the exploration or identification of safeguarding concerns and therefore precluded communication with the named nurse for safeguarding children.

Outer North East London Community Services

3.3.38 The long standing confusion about mother's mental health diminished the accuracy and in consequence the value of many inter agency exchanges e.g. as recently as May 2010 the otherwise well informed and wholly justified referral from the named doctor to Children's Social Care was referring (erroneously) to mother's 'schizophrenia'. Inevitably inaccurate references to presumed diagnoses served to undermine their potential ability to predict likely impact on parenting.

North East London Foundation Trust

3.3.39 Mother's most recent psychiatric medical review was undertaken in September 2009 by psych. 7. A perinatal nurse visited mother at home and a social work assessment was undertaken later that month.

3.3.40 Whilst the psychiatrist was aware of mother's long history of personality difficulties and impulsive behaviours and her Child & Family Consultation Service tentative diagnosis of 'borderline personality disorder', she was not in possession of the full case file at this point and made a note to request the Child & Family Consultation Service records.

3.3.41 It does not appear that this process was carried through and she was not aware of the full risk history; there is no evidence of a separate formal risk assessment form completed by any clinician on any of the paper or electronic records; the risk issues have to be searched for within the psychiatric assessments.

3.3.42 Mother had not taken medication for the preceding two years and was presenting with irritability, mood swings and poor sleep and appetite. The examining psychiatrist found no evidence of thought disorder or depressive symptoms and mother expressed a wish to resume taking her previously prescribed medications. She was prescribed one of the two drugs with a review planned a month later.

3.3.43 Mother subsequently made phone contact with this psychiatrist as she felt that the medication had not diminished her anxiety and mood swings. She was advised to increase the dose. Thereafter there was no more contact with as mother missed appointments two further appointments.

3.3.44 The perinatal team's protocol at that time (it had only been operational for a few months) was to discharge mothers once their baby reached six months of age and to close a case after two missed appointments so long as there were no risk concerns.

3.3.45 Mother's non-engagement meant that an opportunity to access psychological support was missed, because the psychiatrist had set out her intention to pursue this after their only meeting.

3.3.46 An important component of any psychiatric assessment is to identify any history of mental illness within the family system. An Access Team assessment undertaken in February 2010 evidenced that mother's paternal aunt suffered with depression arising from being raped by her father. Mother was never permitted to meet this grandfather. Her paternal uncle, youngest brother of her father, was reported to have committed suicide at the age of fifteen years by jumping in front of a train.

3.3.47 The notes evidence that when mother was under the care of Child & Family Consultation Service staff did conclude following home visits and the adolescent unit admission that she did not have a severe psychotic or depressive disorder, but did have a conduct disorder. Subsequent work suggested that the most effective and helpful intervention to address her experience of isolation within the family was to offer to work with the whole family. The family did not attend the initial meeting and the opportunity was lost.

3.3.48 Once mother was treated in Adult Mental Health Services, records suggest possibly that staff were unable to gain a comprehensive overview of her needs as they were unaware of risk incidents and details of the complexity of her childhood and adolescent relationships and the impact of her father's death at such a young age.

3.3.49 Psych. 7 did identify a role for psychological treatment but, as so often, mother did not return for further consultations. Mother's historical pattern of missing many appointments might suggest that she would not have been able or willing to engage with a longer-term treatment such as psychology.

3.3.50 When in February 2007 he was asked by Children's Social Care for his view of mother's capacity to parent Child & Family Consultation Service psych. 1 had reflected that, from his historical knowledge of her, he would have 'tremendous reservations' and suggested that Children's Social Care might consider a mother and baby unit or a setting where a foster mother provide support.

3.3.51 In the event the mental health worker was the only Trust professional to assess mother in the presence of her then two children in September 2009. Mother's mood was low at that time due to problems between her and the paternal family. Her mental state was however stable and her partner who was also present was supportive of her.

3.3.52 The nurse noted that both children seemed to 'be bonding well' with their mother 'she has a very good relationship with both of them'. Furthermore, 'the children appeared well taken care of and are happy kids around both their parents'. There were thus no concerns about either her parenting capacity or her mental health at that time.

Early Years

3.3.53 Staff attending a meeting in Summer 2010 with the consultant community paediatrician (paed. 1) were told that mother had a diagnosis of schizophrenia and was not complying with medication.

3.3.54 No evidence has been presented about the extent to which this misinformation was shared amongst all staff or how it influenced responses to mother.

3.3.55 Insofar as can be discerned from records, staff continued to operate in a determined and commendably child-centred manner.

Ascham Housing

3.3.56 Prior to September 2009 there is no evidence that Ascham Homes had any insight into the mental health needs of child B's mother.

3.3.57 On receipt of information provided by psych. 7, the agency had available to it, clear information which outlined mother's history of mental health difficulties dating and highlighting concerns of recent worsening mental health.

3.3.58 Importantly the information provided reported that mother had voiced her own concerns regarding how her worsening mental health was impacting on her family's functioning and ability to cope with caring for her (then) two young children.

3.3.59 The continued unavailability of the relevant tenancy services officer has rendered it impossible to discern why, in the light of the above information, Ascham's tenancy support team was not involved, nor any safeguarding referral made.

3.3.60 It would appear though as though the possible impact of mother's condition for safeguarding her children was not sufficiently recognised.

Environmental Health: NOT APPLICABLE

THE EXTENT & IMPACT OF DOMESTIC VIOLENCE IN THE PARENTS' RELATIONSHIP & IN THE WIDER FAMILY & THE IMPACT OF THIS ON THEIR PARENTING OF THE CHILDREN

Children's Social Care

3.3.61 The Children's Social Care individual management review provided a thorough exploration of the above issue. Research in the USA and in the UK has shown a significant association between abuse and neglect of children and of a parent spouse.

3.3.62 Correlation levels vary across studies but are probably as high as 60-80%.

3.3.63 Radford and Hester[9] have clarified the nature of the risks to children where there is violence between intimate adult partners:

- The perpetrator may also be directly physically or sexually abusive to the child
- The perpetrator may abuse the child as part of their violence against the partner
- Witnessing violence may have an abusive and detrimental impact on the child/ren concerned

3.3.64 The risks of the latter experience have been recognised in English law since the Adoption and Children Act 2002 extended the definition in s.31 Children Act 1989 of 'significant harm to include …' impairment suffered from seeing or hearing the ill treatment of another'.

3.3.65 The impact of witnessing the alleged domestic violence in this case seems not to have been considered.

3.3.66 An obstacle to the recognition of domestic violence itself and hence to the further possibility of risk to a child is the frequent withdrawal of allegations made. It is understood the 'average victim' in England has experienced about twenty incidents of abuse before involving the Police and many

[9] Mothering Through Domestic Violence by Lorraine Radford & Marianne Hester Jessica Kingsley 2006

victims, through fear of repercussions, anyway withdraw allegations or refuse to support prosecution [10]

3.3.67 Clearly though, each case has to be individually managed and reviewed on the basis of the evidence as opposed to any preconceived presumptions.

3.3.68 In this case however, as articulated in the Children's Social Care individual management review, it remains *unproven* that there was any (physical) domestic violence between the parents (or amongst extended family members about whom relatively little is known).

3.3.69 By their own admission, mother and father did have 'quite a few arguments from time to time' and there were a number of separations and reunifications confirmed in the local authority files.

3.3.70 All disclosures of domestic violence made by mother were later retracted, and most other reports by neighbours involved noisy confrontations as opposed to violence.

3.3.71 On one occasion in mid December 2010 an allegation of violence perpetrated by mother on father was made. If mother's mental health history and frequently observed verbal outbursts and threats, is compared to the absence of developmental problems and direct observations of father's demeanour, it seems that the probability of father being a victim is greater than that of this partner.

3.3.72 Setting aside who was at greater risk of victimisation, no records have been seen offering medical or other corroborative evidence of adult on adult violence.

3.3.73 The short term impact on the children of the acknowledged verbal altercations must not be understated. These must have been distressing for the children to witness and there would have been an on-going risk of them being caught in the crossfire.

3.3.74 The unresponsive demeanour of sister 1 in the context of her mother's angry outbursts with professional may well have been an adaptation to her parents' conduct.

3.3.75 There are also likely to be longer term consequences to any aggressive confrontations in terms of emotional wellbeing, self esteem, confidence and academic achievement (chapter 4 of Mothering Through Domestic Violence footnote 8)

[10] Prosecuting Domestic Violence without Victim Participation Louise Ellison Article first published online: 28 JUN 2008 Issue The Modern Law Review Volume 65, Issue 6, pages 834–858, November 2002

Metropolitan Police Service

3.3.76 The first reported domestic abuse was when mother (the aged eleven) made an allegation of assault by her own mother (maternal grandmother to child B) in 1999. In the cases that followed, domestic violence was correctly identified when matters were reported and were appropriately recorded and shared with partner agencies based on the information recorded.

3.3.77 These incidents recorded mother as either the victim, witness or as suspect and all were appropriately risk assessed. When the threshold was reached a MERLIN record was created and shared. Observations made by officers who reported these incidents indicated that they did not appear to have any impact on the children. Appropriate information was shared during the child conference process and strategy meetings.

3.3.78 The Police individual management review comments that with only one set of conference minutes retained by Police for the period that sister 1 was subject of a child protection plan, it was not possible to judge to what extent domestic abuse was considered or featured in the decision making process. It now seems quite possible that the missing minutes were never sent.

GP Services

3.3.79 The interview with the most recently involved GPs indicated they had no knowledge of the existence or type of domestic violence in child B's family.

3.3.80 Whist a question remains about the inclusion of GPs in the circulation of the minutes of the initial conference in early 2007, those from the review conference in November of that year *were* located amongst the GP records.

3.3.81 The independent management review author found no evidence to suggest that clear references to domestic violence within those minutes had in any way informed the future provision of GP services.

North Middlesex Hospital

3.3.82 There was no documentation within the mother's hospital records about any disclosure of domestic violence.

3.3.83 The maternity service had developed a specific local policy for domestic violence (2007), which replaced the previous guidance within the child protection policy. The policy contains the process for midwives to respond to disclosure of domestic violence and the support organisations within the areas served by the hospital that women can access. The policy requires that no recorded information about domestic violence should be documented in client hand-held records, due to the risk to client safety if the disclosure was found by the perpetrator. Documentation for domestic violence and discussion should be recorded in the hospital records.

3.3.84 The new maternity records that have been adopted in 2010 allows for written confirmation that a question about domestic violence has been asked at the booking appointment (a facility not previously available in the maternity records). Since 2010 there has been an outreach local domestic violence worker providing a service for eight hours per week to the A&E for women experiencing domestic violence which allows for confidential discussion and support to be offered.

Whipps Cross Hospital (Midwifery)

3.3.85 The allocated midwife followed the required routine when mother booked in for ante natal care and asked about the possibility of domestic violence. Mother denied that this was an issue and, given also that the GP's referral had referred in the negative to this possibility the midwife reasonably concluded that it was not a factor that need to influence her approach.

3.3.86 Positive observations of father and of the children at ante natal and post natal contacts gave he midwife no reason to suspect tensions or that domestic violence was an issue to be addressed.

Whipps Cross Hospital (Medical)

3.3.87 There seems to have been little exploration at the early pregnancy assessment unit, of the paternity with respect to any of the pregnancies nor of the potential for domestic violence.

Outer North East London Community Services

3.3.88 According to this agency's individual management review the first time the health visiting service was aware of concerns about domestic violence was in 2008 [incorrect date recorded] when HV1 received information from SW3 about a serious incident of domestic violence where it was recorded that mother had been threatened by father with a knife and that father had been hit over the head with a spanner resulting in admission to an intensive treatment unit. SW3 is also said to have reported that there had been a history of domestic violence.

3.3.89 The incident to which the above refers actually occurred on a different date The social worker may well have relayed mother's *claims* of previous domestic violence and that father had carried a knife, but the Police account of the incident (which the overview author considers to be the most likely to be accurate) recorded that father (knocked unconscious before having any opportunity to hide it) had no knife in his possession.

3.3.90 HV 1 had not previously been aware of any history of domestic violence and had not recorded and sought to explain in her records, some previous observed bruising on mother's arm. Such information should have been shared with Children's Social Care for the reasons clearly described in the Outer North East London individual management review (and in turn, anything Children's Social Care knew or suspected in this regard should have been made known to the health visiting service).

3.3.91 At interview HV1 confirmed her expectation that health visitors are usually informed by Children's Social Care about domestic violence incidents *and* are sent copies of Police MERLIN forms.

3.3.92 In this case, the Police individual management review confirms that from amongst a larger number of incidents in which officers were involved, MERLINs was sent to Children's Social Care on:

- May 2006 (following an argument between mother and father when she threw him out of the home)
- August 2007 (the assault referred to above on father by mother's then new boyfriend)
- October 2007 prompted by a row between mother and maternal grandmother
- December 2008 (an anonymous allegation mother was beating sister 1)
- June 2009 (following an argument between mother and father when she had again thrown him out of the home)

3.3.93 It has not been confirmed which, if any MERLINs were sent also to the health visiting service. It is clear that there was insufficient exploration by health (and social care) agencies of the episodically alleged domestic violence.

3.3.94 However, notwithstanding the fact that allegations and subsequent denials by victims are common, there is in this case actually very little evidence of violence perpetrated by father on mother and indications are that the probability of mother being the aggressor is higher.

3.3.95 The Outer North East London Community Services individual management review usefully identifies a need for a joint pathway between Children's Social Care and health services about the management of domestic violence and a recommendation in section 5 offers a means for its development.

North East London Foundation Trust

3.3.96 The first reference to domestic violence is located in an assessment that took place at Whipps Cross Hospital of father and was sent in letter form to his GP. Father had presented in A&E some seven months after the birth of sister 1.

3.3.97 Father told two psychiatric nurses he and mother 'had argued constantly since their baby was born and said she does not feel safe around him'. He stated that he had pushed mother against a wall that day when she said that she was going to leave him. He had then shut himself away in the bathroom 'in order to cut his wrist and stab himself in the abdomen'.

3.3.98 Neither Access nor Perinatal staff would have seen this assessment as it was not referred to on mother's electronic case file. Father was referred on to the Community Drug and Alcohol Team but the case was closed due to his not attending the two appointments offered.

3.3.99 The North East London Foundation Trust individual management review reflects that this assessment should have been highlighted to colleagues in the Access Team, to other mental health staff and to mother's GP who worked at a different practice to father's GP. It should also have been reported to Children's Social Care. The handwritten assessment form evidences that father shared the fact that mother had been 'under Child & Family Consultation Service psych.1 'borderline schizophrenic'. They were thus aware that mother had been a vulnerable child who might still be in receipt of Mental Health Services as an adult.

3.3.100 The opportunity for this additional information about domestic violence and substance misuse in the family home – and the implications for both adult and child safeguarding – to inform the further assessments undertaken by the Access and Perinatal teams was thus lost. Each nurse may have thought the other was going to alert Children's Social Care.

3.3.101 The second reference is contained in a Children's Social Care chronology of significant events that cites an excerpt from psych. 1 that he wrote of mother to the Department for Work & Pensions: 'many attempts at self-harm, can be violent to boyfriend'. As this reference to violence is within a larger document, it is again likely that the perinatal team in particular had no knowledge of the issue.

Early Years

3.3.102 Because the outreach worker had been told only that mother and father had a 'volatile' relationship and had not further explored this description, she was unable to share relevant information held by health visitor or social worker with those caring for and teaching sister 1.

3.3.103 Setting aside the truth about what is still unconfirmed domestic violence, it would certainly have enabled them to better contextualise sister 1's behaviours e.g. her anxiety when she spilt milk or reactions to men entering the nursery, *if* staff had been briefed.

Ascham Housing

3.3.104 The failure to link alleged domestic violence repair requests prevented this agency from providing support to child's B mother at an early stage, and potentially assisting her with possible access to temporary accommodation.

3.3.105 If the tenancy services officer had been more comprehensive in the information shared with Children's Social Care in Autumn 2010 it would have included the history of repairs necessitated by alleged domestic violence.

Environmental Health: NOT APPLICABLE

HOW THE PARTNERSHIP RECOGNISED & UNDERSTOOD THE EXTENT OF NEGLECT IN THE FAMILY & SUPPORTED THE FAMILY IN RELATION TO THE ISSUE OF NEGLECT

3.3.106 The NSPCC research briefing Child Neglect[11] indicates that neglect is underreported and underestimated. It was though the most common reason for children becoming subject of a child protection plan.

3.3.107 The briefing acknowledges that because it is complex and hard to define and varies by type, severity and chronicity as well as a child's age it can be difficult for professionals to identify.

3.3.108 The briefing points out that there is an increasing recognition that emotional neglect can occur even when physical needs are met whereas physical neglect always has some emotional impact on the child (Minty 2005). This understanding challenges traditional assumptions that a child can be 'dirty but happy' and is relevant to the appearance of sister 1 and sister 2 at various times during the course of this serious case review.

3.3.109 The NSPCC briefing is clear from the research that it examined that neglect has adverse short- and long-term effects (and in extreme cases, may be fatal) and cites the following research findings.

3.3.110 'Neglect causes great distress to children and is believed to lead to poor outcomes in the short and long-term. Possible consequences include an array of health and mental health problems, difficulties in forming attachment and relationships, lower educational achievements, an increased risk of substance misuse, higher risk of experiencing abuse as well as difficulties in assuming parenting responsibilities later on in life (Taylor & Bridge 2005). Glaser's (2000) review of work carried out in the fields of neuro-biology and developmental psychology showed that emotional neglect can have adverse effects on the development of a child's brain'.

3.3.111 The overarching view in this case is that there was amongst social workers and health visitors in particular insufficient recognition of the likely long term consequences of individual parental failures to meet physical or emotional needs of their children.

3.3.112 Ofsted's 'Learning lessons, taking action'[12]: highlighted issues arising from its first year of evaluating SCRs and noted that five cases involved chronic neglect. The common themes identified were as follows:

- No single agency had a complete picture of the family and a full record of all concerns
- Agencies tended to respond reactively to each situation as it arose rather than seeing it in the context of the case history

[11] Child Protection: Child Neglect NSPCC October 2007
[12] Learning lessons, taking action Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008

- Staff became resigned to and accepting of standards of care that would not be acceptable in other families
- Little direct contact was made with the children to find out what they thought and how they felt about their situation
- On the occasions when the children tried to tell agencies they were not understood or taken seriously.
- Schools had a critical role to play in recording how children were over time, both generally – whether children were dirty, tired, hungry and so on – and any specific changes in their behaviour and demeanour
- Professionals became confused and uncertain about the significance of issues in complex and chaotic families
- Too much reliance was placed on what parents said, and on supporting parents, rather than seeing the situation from the child's perspective and experience
- Families were often hostile to contact from professionals and developed skilful strategies for keeping them at arms length
- Families were subject to multiple assessments and plans without any clear expectation of what needed to change for the children, and what the consequences would be if these changes were not forthcoming
- There was little evidence of any attempt being made in any of these assessments to evaluate the quality of the attachments between parents and children, a critical feature of 'good enough' parenting

3.3.113 With the exception of the last bullet point, most of the other themes were also apparent in this case. Paras. 3.3.114-144 address the specific examples in this case of agencies' recognition and responses.

Children's Social Care

3.3.114 The Children's Social Care individual management review highlights that in the three years of episodic involvement, considerable efforts were made to assess and address identified needs or risks. The completion of six core assessments represented a significant investment of time from Children's Social Care as well as the other agencies that contributed to them.

3.3.115 The Children's Social Care individual management review identified some specific and serious (management) failings in the response to examples of neglect:

- The referral from the neighbour in November 2010 to which the manager's response was in essence 'case closed; tell the Police'
- A clear reluctance to hear or respond to repeated expressions of concern from sister 1's school relating during December 2010 and January 2011

3.3.116 In reflecting upon why there appeared to be a growing reluctance to acknowledge or respond to the latest examples of need or risk, it may be the case that an unhelpful degree of 'acclimatisation' had occurred i.e. what had initially been regarded as unacceptable became tolerable.

3.3.117 Until the dramatic (unrelated and unexpected death of child B) each crisis was comparable to the last. Viewed objectively, little positive change was seen across the three years of Children's Social Care involvement but it suited both family (who wanted Children's Social Care out of their lives) and social workers (who wanted to be able to report progress) to regard superficial or transient change as real and lasting progress.

Metropolitan Police Service

3.3.118 The Police individual management review confirms that officers did note the conditions of the home when attending the August 2007 incident and did so again when undertaking on behalf of Children's Social Care what was called a 'welfare visit' later that month.

3.3.119 Though current policy would require completion of a MERLIN report, the incident in September 2007 when officers were called to a playground rather than the address, did not.

3.3.120 Officers again showed a proper sensitivity to the possibility of physical neglect when attending the argument between mother and maternal grandmother in October 2007 and commented that the home seemed clean and tidy.

3.3.121 The final example of recognition of neglect was in September 2010 when the community support officer from the Safer Neighbourhood Team offered a graphic description (whether old or current remains unresolved as the originator is on maternity leave) of the state of the flat. Records of that meeting also quote staff from Ascham Housing who referred to the flat being …'dirty and due to the smell they did not want to enter the premises' and in their words 'she was completely off her face on drugs'.

3.3.122 The implications of these reported conditions were recognised and a MERLIN record created and forwarded to Children's Social Care.

GP Services

3.3.123 Because they did not ask and never undertook a home visit, the GP were as unaware of tangible signs of physical neglect within the home as they were of the children's lived experience in her family or of any domestic violence. Health care seems to have been defined narrowly to mean responding to the symptoms of which a patient (or a parent on behalf of a child patient) complained. It seems that neither the appearance of the children nor the pattern of 'did not attends' were recognised as signs of neglect.

North Middlesex Hospital

3.3.124 Because sister 1 was first pregnancy neglect of children could not be evidenced. However it was clear that mother had spent time in her childhood in the care of the local authority which would have indicated that there were challenges in her family and potential parenting issues. There was no detailed information known by the hospital about mother herself having been neglected except for the assessment received from Children's Social Care and information gathered at the professional meeting. Poor ante-natal attendance should have alerted staff to some possible difficulties.

3.3.125 It was understood that mother had vulnerabilities following her booking for maternity care and this was why she was referred to Sure Start. Any support received was not documented within notes and would have been reliant on disclosure of information by mother.

Whipps Cross Hospital (Midwifery)

3.3.126 The midwife's observations of the children at ante natal clinics, was that they were consistently clean and well dressed. Nor at her post natal home visits did she see anything more than an untidy flat e.g. it was 'not dirty' and the dog, of which she was aware, was kept on the balcony.

Whipps Cross Hospital (Medical): NOT APPLICABLE

North East London Foundation Trust

3.3.127 Staff were unaware of any issues of neglect with regard to mother's children until a telephone referral was received by the Access Team from GP14 in late June 2010.

3.3.128 Mother had raised concerns in the surgery because she had been observed being verbally aggressive to her two children. In response to these concerns, a social worker from the Access Team undertook a home visit in July. There are two records of the outcome of this visit; the first is in a short letter to Children's Social Care stating that there were no mental health concerns and the second is the paper notes made during the visit.

3.3.129 The formal record of the assessment was begun but not completed on the agency's database - RiO. The handwritten notes evidence that the social worker focused on exploring mother's mental state; they do not suggest that the children were discussed other than in the context of mother needing a larger flat as both children slept together in the 1 bedroom flat. The social worker omitted to complete a formal risk assessment as required on RiO.

Outer North East London Community Services

3.3.130 There were key moments when the physical neglect of one or more child and/or the home was clearly recognised and recorded by professionals from this agency e.g:

- Observations by HV2 in late September 2008 that the flat was ‘sparsely furnished and unkempt’
- The observations of HV3 at a home visit in mid April 2010 of a ‘quiet and unkempt’ sister 1 and a ‘miserable and clingy sister 2 with dirty clothes’ and that ‘the floors and surfaces were unclean and that there was an extremely unpleasant odour’
- The child development assessment for sister 1 in June 2010 when (in spite of it being a planned appointment) sister 1’s presentation was noted as having …’ingrained dirt under her finger and toe nails. She also had dried crusty food on her chest and did not appear to be recently washed’
- The physiotherapy assessment in January 2011 when it was noted that sister 1’s ‘socks were very dirty and her feet smelt’ (bruises were also noted over the front of her knees)

3.3.131 The concerns and especially those emerging from the assessment in June 2010 at the child development clinic were shared across the network at the July 2010 strategy meeting. But by the time HV6 gained entry to the flat some two weeks later, it was ‘clean and tidy’ and positive interactions by both parents with their children were observed and recorded.

3.3.132 The above experiences typify the challenge that the family represented. The parents were capable of allowing the physical and emotional neglect of their children to grow to the point where the evidence was substantial and, if challenged were equally capable of making sufficient effort to allay the proper anxiety felt by health (and Early Years professionals).

3.3.133 What was not rendered visible until this serious case review was initiated was the full extent of the ‘did not attends’ at a variety of health related appointments, most of which represented direct or indirect examples of neglect of the needs of a child (or, in the case of ante natal appointments, a child to be).

3.3.134 The Outer North East London Community Services individual management review author justifiably draws attention to the evidence in this case of disguised or apparent compliance and the important distinction between a ‘seen child and a safe child’.

3.3.135 Though not welcomed by the parents, HV3’s challenge about cleanliness and more obviously the positive services offered by child development, physiotherapy, and orthoptics (when taken up by parents) offered the children substantive sources of support.

Early Years

3.3.136 Early Years staff, without the benefit of the whole picture that would have allowed a more holistic or contextualised interpretation, nonetheless showed a high level of sensitivity to signs of neglect in sister 1.

3.3.137 Attendance became the major quantifiable subject in the exchanges with Children's Social Care but staff had previously identified a larger number of less quantifiable indicators that distinguished sister 1 from the average child of her age.

3.3.138 Staff recognised the significance of the parents' failure to present sister 1 for medical appointments; they noted the child's reluctance to speak of home; her anxiety if a man entered the room; that she had insufficient confidence to be disobedient; and her anxiety if she were to spill her milk.

3.3.139 Staff also took practical steps to support sister 1 and her family. The physiotherapy appointment was relocated to the school; they ensured that the snack trolley provided sister 1 with a source of food and latterly Primary School 1 persisted with their attempts to persuade Children's Social Care of the significance of their concerns.

Ascham Housing

3.3.140 No home visit was undertaken by any member of Ascham Housing and thus none had the opportunity to see for themselves any signs of physical neglect of the property or of the children.

3.3.141 The absence of home visits was *not* a function of mother being placed on the list of 'aggressive customers' because the determination to do so was not followed through and thus no warning shared amongst relevant staff, as it should have been.

3.3.142 Various contractors were able to gain access to the home to effect repairs or improvements and none reported concerns about neglect to Ascham Housing.

Environmental Health

3.3.143 Environmental Health operatives treated the premises for carpet beetles (a problem that can be associated with poor housekeeping) but they recorded no observations of neglect on the premises.

HOW THE PARENTS' AGGRESSIVE PRESENTATION AFFECTED HOW THE PARTNERSHIP WORKED WITH THE FAMILY

3.3.144 A recent article in Community Care (06.10.11) referred to Professor Littlechild's 2003 research[13] in which he found a significant increase in levels of aggression from service users when compared to ten years before then. There seems little reason to believe that levels of aggression have reduced since then and for most front line staff, the prospect of hostility, aggression or occasional violence is real.

3.3.145 Professor Littlechild's paper referred in turn to papers by Stanley and Goddard (1997, 2002) suggesting from their research into the effects of violence against child protection social workers in Australia that the Stockholm Syndrome (Wardlaw, 1982) can apply to social workers in child protection settings. This theory explores the accommodation of aggression by the victim within the relationships between hostage and terrorist. Stanley and Goddard also argued the same dynamics can apply to relationships in and surrounding abusing families. In addition, bullying, which is how some workers can experience the behaviour of such abusive parents, can also produce fear and disempowerment in adults in work situations (Randall, 1996).

3.3.146 The practical implication of this thinking is the need to use supervision to uncover such effects on workers, within a process where the worker feels safe to report and explore this difficult territory. If this is not done the family can prevent challenges about their abusive parenting which in turn can mean that work to reduce the risk for children is more limited.

3.3.147 Some researchers e.g. Mudaly and Goddard, 2001 speculate that child protection workers may exhibit the same reactions as some other abused family members to severe intimidation and threat (and are joining in the family dynamics rather than remaining outside- and are therefore unable to objectively assess, and work with, them (Reder et al. 2003).

3.3.148 The levels of hostility and aggression, or the number of complaints (themselves a more acceptable and still effective way of distracting professional attention) were not extreme in this case. However, in the view of the author, it is possible to extract from several specific events a link between professionals who either challenged mother's account or failed her expectations, and her hostile reaction:

- Mother's threat to petrol bomb the building when refused money and her aggressive response to the proposed 'working agreement' both in August 2007
- Her response to the attempt to prolong her stay at North Middlesex Hospital following birth of sister 1 in January 2007

[13] Working with aggressive and violent parents in child protection social work, Practice, 15(1), 2003 Author: Brian Littlechild, University of Hertfordshire

- Mother's damage to Asham Housing premises when staff failed to help her find a new property in July 2009
- The unfounded allegation against the head of Pre School 1 in March 2010 probably in reaction to the school raising sister 1's poor attendance as an issue
- Mother's retaliatory action when HV3 was blamed for alerting Children's Social Care to neglect of the health needs of sister 1
- The unsubstantiated allegation of bullying of sister 1 at School 1 in late 2010

3.3.149 An agency by agency account is provided below.

Children's Social Care

3.3.150 The Children's Social Care individual management review explained well the effort and relative success of SW1 and SW3 in developing a working relationship with child B's parents in spite of their (and in particular mother's) hostility.

3.3.151 The severity of mother's hostile reaction to a proposed 'working agreement' in mid August 2007 was sufficient to drive the Children's Social Care staff from the house in which the visit was taking place.

3.3.152 At interview with the overview author, mother paid a smiling tribute to SW1 for not being intimidated by her outbursts and being able for example, to tell her on occasions, to go and calm down and come back into the room.

3.3.153 Without wishing to diminish the success of the above workers in forging a useful relationship with mother, it does raise the possibility of unintended consequences hinted at by the individual management review author.

3.3.154 Firstly, to what extent might the (very real) achievement of a working relationship have served to divert attention from an ongoing failure of parents to comply with key elements of the protection plan? The positive professional relationship might have had some *intrinsic* value e.g. increasing the likelihood of parental co-operation, but this would last only for as long as these workers were allocated.

3.3.155 Secondly, to what extent is it anyway reasonable to expect other professionals e.g. teachers, housing officers and above all – children of the family – to accept and adapt to verbal abuse and threats from adults (mother and possibly also father) neither defined as suffering from any formal 'mental illness' that might otherwise require such tolerance.

Metropolitan Police Service: NOT APPLICABLE

GP Services

3.3.156 Aside from an isolated incident in 2009 when mother became upset about a delayed consultation, the GPs had no experience of mother's aggression.

North Middlesex Hospital

3.3.157 Mother had not been noted by practitioners at this hospital to have been aggressive. The booking midwife at interview recalled that she 'had no concerns' with her presentation and there were no issues raised about aggressive behaviour during presentations.

3.3.158 It was noted that when the couple wished to be discharged from hospital they did become 'extremely annoyed'. Staff appropriately sought senior support first by the paediatrician and then named midwife who both were able to have discussions with the couple.

3.3.159 It is clear from consideration of all available reports, that the hostility ad aggression shown by mother (and to much less extent, father) was occasional and (to an unknown extent) instrumental i.e. calculated to achieve a personal objective.

Whipps Cross Hospital (Midwifery)

3.3.160 During (an un-stated proportion of) ante and post natal contacts, father was present. The midwife's recollection is that there were no signs of tension or aggressive behaviour by either parent. Mother spoke of the maternal grandmother in a positive way and throughout the ante natal period appeared happy and positive and to have no anxiety about her pregnancy. Initially at least, mother was relaxed enough to breast feed without difficulty.

Whipps Cross Hospital (Medical)

3.3.161 No signs of aggression were recorded at any of mother's presentations. Indeed the observations of the ward manager in September 2009 was that mother did not have a lot of confidence e.g. could not maintain eye contact.

3.3.162 Staff met father only on the day of child B's death when only his natural distress was apparent.

North East London Foundation Trust

3.3.163 There is no reference on files to either parent being aggressive to or in front of staff once the children were born though mother was often reported as being aggressive by her mother during her childhood and adolescence.

Outer North East London Community Services

3.3.164 Though mother herself acknowledges her temper and its implications for care of her children remained insufficiently explored, her use of verbal hostility and times threats did not seem to intimidate health professionals. Nor indeed did father's less frequent and always verbal only hostility.

3.3.165 What *was* achieved though, primarily by mother's conduct was an unhelpful level of distraction when challenged about non compliance with agreed tasks arising from protection or child in need plans; or manipulation e.g. the refusal to be in the same room as HV3 whom the parents blamed for the referral to Children's Social Care in May 2010 and the subsequent change of health visitor.

Early Years

3.3.166 The parents (and especially mother) used hostility and verbal aggression toward a range of professionals, including senior staff at Pre-School 1 and Primary School 1.

3.3.167 Such behaviour *may* have reflected their own 'norms' from childhood (the maternal grandmother's hostile outburst at Pre-School 1 had prompted staff to ask her to leave) or more probably mother's often labile mood state. It also served a clear instrumental purpose relevant to the welfare of the children i.e. it distracted professionals' attention and rendered challenge less likely.

3.3.168 The almost certainly fallacious complaint about the head of the Pre-School 1 was the most significant example from the early years context but there were several others.

3.3.169 In spite of the ongoing intermittent hostility which must have been very uncomfortable for those on the receiving end, there is no indication that Early Years staff reduced their level of attentiveness to sister 1.

Ascham Housing

3.3.170 Although after her outburst in July 2009 mother's name was identified to be placed on the agency's list of 'aggressive customer list', this action was not completed.

3.3.171 Thus, although others might as a result of what seems to have been a simple oversight, been exposed to heightened risk, the service actually provided to mother and her family remained unchanged.

Environmental Health

3.3.172 Environmental Health staff did not identify or record either parent as being aggressive so no comment can be offered with respect to this question.

ROLE OF THE EXTENDED FAMILY IN SUPPORTING THE PARENTS & THE CHILDREN IN THE FAMILY

Children's Social Care

3.3.173 Although as a child, mother's relationship with the maternal grandmother was conflictual, it became closer as mother entered adulthood and became a parent. Records and the interview with the maternal grandmother confirm a high level of involvement with mother, father and grandchildren over the last three years. This involvement has been in terms of material (loans, gifts) and non-material matters (accompanying mother to meetings, collecting children from pre-school etc).

3.3.174 The maternal grandmother's perspective on the contribution of the children's paternal grandmother was a good deal more balanced than accounts provided to professionals by mother. The maternal grandmother acknowledged that her paternal equivalent remains in near full time employment and that her capacity to assist with the grandchildren was and is more limited than her own.

3.3.175 Whilst it is understandable that the paternal grandmother will have had concerns about mother's ability to safely care for her grandchildren, Children's Social Care did not apparently seek to consult her, explore her concerns or exploit the potential she represented as a further source of family support.

Metropolitan Police Service: NOT APPLICABLE

GP Services

3.3.176 Again as a function of the focus only on presenting symptoms, the GPs had no understanding of the extended family and its impact on the well being of the children in the family. The fact that the maternal grandmother had often accompanied mother and/or children offered the GPs opportunities to observe and evaluate at least this aspect of the extended family.

North Middlesex Hospital

3.3.177 The only person reported to have attended with mother during the period of the review was father (her partner) and there were no reported visitors to the ward following the birth of sister 1.

3.3.178 Mother had indicated that her next of kin was her own mother (child B's maternal grandmother) though there was no contact made with her and no record of her being involved actively in mother's pregnancy. Mother did not disclose any other family members who were actively supporting her with the pregnancy and at the time this was not a question routinely asked at the booking appointment.

3.3.179 The maternity service has now implemented new maternity hand-held records where there is a routine screening question asked at booking for maternity care about the level of support from family and friends.

3.3.180 When sister 1 was brought to the A&E with a chesty cough, mother herself was identified as the accompanying adult and next of kin.

Whipps Cross Hospital (Midwifery)

3.3.181 The only reference to the parents' extended family was the midwife's recollection that mother spoke of the maternal grandmother in a positive way, indicated that she was very supportive and that the family visited her regularly. At no time did the midwife meet the maternal grandmother. The agency's individual management review includes no reference to father's extended family.

Whipps Cross Hospital (Medical)

3.3.182 During the period under review, there does not appear to have been any exploration of the extended families or their potential as a source of support by hospital medical staff.

North East London Foundation Trust

3.3.183 An assessment by the Access Team indicates that by February 2007, shortly after the birth of sister 1, her relationships with the maternal grandmother and with father's family had improved. The files do not indicate in any detail how much support the extended family provided.

Outer North East London Community Services

3.3.184 Though the length of those care episodes was not clear to the practitioners, the fact mother had been 'looked after' as a child was known to the health visiting service at the point of initial referral by the midwife in February 2007. HV1 correctly identified that the parents were a young couple with a poor history of parenting and were in need of family support i.e. an 'enhanced health visiting service'.

3.3.185 It was not until August 2008 that mother discussed her childhood and confirmed that she had attended the Child & Family Consultation Service as a teenager and had been diagnosed (she said) with a personality disorder.

3.3.186 Though in fact, Children's Social Care had lost most of mother's care history this would not have been known to the health visitors and it would have been helpful if they had sought from, or been offered by Children's Social Care more historical information so as to better understand mother's behaviours.

3.3.187 Certainly a better understanding of the tensions between mother, maternal and paternal grandmothers meant that at times, these sources of support were in fact a source of stress. At these times, the children would have been denied contact with otherwise familiar faces.

Early Years

3.3.188 The involvement of the extended family with Early Years provision was too limited to conclude anything except that there was conflict within it.

Ascham Housing: NOT APPLICABLE

Environmental Health: NOT APPLICABLE

DID ASSESSMENTS TAKE A HOLISTIC VIEW OF THE CONCERNS AROUND THE CHILDREN

3.3.189 Though *not* as a result of any widespread reluctance to share information, there was nonetheless in this case as in many others, no single agency with a complete picture.

Children's Social Care

3.3.190 Throughout the episodic Children's Social Care involvement over the period covered by this serious case review, there were gaps in thinking or planning which served to reduce the extent to which assessments of need or risk were holistic e.g. the absence of consideration of father's family history or functioning. Similarly, father's reported [by mother] self harming in front of sister 1 remained unexplored.

3.3.191 Other issues that should have been explored so as to establish a more rounded view of the children's lives were the actual level of use and variety of cannabis and (especially with mother's pregnancy with child B) the practical implications of all (including one or perhaps two dogs) living in a second storey one bedroom flat.

Metropolitan Police Service: NOT APPLICABLE

GP

3.3.192 The view of the individual review author is that the GPs 'took a holistic view of the concerns around the children'. The view of this overview author is that they did not and could not.

3.3.193 Records and the interview conducted indicate that:

- No GP had ever undertaken a home visit
- In consequence of the above, none had observed the environment in which any of the children were growing up
- Information exchanges with others e.g. health visitors or social workers were limited and rarely proactive
- No GP had discussed the relative poverty in which the family lived or addressed directly the impact on the children of acknowledged and prolonged use of (expensive) cannabis, alcohol and potentially other illegal substances

- GPs' actions were not informed by the accounts of domestic violence outlined in the child protection conference minutes sent them in 2007
- No GP had engaged directly in a conversation with sister 1 (who for at least the past eighteen months would have been able to engage in a conversation)

North Middlesex Hospital

3.3.194 The professionals' meeting that was attended by the community midwife was focused on the needs of the unborn child and ensuring that there was active planning for birth. The maternity care that was delivered was supportive of mother as a first time parent so that she was supported with feeding the newborn and a demonstration given of bathing the child. There was appropriate vaccination (BCG) given and screening for hearing to ensure the wellbeing of the baby. There were no concerns about mother being receptive to this advice or the support given for parenting.

Whipps Cross Hospital (Midwifery)

3.3.195 As indicated elsewhere, the midwife attempted during the pre-natal period to form a holistic view of the context into which child B was to be born though was constrained by the absence of some information e.g. about mother's historical overdosing and (arguably) some misinformation about the absence of domestic violence or drug misuse.

3.3.196 To the extent that the available records offer confirmation, it seems as though the midwife was alert (prior to and following birth of child B) to the physical appearance of sister 1 and sister 2, the state of the flat as well as to the interactions of the parents with each other and with the new baby.

Whipps Cross Hospital (Medical) NOT APPLICABLE

North East London Foundation Trust

3.3.197 The home visit conducted by the perinatal team in September 2009 demonstrates that key issues such as attachment, bonding and parental interaction were considered although at this point there were no concerns about possible parental neglect

3.3.198 In their current incomplete form, the records do not suggest that the worker undertook a holistic, comprehensive approach to exploring the concerns about the children as the focus appeared to be on assessing mother's mental state e.g. she did not record the quality of any family interaction with the children nor was mother's display of aggression to the children at the surgery discussed.

3.3.199 If such a discussion had been initiated, mother's reaction might have been a useful indicator of both her parenting capacity and her current mental state.

Outer North East London Community Services

3.3.200 As a result of the essentially unknown parental developmental histories, unexplored domestic violence, ill understood mental health of mother or of levels and nature of substance misuse by both parents, underestimate of non compliance with elements of child protection and child in need plans, assessments were *not* sufficiently holistic.

3.3.201 The individual management review author is of the view that use of a Common assessment Framework (CAF) might have pulled together otherwise disparate aspects of the family's needs. The undertaking of six core assessments had though provided ample opportunities to form a holistic view of the needs of the then two children. What was missing was a sufficiently robust multi agency response to all the observed and recorded concerns.

Early Years

3.3.202 The ability of the nursery nurse and teacher at Primary School 1 to develop a holistic view was significantly constrained by sister 1's poor attendance (approx. 50%) coupled with a reluctance to speak of home.

Ascham Housing

3.3.203 Neither the individual repair requests triggered by reported domestic violence or the information about mother's mental health or rent arrears were not seen 'in the round' as an indication of vulnerability.

3.3.204 In the period prior to birth of child B, sister 1 and sister 2, father, dog/s and issues such as drug use remained essentially invisible to Ascham Housing. No holistic assessment drawing together individual elements was undertaken.

Environmental Health: NOT APPLICABLE

FAMILY'S COMMUNITY, SOCIAL SUPPORTS & HOW THEIR CULTURAL, SOCIAL, EMOTIONAL & IDENTITY NEEDS WERE MET

Children's Social Care

3.3.205 Though as White English speakers, family members enjoyed the advantage of belonging to the dominant group within the borough, the level of potential social support was offset by a number of other factors:

- Chronic poverty (neither parent had a history of paid employment)
- Alienation from neighbours (often the source of complaints about noise, or the parents' treatment of their children or dogs)
- No evidence that they belonged to any formal or organised source of support e.g. a Faith group

- Father's physical limitations (residual pain from the attack in 2007 / a later road traffic accident [accounts vary] reportedly prevented him working)
- The practical challenges of living (latterly two adults, three under fives together with one or two dogs in a one bedroom second storey flat)

Metropolitan Police Service: NOT APPLICABLE

GP Services

3.3.206 For the reasons summarised under the question of 'holistic assessments', the GPs seem to have remained wholly unaware of any sources of community support.

North Middlesex Hospital

3.3.207 Mother (with much encouragement from the midwife) maintained a good level of contact ante-natally with the community and was (appropriately) referred for additional support service from Sure Start Children's Service.

3.3.208 It remains unknown how much if any contact mother made with Sure Start to access this source of support.

Whipps Cross Hospital (Midwifery)

3.3.209 It is not apparent from the records available to the individual management review author (nor in consequence, this overview author) if or how the family's community, social support, cultural, emotional or identity needs were addressed by the midwife.

3.3.210 It would not be unreasonable for the midwife's focus to be limited to the immediate and extended family, with the health visitor offering follow on care being better positioned to be aware of and assist the family make us of local sources of social or psychological support or where appropriate Faith related links.

Whipps Cross Hospital (Medical)

3.3.211 The focus of medical and nursing staff at each presentation was on the presenting symptoms and there are no records that suggest any exploration of the family's social or community environment.

North East London Foundation Trust

3.3.212 Earlier Child & Family Consultation Service notes indicated that mother was able to access significant support from the maternal grandmother's sister but it is not known for how long this continued and more recent agency contacts did not explore this issue.

Outer North East London Community Services

3.3.213 There was good deal of liaison between health visitors (of whom seven were involved during the period under review) and significant sources of community supports such as that represented by the outreach worker from Children's Centres or later the Early Years practitioners.

3.3.214 That aside, relatively little appears to have been known about any other more personal sources of community support except the involvement of maternal and paternal grandmothers. As indicated elsewhere, the perceived value of the respective grandmothers varied with the paternal grandmother at times being regarded as hostile by mother and father.

Early Years

3.3.215 The referral to the Children's Centre by the then health visitor showed a proper recognition of their substantial need for support.

3.3.216 The ability or willingness of the family to actually use support offered was constrained by external and mostly internal factors (choice). As a result of the episodically litigious relationship between mother and the paternal grandmother, the former claimed (it was never confirmed) that a court injunction prevented her from attending the Children's Centre.

3.3.217 Before their partial take up of the preschool place for sister 1, the family had been offered and failed to properly engage in a toy library service. The outreach worker also noted that when the family lived on the **XX** Estate that she was making friends with some less positive influences and made no use of other local services..

Ascham Housing: NOT APPLICABLE

Environmental Health: NOT APPLICABLE

HOW THE IMPACT OF THE PARENTS' EXPERIENCE OF THEIR OWN PARENTING AFFECTED HOW THEY PARENTED

3.3.218 The value of exploring parents' respective developmental experiences was insufficiently recognised by those agencies to which it should have held meaning.

3.3.219 The fourth biennial analysis of serious case reviews[14] highlighted what is an ongoing issue (and evident in this case) of a relative dearth of information about men involved in families with children in need or in need of protection. This report refers to a common failure to take fathers into account in assessments as well as rigid thinking about them as all good or all bad. Notwithstanding mother's episodic allegations of domestic violence, there was in this case a generally insufficient exploration of father's experience of parenting and of his capacity to be a moderating influence on his more impulsive partner.

[14] Understanding Serious Case Reviews 2005-07 Brandon et al DCSF-RR129

Children's Social Care

3.3.220 Because as a child, father was known only to universal services and, as an adult, was rarely as significant a source of concern as mother, there had been no exploration by Children's Social Care of his developmental experiences and how they might impact on his parenting.

3.3.221 Direct observations of his handling all three children offered reassurance about his ability in that regard, but exploration with him and indeed the paternal grandmother who was clearly a 'stakeholder' with respect to sister 1 and 2, could have offered valuable indicators of father's potential and perhaps a better understanding of his admitted misuse of skunk and alcohol.

3.3.222 As summarised in section 1 of this overview, mother's childhood experiences were more dramatic than those of father. According to the Children's Social Care individual management review, at least a proportion of her historical records would have been available if those undertaking any of the six core assessments had been inclined to commit time to exploring them.

Metropolitan Police Service: NOT APPLICABLE

GP Services

3.3.223 The GP individual management review author was able to confirm GP records contained historic information about mother's childhood and the then concerns about the maternal grandmother's ability to parent.

3.3.224 The only further 'evidence' that the GPs appreciated the implications of her very disturbed childhood for her own parenting was the assurances given the individual management review author that this was so.

North Middlesex Hospital

3.3.225 Aside from the knowledge in midwifery, that mother had experience of the care system; there was little knowledge of her parenting and none with respect to father. No concerns were noted about mother's manner toward her baby maternity staff routinely supported mother in learning her initial parenting skills with e.g. breastfeeding and bathing.

3.3.226 The attendance at A&E was noted to be appropriate and timely. Immunisations were noted as being up to date and mother appeared to be willing and receptive to information offered her by practitioners.

Whipps Cross Hospital (Midwifery)

3.3.227 The impact of mother's experience of being parented was not explored though it was noted she had been in care and that she described her current relationship with the maternal grandmother as positive and supportive.

Whipps Cross Hospital (Medical): NOT APPLICABLE

North East London Foundation Trust

3.3.228 As staff had little contact with mother once she became a parent, it is not possible to make clear links between her experience of parenting and the impact this had upon her own parenting of her three young daughters. However, the Child & Family Consultation Service file vividly highlights mother's experience of, in particular, her mother's parenting and her father's death. This evidence suggests that she might be ill-equipped on reaching adulthood to understand the emotional and psychological needs of a baby/child.

3.3.229 The individual management review offers further detail to evidence the above conclusions.

Outer North East London Community Services

3.3.230 There seemed to be no explicit attempt by this agency's staff to learn more about the parent's respective experiences of being parented, though mother had acknowledged from her first ante natal contact when pregnant with sister 1 that she had been in the care system.

3.3.231 Some of the facts about mother's childhood as recorded by the midwife in 2006 made it appear that she had spent longer than she actually did as a 'looked after' child. It was nonetheless clear that between the premature death of her father, conflict with mother, educational difficulties and being fostered on three occasions, that her early experiences must have influenced greatly her developing personality and understanding of and ability to be a parent.

3.3.232 The facts with respect to this remain unknown but the information passed from North Middlesex Hospital to the health visitor in February 2007 indicated that the maternal grandmother also had a history of being in care.

3.3.233 No facts about father's (it has now emerged comparatively unremarkable) childhood and its impact on his ideas of or capacity to be, a parent was known or sought.

Early Years

3.3.234 Mother had shared with the outreach worker that she had been placed in care as a child and been 'effectively abandoned'. Though the few available records do not corroborate such a dramatic account, this may have been how mother felt about her upbringing.

3.3.235 Certainly, many of mother's childhood experiences were traumatic and coupled with a reportedly congenital inclination to display anger and act impulsively, will have shaped her notion of and capacity to offer adequate parenting.

3.3.236 The Early Years staff would not have access to details of mother's own experience of childhood.

Ascham Housing: NOT APPLICABLE

Environmental Health: NOT APPLICABLE

IMPACT OF POVERTY ON THE FAMILY FUNCTIONING & THE IMPACT OF THIS ON THE ABILITY OF THE PARENTS TO MEET THE CHILDREN'S NEEDS

Children's Social Care

3.3.237 The Children's Social Care individual management review has rehearsed the general implications of relative poverty and noted the family's long term dependency upon Benefits and ad hoc payments in cash or in kind by Children's Social Care and other agencies.

3.3.238 At her interview, the maternal grandmother also alluded to mother and father constantly seeking money from her.

3.3.239 The maternal grandmother at interview made the overview author aware of the local price of the 'spliffs' used by mother and father throughout the period under review. Even the modest daily consumption admitted to by the parents would have committed a substantial proportion of the family's official income. It also seems likely that the *actual* consumption would be higher than that acknowledged.

3.3.240 In addition to the use of cannabis, father anyway at times reported substantial use of alcohol and both parents were heavy smokers. As no blood samples were ever taken, there remains the possibility that other class A or B drugs were used (Cannabis was anyway re-classified as a class B drug in January 2009).

3.3.241 The family's relative poverty would have constrained members' life style and impacted indirectly on the children's life chances. What tipped them episodically into more absolute need was the parents' choice to prioritise their use of drugs over purchase of milk, food and other essentials for their children (which they sought often to obtain from the maternal grandmother, Children's Social Care and perhaps other unknown sources).

3.3.242 Because such crises were episodic and their impact ameliorated by agencies or the maternal grandmother, the results were never life threatening, thus rendering any decisive response more difficult.

3.3.243 It is unclear to what extent social workers checked the supply of food in the house or perhaps asked about what the children would be eating over the weekend. The family's reluctance to allow Children's Social Care involvement, other than to provide money would of course, have rendered such explorations difficult.

Metropolitan Police Service

3.3.244 Officers did observe and report on the physical conditions in which the family was living on two occasions.

GP Services

3.3.245 For the reasons summarised under the question of 'holistic assessments', the GPs appear to have been unaware of the family's relative poverty (some a function of limited income; some a consequence of expenditure on illegal drugs) and its likely consequences for the children's experiences.

North Middlesex Hospital

3.3.246 At the time of booking in for maternity care, mother was reported to be unemployed and father working as a mechanic. Mother did report that there were concerns about housing which were being addressed by the housing service, but she reported no financial problems nor made any request for financial support.

3.3.247 Thus, the likely impact of relative poverty on parenting performance was (reasonably enough) untested.

Whipps Cross Hospital (Midwifery)

3.3.248 As with other specific items of the terms of reference, the absence of the post natal notes renders certainty impossible. To the extent the midwife's diary coupled with her recollection at interview allows it, indicators of the family's relative poverty were recognised and noted e.g. sleeping arrangements and perceived overcrowding. Understandably, there seems to have been no direct discussions about sources of income or how it impacted upon the quality of life for the children.

3.3.249 The midwife was able to confirm during her visits that child B was 'well and active' and that she was gaining weight; further that all the children appeared 'neat and tidy in appearance'.

Whipps Cross Hospital (Medical)

3.3.250 The focus of medical and nursing staff at each presentation was on the presenting symptoms and there are no records that suggest any exploration of the family's income or the potential impact of that on their ability to care for their children

North East London Foundation Trust

3.3.251 Notes indicate that mother regarded her main social problem to be one of inadequate housing and there are references to outstanding repairs and a letter from the psych. 7 to advocate that she be re-housed.

3.3.252 The individual management review author notes that unlike many other patients living on a restricted income, mother did not ever request a loan or mention that money was a problem, though she did do exactly that with other agencies e.g. Children's Social Care and with the maternal grandmother.

Outer North East London Community Services

3.3.253 The first health visiting assessment in 2007 recognised and recorded the family's relative poverty. References later that year to mother having to repay money 'lost' in the course of her sessional work as an 'Avon lady' and an indication of practical support by the maternal grandmother, suggest an ongoing awareness by the health visitor of the family's financial constraints.

3.3.254 The offer of a taxi to transport mother and sister 1 to her very overdue multi disciplinary assessment in late April 2010 showed sensitivity and imagination and though unsuccessful, was a commendable effort.

Early Years

3.3.255 The family was preoccupied with the need for more money though their income and accommodation (whilst sub optimal) would have been no worse than many other users of the Early Years services.

3.3.256 Though only the fact that the parents smoked and that there was a dog to be fed would have been apparent to staff in the nursery and school, the high level of cannabis use must have represented a very substantial drain on the funds otherwise available to buy food and offer the children some type of stimulation.

Ascham Housing: NOT APPLICABLE

Environmental Health: NOT APPLICABLE

QUALITY OF THE WORKING RELATIONSHIP BETWEEN CHILDREN & ADULT SERVICES

Children's Social Care

3.3.257 As acknowledged by the Children's Social Care individual management review, though the interactions might at times have been speedier, there was effective liaison between Children's Social Care and Adult Mental Health Services.

3.3.258 The fact that she was assessed as not suffering from any formal mental illness which might have been 'treatable' (and this is not disputed) left Children's Social Care staff having to live with the anxiety about mother and monitor her presentation and behaviours and the consequent impact on the children.

Metropolitan Police Service: NOT APPLICABLE

GP Services: NOT APPLICABLE

North Middlesex Hospital

3.3.259 The *only* direct experience of this was at the apparently collaborative and successful professionals' meeting where there was representation from health, housing, mental health and Children's Social Care professionals.

Whipps Cross Hospital (Midwifery): NOT APPLICABLE

Whipps Cross Hospital (Medical): NOT APPLICABLE

North East London Foundation Trust

3.3.260 The files demonstrate close joint-working between the Trust and Children's Social Care at times of crisis and the individual management review offers further evidence to support this overall conclusion.

Outer North East London Community Services

3.3.261 Though with the exception of the named doctor's concerns about SW2's attitude when she initiated a referral in May 2010, working relationships between this agency's staff and others appeared unproblematic.

3.3.262 What the network lacked was a shared understanding of the family and a coherent multi agency plan to which all were committed. Probably because they were not being produced and/or circulated in a timely fashion by Children's Social Care, health visitors did not appear to be in possession of the minutes of conferences or strategy meetings. There is no evidence that the missing documents were chased up.

Early Years: NOT APPLICABLE

Ascham Housing: NOT APPLICABLE

Environmental Health: NOT APPLICABLE

ATTACHMENT OF THE CHILDREN TO THEIR PARENTS

3.3.263 There was a consistency in the six completed core assessments with respect to the issues of the (respective) children's attachments. Observations by all three social workers were of secure attachments to mother, father and to the very involved maternal grandmother.

3.3.264 The legitimate professional concerns were largely about the emotional impact on sister 1 and later sister 2 of witnessing or at times being the victim of verbal outbursts some associated with parental arguments.

3.3.265 A further and less recognised risk was the cumulative damage to the children arising from the parents' inability or episodic unwillingness to place the children's needs before their own. Examples of this were seen in the failure to attend medical appointments, children's lack of cleanliness and ongoing use of various drugs in the presence of their children.

Metropolitan Police Service

3.3.266 Though unable to evaluate security or nature of attachment, officers did note the condition, affect and interaction of present children with parents.

GP Services

3.3.267 GP records make little explicit mention of attachment (though there was a comment in June 2009 that 'mother had bonded well with baby [sister 2] who is well cared for'). There are several observations of the manner in which mother related to her own children, and indeed the then GP was concerned enough to alert a health visitor when in 2005 he observed mother (then seventeen and manifestly disturbed) in charge of a small baby.

North Middlesex Hospital

3.3.268 Although the value of the observations were constrained by time, there were no concerns about sister 1's attachment to her mother, whilst on the antenatal / postnatal ward. Mother was reported to be acting appropriately toward her new baby who appeared to respond well.

3.3.269 When sister 1 was brought to A&E by her mother because of a 'chesty cough' the baby was observed by staff to be 'playful' and 'not distressed' in the maternal attachment.

Whipps Cross Hospital (Midwifery)

3.3.270 The physical state of the children when seen at ante-natal contacts was noted but regrettably (given the family had been defined as vulnerable) there was no comment upon the way either parent interacted with sister 1 or sister 2. Post-natally, 'good' interaction was noted between all family members.

3.3.271 Post-natally, no problems with the mother–child relationship were noted whilst they were in the hospital. Records indicate that child B was being breast fed 'well'. The reasons for mother later resorting to bottle feeding might usefully have been discussed as a means of exploring how child B's attachment to her mother was developing.

Whipps Cross Hospital (Medical): NOT APPLICABLE

North East London Foundation Trust

3.3.272 Staff only saw the children with their parents on two separate home visits in September 2009 and July 2010 when no concerns were noted about any parenting or attachment issues.

Outer North East London Community Services

3.3.273 The majority of contacts by health visitors and other staff with any or all the children recorded observations of their appearance and usually of interactions with parent/s. Few practitioners had or took the opportunity to engage directly with sister 1 or sister 2 to perhaps spend time playing or drawing in an attempt to learn more about their feelings.

3.3.274 The observations were of physical appearance or overt conduct rather than interpretive analysis of the quality or nature of relationships.

3.3.275 The observations of Early Years staff whose role enabled more 'quality time' revealed some worrying observations e.g. sister 1's reluctance to speak of home at all. The observations of the overview author and health colleague when meeting the parents for the purposes of this serious case review suggested some 'watchfulness' or reticence on the part of sister 1 with respect to her mother.

Early Years

3.3.276 The poor attendance coupled with the child's reluctance to speak of home even when encouraged to do so, rendered it difficult for staff to evaluate the extent of sister 1's secure attachment to either parent.

3.3.277 Sister 1 was considered a 'serious' child who for example, showed no response to her father's pejorative and one would imagine upsetting, comment about her school photograph. Her reported lack of affect on one occasion when leaving her mother to enter the classroom following a prolonged absence was also seen by the overview author when sister 1 returned from nursery toward he end of the interview with parents.

Ascham Housing: NOT APPLICABLE

Environmental Health: NOT APPLICABLE

EXTENT TO WHICH THE CONCERNS FOR THE CHILDREN BY DIFFERENT PROFESSIONALS WERE GIVEN WEIGHT & ACTED ON

Children's Social Care

3.3.278 For most of the period under review, Children's Social Care staff worked reasonably well with partner agencies, the health visiting service being the primary example. In the early stages of agency involvement, there was a higher level of concern about mother's presentation and behaviour by contact worker and allocated midwife than the then social worker.

3.3.279 Arguably insufficiently informed, there was a year later a high degree of consensus e.g. when HV2 and the then social worker in July 2008 recommended case closure.

3.3.280 There were also some significant failures within Children's Social Care when concerns of other professions were not 'given weight' and/or acted upon in a timely fashion:

- The response to the alert from the consultant paediatrician at the child development clinic in May 2010 (the promised initial assessment was only completed when the second alert from another consultant was received in early June)
- A substantial delay before the promised strategy meeting finally convened in July 2010 during which time the children were not seen at home
- The result of the further assessments triggered by the anti-social behaviour allegations of September 2010 (no further action) was not proportionate to the available evidence
- (Though not a professional source) the allegation from a neighbour in November 2010 was not even investigated
- The then deputy team manager failed to respond to the legitimate concerns of sister 1's school in late 2010 / early 2011 and prevented further input by the social worker who had most recently completed a core assessment

Metropolitan Police Service: NOT APPLICABLE

GP Services

3.3.281 The GP individual management review offers an assertion from the GPs interviewed that *their* (unspecified) views were awarded insufficient weight.

3.3.282 The primary purpose of an individual management review is for each agency / service to examine *its own* practice. In this instance an important (albeit historical) question is why it was only after four overdoses a vigilant GP3 recognised the risk of allowing mother unrestricted access to anti psychotic / depressive medication.

3.3.283 A missed opportunity to weigh up the implications for sister 1 and the unborn sister 2 arose in September 2008 when GPs took no action in response to the acknowledgement by mother that she was smoking three joints of cannabis per day and 'had a tendency to aggression …but only toward her partner'. It should have been seen as unlikely that mother would be able to protect her children and *only* her children from the impulsive outbursts observed by many others (including later at the GP practice).

3.3.284 It should be borne in mind that the impact of such outbursts would inevitably be greater for wholly dependent babies and toddlers and later observations of Early Years staff illustrate how the children had adapted to and perhaps now regard as normal, their mother's episodic uncontrolled anger.

3.3.285 The referral letter to North Middlesex Hospital sent later that month though sensitive to some non medical issues failed to reflect the admission to his colleague of *current* cannabis use and indicated instead mother had given it up.

North Middlesex Hospital

3.3.286 Following the birth of sister 1, contact was made promptly with Children's Social Care who came to the hospital the same day to see the parents. The named midwife was made aware of potential issues associated with mother wanting to self discharge and made herself available to speak with the parents so as to dissuade them.

Whipps Cross Hospital (Midwifery)

3.3.287 Though she overlooked the potential significance of mother's general mental health, use of illegal drugs and the possibility of domestic violence, the only information *provided by another professional* which the midwife should have given more weight to, was the issue of post natal depression and its possible impact upon parenting.

Whipps Cross Hospital (Medical): NOT APPLICABLE

North East London Foundation Trust

3.3.288 The psychiatric assessment requested by Children's Social Care after the birth of sister 1 was primarily to clarify mother's diagnosis; there were no parenting concerns at that time. Eight weeks after the birth of sister 2 the GP referred mother for a perinatal assessment because of concerns about post-natal depression. Again, there were no concerns cited by the GP about the children; 'baby well cared for...good support network…no apparent child protection issues…baby thriving'.

3.3.289 Psych.7 did not identify any safeguarding issues during her review of mother in August 2009 and as noted above, the mental health worker from the same team observed in September 2009 that the children appeared to be well cared for and happy around both parents.

3.3.290 The Trust was first alerted to professional concerns about mother's parenting capacity by the GP 14 in June 2010. The social worker's response to Children's Social Care was brief and focused solely on mother's mental state which had appeared stable.

3.3.291 Mental health services should also have explored the incident the GP had observed when mother was being verbally aggressive to her children and they should have thought about the children as per Trust policy (2009).

3.3.292 Mother was advised to self-refer to counselling services. As noted previously, staff in psychiatric liaison should also have considered the welfare of father and sister 1 when he presented at Whipps Cross Hospital in August 2007.

Outer North East London Community Services

3.3.293 To a large extent there was a good degree of what can be described in retrospect as mistaken agreement between health visitors and social workers throughout the period under review.

3.3.294 Neither the individuals nor their respective sources of supervision developed or retained enough objectivity or rigour of response to see clearly enduring (albeit episodic) and cumulatively damaging parenting.

3.3.295 When a clear and authoritative referral *was* initiated by the community paediatrician in May 2010 her concerns were not afforded sufficient weight or acted upon in a timely fashion:

- A promised initial assessment was only completed when the second alert from another consultant was received in early June
- There was a substantial delay before a strategy meeting' in July 2010 during which time the children were not seen at home
- The case was closed within weeks leaving the parents to determine if/when they wanted further involvement

Early Years

3.3.296 Early Years staff were sensitive to signs large and small of neglect of sister 1. Even without the larger picture (which would have reinforced concerns) they tried to persuade Children's Social Care of the significance of their various observations.

3.3.297 An attempt at escalation of concerns *was* made and (given the very disappointing failure of Children's Social Care even to need to be pursued further. Given the position adopted by Children's Social Care, Primary School 1's attempt to self-manage was well intentioned but under informed and unsustainable.

Ascham Housing

3.3.298 No concerns about the children were recognised so no action initiated. Hindsight has identified a number of risk factors (domestic violence claims, mother's mental health) which, had they been known or better recognised would have informed and rendered more likely appropriate actions.

Environmental Health

3.3.299 Staff who visited the home observed and reported no concerns.

HOW HEALTH SERVICES SUPPORT FAMILIES WHERE THERE HAVE BEEN PREVIOUS CHILD PROTECTION CONCERNS

Children's Social Care: NOT APPLICABLE

Metropolitan Police Service: NOT APPLICABLE

GP Services

3.3.300 The GPs were not ascribed any role within the child protection plan formulated in 2007 and although clearly aware that sister 1 had been subject of a protection plan it is unclear from records or from the individual management review provided how this impacted upon their subsequent dealings with child B's family.

North Middlesex Hospital

3.3.301 The hospital's child protection policy (2002) stipulates that when families are identified that have had previous child protection concerns, referrals should be made to Children's Social Care to enable preventative work with the family.

3.3.302 Mother had been recognised as a vulnerable person by the booking midwife and was appropriately referred to Sure Start for support. However a referral was not made to Children's Social Care, rather a request was made to that agency to ascertain the current level of involvement. This action was not in accordance with the child protection policy. Midwifery staff were present at the professionals' meeting and following delivery, there was appropriate liaison with Children's Social Care and Whipps Cross Hospital.

Whipps Cross Hospital (Midwifery)

3.3.303 Given what was known of the family, Children's Social Care should have been contacted *prior* to the birth of child B to confirm mother's assertions, though staff *did* initiate such contact prior to the baby's discharge and arranged routine transfer of responsibility to the community midwife and in due course to the health visitor.

Whipps Cross Hospital (Medical): NOT APPLICABLE

North East London Foundation Trust

3.3.304 The Trusts' individual management review explains more recent arrangements introduced in 2011 and also notes that once the perinatal team was fully operational in May 2009, close working with other NHS teams of midwives and health visitors and with the children's First Response Team became formalised through a weekly perinatal network meeting at the hospital where all concerns about the mental health of mothers / pregnant women and the safety of their babies / children were discussed.

Outer North East London Community Services

3.3.305 The 'enhanced health visiting service' is intended to address the additional health needs of specified families including those about whom there is concern for safety of child/ren. For the majority of the period being reviewed, child B's family was in receipt of an enhanced service.

3.3.306 Aside from opportunities for better decision making by individuals and identified elsewhere, there was some significant gaps in the intended provision of service e.g:

- There was a gap between the departure of HV2 in February 2010 and HV3 first visit in April that year
- HV3 last visited the family in July 2010 and in October transferred the case to HV6; no visit was then made until an agency HV5 completed a new birth visit in April 2011.

Early Years: NOT APPLICABLE

Ascham Housing: NOT APPLICABLE

Environmental Health: NOT APPLICABLE

QUALITY OF REFERRALS & INFORMATION SHARING ACROSS THE PARTNERSHIP

Children's Social Care

3.3.307 No criticisms were seen of referrals received by Children's Social Care. An unintended result of the failure to organise a pre-birth assessment in 2007 prior to birth of sister 1 was the loss of an early opportunity to exchange information.

3.3.308 Thereafter, information exchange seemed to be unproblematic with the exception of the mishandled referral from the child development clinic in May / June 2010 when (according to the referring doctor) the social worker was rude and obstructive.

3.3.309 Though it is known that his manager subsequently addressed the concerns of the referrer with him, the Children's Social Care individual management review does not explain whether the difficulties of the exchange had been a function of the individuals concerned or in any way reflected more systemic issues.

Metropolitan Police Service

3.3.310 There is nothing recorded to suggest that there was anything but a good exchange of information between Police and Children's Social Care.

3.3.311 The Police individual management review indicates that several strategy meetings / discussions were held and that the conference process was prompt and included all relevant information known at that time.

3.3.312 There does remain doubt about the timely receipt, or perhaps safe storage of conferences minutes from Children's Social Care.

GP Services

3.3.313 It is a matter of concern that the GP practice may well not have been sent or (less likely) perhaps retained a copy of the conference minutes from February or August 2007, though a copy of minutes from the November review conference were found by the individual management review author.

3.3.314 Though there were 'information exchange' failings within Children's Social Care discussed elsewhere, e.g. case closures without notifying partner agencies in August 2010, it seems from the records that GPs communicated *only* with health colleagues (medical and health visiting) and at no time since the birth of the children had initiated contact with Children's Social Care.

3.3.315 On one occasion GP9 (on learning of mother's pregnancy with child B), recorded his rationale for not contacting Children's Social Care. His decision was not unreasonable.

North Middlesex Hospital

3.3.316 Although no independent midwifery referral was made ante-natally to Children's Social Care there is evidence of appropriate information sharing prior to and immediately after the birth of sister 1.

3.3.317 The professionals' meeting allowed for agencies to share information and formulate a plan to safeguard the unborn child whilst assessments were taking place and an appropriate referral had been made for support from Sure Start.

Whipps Cross Hospital (Midwifery)

3.3.318 No need for a formal referral to Children's Social Care arose and when (belatedly) the hospital checked with Children's Social Care about the possibility of its current involvement and a comment upon the plan to discharge mother and child B, confirmation that the agency was not currently involved was provided readily enough. No other referrals were thought to have been necessary.

Whipps Cross Hospital (Medical): NOT APPLICABLE

North East London Foundation Trust

3.3.319 The quality of referrals and information sharing from Children's Social Care and the GP was consistently clear and responsive. The files evidence that the then SW1 liaised consistently with Trust staff; similarly, Child & Family Consultation Service had demonstrated close joint-working with Children's Social Care.

3.3.320 The GP and psych.7 worked closely together whilst mother was being assessed by the perinatal team in 2007. Because mother did not require constant psychiatric input or meet the criteria for a care-coordinator (and workers in Children's Social Care would change by the time of the next episode and because the Trust was unaware of any child protection concerns until 2010), not all correspondence was, or needed to be, routinely copied to Children's Social Care.

Outer North East London Community Services

3.3.321 The individual management review identified and explored a significant variation in the quality of information sharing between health visiting and GPs from none after the birth of sister 1 to regular liaison during allocation to HV2.

3.3.322 There was no liaison between health visiting and midwifery during mother's pregnancy with child B and the GP informed the individual management review author that since the health visitor allocation became geographical, she was unclear who the relevant health visitor was. The author confirms that here have been and continue to be opportunities provided to GPs to meet the relevant personnel.

3.3.323 There was considerable contact between health visitors and Children's Social Care social workers though (as noted elsewhere) what was lacking was fully informed and robust plan.

3.3.324 A significant obstacle to effective communication (attributed by the community paediatrician 1 to SW2) and relating to the May 2010 referral was 'rudeness, obstructiveness and poor communication skills'. It is not clear to what extent this social worker's manager was able to resolve this serious allegation at the time and a recommendation has been added to section 5 to ensure that the issue is not overlooked.

3.3.325 The paediatrician who was unable to attend the strategy meeting in July 2010 received no minutes (assuming there were minutes) nor received oral feedback from Children's Social Care or the health visitor who attended that meeting.

3.3.326 There were some weakness in HV2's referral in November 2008 to the peri-natal mental health service and (in spite of a high level of liaison) to the Children's Centres, in each case the issues of maternal care history, mental ill health, possible substance misuse and alleged domestic violence were overlooked.

Early Years

3.3.327 The health visitor should have provided the outreach worker at the Children's Centre with more background information when she initiated her referral but the Early Years staff thereafter shared information well with the consultant paediatrician and (to an extent that exceeded Children's Social Care's wish for that information) with Children's Social Care.

3.3.328 The difficulty with convincing Children's Social Care that the concerns satisfied threshold criteria was a function of issues internal to Children's Social Care not as a result of insufficient quality of information shared.

Ascham Housing

3.3.329 The information provided by psych.7 coupled with the records of several repairs necessitated by alleged domestic violence, would have justified an internal referral to the agency's tenancy support team and, together with information about mother's aggressive outbursts etc could have informed a referral to Children's Social Care.

Environmental Health

3.3.330 No referral was formulated because no concerns had been identified when the home was visited.

TO WHAT EXTENT WAS PROFESSIONAL OPTIMISM A FACTOR

Children's Social Care

3.3.331 Though by no means the sole preserve of Children's Social Care professionals, there is clear evidence of 'professional optimism' during the period covered by this serious case review.

3.3.332 The Children's Social Care individual management review identified it even in the first engagement following birth of sister 1 when she felt more direct support rather than just monitoring of performance was required. In fact, one identified element of the first 'working agreement' of late January 2007 was that the local authority would provide 'parenting advice and guidance'. In practice this amounted to no more than the observed parenting sessions.

3.3.333 Examples of the optimism seen amongst other professionals are provided later but the overview author would adduce as evidence the following Children's Social Care examples:

- Reassurances given at a home visit in late February 2007 (for the second time) about the disposal of the dog and parental reassurances of 'not smoking near the baby' (in spite of the worker's recorded observations of full ashtrays in the only bedroom in the flat)
- Marginalisation of the expressed concerns of midwife and contact worker when in June 2007 the case was to be transferred to the Community Safeguarding and Intervention Team
- The focus at the fourth core group in March 2008 on positive assertions by parents or maternal grandmother as opposed to non-compliance with the protection plan and credible concerns of the paternal grandmother
- The poor response to the allegation of abuse of sister 1 received in December 2008 when there was no direct interaction with sister 1, no medical examination and no challenge to the parental

denials – instead and presumably on the risky assumption that the allegations were untrue, a new 'working agreement' was identified as necessary

- The recommendation of SW2 in his initial assessment of June 2010 that on the basis of parental assurances they would clean up their accommodation and without regard to historical experience of such promises, no further action should be taken [his view was superseded following supervision, but illustrated the wish seen amongst others to believe that the family *would* cope]
- The acceptance at face value the excuses given for not bringing sister 1 to her pre school place as had been negotiated
- Case closure in August 2010 after no home visit for eight weeks, within twenty four hours of the formulation of the latest 'working agreement' and presumably on a very optimistic belief that even without Children's Social Care involvement, the parents would choose to be guided by the contents of that agreement

Metropolitan Police Service

3.3.334 There is no evidence to suggest any level of professional optimism in the records of observations by, and of notifications from police officers to Children's Social Care.

GP Services

3.3.335 Amongst those more directly involved with the family e.g. social workers, and health visitors there were signs of professional optimism, this was not apparent in the significantly less involved and less child oriented work of the GPs.

North Middlesex Hospital

3.3.336 The view of the individual management review author (with which the overview author concurs) is that the scope for improved practice largely reflected a lack of understanding of safeguarding duties and responsibilities by individual practitioners e.g. initially at mother's attendance for maternity care, there was an over reliance on other professionals to manage and provide information about concerns, rather than a full understanding of individuals' responsibilities. This differs from the 'professional optimism' which is evident in the practice of some others and reported in this overview.

3.3.337 The response to safeguarding and following appropriate child protection policy was not a function of professional optimism. The focus was on ascertaining the current level of involvement of mother with Children's Social Care. The midwife should have made a standard referral to Children's Social Care which would have resulted in awareness of that agency's current involvement. The midwifery service could then have been provided with the current assessment of risk at an earlier stage, rather than trying to plan collaboratively only a matter of days before the birth of sister 1

Whipps Cross Hospital (Midwifery)

3.3.338 At the time of mother booking in for maternity care the midwife's acceptance of the assurance that she no longer used cannabis was optimistic, as was the apparent assumption that mother's attendance for ante natal care would be better than for her last pregnancy. Hospital ante-natal clinic staff should have notified the community midwife of mother's 'did not attends' so as to allow her to undertake a home visit and encourage take up of ante natal monitoring and support.

3.3.339 The failure of the midwife to raise the case at her supervision sessions reflected her unduly optimistic perception of the family's capacity to cope.

Whipps Cross Hospital (Medical): NOT APPLICABLE

North East London Foundation Trust

3.3.340 As there were no child protection concerns communicated by either the GP or Children's Social Care prior to June 2010 this issue was not a factor for mental health services.

Outer and North East London Community Services

3.3.341 Though far less than that apparent within Children's Social Care, there was some professional optimism apparent in the failure to refer to Children's Social Care in May or oppose in July 2010, the unjustified decision by Children's Social Care to close the case.

Early Years

3.3.342 No professional optimism was apparent in the consistently realistic views of those who by virtue of their role spent more face to face time than any other professional with sister 1.The observations of sister 1 offered a glimpse into the experience of being a small child in this family,

Ascham Housing

3.3.343 There was a slight degree of professional optimism when the parental reassurance about removal of the pets and a cessation to the anti-social behaviour was accepted at face value, though it should be acknowledged that a period of monitoring followed and the case closed, in accordance with Ascham Homes' anti-social behaviour procedures following there were no further adverse reports. As far is known, the dog/s remained.

Environmental Health: NOT APPLICABLE

IMPACT OF ACCOMMODATION / OVERCROWDING

Children's Social Care

3.3.344 Children's Social Care had quite properly considered and explored the significance to the family's functioning of their accommodation when they moved to address 3 in January 2007 and after their transfer to their final location at address 4.

3.3.345 Advise from Housing received in 2008 confirmed that with two adults and two 'under fives' the family was not technically overcrowded, though managing the stairs with buggies, children and shopping cannot have been easy.

3.3.346 SW2 did in late 2010 support the initiative taken by the family to take over the tenancy of the paternal grandmother who was said to be at risk of eviction as a result of rent arrears.

3.3.347 Though the event itself was unknown to Children's Social Care, with the arrival of child B in March 2011, the pressure on the family (now two adults, three under fives and at least one dog in a second storey one bedroom flat) must have been considerable.

3.3.348 It should be borne in mind though, that for an unknown and possibly significant proportion of the period of tenancy at address 4, the family *actually* lived with the maternal or at times paternal grandmother.

Metropolitan Police Service

3.3.349 Though the question of overcrowding was in itself not addressed by officers attending the property, its condition and the implications for children of the family were noted on two occasions.

GP Services

3.3.350 The GPs, either because they did not ask or did not record the answer, appear to have been unaware of the occupancy of the parents' home. Given mother's assiduous attempts to get different accommodation, it is surprising that she did not seek a supportive letter from a GP as she had done from other professionals.

North Middlesex Hospital

3.3.351 Presumably because at the time of sister 1's birth, the parents did not feel it to be so, mother made no reference to overcrowding. She did report to the midwife that she was accessing support from the housing service as her property was not 'habitable'. This issue was also addressed in the professionals' meeting attended by the midwife, when it was reported that mother was in the process of being moved to different accommodation.

3.3.352 There was therefore no reason why North Middlesex Hospital staff should have taken any further or different action in respect of occupancy of the then accommodation.

Whipps Cross Hospital (Midwifery)

3.3.353 The midwife was clear that all members of the family (parents, sister 1, sister 2 and child B) slept in the same bedroom and may have known that this was not technically 'overcrowding'. Available records do not confirm that she discussed with mother or father what arrangements they might make to reduce the very real difficulty of reconciling the needs of two active under fives, a new baby and the parents' own needs for sleep and some privacy.

Whipps Cross Hospital (Medical): NOT APPLICABLE

North East London Foundation Trust

3.3.354 Mother requested supporting letters for re-housing from psychiatrists in both 2006 and 2009 and it seems likely that for any family, the co-existence of two adults and two (later three) children in a one-bedroom flat would place the family under significant strain, especially if there was no garden on which the children could play.

Outer North East London Community Services

3.3.355 The health visitors were aware of the level of occupancy throughout the period under review. They may have known that even with the arrival of child B, it did not officially (contrary to an intuitive understanding of the word) amount to 'overcrowding'.

3.3.356 Alternatively, they may have appreciated that while poverty or overcrowding is likely to increase the likelihood of it, it does not predetermine neglect and most families on low incomes and in crowded homes are able to provide warm and loving homes for their children.

Early Years

3.3.357 Whilst the family was not 'overcrowded' in terms of social housing policy, the stress on parents and children having to share a one-bedroom second storey flat was recognised by Early Years staff. Clearly, the parents had more scope for determining how *they* addressed this stress than did their children. Sadly, some of their responses e.g. use of cannabis, tobacco and alcohol would have had direct and indirect adverse impact on the children's welfare.

Ascham Housing

3.3.358 The Ascham Housing individual management review provides a comprehensive account of the local authority's allocation policy and the minimum standards and processes relevant to a family such as that of child B's.

3.3.359 The management review makes it clear that the family (though perhaps cramped in terns of the ideal) was not technically overcrowded and that even if the family had bid for advertised alternative vacancies, it would have been unlikely to succeed on the basis of 'reasonable preference' alone.

3.3.360 The probability of securing a successful bid would have risen if a referral had been made to the 'social needs panel' which has the ability to award 'additional preference' points.

3.3.361 Though no formal assessment of overcrowding was completed, there is no evidence to suggest that the family's functioning would have materially changed in a larger property.

Environmental Health

3.3.362 No concerns about overcrowding were identified by environmental health staff.

PRESENCE OF THE ANIMALS IN THE HOME, CARE PROVIDED TO THEM & THE IMPACT OF THIS ON THE CARE RECEIVED BY THE CHILDREN

Children's Social Care

3.3.363 From the initial contact with the family in 2007 to the death of child B, there was always and in breach of their tenancy agreement, at least one and at times more dogs sharing the one-bedroom second storey flat.

3.3.364 Initially a promise was made that the maternal grandmother would be taking the 'long haired Irish staff', though this was never honoured and the maternal grandmother at interview was clear that she had *never* had a dog (the immaculate presentation of her home and garden reinforce the credibility of her assertion).

3.3.365 At times e.g. early August 2007 the evidence suggests that mother lied when she claimed to have got rid of the then dog. The significance to the children of the presence in such cramped top floor accommodation of powerful dogs (one suspected by the animal warden to be an illegal Pit Bull type) and given their episodic mistreatment was:

- The direct risk posed to such small and vulnerable children (mother was bitten by and consequently disposed of a dog in October 2009)
- (Given the poor standards of hygiene observed at times) the health risk associated with the animal's faeces e.g. 'toxocara canis' (canine roundworm) with its associated risk of blindness
- The cost of feeding the animal/s (estimated by mother at £15 per week for one dog even four years ago) further reducing the scope for providing a nutritious and varied diet for the children

3.3.366 Though records are silent on the subject, it may be that ambivalence and uncertainty amongst social work staff about their need or right to take action with respect to the dog/s, mean that they came eventually to be accepted without comment. At no point was there a discussion with the Housing Provider about the legitimacy of keeping dogs, though in fairness even when Ascham Housing became aware it took no action.

3.3.367 The comment made by the family to the RSPCA inspector i.e. that the dog was kept on the balcony *only* when welfare visitors called might have offered reassurance to that officer whose concern was for the animal's welfare but would (*had* it been shared with Children's Social Care) have reinforced awareness of the close proximity in which children and dog/s lived and slept.

Metropolitan Police Service

3.3.368 On some occasions, Police assist the RSPCA in the discharge of their duties under s.4 Animal Welfare Act 2006 (unnecessary suffering). There was no such incident in this case and no reason to expect police officers to do more than include in their notifications to Children's Social Care the fact there was a dog in the household.

GP Services

3.3.369 The GPs were entirely unaware of the presence in the family home of a dog or dogs and therefore of its implications for the health and safety of any of the children, nor clearly how the animals were treated.

North Middlesex Hospital

3.3.370 Provision of antenatal care to mothers was and is conducted either within the hospital or community clinics i.e. It does not include home visits. The condition of sister 1 presented to A&E with a chesty cough was not attributed to any potential allergy that might have arisen by virtue of an animal present within the home. Thus, there was no documentation or reference made within any hospital record about the presence or care of animals in the family home.

Whipps Cross Hospital (Midwifery)

3.3.371 The community midwife was aware of the presence of a dog which she recalled was kept (at least during her visits) on the balcony of the family's flat. Though there may be more material about the significance of the dog in the still missing post natal notes, nothing has emerged from the individual management review supplied to suggest that its impact – either direct (space; hygiene etc) or indirect (cost; risk to small children) was evaluated.

Whipps Cross Hospital (Medical): NOT APPLICABLE

North East London Foundation Trust

3.3.372 Files contain only one reference to a dog which was noticed during the July 2010 home visit. It is unknown what impact any animals may have had on the children.

3.3.373 The interview with consultant psych. 7 introduced the notion that abuse of animals can indicate an increased risk of child abuse in a family.

Outer North East London Community Services

3.3.374 The initial contact by the health visitor from Haringey in February 2007 revealed the presence of a 'very large dog' and she had subsequent discussions with the parents about the implications for the baby (sister 1's) safety and well being.

3.3.375 A month later the dog (assuming it to be the same one) was described by the midwife to HV1 as a Staffordshire Bull Terrier. At her visit at the end of March 2007 HV1 recorded that her 'only concern is regarding the family pet'. In August mother indicated to HV1 (inaccurately) that she 'had got rid of the dog'.

3.3.376 In fact, one or more dogs remained as a member of the household throughout the period of the serious case review. If mother ever did get rid off / pass one on to the maternal grandmother (and in the view of the overview author, she did not) it was a very temporary arrangement.

3.3.377 In essence, the parents manipulated health and other visitors with false assurances about precautions taken and other diversionary tactics. Because they wished to convince him of their love of the animal, the comment made to the RSPCA inspector – that the dog was kept on the balcony of the flat *only* when a welfare visitor came was probably closest to truth.

3.3.378 Thus, for some four years, the dogs (and HV5 completing her new birth visit to child B used the plural) remained in close proximity to one, two and latterly three small children, whilst cooped up in a second storey one-bedroom flat possibly being ill treated from time to time.

3.3.379 Because of the failure of the animal warden to take a proactive stance when he thought the dog might be an illegal Pit Bull type and have its provenance verified by experts, it is possible only to conclude that the immediate risk to the children of attack and of disease was never mitigated and purely by luck never eventuated.

Early Years

3.3.380 The presence of a dog or at times dogs in the second storey one-bedroom flat must have added stress in terms of noise, mess, smell and cost of feeding.

3.3.381 The Early Years individual management review notes a substantial sum of money was paid for one of the dogs and mother had complained to other professionals about the cost of dog food. For a pet said by mother to be 'sister 1's', it is interesting to note she never mentioned its existence whilst at nursery.

Ascham Housing

3.3.382 At no time did mother apply for written permission to keep a pet (a tenancy condition).

3.3.383 An element of the complaint about anti-social behaviour in Summer 2010 was about the family's dog/s fouling communal areas and the balcony. In spite of that, and an acknowledgement by mother that sister 1 and sister 2 did have access to that balcony, no action was taken by Ascham staff in terms of agreeing or prohibiting presence of a dog.

Environmental Health

3.3.384 The only direct contact between Environmental Health and the premises was in relation to the family dog. Officers and managers were not aware at that time of any research linking the abuse of pets to the abuse of children. There are no recorded observations by officers about the children and the care they received.

3.3.385 Without regard to the possibility of an association between animal and child abuse, a more obvious and immediate risk which seems to have been overlooked by the animal warden was the risk posed to small children of what he thought might be a Pit Bull–type dog.

3.3.386 Checking out with Police the (presumably well informed) speculation should not have been left to mother's discretion.

EXTENT TO WHICH PROFESSIONALS WERE AWARE OF & CONSIDERED PARENTAL DRUG USE & IMPACT OF THIS ON ABILITY TO PARENT

3.3.387 Risks of harm associated with parental substance misuse are well documented e.g. Hidden Harm: Responding to the Needs of Children of Problem Drug Users [15]. A consistent finding across all biennial reviews of completed serious case reviews is of a significant proportion of children in households where one or both parents misuse illicit drugs and/or alcohol.

3.3.388 Whilst misuse is not of itself predictive of abuse, cost alone implies an inevitable level of neglect because of the priority awarded consumption of the chosen substance/s and justifies a referral for assessment by a drug action and alcohol team. Though that opportunity was offered father in this case, it was not taken up and both parents evaded any formal assessment throughout the period under review.

[15] Hidden Harm: Responding to the Needs of Children of Problem Drug Users (2003) – a report of an inquiry by the Advisory Council on the Misuse of Drugs London: Home Office

Children's Social Care

3.3.389 Children's Social Care's First Response Team and other professionals were aware from the initial involvement in early 2007 that both parents smoked tobacco and that mother had, according to the last psychiatrist who had seen her, 'abused drugs at different times'.

3.3.390 The perceived value of drug testing (for which substances it remains unclear) diminished over time. Although the question recurred in child protection or child in need plans, what actually happened was largely determined by assertions made or strategies adopted by either parent:

- Mother admitted that she 'does smoke marijuana outside to relax but does not do so when has sole care of sister 1' [early August 2007]
- Mother alleged that father used drugs including cocaine [mid August 2007] which although not known to Children's Social Care at the time was reinforced by father's contemporaneous account offered to A&E of use of ecstasy, speed and (in the past) cocaine as well as currently large quantities of alcohol and skunk
- By late September 2007 father was denying any use of cannabis and both parents 'agreed to be tested'
- By December 2007 the parents were 'refusing to be tested'
- In March 2008 mother was reporting that she 'wanted to quit cigarettes and marijuana' and convinced staff that testing was not available 'unless a court order required it'

3.3.391 By February 2008, staff seemed to have been worn down and proposed only that the maternal and paternal grandmothers be informed that the parents had refused to be tested. By April that year, the child in need plan included and presumably trusted a renewed assurance from the parents that they would not 'care for sister 1 if they were drinking or taking drugs'

3.3.392 In essence, all involved Children's Social Care practitioners were aware of parental use of cannabis and may have suspected misuse of other drugs but its likely or actual impact on sister 1 and later sister 2, was not explored, nor were the sometimes fanciful reassurances of the parents robustly challenged.

3.3.393 Alternative maternal accounts of drug misuse were those subsequently offered to health professionals e.g. cannabis twice daily (June 2008 when registering with the new GP); 3 joints a day (with a different GP September 2008); total denial (initial booking with midwife for sister 2 pregnancy).

3.3.394 The paternal grandmother was reporting mother's use of cannabis in front of the children in July 2009 and the (named) neighbour who made a referral in November 2010 noted that the flat 'stinks of weed'.

3.3.395 In essence, the parental obfuscation of the issue served to prevent a clear and confident conclusion that the parents were significant drug mis-users and for safeguarding responses to be based upon that presumption.

Metropolitan Police Service

3.3.396 As the Police individual management review points out, this was not an aspect that was assessed by officers other than when dealing with the assault allegation against father in September 2007 and the anti-social behaviour meeting in September 2010 which indicated that the housing provider staff had seen mother suffering the effects of substance abuse.

GP Services

3.3.397 The assertion by the author of the individual management review that the GPs were 'unaware of any parental drug use' is self evidently at odds with the numerous occasions on which mother acknowledges and is recorded as having accepted that she used (varying) amounts of cannabis and the conferences minutes that referred also to alleged misuse of alcohol and a variety of other drugs by father.

North Middlesex Hospital

3.3.398 Mother acknowledged at her booking appointment with the midwife that she and her partner had used marijuana. Any substance misuse would be an indication that a pregnancy is high risk and the booking midwife appropriately booked mother for consultant-led care in accordance with the Trusts' antenatal care guidelines (2003)

3.3.399 There appeared to be an over reliance on the consultant to ensure the issue of substance misuse was managed. This failed when mother did not attend any of the consultant's appointments. There was a lack of awareness of the significance of the disclosure of substance misuse and insufficient understanding of the responsibility to follow this up when mother 'did not attend'.

3.3.400 There appeared to have been no assessment to ascertain whether the substance misuse was past or current nor to address the level of usage and potential impact of this on the unborn child (the Trust's Child Protection Policy (2002) and London Child Protection Procedure (2002) indicate that a referral should be made to Children's Social Care if it was considered to be impacting on parenting capacity.

3.3.401 It seems that one practical and immediate result was that no urine testing was undertaken to confirm misuse of specified drugs.

Whipps Cross Hospital (Midwifery)

3.3.402 As indicated above, the midwife should not have accepted at face value mother's assertion that cannabis use was historical only. She should have explored further its use (reasons, quantities etc) and sought consent for a blood sample to test for other substances. Because of the assumption that cannabis (and other illegal substances) were not being used, their impact on future parenting was not addressed.

North East London Foundation Trust

3.3.403 The individual management review confirms awareness of cannabis use by both parents across several years but (with the exception of father's revelations at Whipps Cross Hospital in August 2007) not at a level or in a manner that caused concern about their ability to safely parent.

3.3.404 What would not have been apparent was the variation in quantities described to various professionals or the fact that reassurances about not smoking in front of the children were unreliable.

Early Years

3.3.405 Aside from the observations of the teacher at her home visit of the flat smelling strongly of cannabis (and reported to Children's Social Care), no other reference to drugs were made or received by Early Years services.

Outer North East London Community Services

3.3.406 The health visiting service was aware of the history of maternal drug use at the point of initial referral to the service in February 2007 from midwife 3. This information did not prompt further enquiry at the visit or liaison with the social worker following the visit to explore the nature of maternal drug use, its potential impact on parenting capacity and what services / supports were to be put in place to address the concerns.

3.3.407 HV 1 recorded her aims of discussing parenting capacity and child development which would be expected to encompass identification of any concerns about parenting capacity including substance but the reference to parental drug use was in relation to notes made by HV2 at the child protection review conference in November 2007 where it was recorded that a drug and alcohol assessment was to be undertaken in view of paternal aunt's allegation that sister 1 had been present when father was using drugs. This did not happen.

3.3.408 No copy of the health visitor's conference report or a copy of the conference minutes have been located so it is not possible to confirm whether parental drug use was discussed at that meeting.

3.3.409 At a core group in March 2008 the record indicated that 'no drugs tests had been undertaken due to new ruling….. and that 'the SW was to follow this up'.

3.3.410 There was no recording about any further outcome and in summary, reference to drug use was intermittent throughout the records but there was no systematic and clear understanding of the nature and extent of parental drug use nor its likely impact on parenting capacity

Ascham Housing

3.3.411 The allegation of misuse of drugs was first made to Ascham Housing as part of the wider range of complaints in late 2010. The letter subsequently sent to the residents omitted reference to this issue and there is no indication that the potential impact on the children (or unborn child) was considered.

Environmental Health

3.3.412 Environmental Health officers were not aware of any actual or alleged misuse of drugs at child B's home.

……

3.3.413 Few agencies addressed the question within the given terms of reference of 'were there any issues in communication, information sharing or service delivery between those with responsibilities for work during normal office hours and other providing out of hours services?' No evidence has emerged to suggest that the issue was relevant to this case and to avoid unnecessary lengthening of this report, an agency by agency response in what would be the negative has not been provided.

3.4 THE CHILDREN'S WORLD

3.4.1 'Learning Lessons, taking action' (footnote 12) concluded the single most significant practice failing in fifty serious case reviews considered by Ofsted in that report, was a failure to see the situation *from the child's perspective and experience* e.g. to see and speak to the child; to listen to what s/he says or to take serious account of their views in supporting their needs.

3.4.2 It is possible to differentiate and offer some very limited observations about the probable lived experience of each child of this family.

SISTER 1

3.4.3 This author found virtually no professional recordings of conversations with sister 1, though this would have been possible since at least the age of two and a half to three years of age.

3.4.4 The core assessments contained some descriptive material of her appearance but only Early Years staff (with whom the child spent more time than any others) was able to provide any real sense of how she saw the world e.g. a quiet child whom it was thought 'did not have the confidence to be disobedient', often telling other children to 'be good'; a child who 'never [even with explicit encouragement from staff] spoke about home or her sister'.

3.4.5 Sister 1 always had a dummy, liked to sit with adults and be cuddled. She was described as scruffy and sometimes having a ‘stale smell’ and being tired.

3.4.6 Sister 1’s reluctance to speak of home e.g. what she had done at the weekend even extended to a failure to speak at all of the dog which, according to mother, was her pet.

3.4.7 When compared with other children, sister 1’s high level of anxiety was noted e.g. her reaction to accidentally spilling her drink suggested this was an event that she expected to evoke reprimand or punishment.

3.4.8 The view formed by the author and senior nurse when meeting mother and father to discuss this serious case review was of a very passive, watchful child who did show any enthusiasm for meeting up with her mother after her pre-school session. This one-off observation might just have been about the child being tired or wary of two strangers or it may have reflected an aspect of her relationship to mother.

SISTER 2

3.4.9 If information about sister 1 was limited, an appreciation of the experiences of sister 2 experiences (who had not begun any form of day care in the course of this serious case review) was even more difficult to discern. Contacts with the agencies contributing to this serious case review were anyway minimal and where any commentary was provided e.g. the Children’s Social Care core assessments, it was chiefly a note of her appearance and (more helpfully) some confirmation of her being played with by parents.

3.4.10 The opportunities for sister 2 to be seen by a Whips Cross Hospital paediatrician were lost because parents failed the appointments.

3.4.11 It remains unknown how the development of sister 2 is being influenced by her mother’s erratic behaviours or by the parents’ frequent ‘separations’.

CHILD B

3.4.12 Only midwives, GPs and the health visitor had more than a passing acquaintance with child B in her tragically short life. None recorded more her physical characteristics or symptoms.

3.5 GOOD PRACTICE

3.5.1 Some examples of best practice were identified by individual management review authors and/or the panel and the most significant *or* those that offer learning opportunities for future service delivery are outlined below:

- The follow up of mother by the community midwife at North Middlesex Hospital in 2006 after each failed appointment in order to encourage her to attend for antenatal care
- The contact initiated by Labour ward staff at North Middlesex Hospital with the local Children's Social Care when sister 1 was born
- Some swift and thorough collaborative work by SW1 at the time of birth of sister 1
- GP3 whose sensitivity to mother's history of overdosing, prompted him to insist that the maternal grandmother retained control of access to prescribed medication
- The pragmatic offer of a taxi to get mother and sister 1 to a much needed developmental assessment in April 2010 (the refusal of which by mother offered an insight into the real obstacles to service take up)
- The sensitivity and caring child-centeredness of staff at Pre-School 1 and Primary School 1 in spite of the challenge presented by dysfunctional parents and a reluctant Children's Social Care

4 CONCLUSIONS & LESSONS LEARNED

4.1 CONCLUSIONS

4.1.1 The numerous italicised comments in section 2 and further analysis in section 3 enable the following succinct list of conclusions:

- As a child, mother manifested a very high level of emotional disturbance
- Mother's developmental history was recognised only by *some* professionals as indicative of probable difficulties in providing adequate parenting and opportunities for mitigating probable risks prior to birth of her first child were missed
- The nature and significance to her parenting capacity of mother's possible mental health difficulties remained insufficiently clear to health and CSC services throughout the period under review
- Father's developmental history reveals involvement only with universal services, but some behaviours observed by professionals in the period under review indicated significant mental health and substance misuse difficulties in the context of an intrinsically unstable yet enduring relationship with mother and required more exploration
- Overall, there was a collective failure to collate and analyse information about the parents' formative experiences and to use that information to assist in understanding them individually, as a couple and as parents
- Considerable amounts of practical, psychological and medical assistance from local agencies were offered the family throughout the period under review
- The proportion of health related appointments failed by the parents offered a convenient and measurable indicator which was not exploited, of parental inability or unwillingness to organise in the best interests of their child/ren and of 'non compliance' with 'agreed' child protection or child in need plans
- 'Disguised compliance' was evident, examples being parental promises to pursue a mental health re-assessment of mother or to relinquish the dog/s
- There was a lack of rigour in pursuing parental failure to complete agreed tasks and (in spite of those planned or promised) very limited consequences
- There was insufficient challenge by health and social care agencies about the nature and scale of substance misuse by both parents
- There was a consistent tendency to assess incidents and circumstances in isolation and not to contextualise them by reference to known history

- Professional optimism by midwife, health visitor and specified social work practitioners and managers was evident
- The parents (mainly mother) successfully deployed attack as a means of defence and diversion when challenged
- Case supervision within CSC and the health visiting service supervision was insufficiently reflective
- Domestic violence whether real or more probably fabricated was insufficiently explored with an unhelpful and ill evidenced assumption that mother was the recipient
- Though attentive to presenting symptoms, the service provided by GPs was reactive, at times ill informed and took little account of information contained in the regrettably limited child protection conference minutes provided by CSC
- A very significant source of support, socialisation and monitoring of sister 1's safety and well being was provided by Pre School 1 and later Primary School 1
- With the exception of early years practitioners, there was insufficient recognition of *day to day* experiences and likely long term impact of non life threatening neglect of physical and emotional needs
- The lack of understanding of life in the family from the perspective of the children meant that any analysis of the risk of harm to them was insufficiently informed
- Latter CSC assessments were formulaic and reflected a management-led reluctance to respond to entirely proper referrals from other professional and non professional sources
- Though their love and wish to care for their children was often evident, and the children's attachment to their parents appeared secure, the capacity of the parents to provide *consistent* rather than episodic 'good enough parenting' to their growing family remained insufficient across the period under review
- The level of risks to her elder sisters and to child B (immediate and longer term) were reduced only for as long as there was active and current professional intervention
- Though the results of any legal proceedings would not have been certain, legal advice should have been sought at an earlier stage
- In spite of identified weaknesses in planning, communication and service delivery and a regrettable likelihood of long term 'significant harm' to all 3 children in consequence of neglect, there are *no* grounds for concluding that the sudden death of child B could have been predicted nor with any level of confidence that it was preventable by the professionals involved
- Whilst the parents' (atypical) failure to seek medical attention for what would have been a sudden and obvious onset of diarrhoea and vomiting is believed to be a significant contribution to the death of child B, the precise cause of death and the issue of any criminal liability remain for determination by the Coroner and Police respectively

- A number of opportunities for improving the effectiveness and efficiency with which local services operate and collaborate have been identified by this SCR and should be realised through implementation of the recommendations provided

4.2 LESSONS LEARNED

4.2.1 The overall lessons emerging from the involvement of all agencies are that:

- The *aggregated* impact on children of apparently minor concerns is as important as a few more dramatic incidents especially when those concerns are viewed from the perspective of the children
- To monitor such aggregation requires an appreciation of its importance and the means to recognise it i.e. clear and accurate records, effective *reflective* supervision and a willingness and efficiency about the sharing of relevant information across professions
- Distracting behaviours and hostility from parents can reinforce ambivalence about challenge and professional optimism, as well as a natural professional reluctance to disrupt marginally or episodically 'good enough' parenting
- The direct and indirect impact on small children of chronic mental health difficulties and the long term use of expensive illicit drugs (in addition to tobacco and alcohol) must not be marginalised
- The evaluation of a series of minor concerns, parental hostility and distracting behaviours, mental health issues and drug / alcohol use and the impact on the children needs to be undertaken in the context of an understanding of the parents' formative experiences
- Formulaic compliance with prescriptive pro formas, however timely and useful for local or national performance indicators, is no substitute for open minded, challenging and *child centred* enquiries

5 RECOMMENDATIONS

5.1 INTRODUCTION

5.1.1 Mindful of the DfE research report[16] that focused on recommendations from SCRs, the panel sought to minimise their number and maximise specificity and achievability. A number of recommendations made by IMR authors were rejected as being redundant e.g. some had already been actioned or because they were insufficiently related to the evidence within this case.

5.1.2 In many instances, the recommendations follow that of Lord Laming (Victoria Climbie Inquiry report 2003) concerning the need to do simple things well. Information gathering, understanding the child's perspective, analysis and challenge through the supervision process were and are the basic tools underpinning the assessment process without which comprehensive plans to safeguard children cannot be made

5.1.3 The SCR panel has found it necessary to formulate the following recommendations, most reproduced from IMRs and in many cases modified to render then 'SMARTER'), several more identified by the overview author and/or panel and 5 additional recommendations which emerged from the health overview. These have all been divided into those requiring action by:

- Waltham Forest's Safeguarding Children Board or
- The agency specified

5.2 WALTHAM FOREST SAFEGUARDING CHILDREN BOARD (LSCB)

5.2.1 The LSCB should seek from the chief executive / director of each partner agency a written assurance that s/he is confident that existing archive arrangements enable the retrieval of relevant historical records; and if such an assurance cannot be given that current arrangements are reviewed so as to ensure within 6 months, records are sufficiently secure and retrievable for operational use in their respective settings and to be made available for formal case reviews [letter to be sent by 30.11.11].

5.2.2 The LSCB should:

- Ask the chief executive of Waltham Forest to obtain written confirmation from all relevant departments that senior managers are aware of and have acted to make all relevant staff aware of the duties introduced by s.10 and s.11 Children Act 2004 and expectations of the London Child Protection Procedures [by 31.12.11]
- Seek a comparable confirmation from the chief executives / directors of all other agencies specified in s.10 and s.11 of the Children Act 2004 [by 31.12.11]

[16] A study of recommendations arising from serious case reviews 2009-2010 Brandon etc al DFE RR157

5.2.3 The LSCB should issue guidance to all early years settings in the borough outlining the requirement for information about children to be shared with receiving settings or schools at the point of transfer so that their practice is in line with that required of schools [by 31.12.11].

5.2.4 The LSCB should issue guidance to early years settings and schools about a formal process for the oversight and management of non-statutory attendance of children who are referred for placements due to their level of vulnerability and their family's needs [by 31.03.12].

5.2.5 The LSCB should ensure that staff across all agencies are aware of the need to take account of the formative experiences of adults (including their experience of parenting) and the child's experience of being cared for within their family environment when undertaking assessments, making plans or otherwise working with children and their families. Actions related to this recommendation would include seminars / training programmes; evidence of impact through case audit programme [ongoing programme from 30.04.12]

5.2.6 The LSCB should note that vulnerable children can be further safeguarded if A&E departments have access to up to date information about children who are the subject of a protection plan. Accordingly, the LSCB should:

- Discuss with partner agencies / neighbouring authorities how a 'real time' list of children subject to protection plans can be made available to local A&E departments on a sub-regional basis; and
- Write to the London Safeguarding Children Board to propose that it consider how a 'real time' list of children resident in London Authorities and subject to protection plans can be made available to A&E departments across the London area. [initiate discussions and letter by 31.01.12]

5.3 OUTER & NORTH EAST LONDON (ONEL) COMMUNITY SERVICES [NELFT IS NOW ACCOUNTABLE FOR IMPLEMENTATION]

GP SERVICES

5.3.1 The GP practice should review the way it records child health surveillance appointments and ensure that clinical measurements are recorded in the medical records and that the triplicate sheets in the 'Red Book' are also scanned into the records [by 31.01.12].

5.3.2 The GP practice, with the explicit consent of mother, should request a review of her psychiatric condition to establish if she does have a formal diagnosis and to consider if it is appropriate to treat her with anti-psychotic medication [by 31.12.11].

5.3.3 The GP practice should review its internal safeguarding procedures to ensure that all the clinicians have an appropriate understanding of the role that domestic violence can play in child protection issues and that they understand the guidance available in the London Child Protection procedures [by 30.12.11].

5.3.4 The GP practice should ensure that allegations of assault made by patients are fully considered and that, particularly for children and vulnerable adults, thought is given to the need for either Children's / Adults' Social Care or Police referral and that this is noted in the records [by 30.12.11]

5.3.5 The GP practice should consider its approach to the provision of contraception and sexual health services to children under 16 so as to ensure that issues about competence are considered and *fully recorded* [by 30.12.11].

5.3.6 The GP practice should review its systems and processes for summarising records to ensure the protocols are precise enough and introduce a quality assurance process that looks at a sample of summarised records for accuracy [by 31.01.12]

OTHER HEALTH STAFF

5.3.7 So as to be assured that its children's services staff are knowledgeable about the indicators of abuse and able to undertake high quality health visiting assessments that identify risk and result in the development of a health care plan in response to identified need, ONEL CS must (action plan provides details):

- Ensure that 100 % of staff have attended the mandatory safeguarding training at levels 1-3 commensurate with their role [by 30.04.12]
- Complete a records audit to include children identified as requiring routine and enhanced health visiting services to look at initial assessments (thus ensuring that risks have been identified and actioned within local and national policy and procedures) [by 30.11.11]
- Brief all relevant staff in relation to lessons learnt from SCR [by 30.04.12]

5.3.8 So that ONEL CS can be assured that all cases in which there are concerns about parenting capacity are discussed within a safeguarding supervisory framework and that an effective care plan is in place, the agency must:

- Provide child protection supervisors with an update by 31.03.12
- Develop a tool to enable an annual audit of the uptake of child protection supervision and documentation
- Undertake an audit of child protection supervision (action plan provides details) [by 30.04.12]
- Quality assure child protection supervision sessions by use of named and designated professionals for child protection [by 31.03.12]

5.3.9 The agency must:

- Update the record keeping standard for all its services to reflect the use of the Assessment Framework and ensure coherent and consistent recordings of significant vents [by 30.06.12]
- Examine the system of recording child health clinic attendances on the Rio system by the health visiting service [by 30.06.12]

ADDITIONAL RECOMMENDATIONS OF HEALTH OVERVIEW AUTHOR

5.3.10 Single agency training on implementation of s.10 and s.11 Children Act 2004, information sharing; and an audit of contractual compliance with independent providers [by 31.05.12].

5.3.11 Review / audit plans for vulnerable children, including those at risk for a consistent approach to responding to risk and thresholds of intervention; training via the LSCB programme to include assessment of need and risk to be accessible to all (including independent) providers and an escalation policy to be made available to include managing disagreement sbout risk between services [by 31.03.12]

5.3.12 Directory of contacts within the service of specialists to be made available to staff; induction to include training on accessing these services as well as an introduction to the organisations' responses to children in need / at risk; specialists to introduce themselves and explain their role [31.03.12].

5.3.13 Mandatory training on principles of recording as specified in the health overview to be provided and records and reports to be routinely audited for compliance [by 31.05.12].

5.3.14 Review policies and procedures relevant to safeguarding children and advise on their updating; provide training to staff on delivering safeguarding supervision; review induction and ensure it includes how to access and use safeguarding supervision [by 31.05.12].

5.4 WALTHAM FOREST CHILDREN'S SOCIAL CARE (CSC)

5.4.1 The quality of case recording was poor and needs to substantially improve with specific focus on the issues raised through this serious case review. Clear expectations about the quality of recording and what should be included need to be provided to staff and reiterated through management oversight and audit [by 31.01.12].

5.4.2 The quality of analysis in assessments has been weak with a lack of consideration given to the role of fathers and parents' past parenting history. Additional support and training needs to be targeted at front line workers analysis skills and a clear risk assessment model developed and implemented [by 29.02.12]

5.4.3 Case closures and step down arrangements to universal services were highlighted in this review, as well as the Ofsted unannounced inspection. Clarity about management sign off and accountability need be confirmed; arrangements to ensure that other agencies are aware of the case closure / step down and monitoring of these cases must be developed [completed].

5.4.4 Supervision was highlighted as poor in this review. A system should be put in place to ensure regular supervision is held, as well as ensuring that all cases are regularly reviewed during this process. Compliance with this requirement should be monitored and supervision audits put in place including quality of management oversight [in place and ongoing].

5.4.5 The issue of disguised compliance should be the subject of training and development for all social workers about 'hard to engage' families. It should be a feature of learning the lessons from this review and be disseminated to all front line staff within 3 months of its completion [by 31.03.12].

5.4.6 The impact of the joint protocol with NELFT about safeguarding families affected by parental mental health problems should be the subject of review through the Safeguarding Children Board [by 31.03.12].

5.4.7 Unless subsequently resolved, the allegations made at the time and repeated by the community paediatrician about SW 2 need to be addressed, investigated and appropriate action taken [by 31.01.12].

5.4.8 Further efforts should be made to establish whether mother and maternal grandmother did in 2000 report sexual abuse by the then foster carer and if one or other did, to evaluate the response given and take any proportionate further action [by 31.01.12]

5.4.9 The arrangements for routine case audits should be reviewed with the aim of capturing a more holistic and informed view of quality than is apparent by an examination only of a core assessment [by 31.03.12]

5.5 NORTH MIDDLESEX UNIVERSITY HOSPITAL (NMUH)

5.5.1 So as to ensure that the learning from this serious case review is embedded across NMUH, there should be:

- Ongoing training for staff for child protection with the inclusion for midwives of antenatal indicators of abuse or neglect toward the unborn child. The vulnerable women training should continue to be in place for maternity staff to increase knowledge, awareness and understanding in the areas of domestic violence, mental health, teenage pregnancy and substance misuse (action plan provides details) [immediate and ongoing]
- Regular child protection supervision for midwives in community to discuss high risk cases, this should be supported by policy and training for the Named Staff in the delivery of supervision to ensure that quality supervision is provided (action plan provides details) [with effect from February 2012]

5.6 WHIPPS CROSS UNIVERSITY HOSPITAL (MIDWIFERY)

5.6.1 There needs to be a review of the vulnerability checklist and action to be taken when vulnerability is identified (this is currently being undertaken following the introduction of the 'vulnerable team' within a revised community midwifery structure [by 31.12.11].

5.6.2 When there has been previous involvement with Children's or Adults' Social Care and especially when there are previous child protection concerns, the midwife must liaise directly with the Children's Social Care team to discuss the family and arrange appropriate support [by 31.12.11]

5.6.3 When a history of mental health has been recognised, a referral should be completed to the 'perinatal mental health service (PMHS), so as to trigger an initial assessment of the mental health status of the mother from a specialist in mental health [by 31.12.11].

5.6.4 When a mother discloses past or present cannabis use, the midwife should ask questions relating to amount used, reasons and request urine for toxicology; additional support and advice on appropriate and safe methods for relaxation should be explored [by 31.1211].

5.6.5 If a woman fails to attend her hospital antenatal appointments hospital staff should inform the community midwife who can then arrange a home visit and plan follow up antenatal care and support [by 31.10.11]

5.6.6 The importance of returning post natal records following discharge by midwifery services should be discussed with all mothers / families and:

- The 'no return rate' should be reviewed by community managers and a review of current practice be initiated if the problem that arose in this case is judged prevalent enough [by 30.04.12].
- If the records are not returned following repeated requests the community midwife needs to escalate this to the line manager [immediate]
- A record of all records not returned should be collected by the community midwifery team [by 31.03.12]

5.7 WHIPPS CROSS UNIVERSITY HOSPITAL (MEDICAL SERVICES)

5.7.1 So as to ensure that the learning from this serious case review is embedded across WXUH, WXUH must ensure that assessments of injuries in children and young people include exploration of the cause of injury by:

- Making orthopaedic consultants aware of this requirement [by 31.12.11]
- Auditing compliance with the above [by 31.01.12]
- Reinforcing 'safeguarding children' as a routine differential diagnosis when children and young people present with injuries.

- Checking all orthopaedic consultants and their teams are up to date with level 2 safeguarding training [by 31.12.11]
- Reviewing record keeping process for orthopaedic team during out-patient consultations to enable a Trust decision on acceptability of the current system [by 31.12.11]

5.7.2 All staff who come into contact with children/young people must be made aware that assessments and records must include details of who accompanies a child/young person to the hospital, their relationship to the child/young person, and who has parental responsibility for her/him must be recorded in the hospital notes [by 30.10.11] and compliance must be evaluated by an audit [by 31.12.11]

5.7.3 In responding to children who self harm:

- As part of the nursing assessment, a background check must be undertaken with Children's Social Care to determine if the child/young person is known to that service
- Following the Psychiatric assessment of such a child/young person a discussion must take place between hospital staff and the psychiatrist to consider child protection and the need for a referral to Children's Social Care
- When a referral is needed to safeguard the child/young person this must be made by the hospital staff
- The named nurse for safeguarding children (or deputy) must be informed of all children who attend A&E or are admitted
- Consideration must be given to routinely asking all female self harmers of a relevant age whether they are pregnant
- Relevant training must be provided for A&E and paediatric staff [all by 31.12.11]

5.7.4 Review the assessment process in the early pregnancy assessment unit (EPAU) to ensure a holistic approach which incorporates physical, psychological, emotional and social implications of pregnancy [by 31.12.11]

5.7.5 Ensure that all relevant ward and 'Early Pregnancy Assessment Unit' staff are up to date with level 2 safeguarding training [by 31.12.11].

5.7.6 WXUH must ensure that the procedure for children and young people who fail to attend out-patient appointments becomes embedded in practice by:

- All clinic leads for the out patient department being made aware of the relevant follow up procedure [by 31.12.11]
- An audit of compliance with the above [by 31.12.11]

5.8 NORTH EAST LONDON NHS FOUNDATION TRUST (NELFT)

5.8.1 Access and psychiatric liaison teams must undergo 'level 3' child protection training, so that each individual member understands their responsibilities with respect to NELFT and national policies [by 31.03.12].

5.8.2 All NELFT staff must be reminded of the necessity of completing an initial risk assessment and thereafter updating after each risk incident [by 31.12.11].

5.8.3 All clinicians must review a patient's prior history & at each new episode and there should be a psychiatric summary placed in the 'progress notes' on the RiO database [by 31.12.11].

5.9 ASCHAM HOUSING

5.9.1 Information regarding vulnerable households (including safeguarding) to be shared effectively and efficiently between the London Borough of Waltham Forest council departments and Asham Homes (action plan offers methodology) [by 30.04.12]

5.9.2 Future information sharing between agencies and improve multi-agency working with the family to be improved by adding family's name to 'vulnerable adults' list [completed].

5.9.3 All staff to be reminded of the importance of the using the aggressive customer list and displaying information appropriately [[completed].

5.9.4 Victims of domestic violence are directed to appropriate advice and support in a timely way by development of a reporting mechanism and monitoring arrangements (action plan provides details) [by 31.12.11]

5.9.5 All staff and contractors to be aware of their role and responsibilities in regard to safeguarding and how to make appropriate referrals to the Social Needs Panel role-appropriate training and briefings (action plan provides details) [completed]

5.9.6 Ascham Homes 'Safeguarding Vulnerable Adults and Children policy' to be reviewed (internally and by WFSCB) to ensure fit for purpose [completed].

5.10 METROPOLITAN POLICE SERVICE

5.10.1 The MPS IMR contained no recommendations for service improvements.

5.11 EARLY YEARS SERVICES

5.11.1 All staff in early years and education settings should:

- Be reminded of the importance of seeking information about children considered to be vulnerable so as to undertake appropriate monitoring and best safeguarding practice [by 31.12.11]
- When a child is referred to an early years setting and it is known there are possible risk factors within the family or that the family is vulnerable, request information from partner agencies to ensure that there is a clear understanding of that risk and how it should be responded to, monitored and managed [31.12.11]

5.11.2 Early Years should re-issue its 'escalation policy' to all early years settings and schools and consider how it will monitor its implementation and effectiveness [already completed].

5.12 ENVIRONMENTAL HEALTH

5.12.1 Environmental Health should:

- In consultation with relevant individual in Children's Social Care and Mental Health Services, train staff in child protection awareness and procedures and information sharing [as recommended during a recent Ofsted inspection] (action plan provides details) [by 31.03.12]
- Train 'dog enforcement officers' in understanding the links between abuse of dogs and child abuse (action plan provides details) [by 31.12.11]
- Introduce to the list of agenda items in management team meetings a heading of 'safeguarding' (action plan provides details) [by 30.11.11]
- Review induction training so that all new staff including contractors / agencies understand child protection procedures (action plan provides details) [by 31.12.11]