Barking & Dagenham Safeguarding Children Board

CONFIDENTIAL

BARKING AND DAGENHAM SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CHILD B

June 2016

Contents

Serious Case Review Child B

1 Introduction

1.1 Decision To Initiate A Serious Case Review

1.1.1 On 15th July 2015, after concerns were raised by the Named Nurse, Safeguarding Children, at Barking, Havering and Redbridge University Hospital Trust, Child B was referred to Barking and Dagenham Safeguarding Children Board for consideration of the need for a serious case review by the Designated Nurse, Barking and Dagenham Clinical Commissioning Group.

1.1.2 Child B was born in May 2015; Child B's future circumstances had been considered at a pre-birth child protection conference held on 29th April 2015 when Child B was made the subject of a child protection plan. Child B was taken to a local Emergency Department on three occasions in the 42 days following birth: on the first occasion, Child B had a lump on it's head; on the second Child B had stopped breathing and on the third, Child B's heart had stopped beating. Fortunately Child B survived this early trauma and has subsequently thrived.

1.1.3 The case was initially discussed at a Serious Case Review (SCR) panel meeting on the 22nd July 2015. The panel decided that more information was needed in order to determine whether the case met the criteria for a serious case review and that it should reconvene following receipt of expert reports relating to the child's injuries.

1.1.4 The panel reconvened on 25th August 2015; members of the panel were of differing views, four members were of the view that the criteria were not met whilst two members felt that the case did meet the criteria for a SCR. The panel recognized that this was a difficult case and recommended that it should be discussed with the chair of Barking and Dagenham Safeguarding Children Board (BDSCB) as it could meet the threshold.

1.1.5 On the 28th August 2015 the Chair decided that the case did meet the criteria for a SCR for the following reasons:

- Child B sustained a potentially life threatening injury
- One or more agencies or professionals considered that their concerns were not taken sufficiently seriously or acted on appropriately by another.

- Child B was subject to a child protection plan from prior to birth.

1.1.6 Ofsted were informed of the incident on 5th August 2015, with further updates provided to DfE as set out below.

15/07/15	Notification from CCG/Designated Nurse
05/08/15	DFE notified – update due 15/8/15
15/8/15	DFE updated – still awaiting 2nd SCR Panel 24/8/15
03/09/15	DFE updated – awaiting FF hearing information
11/09/15	Notification from CAFCASS
11/09/15	DFE further update
24/09/15	DFE notified that Chair agreed to SCR
29/09/15	DFE notified that SCR Reviewer appointed
05/10/15	DFE acknowledged
23/02/16	DFE notified of delay with the completion of the review
04/04/16	DfE notified of the further delay with the completion of the SCR

1.2 Purpose And Conduct Of The Serious Case Review

1.2.1 The purpose of a Serious Case Review is to identify improvements and to consolidate good practice. Local Safeguarding Children Boards and their partner organisations should translate the findings from reviews into programmes of action that lead to sustainable improvements and the prevention of death, serious injury or harm to children[1].

1.2.2 A SCR should be undertaken where

- Abuse or neglect of a child is known or suspected; and
- Either the child had died; or
- The child has been seriously harmed and there is cause for concern about the way in which the authority, their board partners or other relevant persons have worked together to safeguard the child.

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

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;

[1] Working Together 2015

- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

1.3 Terms of Reference for the Serious case Review.

1.3.1 Draft terms of reference were drawn up following the decision to undertake a SCR and finalized at a meeting of the SCR Panel on 4th December 2015; these are attached as Appendix 1.

1.4 Conduct of the SCR

1.4.1 Steve Liddicott was appointed as the independent lead reviewer. He is a social worker with considerable experience of the management of children's social care services at a senior level, co-editor of the London Child Protection Procedures and experienced in chairing and contributing to Serious Case Reviews and Domestic Homicide Reviews.

1.4.2 In line with the terms of reference it was agreed that the Lead Reviewer would review the detailed chronologies provided by the identified agencies and request IMRs from any agencies where it was felt that this could provide further insight or information.

1.4.3 The following agencies were identified as likely to have information of relevance to the Serious Case Review:

- Barking & Dagenham Clinical Commissioning Group (CCG)
  - Designated professionals and lead commissioners
- NHS England
  - GP Services
- North East London Foundation NHS Trust (NELFT)
  - Community Health Services, Health Visiting
- Barking, Havering and Redbridge University Hospital NHS Trust (BHRUT)
  - Queen's Hospital Services including Emergency Department and Midwifery
- Barts Health NHS Trust
  - Royal London Hospital
- London Borough of Barking and Dagenham

    - Complex Needs & Social Care
    - Strategic Commissioning, Safeguarding and Early Help
    - Legal Services
- Children & Family Court Advisory & Support Service (CAFCASS)
- London Ambulance Service (LAS)
- Metropolitan Police
    - Child Abuse Investigation Team (CAIT)
    - Specialist Crime Review Group
- Crime Reduction Initiatives (CRI) Gateway – Barking and Dagenham
    - Substance Abuse

1.4.4 The period to be covered by the review was agreed to be from 1st August 2014 to 31st August 2015. All agencies were asked to provide a chronology covering this period together with a brief summary of contact with the family prior to the start date.

1.5 Involvement of Staff

1.5.1 All of the agencies that had significant contact with the family during the period covered by the SCR involved staff in the compilation of their IMRs. Details of this were recorded in the IMRs.

1.5.2 The Lead Reviewer also sought to involve staff during the course of undertaking the review. It had been intended that a single practitioner event would provide an opportunity for staff from across all agencies to contribute to the review. However, by the end of 2015, the social worker, team manager and child protection conference chair had left their posts with the Council. A Practitioners' event was held in January 2016, invitations were sent to all agencies that had significant involvement with the family; however, the majority of those that attended were from the health service. It was therefore necessary to have individual discussions with those staff that had previously worked with the family from children's social care to complete the picture.

1.5.3 The views of practitioners are set out in Section 8.5 below

1.6 Involvement of Family Members

1.6.1 Both parents were informed in person that the LSCB had decided to undertake a SCR and invited on two occasions to contribute to the review. They did not respond to either of the invitations.

2 Executive Summary

2.1 On 11th July 2015 a seven week old baby Child B was admitted to hospital in cardiac arrest; this was the second time within a few weeks that Child B had been admitted to hospital with a life threatening condition whilst in parental care.

2.2 The child's father was subsequently arrested (although not charged) and care proceedings were initiated in respect of the baby who had made a full recovery.

2.3 The independent chair of the Barking and Dagenham Safeguarding Children Board determined that the case fulfilled the criteria for a serious case review. At the point at which the serious case review was commenced there was a lack of clarity in relation to the medical basis for the hospital admissions. Specialist medical reports were commissioned during the care proceedings and the findings included in this report following their consideration by the court in March 2016.

2.4 Having considered the expert medical reports the court reached the conclusion that the whilst the first emergency hospital admission might have been as a result of an accident (the father laying on Child B whilst they were asleep in bed), the second had resulted from non-accidental injuries caused by the father. Child B's mother was not thought to be responsible for causing harm to the baby on either occasion.

2.5 At the time of Child B's admission to hospital, Child B was subject to a child protection plan, and had been since before birth. Child B's mother and father were well known to local agencies prior to the birth. Child B's father had been in the care of the local authority as a child. Three older children, the half siblings of Child B, had been removed from the care of Child B's mother in the months preceding Child B's birth and whilst Child B's mother was living with Child B's father.

2.6 Child B's mother was known to have long standing substance abuse problems and a history of involvement in relationships characterised by domestic violence. The father was known to be a perpetrator of domestic violence both within this and a previous relationship. There was a history of non co-operation with agencies and a negative parenting assessment of the mother less than a year beforehand.

2.7 This review sought to maximise learning by involving relevant professionals in the process. Their reflections on events mirrored many of the issues identified in the contributions of individual agencies to the review and the findings of the review. Steps were taken by all agencies to ensure that the most urgent recommendations were implemented prior to the conclusion of the SCR.

2.8 This report offers a comprehensive account and critique of the services offered to Child B and Child B's parents. A number of issues of concern were identified - the findings. The actions already taken by local agencies are noted in the report together with recommendations for further actions.

2.9 Findings

2.9.1 There were a number of practice issues for the agencies involved, particularly in relation to information sharing, communication and recording, for example:

- The plan for the child, which had been agreed at a legal planning meeting, was changed without referring the case back to a review meeting
- The hand over from midwifery to the health visiting services did not explicitly include the key information that Child B was subject to a child protection plan.

2.9.2 There was an absence of multi agency working, for example:

- The pre birth social work assessment lacked the necessary co-ordination and communication to achieve a multi agency and evidence based plan. In addition it was not completed until after Child B was born.

2.9.3 Services could have had access to relevant background information about this family but did not appear to make use of historical records in completing their assessments. For example:

- Little attempt was made to work with child B's father and his history as a child in care was ignored in the pre birth assessment.
- Agencies relied heavily on self reporting by the parents.

2.9.4 Assessments were not evidence based and did not demonstrate awareness of issues relating to domestic violence, substance abuse or disguised compliance.

2.9.5 Agencies did not consistently act in accordance with the London Child Protection Procedures or their own internal policies and procedures. For example;

- Timescales in relation to the completion of pre-birth assessments and pre birth child protection conferences were not adhered to;
- Health visiting plans were not recorded on the correct pro formas;
- No strategy meeting was held following the first hospital admission, despite this following a life threatening incident;
- The recording of supervision by both the Heath Visiting Service and Complex Needs and Social Care was not in accordance with good practice.

2.9.6 The SCR found evidence of local systemic weaknesses, for example:

- Minutes of child protection conferences and strategy meetings were not always received by relevant agencies;
- The local hospital did not have a single IT system and required information to be manually input into three separate systems, which led to the Emergency Department and the paediatric department being unaware that Child B was subject to a child protection plan until her final hospital presentation.

2.9.7 The SCR highlighted issues in relation to multi agency meetings, which should be held prior to discharge from hospital of a child who is the subject of a child protection plan. The review has concluded that, for a child subject to a protection plan, the correct course of action in such circumstances would be to hold a core group meeting rather than a discharge planning meeting. It was felt that this requires further clarity in the London Child Protection Procedures and a recommendation has been made to the London LSB in respect of this issue.

2.9.8 This case has highlighted a number of issues for local agencies. Fortunately, Child B did not suffer any lasting harm but given the very recent history of this family and the troubled backgrounds of the parents it was predictable that they would struggle to successfully parent a child without focussed support and intervention requiring evidence of change over time, particularly in relation to domestic violence and substance abuse.

3 Methodology

3.1 Timetable

3.1.1 Significant milestones in the completion of this review were as follows:

24th September 2015	SCR Panel / LSCB Chair agreed to convene a SCR
4th November 2015	SCR Panel – first meeting *Draft Integrated Chronology / IMR list agreed)*
4th December 2015	SCR Panel – second meeting *(ToR Agreed / Final Integrated Chronology / Draft IMRs)*
22 January 2016	Learning Event – Front line Practitioner/Manager discussion
12 February 2016	SCR Panel – third meeting *(Final Integrated Chronology / Final IMR reports / Draft Overview Report)*
11th March 2016	SCR Panel – fourth meeting – deferred
8th April 2016	SCR Panel – fourth meeting *(Final Draft of the Overview Report – for agreement)*
19th May 2016	Final report presented to the LSCB
26th May 2016	Report sent to the DfE and National Panel
2nd June 2016	Family Members notified and report shared
2nd June 2016	Report Published
16th June 2016	Staff Briefings
7th July 2016	Staff Briefings

3.2 Medical Evidence

3.2.1 Members of the B&DSCB Case Review Panel and the Independent Chair of the B&DSCB were aware that there was a lack of clarity about the medical basis for the hospital admissions giving rise to the SCR. As set out above, it was the view of the Chair that there were sufficient reasons to undertake a review without that medical evidence. Specialist medical assessments were commissioned within the care proceedings that had been initiated in respect of Child B. These were due to be evaluated by the court at a hearing in early February 2016 although the hearing was subsequently deferred until March 2016. The first part of the SCR was therefore conducted in the absence of this information and on the basis that it may be necessary to go back over some of the information provided for the review in

the light of the outcome of the fact finding hearing in the care proceedings.

3.3 Chronologies and Independent Management Reviews

3.3.1 All agencies produced detailed chronologies of their contacts with Child B and Child B's mother and father both together and as individuals along with summaries of any previous involvement. Due to the relatively minimal contact of some agencies it was decided to ask for full Independent Management Reviews (IMRs) from the following agencies only:

- Barking and Dagenham
    - Complex Needs and Social Care
    - Strategic Commissioning, Safeguarding and Early Help
- Barking and Dagenham Legal Service
- Barking, Havering, Redbridge University Hospital Trust - BHRUT
- North East London Foundation Health Trust - NELFT

3.4 Format of this Report

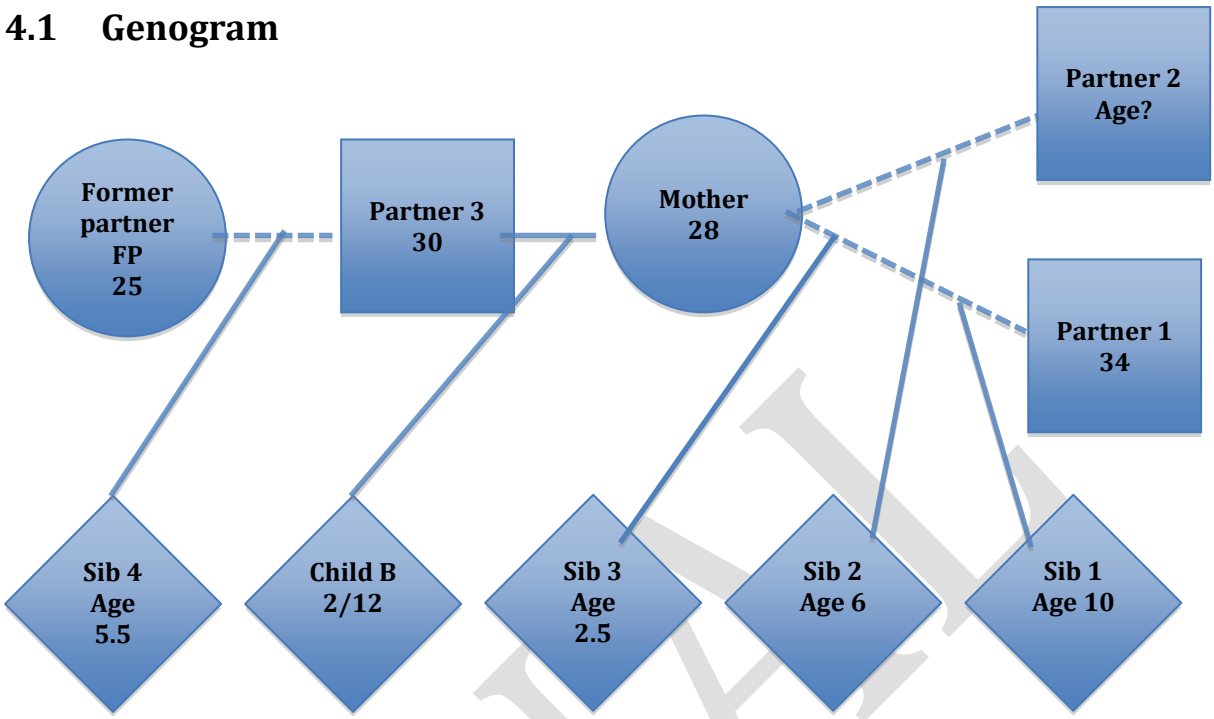
3.4.1 The remainder of this report is structured as follows:

- Section 4 provides information about the family background prior to August 2014
- Section 5 provides a chronological record of the events that occurred between August 2014 and July 2015
- Section 6 provides an analysis of professional practice by agency in the period August 2014 to July 2015
- Section 7 provides a summary of the outcome of the evaluation of the medical evidence in respect of Child B
- Section 8 summarises the issues identified during the course of the case review
- Section 9 sets out the conclusions / findings arising out of the review
- Section 10 sets out the recommendations arising out of the review.

3.4.2 At the end of most sections of the report, there are boxes summarising the key learning points arising out of the previous section, the actions already taken by individual agencies as a result of their management review and whether or not this case review is going to make additional recommendations.

4 Context / Background

4.1 Genogram



Ages are as of July 2015 – dotted line between adults indicates past relationship. In order to protect the identity of family members, references to gender and actual dates have been removed from the final report.

4.2 Table Showing Family Members

Name	Gender	Ethnicity	Relationship to Child B	Age (July 2015)	Comment
Child B		WUK	Subject of SCR	2 months	Child of P3 and M
Mother	Female	WUK	Mother	28 years	
P3	Male	WUK	Father	29 years	
S1	X		Maternal Half Sibling	10 years	Child of P1 and M
S2	X		Maternal Half Sibling	6 years	Child of P2 and M
S3	X		Maternal Half Sibling	2.5 years	Child of P1 and M
P1	Male		None	33.5 years	Father of S1 and S3
P2	Male		None	30 years	Father of S2
FP	Female		None	25 years	Former

					Partner of P3
S4	X		Paternal Half Sibling	5.5 years	Child of P3 and FP

4.3 Family History Prior To The Period Under Review

4.3.1 Child B's mother (M) has had four children, including Child B, with three different partners. The eldest child, S1 was born in 2005, that child's father is P1. The second child, S2 was born in 2009 at a point when M had separated from P1, that child's father is P2. Child B's mother was then reconciled with P1 and S3 was born in 2012. Following the final breakdown of her relationship with P1, Child B's mother began a relationship with P3 in 2013; he is the father of Child B who was born on 19th May 2015.

4.3.2 The relationship between M and P1 was characterised by conflict and domestic violence. In 2007 there were private law proceedings in respect of S1 who's father had tried to remove S1 from M's care due to concerns about M's amphetamine use. S1 was made subject to a residence order to M.

4.3.3 In 2009, M alleged that S1 had been subjected to sexual abuse by the maternal grandmother's partner's father who was later prosecuted for the offence.

4.3.4 From 2011 there were increasing concerns about the family, with S1 and S2 disclosing multiple incidents of domestic violence perpetrated by P1. The Health Visiting service also voiced concerns about appointments not being kept.

4.3.5 M began her relationship with P3 in May 2013. There were further concerns about the children, relating to poor school attendance and M's lack of engagement with services. There were also two instances of police involvement due to domestic violence perpetrated by P3. In October 2013 the children were made subject to child protection plans due to emotional abuse and violence within the home. The children continued to disclose arguments within the home, S1 also made allegations of physical abuse against P3. It is of note that twice during this period P3 was asked to move out of the family home but continued to be there regularly with the collusion of M.

4.4 Care Proceedings

4.4.1 Care proceedings in respect of the older three children were initiated on 4th March 2014 and concluded on 21st November 2014.

4.4.2 During the care proceedings a parenting assessment was undertaken in respect of M. As part of the assessment hair strand analysis was carried out, the results of which indicated that M had ingested significant amounts of amphetamines during the period from October 2013 to April 2014.

4.4.3 The parenting assessment was completed in May 2014 and concluded that the children should not be returned to M's care as "there is no indication that she will be able to demonstrate change within the children's timescale". M had failed to engage fully with services, including drugs services and was not consistently abstaining from amphetamines. The first and third (S1 and S3) children were placed within the extended family, whilst S2 was placed with S2's birth father.

4.4.4 P3 was not assessed as part of the proceedings; M maintained that they had separated. Despite this assertion she became pregnant by him on two occasions during the care proceedings, the first pregnancy ending in a miscarriage, the second resulted in the birth of Child B.

4.4.5 By the conclusion of the care proceedings in November 2014, a great deal of information was known about the family, particularly in relation to M. She was known to have been in two relationships where domestic violence was a factor, she had a long-standing addiction to amphetamines, and she had difficulty maintaining a routine for the children, including ensuring regular school attendance. M had shown reluctance to engage with agencies, including specialist domestic violence resources and drug agencies.

4.4.6 In addition to the above, there was evidence that she was not always truthful with agencies as demonstrated by her continuing her relationship with P3 whilst maintaining that they were no longer together; she repeatedly denied having any drug problems until care proceedings were initiated; and appeared to place her relationship with P3 before the needs of her children.

4.4.7 P3 was not included in the assessment, however, it was known that he had had a troubled childhood and had been in care to Barking and Dagenham from the age of 14. He was known to have a child from a previous relationship and to have no contact with that child. He was the perpetrator of domestic violence in respect of M, one of the children had made allegations of physical abuse against him, and the children had expressed fear of him. He was also known to be colluding with M in maintaining their relationship whilst claiming to be separated.

Learning Points

- *There had been a (very) recent history of significant safeguarding concerns including domestic violence, drug abuse and non-cooperation with agencies.*
- *A recent parenting assessment of M in the course of care proceedings had been negative leading to the removal of three of her children.*
- *Although he was not assessed as part of the care proceedings, P3 had been in care to Barking and Dagenham from the age of 14, detailed information about his background was therefore available to the Social Worker.*
- *This information should have formed the basis of subsequent work with this family*

SCR Recommendations – see Section 10 below

5 Agencies' Contacts With The Family / Key Events

5.1 Antenatal Period

5.1.1 On the 4th November 2014, M attended Queen's Hospital, Romford and booked for antenatal care. She was 14 weeks pregnant with an estimated delivery date of 19th May 2015. On booking she disclosed domestic violence by a previous partner. She said that she had three children who were not living with her; she was not currently in a relationship and "no domestic violence". She stated that she was not currently using drugs and agreed to toxicology testing. A urine sample later tested negative.

5.1.2 A multi agency child protection referral was completed in line with procedures. The referral gave the reason as M's children being in care and domestic violence from the father of two of the children.

5.1.3 It is of note that M denied that she was in a relationship. She did not disclose domestic violence by P3 and referred only to domestic violence by a previous partner. This then became the narrative, which continued throughout all hospital contacts by M, P3 and Child B. This meant that P3 was erroneously seen as a new partner and the history of domestic violence in the relationship was not picked up.

5.1.4 SW1, who had been allocated to the case towards the conclusion of the care proceedings of the older children, continued to be the allocated social worker and responsible for undertaking a pre birth assessment in respect of the unborn child.

5.1.5 The care proceedings concluded on 21st November 2014; the first attempted home visit in relation to the pre birth assessment did not take place until 29th January; the reason for this delay is not clear. When interviewed, the social worker reported that she had been busy with the arrangements for the placements of the older three children throughout December 2014. Although this visit was pre arranged there was no response from M, further attempts by SW1 to contact M were also unsuccessful. This lack of engagement was consistent with M's limited engagement during the care proceedings.

5.1.6 Due to this lack of engagement a decision was made to take the case to a Threshold of Care and Legal Planning Meeting (TCLPM), which is the forum within which to consider whether the threshold is met to issue care proceedings. The meeting concluded that the threshold was met, there should be a pre birth assessment, a pre birth child protection conference and that legal proceedings should be issued following the birth of the child.

5.1.7 On 2nd March the midwife contacted SW1 to advise that having initially failed to engage M was now keeping all her antenatal appointments. On 3rd March SW1 made her first successful home visit to begin the pre birth assessment, both M and P3 were seen. A further visit took place on 11th March when only M was present.

5.1.8 On 16th March M contacted Crime Reduction Initiatives (CRI) Gateway Services and agreed to engage for regular drug screening and key working. On the same day a referral was received from Children's Social Care.

5.1.9 M stated that she was not currently using drugs, and that she was pregnant. She disclosed previous domestic violence by P3 who she referred to as her ex partner and stated that she did not currently have any contact with him. The social care referral referred to M as having a drug habit, which dated back to the age of 16.

5.1.10 M attended her first assessment and drug screening appointment on 26th March, stating that she had been drug free since 2014. She said that there had been no instances of domestic violence since 2012, her current partner did not use drugs and did not live with her.

5.1.11 On the 18th March there was a supervision session between SW1 and her manager. Crucially the supervision notes record the decision of the legal planning meeting as being to complete a pre birth assessment and *if negative* to issue care proceedings

5.1.12 On 19th March information was received from another local authority in relation to P3's child by a previous relationship. The case was closed but there had been contact on two occasions in relation to domestic violence perpetrated by P3 on his previous partner.

5.1.13 On 8th April Gateway Services informed Children's Social Care that M had attended two appointments with Gateway, and had tested negative for cocaine, cannabis and amphetamines on both occasions. The record from Gateway included the information that M had said that her partner was supportive but that she was not living with him. This was a further indication that there were significant inconsistencies in the information that M was giving to different agencies about her relationship with P3.

5.1.14 A pre birth child protection conference took place on 29th April. Despite the fact that the pre birth assessment had not been completed, indeed there had been only two successful home visits and P3 had been present at only one of these, the SW recommendation was that the unborn child should be subject to a child protection plan under the category of emotional abuse. The parents were noted to be co-operating and M had tested negative for drugs. The plan for the unborn child changed from the decision of the legal planning meeting to issue care proceedings at birth to remaining at home subject to a child protection plan.

5.1.15 The conference was held under the Strengthening Families framework. This is a framework adapted from the Signs of Safety[2] model that is used by a number of Local Authorities. The conference was attended by SW1, Police CAIT, Gateway Services, community midwife MW2, M and P3 The Health Visiting Service was not invited, nor was there any liaison with Legal Services. The omission of the Health Visiting Service was significant:

- It contributed to subsequent issues around communication and information sharing;
- It meant that an opportunity for an ante natal assessment was lost;
- Information about the significant involvement from Heath Visitors with Child B's siblings was not shared with the conference; and
- There was no Health Visitor representation on the core group.

5.1.16 The GP for M was invited to the conference but did not attend, nor did he submit a report or send an apology. The involvement of the GP in the safeguarding process was minimal in this case and there is no record of liaison between SW1 and the GP.

5.1.17 The identity of P3's GP does not appear to have been established and consequently no consideration given to involving them in the child protection process. This was particularly important because one of the elements of the child protection plan was for P3 to self refer to his GP for support with anger management within a week of the date of the Child protection conference. There is no record of any discussion about this between the SW and P3's GP. This was not pursued and was still being discussed after the birth of Child B. Indeed no service was ever put in place.

5.1.18 The initial child protection conference was not informed of the outcome of the Legal Planning Meeting, and the chair did not consider whether legal advice should be sought. Although there was discussion of the family history, the minutes do not reflect an in depth discussion. The possibility of a drug relapse and further instances of domestic violence are raised as risk factors, but there is no reference to the lack of engagement with specialist DV services and no requirement to do so in the future. Over reliance is placed

[2] See http://www.signsofsafety.net

on self-reporting by the couple, with no challenge or acknowledgement that most domestic violence is unreported.

5.1.19 The child protection plan did not require M and P3 to engage with any specific domestic violence services in order to evidence change. When interviewed, staff referred to a lack of domestic violence services in the local area. This seems however to reflect the practitioners own lack of knowledge, further enquiries have established that there are local domestic violence resources and there is no evidence that these were explored by either the social worker or her manager. The requirement on M to continue to engage with recovery services was not time specific and left it to her to access any further support services.

5.1.20 The contingency plan in the event of non-compliance did not include seeking legal advice or the possibility of care proceedings. The first core group meeting took place on 13th May 2015. Core Group members were recorded as SW1, her Team Manager, Gateway Services and MW2. The Team Manager did not attend the meeting, and the Health Visiting Service was not invited. Given the imminent birth of the child the HV, as a key professional should have been invited. Good practice is for Child Protection Plans to be developed at the first core group meeting, and reviewed and progressed at each subsequent meeting. This did not happen in this case and the relevant section of the plan was left blank.

5.1.21 On 18th May the hospital records were updated by the Named Midwife Safeguarding Children following discussion with the midwife who attended the pre birth child protection conference and core group, MW2. Although it had not been a decision of the conference, the Named Midwife recorded that the social worker **must** be advised of the birth of the baby whenever it was born and that there should be a pre discharge planning meeting. The record went on to state that MW2 confirmed that domestic violence and drug use were not recent, and the child protection plan "was commenced due to the fact that the other child was not in her care." This, like the Child Protection Plan risk statement was not an accurate summary of concerns and minimised the risk to the child.

Learning Points and Actions Taken by Individual Agencies

- *The pattern of non co operation and attempts by M to conceal her relationship with P3 continued.*
- *The TM and the SW's understanding of the outcome of the legal planning meeting was fundamentally different to that of the legal department.*
- *The decision to change the recorded plan for the child should have been subject to review by a further legal planning meeting.*
- *The health visiting service was not invited to the pre birth child protection conference.*
- *The Health Visiting Service had not received minutes of the pre birth conference or a copy of the child protection plan*
- *The pre birth child protection conference was not held within the timescales set out in the London Child Protection Procedures.*
- *The conference did not give sufficient weight to family history and placed too much reliance on self-reporting by the parents, without evidence of change.*
- *The protection plan recommended that P3 access anger management services that are not routinely available in the local area.*
- *Information recorded in hospital records after the conference was not an accurate summary of the safeguarding concerns and risks to the child.*

Actions taken by individual agencies.
Complex Needs and Social Care will:

- *Revise the terms of reference for Threshold of Care Legal Planning Meetings to clarify what steps should be taken when the there is a change of plan*
- *Review and publicise their guidance to staff about information sharing and recording.*

Strategic Commissioning, Safeguarding and Early Help will:

- *Review their systems for recording invitations, attendance and the provision of reports to child protection conferences.*
- *Review arrangements for the distribution of invitations, minutes and updates of child protection plans.*

Legal Services will:

- *Open a legal file to link cases where a pregnancy becomes known during existing care proceedings relating to the same mother..*

- *Open a legal file as soon as a matter is presented to the Threshold of Care Legal Planning Meeting Panel and diarise a Legal Planning Meeting review.*
- *Have a diary reminder for 7 working days before the estimated delivery date of any unborn child. Where a decision has been made at a TCLPM to issue care proceedings at birth.*
- *Arrange a review/ further Threshold of Care Legal Planning Meeting as soon as a change in care plan becomes known.*
- *Draft a policy to escalate case concerns from Legal to Complex Needs and Social Care*
- *Undertake staff training in relation to managing risk.*

SCR Recommendations – see Section 10 below

5.2 Birth To First Hospital Presentation

5.2.1 Child B was born on 19th May 2015 by ventouse delivery. It was noted that the baby had bruising to the head caused by the ventouse cap and that there were no other concerns.

5.2.2 Midwife to midwife handover noted that there was a child protection plan in place and the need to refer to the E3 system (patient care recording system). The social worker was notified in line with the named midwife's directions, and the need for a pre discharge meeting noted.

5.2.3 A pre discharge planning meeting was held on 21st May, attended by the post natal midwife, MW4, the community midwife, MW5, and a duty social worker. Neither the allocated social worker nor her manager attended which meant that there was no one with detailed knowledge of the family history involved. The meeting focused on the child protection plan and arrangements for the baby to be discharged including daily visits by MW5 for fourteen days and weekly visits by SW1. In the event, the first visit by the social worker did not occur until 3rd June two weeks after Child B had been discharged from hospital. Legal services were not informed of the child's birth, nor was legal advice sought pre discharge.

5.2.4 Given that the unborn child was subject to a child protection plan, SW1 as the child's key worker should have taken the lead in arrangements for ensuring Child B's protection. In the opinion of the author, because there had been significant previous concerns, the

initial core group meeting should have taken place immediately after the initial Child Protection Conference, not some two weeks later, even though that is within the time period set out within the London Child Protection Procedures. A further core group meeting involving all professionals responsible for the implementation of the child protection plan, including the Health Visitor should have been scheduled to take place prior to the child's discharge from hospital rather than a pre discharge meeting. The core group should have been convened and chaired by SW1 or her manager.

5.2.5 On the morning of the pre discharge meeting the community midwife, MW5 telephoned HV1 to tell her that the meeting was due to start in 5 minutes. HV1 advised the midwife to feed back following the meeting. There is no record of any discussion of the reason for the pre discharge-planning meeting.

5.2.6 According to the Health Visiting records there is no other evidence of liaison between the midwifery and health visiting services or between the Health Visitor and the Social Worker in the ante natal period as would have been expected for an unborn baby subject to a child protection plan. Nor was the HV invited to the pre birth conference. There is no evidence of any further contact between HV1 and MW 5 about the meeting, nor are there any minutes on file.

5.2.7 The transfer of care summary from maternity services at BHRUT was received by the Health Visiting Service on 22nd May; it did not state that Child B was the subject of a protection and referred more generally to safeguarding issues.

5.2.8 As a consequence of the health visitor not being invited to either the pre birth conference or the pre discharge meeting and the absence of the social worker and her manager from the latter meeting, the health visiting service do not appear to have been aware that Child B was subject to a protection plan at the point of discharge from hospital.

5.2.9 The pre birth assessment was not completed until 23rd May 2015. The conclusion of the pre birth assessment was that the baby should be made the subject to a child protection plan, monitored but remain in parental care.

5.2.10 The first contact with the Health Visiting Service occurred on 26th May when Child B was taken to the clinic to be weighed; at this point there was no information on Rio (the health visitors' patient care recording system) relating to the baby being subject to a child protection plan, and this appears not to be known to the Health Visiting Service.

5.2.11 On 29th May MW5 and HV1 made a joint visit to the family. M reported that she had a social worker, that she had three children who did not live with her and that there was no history of mental health, drug or alcohol abuse. It is unclear what the rationale was for a joint visit. The maternity records indicate that "all essential information" was passed to HV1. The HV records do not indicate that there was any exploration of the reasons for the pre discharge meeting or exploration of the family history. It would appear that HV1 was still unaware that Child B was subject to a child protection plan. There was extensive information on the linked family records relating to the family's history and child protection concerns relating to the half siblings, this does not appear to have been considered as part of the new birth assessment.

5.2.12 There is a lack of clarity in the HV plan, which was completed following this visit. On the template the family was recorded as being allocated to Universal Plus, which is consistent with a child on a child protection plan, however the plan itself is consistent with allocation to a universal caseload. Details of the baby's father were not recorded and he was erroneously referred to as a new partner.

5.2.13 SW1 made her first post birth home visit on 3rd June, the records indicate that P3 said that he had seen his GP about anger management and the GP had indicated that a resource would have to be identified by social care. It is concerning that the issue of anger management and the attendant risk of violence in the home had not been addressed and was still being discussed after the baby's birth. There is no record of any follow up with the GP about this issue or any attempt by SW1 or TM1 to identify an alternative resource; it would appear that nobody was actually taking responsibility for arranging anger management therapy,

5.2.14 On 4th June M attended the GP's surgery with Child B, who presented with a lump to the head. The GP discussed the case with the consultant paediatrician CP1, at Queens Hospital via the hot line

service. As no space was available in the clinic until the following week, mother was advised to take child B to be seen in the Emergency Department, which she attended the same day. In the opinion of the examining doctor the swelling was likely to be related to birth trauma and Child B was discharged the same day.

5.2.15 As primary health care professionals, general practitioners have a significant role to play in the protection of children. In this case, it would appear that one GP was not fully engaged in the child protection process (the GP responsible for the mother and baby) whilst the other (responsible for the father) was never identified nor engaged. The author is aware that, more widely, there is a concern about the extent to which GPs are engaged with child protection issues across London.

5.2.16 NELFT HV records document receipt of the paediatric liaison record on the 18th June, a 14-day delay in formal receipt The record stated that Child B was NOT subject to a CP plan, indicating that information relating to the child's status and safeguarding concerns was not known to the Emergency Department. It is of note that there are three different electronic patient care recording systems in use at Queens Hospital. The E3 system, used by the midwifery service, had been updated with the information concerning the child protection plan. The Medway system, the overall hospital patient management system and the Symphony system, used by the Emergency Department, had not.

5.2.17 The formal handover from midwifery to HV services took place on 9th June. The transfer letter recorded the reason for social work involvement as being the mother's previous drug history.

5.2.18 On 10th June the new HV, HV2 received an invitation to a review child protection conference, prior to this she was unaware that Child B was subject to a CP plan. HV2 appropriately raised a Datix (part of the governance arrangements of NELFT) in relation to the lapse in information sharing, in that the HV Service was not informed that a child was subject to a child protection plan. She acted swiftly and appropriately liaising with CSC to request a copy of the child protection plan, and adding an alert to Rio. There had been no verbal handover from HV1 and her plan included liaising with both HV1 and the SW and completing a home visit in order to prepare a report for the conference.

5.2.19 HV2 spoke to HV1 and received a verbal handover; however there was no transfer summary and the content of the handover is not recorded

5.2.20 The HV report recorded that M was open in discussing the CP plan, and her history. HV2 concluded that at that point Child B's parents were engaging with services and meeting Child B's needs. The risks identified were that M would relapse in relation to her drug use, and that there would be further instances of domestic violence between the parents. The plan used the "universal format" and stated to access universal services but reflected extra input for a child subject to a CP plan

5.2.21 A child protection review conference took place on 17th June. Neither the allocated social worker nor her manager attended the conference, this was the second key meeting at which CSC was represented by a duty social worker who did not know the family. It also meant that there would never be any formal discussion of the pre-birth risk assessment.

5.2.22 Overall the reports to the conference were positive, however there was no representation or report from Gateway Services. M self reported that her latest drug test was clear and she was to be discharged from the service. M's decision to disengage from the service was not challenged by any of the professionals present. The outcome of the conference was that Child B was to remain subject to a child protection plan

5.2.23 By the time of the review child protection conference the issue of anger management had still not been followed up. There is no evidence of challenge to either P3 or SW1 as to why this had not been progressed.

5.2.24 The child protection plan remained essentially the same as at the initial conference. The requirement for support with anger management remained but the timescale was changed to ongoing, suggesting that it was not seen as a fundamental element of the child protection plan.

5.2.25 A core group meeting took place on 18th June; no agency has any record of minutes or actions arising from this meeting.

Learning Points and Actions Taken by Individual Agencies - birth to first hospital presentation

- *A core group meeting (not a pre discharge meeting) should have been convened by CSC following the birth of child B.*
- *The SW as the child's key worker should have prioritised the meeting.*
- *The Health Visitor was not invited to the meeting and remained unaware that Child B was subject to a child protection plan.*
- *Liaison between the MW and the HV was limited and did not include key information.*
- *The transfer of care summary from BHRUT contained no information about safeguarding concerns.*
- *The role of the GPs responsible for mother / Child B and for father could have been considerably improved.*
- *The information that child B was subject to a child protection plan had not been uploaded to the Symphony system used by the Emergency Department.*

Actions taken by individual agencies
BHRUT will

- *Reinforce good practice in relation to ensuring that referrals to external agencies regarding the same event contain the same information*.

SCR Recommendations – see Section 10 below

5.3 First Hospital Admission.

5.3.1 On 24th June Child B was taken to Queens Hospital by ambulance having stopped breathing. The ambulance records show that the baby was lifeless and cyanosed[3] when they arrived at the home address. Both parents were present; P3 reported that he had fed the baby at 4.20am taking the child into the bed with him, he had then fallen asleep and rolled on top of the baby waking up to find Child B lifeless. M administered CPR and gave mouth to mouth resuscitation.

[3] having a bluish discoloration of the skin, fingernails, and mucous membranes caused by a deficiency of oxygen in the blood.

5.3.2 Hospital staff were aware of the involvement of CSC, although the records make no reference to Child B being subject to a CP plan, on the paediatric liaison report the reason for involvement is recorded as domestic violence by (sic) previous partner.

5.3.3 BHRUT nursing records record good interaction between parents and child on the ward. They also identify the need for a strategy meeting once the results of the skeletal survey are known.

5.3.4 A pre discharge planning meeting was held on 26th June at Queen's Hospital, the meeting was attended by the parents, Social Worker, Team Manager, Ward Sister, Hospital Consultant and Health Visitor. The incident was regarded as accidental lay over by P3, reports about the interaction between parents and child on the ward were positive. For the first time the issue of drug use was raised with P3, he reported that he smoked cannabis once a week. There are no minutes of this meeting in the HV records; the HV recorded that the issue of P3's drug use was to be followed up later.

5.3.5 The meeting was not recorded in line with hospital policy, the correct pro forma was not used and no discharge plan was documented. There are no agreed minutes of this meeting, each agency appears to have made their own record.

5.3.6 There was no discussion with the police about this incident and the need for a strategy meeting would appear not to have been considered despite the reference to the need for a strategy meeting in the medical notes, see 5.3.3 above. Child B was discharged the same day, with a plan for follow up visits by SW1 and HV2, and follow up hospital appointments.

5.3.7 HV2 visited on 29th June, fathers drug use and safe sleeping were discussed. She noted multiple bruising on the baby's hands and feet, these were recorded as being consistent with cannulas/ needle punctures, although there is a detailed verbal description, a body map should have been used in these circumstances (see also 6.2.1.14).

Learning Points and Actions Taken by Individual Agencies – first hospital admission

- *There was no reference in the hospital records to Child B being subject to a CP plan.*
- *There was no discussion with the police and no strategy meeting was held despite the life threatening nature of the incident.*
- *The pre discharge meeting was not recorded in line with hospital policy.*

BHRUT will

- *Ensure that all acute life threatening events are considered as a safeguarding concern, until investigated and concluded otherwise.*
- *Review maternity and paediatric child protection meeting templates.*

SCR Recommendations – see Section 10 below

5.4 Second Hospital Admission.

5.4.1 On 11th July Child B was taken to the Royal London Hospital by air ambulance. The LAS call log recorded that the baby had accidentally been knocked off the kitchen counter sustaining a chest injury and was having difficulty breathing. The air ambulance staff recorded that Child B was in cardiac arrest. The triage paperwork logged that the baby was dropped/ fell from the kitchen counter to the floor. The Barts Hospital records state that the baby was being held by P3, fell back and sustained a blow to the head.

5.4.2 Child B was admitted to the paediatric intensive care unit. The hospital records note the following account as given by the parents: "Mother was out shopping, father was cooking and holding the baby, he leant to open the oven door and the baby hit it's head and the side of it's body on the kitchen counter".

5.4.3 There were concerns about P3 giving different accounts of events leading to Child B going into cardiac arrest. The police were called and P3 was arrested on suspicion of neglect and bailed to his father's address. A skeletal survey revealed a healing rib fracture estimated to be 2-3 weeks old.

5.4.4 On 12th July Child B was transferred to Queens Hospital. At this point the baby was 7 weeks old and had suffered a respiratory and then a cardiac arrest for which there was no organic explanation.

5.4.5 A strategy meeting was held on 14th July, the legal service was in attendance and the decision was taken to initiate care proceedings. P3 was to have no contact with the child and M was to have supervised contact only. M claimed that she was now separated from P3 (as she had during the original care proceedings). An application for a care order was made on 16th July and an interim care order granted on 20th July. The Children's Guardian recorded her concerns about the case in respect of:

- The limited work, which had been undertaken with the parents in relation to domestic violence. P3 had not accessed an anger management course.
- The lack of monitoring by agencies following the first incident in June.

She was of the opinion that the case should be considered for a serious case review, SCR.

5.4.6 On 29th July Child B was discharged to foster care. At the point of discharge the medical information indicated the presence of a healing rib fracture between 2 to 4 weeks old. Whilst this could have occurred during CPR the incidence of fracture following CPR is low and the fracture was seen as suspicious of possible inflicted injury.

5.4.7 At a case management hearing on 12th August the child's guardian requested that the Local Authority fund a domestic violence assessment, as there appeared to be a gap in the local authority's evidence as to what if any assessment was undertaken as part of the child protection plan. M continued to deny that she was with P3 but on 14th August the paternal grandmother reported to the social worker that they were still in a relationship.

5.4.8 On 26th August the radiologists report was received. The report indicated that, "the rib fracture was aged 2-4 weeks. Cardiopulmonary resuscitation could not be excluded as the cause. (According to a police report, CPR was administered by a "first aid trained neighbour" following the second incident). A more detailed account of the CPR administration was recommended as the fracture could have been caused also from a non- accidental injury."

Learning Points and Actions Taken by Individual Agencies - following second hospital admission

- *Child B had had two admissions to hospital following life-threatening incidents by the time Child B was 7 weeks old.*
- *Legal advice was taken and a strategy meeting held in line with child protection procedures.*
- *Following the second Hospital admission all agencies acted in accordance with procedures and good practice to protect Child B.*
- *The decision to initiate care proceedings was appropriate.*

SCR Recommendations – see Section 10 below

6 Analysis of professional practice

6.1 Children's Services (Complex Needs and Social Care and Strategic Commissioning, Safeguarding and Early Help

6.1.1 Compliance with policies and procedures

6.1.1.1 The London Child Protection Procedures state that a pre birth assessment should be carried out as soon as possible and preferably before 20 weeks[4]. Children's Social Care received a referral from Maternity Services on 4th November 2014 when M was 14 weeks pregnant, no attempt was made to begin the assessment until 29th January 2015, almost three months later which was not in accordance with recommended timescales.

6.1.1.2 The decision to undertake a pre birth assessment was appropriate and in accord with child protection procedures. However, the delay in commencing the assessment and initial lack of cooperation meant that its completion was delayed and timescales were not met.

6.1.1.3 The assessment itself did not comply with child protection procedures as it was undertaken without multi agency involvement and was not completed until after the birth of the child. Following the initial referral in relation to the pregnancy it would have been good practice to hold a multi agency planning meeting or strategy meeting to plan the assessment and to ensure input from all relevant agencies, this did not happen.

[4] Recent judicial guidance has underlined the need to complete pre-birth assessments in a timely manner – http://www.bailii.org/ew/cases/EWHC/Fam/2016/11.html

6.1.1.4 The pre birth assessment was not discussed at the pre birth child protection conference - indeed it had not been completed by the date of the conference, and therefore the opportunity for multi agency discussion and challenge of this key assessment was lost.

6.1.1.5 Following the initial difficulties in engaging M and P3 in the pre birth assessment the case was taken to the Threshold of Care and Legal Planning Meeting, this was good practice given the concerns for the unborn child. The decisions of this meeting are clearly recorded in the minutes and include that care proceedings are to be issued at birth. It is concerning that by 18th March in supervision between SW1 and TM1 this decision has been incorrectly re interpreted to mean that care proceedings will only be issued if the pre birth assessment is negative.

6.1.1.6 This is a key point in the case, as without returning to a TCLPM without taking legal advice and without reference to the earlier TCLPM decisions or any recorded discussion with the senior manager who chaired the meeting, the plan for the unborn child was changed from removal at birth to remaining at home subject to a child protection plan.

6.1.1.7 The pre birth child protection conference was not held until 29th April 2015, less than four weeks before the expected date of delivery, this was not in line with procedures. The requirement in the All London Procedures is that the pre birth conference should take place as soon as practicable and at least ten weeks before the due date, to allow ample time for support and planning prior to the birth to ensure the safety of the child.

6.1.1.8 The decision to take the case to a pre birth child protection conference was appropriate as was the decision to make the unborn child subject to a child protection plan. Whilst the conference did discuss the risks and concerns, the agencies presented a generally positive view. There was no evidence of challenge to the parents about their previous lack of engagement with services and the lack of transparency about their relationship, it appears that considerable reliance was placed on self reported change both in the reports of professionals and during the conference itself. Tellingly, references were made to

"previous" domestic violence, which failed to recognise the reality that most DV is not reported to the police and that there had been no engagement by either parent with DV agencies.

6.1.1.9 In view of the fact that care proceedings in respect of the previous three children had only recently concluded, it was appropriate to hold a TCLPM at an early stage. However, any change to the plan agreed at that stage should have been a consequence of the outcome of the pre birth assessment and / or the pre birth child protection conference in order that the original decision could have been tested. This would have given the opportunity for more challenge of the work undertaken during the pre birth period in the light of the evidence in the previous court proceedings. Legal advice would have been available in relation to the conclusion of the assessment and the proposed child protection plan, including the possible use of the public law outline.

6.1.1.10 Following the birth of Child B a pre discharge meeting was held at the hospital. This meeting was not attended by the allocated social worker and made limited decisions regarding discharge from hospital and the immediate frequency of visits by the SW and the MW. It did not involve the health visitor. The SW was to visit weekly, in the event she did not visit until 3rd June, two weeks after discharge from hospital. This should have been seen as a key meeting to ensure that appropriate safeguarding plans were in place prior to the baby's discharge. It would have been good practice to have convened a core group meeting, involving all key professionals including the Health Visitor. As the key worker the attendance of the allocated SW should have been a priority.

6.1.1.11 This was a missed opportunity to involve the Health Visiting Service and include them in the protection plan. Given that the pre birth assessment was not concluded until 23rd May after the birth of Child B, it was a further missed opportunity for this to be considered in a multi agency forum.

6.1.1.12 There is no evidence of any contact between the SW and the HV prior to 10th June when contact was initiated by HV2 following receipt of an invitation to the review child protection conference.

This is concerning and not in line with procedures and the requirement for multi agency working and information sharing.

6.1.1.13 SW1 was also not present at the review child protection conference, which took place on 17th June. It is surprising that the conference went ahead without the presence of either the SW or her manager; this was the second meeting since the birth of the child at which neither of them had been present. The birth of a child subject to a child protection plan should have been seen as a major change and one, which merited the attendance of the key worker. Although the London Child Protection Procedures make provision for a colleague to attend a conference in the absence of the Social Worker, in the opinion of the report writer this is not appropriate for the first review conference following the birth of a child. In this particular case it could be argued that the absence of the social worker from two key meetings sent the wrong message to the family about the strength of the agencies concerns.

6.1.1.14 No strategy meeting was held after the child's first hospital admission after Child B had stopped breathing. Given that Child B had suffered a life-threatening event which, even if accidental, could have been an indicator of neglect, the Team Manager should have convened a strategy meeting not a pre discharge meeting, this would have allowed for the involvement of the police and the full consideration of any safeguarding implications.

6.1.1.15 When Child B was subsequently admitted to hospital for the second time appropriate action was taken to safeguard the Child with the convening of a strategy meeting and the commencement of care proceedings.

Learning Points and Actions Taken by Individual Agencies

- *The plan for the child was changed without a review legal planning meeting or any discussion with a senior manager.*
- *The timing of the Initial child protection conference was not in line with the London Child Protection procedures.*
- *A core group meeting should have been held prior to the baby's discharge from hospital.*

- *There is no evidence of any contact between the SW and the HV prior to or immediately following the birth of the baby.*
- *Neither the SW nor her manager attended the review child protection conference.*
- *A strategy meeting should have been held following Child B's first hospital admission.*

Actions Taken By Individual Agencies.

Complex Needs and Social Care will

- *Provide clarification in relation to strategy meetings and discharge from hospital meetings and ensure that this is communicated to all staff.*

SCR Recommendations – see Section 10 below

6.1.2 The pre birth assessment

6.1.2.1 Although the allocated social worker was also the social worker for the three older siblings, she did not complete the parenting assessment of M, becoming involved towards the end of the care proceedings.

6.1.2.2 The pre birth assessment shows little evidence of a detailed consideration and analysis of the court assessment and how that might be relevant to the current situation. Although it was known that P3 had been in care to Barking and Dagenham, there is no evidence that the case records were accessed in order to inform the risk assessment.

6.1.2.3 It is now known that these records contain information about P3's background, which is of great relevance to any assessment. As set out in the CSC IMR: "*The Case records indicate that P3 had difficulties as a child following his parents' separation and he was described as being an extremely angry child. He had a problematic relationship with his stepmother and father, which included allegations of being hit by his stepmother. He is known to have misused cannabis and alcohol in his teenage years. He had a history of offending which included two periods in custody and being subject of a probation order. His history is also chequered with incidents of running away, dishonesty, sleeping rough at times and many moves of places where he stayed. He had been excluded from*

school and was seen by a psychologist. He had a lack of education and training except when he was in custody."

6.1.2.4 There is no evidence of liaison with other agencies to inform the assessment. A key part of the pre birth assessment process should be to convene an early planning meeting so that the requirements of the assessment and the roles and responsibilities of the agencies can be agreed and made clear. This did not happen in this case.

6.1.2.5 The case notes and the chronology are not consistent with the pre birth core assessment. The case notes indicate two home visits at only one of which P3 was present. The core assessment indicates a further two visits, on 19th March and 28th April again P3 was present at only one of them. The content of the visits is not recorded in the case notes so it is impossible to say with any accuracy what was discussed. It is questionable whether either one or two visits at which both parents were present could be seen as sufficient to complete an in depth pre birth assessment given the deep seated nature of the problems, the recent conclusion of care proceedings and the previous negative parenting assessment of M

6.1.2.6 M had repeatedly failed to engage with domestic violence agencies, she had grown up witnessing domestic violence and had had more than one long-term relationship in which violence was a factor, the significance of this was not recognised in the assessment. P3 also had a history as a perpetrator of DV in more than one relationship; his violence had been one of the key reasons why care proceedings were initiated. Despite this the assertions of M and P3 that there had been no further instances of DV appear to have been accepted. No use was made of screening tools such as the Barnado's matrix and no specialist advice was sought from Domestic Violence Agencies. The pre birth assessment did not reference the need for both parties to engage with specialist DV agencies and this did not form part of the child protection plan, a major omission.

6.1.2.7 The assessment references key changes as being "M and P3 engaging with the services involved and this being different to previous lack of, or inconsistency in, engagement and indeed, at times, their dishonesty and attempts at disguised compliance

about their relationship. Appointments were attended with Social Care, Health and the Drug Agency. M's change in drug misuse which was supported by drug tests during pregnancy, and there being no further reported incidents of domestic violence." There is no evidence provided to support this statement other than recent drug tests, it could be argued that given the length of time during which M had had drug problems a longer period was required in which to evidence sustained change. The possibility of drug use by P3 is also not addressed in the assessment. Had his case records been accessed it would have been clear that he too had a history of drug misuse.

6.1.2.8 The positive view arrived at in the pre birth assessment seems to rely heavily on self reporting by M and P3 despite the known fact of their previous dishonesty.

Learning Points and Actions Taken by Individual Agencies

- *The pre birth assessment was not conducted in line with the timescales in the London Child Protection proceedings.*
- *The assessment was not multi agency and was not completed prior to the birth of the baby.*
- *Case records relating to P3's history were not accessed meaning that significant information was not considered as part of the assessment.*
- *The assessment did not make use of the Domestic Violence screening tools available within the London Child Protection Proceedings*
- *The couple were seen together on a maximum of two occasions, insufficient for an in depth assessment of their relationship.*

Actions taken by individual agencies.

Complex Needs and Social Care will

- *Review their guidance on pre birth assessments in accordance with the London Child Protection Procedures*
- *Issue a reminder to social work staff about the importance of working with fathers and stepfathers and fully including them in family assessments.*
- *Provide further guidance to staff about assessments of families where there are issues of domestic violence and/or substance abuse and available resources.*

SCR Recommendations – see Section 10 below

6.1.3 Management oversight and Supervision.

6.1.3.1 Supervision took place between SW1 and TM1 at the required frequency and it is clear that they were in agreement as to the plan.

6.1.3.2 There is however no evidence of challenge or reflective supervision, the complexity of the case and the need for in depth multi agency assessment and evidence of change is not recognised.

6.1.3.3 The seriousness of the issues particularly the violence within the home and the couple's lack of honesty was not given the attention it merited by either the Team Manager or the Social Worker.

6.1.3.4 There is no evidence of the manager giving any guidance in relation to the areas to be addressed in the pre birth assessment. The significance of the recent history, including the failed parenting assessment seems not to be recognised. This is then carried through to the child protection conference process in which again the concerns appear to be minimised given the very recent history of the family.

6.1.3.5 There is no evidence within the supervision notes of an in depth consideration of the balance of risks involved in the change of plan from issuing care proceedings to remaining at home on a CP plan. The rationale for this change of plan is not documented within the records.

6.1.3.6 There is no evidence of any discussion with the social worker about the need to meet timescales as set out in procedures. In particular there is no evidence that the failure to conclude the pre birth assessment prior to the initial child protection conference was ever discussed.

Learning Points and Actions Taken by Individual Agencies

- *There is no evidence of challenge or reflective supervision.*
- *There is no evidence of any guidance being given to the social worker about the conduct or content of the pre birth assessment.*
- *There was no consideration of the balance of risks involved in changing the plan agreed at the legal planning meeting.*

- *The rationale for the change of plan is not documented*.

Actions taken by individual agencies.
Complex Needs and Social Care will

- *Take steps to ensure that supervision is being provided and recorded in accordance with the supervision policy framework, and that recording shows evidence of reflection and challenge.*

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SCR Recommendations – see Section 10 below

6.2 North East London Foundation Health Trust

6.2.1 Compliance with policies and procedures.

6.2.1.1 Prior to the birth of Child B the Health Visiting and School Nursing Service had provided services to the older siblings and there were clearly documented safeguarding concerns relating to domestic violence and neglect in the linked records of M and the older children. The care proceedings leading to the removal of the older children were also documented.

6.2.1.2 The Health Visiting service were not invited to the pre birth conference, they had not been consulted as part of the pre birth assessment and there is no record of SW/HV liaison in the pre birth period nor was there any liaison from the midwifery service during the pre birth period. In addition they did not receive a copy of the child protection conference minutes or the CP plan. As a result no pre birth assessment was undertaken by the HV service as would have been expected for an unborn child subject to a CP plan.

6.2.1.3 The first documented contact in relation to Child B was therefore the telephone call from MW5 on 21st May advising that a pre discharge meeting was about to start.

6.2.1.4 No information was recorded in relation to the reason for the discharge planning meeting. Good practice would have been for the HV to record the reasons for the meeting and to follow up the outcome with both the midwife and the SW. This did not happen, recording policies were not complied with and there was a significant gap in information sharing and communication with HV1 being unaware that Child B was subject to a CP plan.

6.2.1.5 On 29th May MW5 and HV1 undertook a joint home visit, to complete the New Birth Assessment. This is not standard practice and there is no rationale for this in the records. This visit could have provided the opportunity for good information sharing between MW5 and HV1, however this does not appear to have happened. There is no evidence that the reason for the discharge planning meeting was explored, no evidence of exploration of the reason why the family had an allocated SW and no liaison with the SW to gather or share information. There is also no evidence that the family history was considered in order to inform the new birth assessment.

6.2.1.6 There is no documented evidence that the HV was aware of the CP plan and consequently she did not place a CP alert on Rio (the electronic recording system). The HV plan subsequent to the visit was inconsistent in that it referred to the family being allocated to a universal plan although in the new birth record they were recorded as being allocated to the universal plus template. Standard practice would be that the handover from midwife to Health visitor includes information in relation to the child being subject to a CP plan, this appears not to have happened.

6.2.1.7 As stated by the author of the IMR: "*The joint visit indicates a lack of professional curiosity, testing of the information and gaps in record keeping. Furthermore, there is no demonstration of a healthy scepticism and respectful uncertainty (Laming 2003[5])*."

6.2.1.8 HV2 became the allocated HV on 1st June; there was no verbal handover from HV1. Good practice would have been for there to have been a handover, even if the HV service were not aware that the child was subject to a CP plan, HV1 was aware that there had been a pre discharge meeting. HV2 was also unaware of the history of domestic violence. Trust policy dictates that visits should be undertaken jointly in such circumstances; this was not complied with.

6.2.1.9 When on 10th June, HV2 received an invitation to a CP conference on the 17th June she acted swiftly and in line with trust policy and good practice, ensuring that appropriate action was taken to inform her managers of the lapse in information sharing,

[5] Victoria Climbie Enquiry, Lord Laming, 2003

identifying the need to gather information from HV1 and SW1 and making arrangements to complete a report for the child protection conference. She also ensured that she received a copy of the minutes of the pre birth conference and the CP plan

6.2.1.10 The plan prepared by HV2 also contained inconsistencies, in that it stated to access universal services although the details reflected additional input for a child subject to a CP plan.

6.2.1.11 Details of the handover from HV1 to HV2 are not recorded. This is not in line with good practice or Trust recording protocols. Good record keeping is essential to inform decision-making, particularly where there are safeguarding concerns.

6.2.1.12 The HV report to conference relied heavily on self-reporting by M and P3 in relation to safeguarding concerns, specifically drug use and domestic violence. Child B was reported to be developing well.

6.2.1.13 HV2 attended the review CP conference on 17th June, she was in agreement with the outcome and appeared to share the professional optimism of the professionals present.

6.2.1.14 Following the second hospital admission on 24th June, HV2 visited the family on 26th June. She recorded bruising to the child, which she assessed as consistent with cannula/ needle marks. A body map should have been completed by hospital staff prior to discharge to record the bruising which would have been good practice when describing a complex set of marks on a young child. In the event, the HV did not complete a body map either and there is also no evidence of liaison with either the SW or the hospital to exclude Non Accidental Injury (NAI)

6.2.1.15 Following the second hospital admission and Child B's discharge to foster care HV2 liaised with the receiving HV completing a transfer out summary and also giving a verbal handover in line with good practice.

Learning Points and Actions Taken by Individual Agencies.

- *Communication and information sharing between the midwife and the health visitor was not in line with good practice.*

- *Recording protocols were not adhered to in relation to both the pre discharge-planning meeting and the handover of care from midwifery to the HV service.*
- *The linked family records, which contained significant information, were not accessed by Health Visitors in order to inform the new birth assessment.*
- *Professionals from the health visiting and midwifery services displayed a lack of professional curiosity in failing to follow up information.*
- *Health visiting plans were inconsistent and were not recorded on the correct pro forma for a child subject to a child protection plan.*
- *The health visiting report to the review child protection conference relied heavily on self reporting by the parents.*
- *Bruising to the baby's hands and feet was not recorded on a body map prior to discharge from hospital nor by the health visitor following a home visit; no checks were made with the hospital or the social worker to confirm the cause of the bruising.*

Actions taken by individual agencies.
NELFT will

- *Ensure that the care provided by the Health Visiting Service is in line with standard operating procedures.*
- *Ensure that early identified learning from the serious case review is cascaded through the service to strengthen its safeguarding capacity.*
- *Share emerging learning with child protection supervisors.*
- *Achieve the electronic transfer of A& E attendance information and paediatric liaison forms.*

BHRUT

- *Ensure that all staff are aware of best practice in relation to the use of body maps to record injuries at hospital discharge*

SCR Recommendations – see Section 10 below

6.2.2 Management oversight and Supervision

6.2.2.1 HV2 appropriately brought the case to supervision; this is in line with the NELFT Safeguarding Children Supervision Policy (2015). NELFT has clear standards relating to the child protection supervision. This includes the analysis of information, recording of risks and the development of a plan commensurate with the assessed risk. In this case supervision was not recorded in line

with the standard. Although it was recorded on the correct format it did not include an analysis of historical risks, protective factors or time scales.

Learning Points and Actions Taken by Individual Agencies

- *Supervision was not in line with Trust standards, in that the recording did not include an analysis of historical risks, protective factors or timescales.*

Actions Taken by Individual Agencies
NELFT

- *See recommendation above in relation to Trust operating procedures*

SCR Recommendations – see Section 10 below

6.3 Barking, Havering, Redbridge University Hospital Trust

6.3.1 BHRUT provided care to Child B within Maternity Services and through the Hot Line Clinic at Queens Hospital

6.3.2 Maternity Services

6.3.2.1 Staff within the maternity services demonstrated good practice in recognising the risk factors in relation to domestic violence and abuse, arranging toxicology tests and appropriately referring to CSC. Unfortunately M was not honest with the booking midwife which led to inaccurate information being recorded which was then repeated over multiple contacts. Specifically she referred to DV in a previous relationship and stated that she was not currently in a relationship.

6.3.2.2 MW1 also diligently followed up M's initial lack of engagement and failure to attend appointments and communicated this to the SW1.

6.3.2.3 MW5, the community midwife, attended the pre birth CP conference (along with MW1), the core group and the pre discharge-planning meeting. The information taken from the child protection conference and passed to the Named Midwife Safeguarding Children was not entirely accurate; it referred to the concerns as historical because that was how they had been presented to the conference. The NELFT chronology documents a conversation between HV1 and MW5 just prior to the pre discharge meeting, this is not referred to in the BHRUT records.

6.3.2.4 There are concerns about the communication between MW5 and HV1 in relation to Child B being subject to a CP plan, BHRUT records state that following the joint visit all essential information was handed to HV1 but the detail of this is not documented. The notification of maternal transfer to the HV notes "care plan in place regarding safeguarding issue see E3" but does not specifically state that the child is subject to a CP plan

6.3.2.5 The Midwifery electronic record in E3 records that fact that Child B was subject to a protection plan although the screenshot of the E3 seen by the report author refers to a SW and the date of the next core group meeting but again does not explicitly state that the child was subject to a CP plan.

6.3.2.6 The copy of the written discharge form from the Community Midwife to the HV is illegible and the summary of any issues or problems with the baby says "has a social worker due to previous drug history"..

Learning Points and Actions Taken by Individual Agencies

- *Communication with the Health Visiting Service was not in line with good practice and failed to convey that Child B was subject to a child protection plan.*
- *There were issues in relation to the accuracy of information shared internally to the service.*
- *Recording was not in line with good practice.*
- *Neither the notification of maternal transfer, the E3 system or the written discharge form from the midwifery service made reference to Child B being subject to a child protection plan.*

Action taken by individual agencies

BHRUT will

- *Agree a process to ensure that child protection alerts for unborn children are consistently added to electronic systems when the baby is born, and when child protection alerts for children are received*
- *Reinforce good practice in relation to ensuring that referrals to external agencies regarding the same event contain the same information.*
- *Ensure that discharge forms are properly completed and state explicitly whether or not a child is subject to a protection plan*

SCR Recommendations – see Section 10 below

6.3.3 Emergency Department Attendances

6.3.3.1 When Child B first presented to the Emergency Department at Queen's Hospital on 4th June with a swelling to the head, the paediatric staff did not demonstrate awareness of potential indicators of abuse or neglect.

6.3.3.2 The presentation was a direct referral by the GP. Unfortunately the referral letter did not contain any information relating to safeguarding concerns and did not refer to the fact that Child B was subject to a CP plan. There was a verbal discussion between the GP and Consultant Paediatrician 1 but the paediatrician cannot clearly recall what information was shared and there are no notes of the conversation.

6.3.3.3 There are three IT systems in the hospital, which do not speak to each other. The E3 system is used within maternity, Medway is used across the hospital, and Symphony is the system used in the Emergency Department. The Safeguarding Administrator is currently expected to input information from three Local Authorities into all three systems. The minutes of the pre birth child protection conference were on the E3 system; neither the minutes nor an alert were uploaded onto the Symphony or Medway systems. This is clearly unsatisfactory and as happened in this case open to error or delay and potentially serious consequences. It is the understanding of the author that the hospital are hoping that the implementation of the CP-IS system in 2016 will resolve this issue by making the core data available through all three systems.

6.3.3.4 Due to an earlier omission the E3 alert had also not been transferred to the system following the birth of the baby, this should have acted as an additional alert. There was therefore no flag on the system to alert them to Child B's child protection status.

6.3.3.5 The safeguarding screening tool, which was completed, identified that there was an allocated social worker due to domestic violence issues in a previous relationship. This should have alerted staff to

contact CSC for more information, particularly as they were dealing with a possible head injury to a very young baby.

6.3.3.6 Staff should also have completed a HV Notification Liaison Form and possibly a MARF. The author of the IMR notes that: "*It is concerning that Consultant Paediatrician 1 stated that there were no reasons to be suspicious and for that reason he did not explore the Emergency Department documentation which indicated safeguarding concerns*."

6.3.3.7 When Child B presented at the Emergency Department at Queen's Hospital for the second time Child B was in respiratory arrest, The HV and SW were notified, however this was not a sufficient response and not in line with procedures. The incident should have been recognized as an acute life threatening event, and a safeguarding issue necessitating completion of a MARF.

6.3.3.8 It was known that Child B's siblings were not in their mother's care. Communication between nursing staff and CSC took place by phone but information sharing was limited. The Paediatric Ward Sister recorded that SW1 contacted the ward for an update on child B's condition. She said that she was unable to share information about Child B's siblings, and would attend a proposed strategy meeting. In the event there was no strategy meeting. The SW should have ensured that hospital staff were fully informed of the family history and the risks to the child at the earliest opportunity, even if a strategy meeting had taken place within a few days. The ward staff should also have challenged the SW since they were responsible for Child B's care at that time. The communication between the two agencies at this time significantly failed to identify that Child B was subject to a child protection plan.

6.3.3.9 The documentation relating to the pre discharge meeting was insufficient, the pre discharge pro forma was not completed, and there was no record of information shared or a discharge plan. It appears also that the information that Child B was subject to a child protection plan was not shared at this meeting

6.3.3.10 There was a lack of leadership on the ward with no evidence of challenge or informed decision making. Despite the pre discharge meeting, at the point when Child B was discharged home, the paediatric staff were still unaware that she was subject to a CP plan.

6.3.3.11 The Consultant Paediatrician Named Doctor Child Protection did appropriately question the status of the meeting but there was no further challenge.

6.4 Barts Health NHS Trust (Royal London Hospital)

6.4.1 When Child B was admitted in cardiac arrest to the Royal London Hospital, the response was in line with procedures. There is evidence of informed assessment and decision-making and recording was in line with procedures and good practice.

Learning Points And Actions Taken By Individual Agencies.

- *Paediatric staff did not demonstrate an awareness of potential indicators of abuse or neglect.*
- *The minutes of the pre birth conference had not been uploaded onto the Symphony IT system used by the Emergency Department. The E3 alert had also not been transferred to the system.*
- *Staff did not complete a MARF on either the first or second hospital presentation.*
- *Communication between the ward staff and CSC was limited and not in line with good practice. Information sharing by CSC fell well below the standard expected.*
- *Hospital staff did not challenge the position of CSC, nor did they escalate their concerns in relation to the status of the pre discharge meeting. Documentation in relation to the pre discharge-planning meeting was inadequate and not in line with good practice.*
- *The ward staff remained unaware that Child B was subject to a Child Protection plan.*

Actions Taken By Individual Agencies.

BRHUHT will

- *Review communication in relation to safeguarding processes within Paediatrics.*

- *Undertake a review of maternity and paediatric child protection meeting templates.*
- *Review engagement with the Liaison Social Worker at Trust CP meetings in order to facilitate the sharing of information between services.*

SCR Recommendations – see Section 10 below

6.5 Barking and Dagenham Legal Service

6.5.1 The Legal Service were involved in the care proceedings relating to Child B's half siblings. They next provided legal advice at the Legal Planning Meeting of 18th February 2015. The legal advice given was that the threshold was met, and instructions were to issue care proceedings once the child was born.

6.5.2 There was no further involvement until 13th July 2015 when Child B was hospitalised for the second time. Legal advice provided was to issue an application for a care order.

6.5.3 On both occasions the advice given was appropriate. At the Legal Planning Meeting the advice was based on the history of the parents and their lack of engagement.

6.5.4 As previously stated it is of concern that the plan agreed at this meeting was later changed without further reference to Legal Services and without a further Legal Planning Meeting.

6.5.5 Although there are terms of reference for the Legal Planning Meeting there is no guidance as to the contents of the minutes.

6.5.6 The advice given at the meeting was not expanded upon in the minutes. No date was set for a review meeting; good practice would have been for a further meeting to have taken place prior to the birth of Child B. In the event the plan for the child was radically changed without any further legal input or the opportunity for outside challenge as to the rigour of the pre birth assessment. There were five occasions during this case where the opportunity to seek legal advice was missed.

- The pre birth Child Protection Conference
- The birth of Child B
- The pre discharge meeting following the birth.

- The review Child protection conference
- The pre discharge meeting following the first admission to hospital on 24th June

6.5.7 It is important for Social Work staff to be aware of and alert to the need to seek legal advice in relation to any proposed change of plan for a child and following an injury or any other significant event with safeguarding implications.

6.5.8 A legal file was not opened in relation to Child B. This has now been rectified as part of the recommendations arising from this Serious Case Review; a legal file is now opened to link cases where a pregnancy to the same mother becomes known during existing care proceedings.

7 Medical Evidence

7.1 Child B was admitted to hospital on two occasions experiencing life-threatening events within a very short period of time. However, whilst abuse or neglect was suspected, establishing the cause of these events required that expert medical opinions be sought and tested.

7.2 Following Child B's second admission to hospital, the local authority initiated care proceedings under Section 31 of the Children Act 1989, there being reason to believe that Child B suffered significant harm. These concerns were founded upon the circumstances leading to the hospital admissions detailed at Sections 5.3 and 5.4 of this report. Within the care proceedings, there was a "fact finding hearing" at which medical evidence was considered in respect of the injuries sustained by Child B that resulted in those hospital admissions.

7.3 In respect of the first hospital admission, where the father said he accidentally laid on Child B when Child B was sharing the bed with him and mother, no finding was made because the medical experts indicated that the explanation given by the parents could have caused those injuries.

7.4 In respect of the second hospital admission, the court found that the father was responsible for the injuries caused and that they were non-accidental injuries

7.5 No findings were made against mother.

Learning Points and actions taken by individual agencies.

- Child B's parents appeared to be unaware of safe sleeping guidelines.

BHRUT will

- *Promote awareness of safe sleeping in the Emergency Department and the Department of Paediatrics.*

SCR Recommendations – see Section 10 below

8 Issues

8.1 Information sharing and communication.

8.1.1 There are significant issues for some agencies in relation to communication and information sharing. With a few exceptions communication and information sharing fell well below the required standard.

8.1.2 When M first booked for ante natal care there was evidence of good information sharing by the midwifery service.

8.1.3 The pre birth core assessment was not conducted in line with best practice, and did not comply with the London Child Protection Procedures. There was no evidence of consultation with other agencies and no multi agency planning meeting. This was a missed opportunity to involve all relevant agencies in the process.

8.1.4 Despite the fact that the pregnancy had been known about since November 2014 the pre birth conference did not take place until 29th April at which point M was around 37 weeks pregnant, leaving little opportunity for implementation of the child protection plan prior to the child's birth.

8.1.5 The Health Visiting Service was not invited to the pre birth conference. Although at that point there may not have been an identified Health Visitor, if an invitation had been sent to the generic service address, there would have been the opportunity for early allocation or at the very least representation from the service. This would have alerted the HV service to the need for a pre birth assessment. The importance of Health Visitor representation should have been recognized in the light of the safeguarding concerns and particularly in view of the imminence of the birth.

8.1.6 There is no evidence of communication between the SW and HV1 during the ante natal period or the period immediately following the child's birth.

8.1.7 The HV was not invited to the pre discharge planning meeting, which took place on 21st May following the birth of child B. Only the postnatal midwife, MW4, the community midwife, MW5, and a duty social worker attended. The HV was informed by MW5 that the meeting was due to take place just before it began. There was no follow up of the outcome of this meeting by either MW5 or HV1

8.1.8 Given that Child B was subject to a child protection plan the correct forum in which to discuss plans for the child's discharge would have a been a core group meeting not a pre discharge planning meeting.

8.1.9 Communication between MW5 and HV1 was limited and fell below the required standard. Despite undertaking a joint visit to the family the handover to the Health visitor did not identify that Child B was subject to a child protection plan.

8.1.10 There is a lack of clarity in relation to where responsibility lies for inviting the HV to pre discharge planning meetings. It is recorded in the BHRUT IMR that there is a local agreement that the SW should invite the HV. It is also recorded that the Named Nurse Safeguarding Children and the Named Midwife have a professional difference regarding responsibility as the Named Nurse feels that responsibility for co-ordinating pre discharge meetings should lie with the hospital staff.

8.1.11 This case has also raised a number of concerns relating to the distribution of invitations to and the minutes of child protection conferences minutes, child protection plans and other key meetings.

8.1.12 The minutes of the initial child protection conference were not received by the health visiting service from the Child Protection and Reviewing Service until requested by HV2 on 10th June, when she received an invite to the review child protection conference. Coupled with the communication issues between MW5 and HV1 this led to a potentially dangerous situation where a key agency was unaware of the child's status and the existence of a CP plan.

8.1.13 The Initial child protection plan, dated 29th April 2015 was not received by the Named Midwife Safeguarding Children until 18th May 2015 – according to BHRUT, this followed repeated requests to the Child Protection and Reviewing Service. Records held within the Child Protection and Reviewing Service indicate that the child protection plan was distributed to all agencies on 6th May. It remains unclear why there is a discrepancy in dates between the agencies.

8.1.14 There is also a serious issue for the LSCB because information was not being shared effectively between CSC and BHRUT in that there was no notification on the Medway or Symphony systems that Child B was the subject of a child protection plan. The child protection alert was not received from the local Authority until 1st July 2015 when it was uploaded to the system. Following further investigation, it has been established that following the Pre birth child protection conference on 29th April 2015, a daily sheet was issued to the Hospitals and the GP which indicated that "unborn M" had been made subject to a child protection plan, B was listed under the heading "alias". At birth the child was known under the surname B. It would seem that the hospital system did not have the facility to cross check names (or addresses?) and therefore child B's name did not appear on the list of children subject to a child protection plan when the child attended hospital on the first two occasions. Following the review child protection conference on 17th June, a further child protection notification was sent out to agencies changing the baby's name from "unborn M" to Child B, it would appear that this was the notification received by the hospital on 1st July. The new Child Protection Information Sharing System which is due to be implemented in the local area in June 2016 will close this potentially dangerous loophole.

8.1.15 Communication issues also arose in relation to the first two hospital presentations. As previously noted, on the first occasion, the referral letter from the GP did not indicate that Child B was subject to a protection plan. On the second occasion, despite knowing that Child B had an allocated social worker no steps were taken to contact CSC to establish the reason for this.

8.1.16 In relation to the second hospital presentation, it is of concern that the social worker did not share information at the earliest

opportunity, preferring to wait for a formal strategy meeting. This is particularly pertinent given that a decision was taken not to hold a strategy meeting despite the life threatening nature of the event.

8.1.17 It is of great concern that following a respiratory arrest, hospital admission and a pre discharge meeting, information sharing by agencies had failed to inform the hospital staff that Child B was the subject of a child protection plan.

8.2 The Invisible Father

8.2.1 P3 was not included in the parenting assessment carried out during the court proceedings in respect of Child B's half siblings; M having claimed to be separated from him.

8.2.2 Despite her denial that they were in a relationship M became pregnant by P3 twice during the care proceedings. During her contact with professionals, she made a number of attempts to try and conceal the fact that she had resumed her relationship with P3. She told the booking midwife that she was not in a relationship and that she had suffered domestic violence in a previous relationship. In April 2015 she told the Gateway Drug Agency that her partner was supportive but did not live with her. Following the initiation of care proceedings in respect of Child B she again claimed to have separated from P3.

8.2.3 The primary agencies were aware that the couple were living together and were intending to parent child B as a couple. In particular, SW1 was aware of this whilst carrying out the pre birth assessment and was also aware of P3's history within the relationship. Never the less, significant information about his background was not accessed as part of the assessment and the role his violence played in triggering the earlier care proceedings was not adequately recognised.

8.2.4 The information given by M at her first hospital appointment continues to be repeated at every hospital presentation, despite MW1 having attended the pre birth conference. As a result P3 is seen by some as a new partner, and the domestic violence as historical and having taken place within a previous relationship. Coupled with the fact that the staff in the emergency department were unaware that Child B was subject to a child protection plan this meant that in effect the assessment of risk following the first hospital presentation with a

swelling to the head and the hospital admission in respiratory arrest in June was undertaken in the absence of key information about P3.

8.2.5 Health Visitor records completed after the post natal visit as part of the new birth assessment contain no details of the child's father.

8.2.6 There is now a substantial body of research, which addresses the phenomenon of the "invisible father" in child protection cases[6]. The importance of working with and considering the background history of both partners when completing assessments of risk cannot be emphasised too strongly[7].

8.2.7 Throughout the period of time covered by this review, it was known that P3 had allegedly been the perpetrator of domestic violence in a previous relationship; he was also alleged to have been violent towards Child B's mother and her older half sibling. This was acknowledged in the protection plan by reference to him seeking treatment for anger management. Insufficient attention was paid to this issue or that of domestic violence. The likelihood of P3 seeking such assistance on his own was probably minimal.

8.2.8 Both staff interviewed as part of the review process and members of the SCR Panel commented upon a lack of suitable services within the local area. It would appear that this limits the ability of a child protection conference to make an appropriate protection plan.[8]

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[6] **Understanding Serious Case Reviews and their Impact - A Biennial Analysis of Serious Case Reviews 2005-07**
Marian Brandon1, Sue Bailey1, Pippa Belderson1,
Ruth Gardner1, Peter Sidebotham2, Jane Dodsworth1,
Catherine Warren1 and Jane Black3
1 University of East Anglia
2 University of Warwick
3 NHS Norfolk pages 51-54
Also SCRs 2012 by the same people

[7] **Engaging fathers in child welfare services: A narrative review of recent research evidence.** . Child and Family Social Work, 17 (2): 160-169.
Maxwell, N., Scourfield, J., Featherstone, B., Holland, S. and Tolman, R. (2012)
http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2206.2012.00827.x/abstract

[8] A neighbouring local authority, Tower Hamlets, provides a service that assesses the risk of alleged perpetrators of domestic violence to their partners and children.

8.3 Professional Optimism.

8.3.1 There was evidence of professional optimism displayed by those involved in the case. There was insufficient challenge to the parents, particularly in accepting self-reporting of change in the absence of evidence to support these assertions. Insufficient importance was given to the parents past history, both as individuals and as a couple. They were both individuals with difficult childhoods, the effects of which had not been addressed.

8.3.2 As a couple there was a recent history of violence within the relationship and a lack of acknowledgement or engagement with domestic violence agencies. The seriousness of domestic violence within relationships was not recognised by professionals, reliance was based on self reporting of change by P3 and M with no evidence other than that no incidents had come to the attention of the police.

8.3.3 There were also issues about the lack of honesty by both M and P3 about their relationship. It had already been demonstrated that M was prepared to put her relationship with P3 before her children. Such entrenched problems were unlikely to change without significant professional input and support.

8.4 Disguised Compliance

8.4.1 Professionals should also have been alert to disguised compliance by the parents. 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[9].

8.4.2 M did not engage with professionals until around the 27th week of her pregnancy, she then kept all appointments and agreed to engage with drug services Compared to her previous lack of engagement this was a very short period of time on which to base a positive assessment. It was also at a time when the parents were understandably anxious to keep their baby and would have an incentive to be seen to be co-operating with the agencies.

8.4.3 In relation to P3, he was present at a maximum of two pre-arranged appointments with the SW during the pre birth assessment, which

[9] Disguised compliance - nspcc https://www.nspcc.org.uk

should have raised some questions about his commitment to change. In addition he did not follow up support with anger management prior to the birth of Child B, which would suggest that he did not see it as a priority.

8.4.4 M's attendance at the Gateway Service and the negative toxicology tests was indeed a positive factor, however it is notable that she did not access the more in depth support offered and that she made the decision not to continue attending without any discussion with professionals. Given the length of time during which she had been abusing amphetamines, support to address the trigger factors and a longer period of toxicology tests linked to the child protection plan might have been advisable.

8.5 The Views of Staff

8.5.1 The lead reviewer met with practitioners and their supervisors halfway through the period during which the review was conducted. Their contribution served to reinforce the themes already emerging from the documentation submitted by their agencies.

8.5.2 It was evident that, in sharing with the practitioners an outline of the chronology, they learnt new information about the family circumstances that would have been of relevance to their involvement. This could either have been obtained from multi agency meetings or, in some instances, through reading their own agency records.

8.5.3 It was also evident that, at key points highlighted elsewhere within this case review, significant information (about the child protection plan and about the history of domestic violence) had not been shared and / or documented. As a consequence, professionals were often reliant upon the accounts given by the parents.

8.5.4 Practitioners also commented upon the distribution of child protection conference invitations and conference minutes.

8.5.5 The allocated social worker, team manager and child protection conference chair were unable to attend the practitioners' meeting. The lead reviewer had the opportunity to speak to all of them on the telephone during the course of the review period.

8.5.6 The social worker was first allocated to the family in July 2014 and was therefore involved throughout the second half of the care proceedings relating to Child B's older half siblings that had commenced in February of that year. The SW had direct knowledge of the mother's lack of transparency in some of her contacts with professionals (e.g. originally denying that she was pregnant, claiming that her relationship with P3 had ended when it had not). She didn't manage to see Child B's mother to begin the pre-birth assessment until February 2015 partly because of the completion of work around the placement of the older children and partly because of missed appointments. By that time, Child B's parents were presenting as a couple and asking to be assessed together.

8.5.7 The SW was aware that most professionals were pessimistic about the outcome of the pre-birth assessment although the SW did not consider that the outcome of the Threshold of Care Legal Planning meeting was as clear cut as recorded in the minutes and that the future plan would be dependent upon her assessment of the parents.

8.5.8 The SW reported having met with the parents on a number of occasions (although only two visits are recorded and the assessment was not completed until after the birth of Child B). Significant to her assessment were the lack of any reports of domestic violence and a denial of any drug use. The SW was on leave at the time of Child B's birth; when she visited in early June, she formed a positive impression of the parents' care of Child B. The SW thought that there were HVs present at the pre-birth conference although there is no record of that in the minutes. The SW recalled that the first review child protection conference was positive, without any concerns being expressed and was therefore surprised to learn about the emergency admission to hospital that occurred soon after. The SW did not realise that the hospital had not known that Child B was the subject of a protection plan at that time.

8.5.9 The SW recalled visiting the family shortly after that admission to hospital to discuss safer sleeping and did not identify any further concerns at that stage; she was shocked when the second emergency admission to hospital occurred. In the view of the SW, the professional network had all thought that the parents were making good progress in their care of Child B.

8.5.10 The Team Manager was responsible for the supervision of the social worker from September 2014, shortly after the case was allocated to the SW. The TM described the SW as being hard working and conscientious. He recalled that in May / June of 2015 the SW was involved in a car accident and that, whilst not seriously injured, this did result in some time off work.

8.5.11 The TM attended the Legal Planning Meeting referred to elsewhere in this review. It is the TM's recollection that the conclusion of that meeting was not as specific as recorded in the minutes and that the future course of action was to be determined following the pre-birth assessment; the TM regrets not checking the minutes at the time. The TM believed that the delay with the completion of the pre-birth assessment was due to the SW's other commitments.

8.5.12 The TM was aware that there had been some concerns expressed about information sharing. However, the TM had not been aware of the full extent of those concerns until brought to his attention during the early stages of this SCR. Finally, the TM expressed regret that a Strategy Meeting and S47 enquiries had not taken place following the first emergency hospital admission.

8.5.13 Finally, the Child Protection Conference Chair reported that whilst he had been aware that older half siblings had been the subject of care proceedings and removed from the care of Child B's mother, the recommendation of the legal planning meeting had not been shared at the pre-birth conference; the CPCC did not know about that recommendation until contributing to the Social Care IMR for the SCR. The CPCC was not aware that the information about Child B being the subject of a protection plan had not been effectively communicated or that there was a delay in the receipt of the conference minutes in this instance; however, the CPCC commented that this was not an unfamiliar issue. So far as the CPCC chair was concerned, decision sheets were compiled and dispatched within 24 hours of a child protection conference. The CPCC was not aware that P3 had been looked after by the local authority as a child.

8.6 The Voice of the Child

8.6.1 Clearly Child B didn't have a voice in the conventional sense. However, the older siblings had already spoken for Child B when

they had voiced their concerns about their family circumstances. This information was available to the agencies working with the family following the birth of Child B and could have provided a baseline against which to measure whether or not there had been any tangible changes in the ability of her parents to care for the child.

9 Conclusions

9.1 Child B was M's fourth child. The care proceedings that resulted in the removal of her older (half) siblings from their mother's care concluded less than 7 months before her birth. Significant in those care proceedings were the domestic violence in the relationship between Child B's father and mother, allegations of physical abuse made by one of the children against P3, and the children's expressed fear of him as well as concerns about M's use of drugs.

9.2 M had grown up witnessing domestic violence; she had been in a violent and abusive relationship from the age of 15 with the father of two of her children and had had a significant drug problem since the age of 16.

9.3 M had failed to engage with specialist domestic violence and drug agencies during the care proceedings, she had been inconsistent in contact with the children and had shown herself to be untruthful about the nature of her relationship with P3, becoming pregnant twice by him during the course of the care proceedings.

9.4 P3 was also from a difficult family background and had been looked after by Barking and Dagenham as a teenager. There was a lot of information available about his background, which was not accessed as part of the pre birth assessment; he was known to have been the perpetrator of domestic violence in a previous relationship. His background included drug and alcohol abuse, a lack of education, fractured family relationships, and offending including periods in custody.

9.5 With this history it should have been predictable that this couple would struggle to successfully parent Child B without action to address the issues in their background and specifically to address the domestic violence in the relationship. This should have been addressed as part of the pre birth assessment and formed part of the chid protection plan.

9.6 It was agreed that care proceedings would be commenced following the birth of Child B at a legal planning meeting. The decision to change that plan without clear evidence of change and without a further legal planning meeting was clearly flawed. There was a lack of analysis in professional assessments, and a lack of challenge in relationships with the parents and also between professionals.

9.7 Practice in relation to the pre birth assessment and the pre-birth child protection conference were not in line with the London Child Protection procedures; timescales were not adhered to and there is no evidence of multi agency involvement in the assessment.

9.8 The Child Protection Conference, held within the Strengthening Families Framework, did not have sufficient focus on the past history of the couple both as parents and as individuals.

9.9 Practice in this case, across all agencies, was not evidence based and there was no evidence of reflective supervision.

9.10 There are instances of inadequate recording across agencies, including insufficient or missing records and in the case of the Health Visiting Service confusion as to the appropriate recording format for children subject to child protection plans.

9.11 A striking feature of the case was the lack of effective communication and information sharing between agencies. Written and verbal communication and information sharing between the professionals involved was poor and not in line with procedures falling well below standards expected. Basic information relating to Child B being subject to a child protection plan was not effectively communicated between professionals.

9.12 Poor communication was compounded by gaps in the systems for distributing and logging information relating to children who are subject to child protection plans, including alerts, minutes of conferences, core groups and strategy meetings and copies of child protection plans. Effective information sharing is at the heart of a safe child protection system; its failure placed Child B at risk of harm.

10 Recommendations

10.1 Individual agencies have identified recommendations and actions within their Independent Management Reviews that have been

referenced in this report. The following recommendations are therefore in addition to those in the IMRs.

10.2 Health Service

10.2.1 BHRUT should ensure that midwife transfer summary reports are explicit about whether or not a child is subject to a protection plan including the reason why there is a plan, name of the social worker and dates of forthcoming meetings.

10.2.2 BHRUT should produce a Child Protection meeting matrix as guidance for staff in relation to meetings, attendance, timescales and responsibility for organisation and chairing

10.3 Barking & Dagenham Safeguarding Children Board

10.3.1 B&DSCB should recommend to the London SCB that the London CP Procedures are amended to say that "*Whenever a child subject to a protection plan is admitted to hospital (other than for a planned admission for a pre existing health condition) consideration should be given to the need for a strategy meeting following that admission and to a core group meeting (rather than a discharge planning meeting) prior to discharge. The latter requirement should not alter existing arrangements within hospital settings for arranging discharge planning meetings following medical admissions to hospital*

10.3.2 The B&DSCB should undertake an audit of information sharing between agencies with particular reference to agency systems for the distribution and recording of notifications, minutes and protection plans relating to children subject to child protection plans.

10.3.3 B&DSCB should monitor the progress across local agencies of the implementation of CP-IS which will enable any unscheduled health care setting to access information about a child's child protection status

10.3.4 Through case audits, the B&DSCB needs to be satisfied that issues relating to domestic violence, invisible fathers, professional optimism, disguised compliance and respectful challenge are being addressed on a multi agency basis.

10.3.5 Child B's mother had a history of multiple pregnancies and is reported to be pregnant again. Within some local areas, projects

have been established to try to reduce the frequency of repeat pregnancies / removals. Apart from the human cost of repeated pregnancies and removals, there is a considerable financial cost. B&DSCB should facilitate local consideration of such an initiative in Barking and Dagenham[10].

10.3.6 B&DSCB should seek assurance from all agencies that supervisors are equipped with the knowledge and skills to provide high quality reflective supervision on all cases where there are child protection concerns.

10.3.7 There is a need to improve the analysis of risk across all agencies. B&DSCB needs to be satisfied that available history is taken into account and analysed in line with research and best practice in Child Protection Conferences. Individual agencies must also ensure that conclusions are evidence based and that over reliance is not placed on self reporting by families.

10.3.8 B&DSCB should raise awareness of the interagency escalation procedure so that staff are aware of how to raise concerns that may arise in multi agency working.

10.3.9 B&DSCB should recommend that the local Community Safety Partnership undertake a review of the availability of domestic violence services, with particular reference to those available where there are child protection concerns.

10.3.10 B&DSCB, in conjunction with B&D CCG, should undertake a review of the engagement of GPs with the professional network in child protection cases and make recommendations to the London Safeguarding Board and NHS E arising out of that review.

[10] See the "Pause Project" – DfE Innovations funded project

Appendix 1 – Terms of Reference

Scope and Terms of Reference for Serious Case Review
Child B (DoB: 19.5.2015)

PRIVATE & CONFIDENTIAL

Introduction

1. A notification was received by the LSCB Business office on 15th July 2015 advising of incidents of concern relating to XXX Following this, the Barking & Dagenham Safeguarding Children Board (BDSCB) convened a SCR meeting on 22nd July 2015 to consider if the criteria had been met for a Serious Case Review in the case of Child XXX, from here on referred to as Child B.

2. The Criteria under which this Review was considered is as follows :

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:
5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
(2) For the purposes of paragraph (1) (e) a serious case is one where:
(a) abuse or neglect of a child is known or suspected; and
(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Cases which meet one of these criteria (i.e. regulation 5(2)(a) and (b)(i) or 5 (2)(a) and (b)(ii) above) must always trigger an SCR.

3. In considering the facts presented to the Panel by a range of partners, the Chair of the BDSCB agreed that the criteria above had been met and a decision was subsequently made to conduct a Serious Case Review, in line with Chapter 4, Working Together 2015

SCR Panel

4. A Serious Case Review Panel has been established and will be chaired by Teresa Devito, Acting Divisional Director – Strategic Commissioning, Safeguarding & Early Help

5. Steve Liddicott has been appointed as the Independent Reviewer, and the DfE have been informed of his position.

6. Additional members of the SCR Panel are:

- LBBD Divisional Director of Complex Needs and Social Care
- CAIT Police
- CAFCASS Head of Corporate Services
- NELFT Integrated Care Director
- BHRUT
- BD CCG Designated Nurse
- BD CCG Designated Doctor
- BD CCG Named GP
- LBBD/Thurrock Principal Solicitor

(This list is not exhaustive and may require other professional roles/services to be part of the SCR, dependent upon the findings made during the SCR process):

Specific Agencies relevant to this Review

7. All BDSCB partner agencies, including contracted services on behalf of an agency, which had significant contact with the family are required to present a detailed chronology of their involvement and interaction with the family within the dates agreed. Agencies to be included in this process are:

Barking and Dagenham Health Services:
- Barking and Dagenham Clinical Commissioning Group (CCG) (including Designated professionals and lead commissioners)
- North East London Foundation NHS Trust (NELFT) (including Community Health Services, Named GP and Mental Health Services)
- Barking, Havering and Redbridge University Hospital NHS Trust. (BHRUT)

Metropolitan Police
- Child Abuse Investigation Teams

London Borough of Barking and Dagenham - Children's Services
- Children's Social Care and Complex Needs Division

London Borough of Barking and Dagenham - Services other than Children's
- Legal Services

London Ambulance Service (LAS)
CAFCASS
Barts Hospital Trust
- Royal London Hospital

Other LSCBs and their partner agencies will be invited to contribute if required.

Methodology

8. The format of this SCR initially, will be to draw analysis based on detailed chronologies provided by each agency. The Independent Reviewer will conduct a

Case Review based on the information provided. The serious case review process map is detailed in *Appendix A*.

9. Agencies will not be required to draw up IMR's as much of the information required will be contained within the chronology. The Independent Reviewer will explore this further and will request IMRs from any agency where they feel his could provide further insight or information.

10. The Independent Reviewer will interview and meet with the key agencies involved in their analysis of the information provided and draw up any key lines of enquiry to pursue as part of this review

11. Relevant agencies will be expected to identify a Lead Manager to work alongside the commissioned external Independent Reviewer. The Lead Manager will be responsible for producing the chronology for their agency. They must be free from any direct line management responsibility of the case.

12. All agencies required to produce a chronology will abide by the guidance, timescales and minimum standards for completing these as set out and agreed with the Independent Reviewer. The timeline will be ratified by the Chair and will be set out in a timeline document that will be circulated to the SCR Panel, the Independent Reviewer, and partners.

13. The Independent Reviewer will have responsibility for producing the final overview report within a 6 month time period. The report will be based upon a critical analysis of the single agency chronologies, any subsequent agency overview reports, discussion with key stakeholders and review meetings with representatives of all agencies. The Independent Reviewer will contribute to the subsequent dissemination of lessons learned as part of London Borough of Barking and Dagenham Learning and Improvement Framework.

14. On its completion, the final overview report and integrated chronology will be submitted to the SCR Panel for sign off and then to the Barking and Dagenham Safeguarding Children Board for final ratification. The Board will sign off and agree the report and chronology and the report will be presented to the DfE one week prior to publication on the LSCB website. The publication date will be dependent upon the completion of any criminal trial associated with this SCR.

15. The BDSCB will oversee the dissemination of lessons learnt across the LSCB partnership, based on the final report.

16. In line with good practice, the family will be informed of the SCR. In partnership with the Police, the Independent Reviewer will be responsible for advising if any work should be undertaken with the family.

Depth and Scope of Review

17. The SCR will consider in detail, a chronological account of the involvement of professionals and the services provided to the family from 1 August 2014 to 31 August 2015. If agencies hold information pertaining to the parents prior to this date, this should be summarised and may be requested by the Independent Reviewer as part of this Review. Similarly, if agencies have information pertaining to the family in the period after the notification, this should also be summarised.

18. Chronologies should specifically include information about the child, the family and those in the child's household, including any particular comments around ethnicity, culture, religion, age, financial circumstances and disability within the family.

19. In order to focus on the core lessons to be learned, the chronology should contain significant milestone events for the family. (E.g. births, deaths, transitions within the family and interventions by the agency.)

20. In addition to the child, who is the subject of the review, information about other family members and in particular, known family associates, will also be included within the scope of the review. This should include as a minimum:

Mother	Age: 28:
Father	Age: 29
Child (Subject)	Age: 1

21. The overall purpose of the SCR is to enable BDSCB to derive potential key lessons from an open examination of any issues identified within this review.

22. In particular, the review is seeking;

- a record of all statutory and non-statutory agency involvement with the family between 1 August 2014 and 31 August 2015. These dates have been drawn up based on the date of previous care proceedings, and up to the point of post notification. All agencies should also present a summary of any relevant additional information outside the scope of the chronology.

23. The review seeks to learn lessons for future practice by examining the following key issues relevant to this case:
    1. Were practitioners aware of the needs of the children in their work, and knowledgeable about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?
    2. Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
    3. What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
    4. Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?

5. Were there any issues, in communication, information sharing or service delivery, between workers/agencies?
6. Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
7. Were senior managers or other organisations and professionals involved at points in the case where they should have been?
8. Were there organisational difficulties being experienced within or between agencies? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
9. Was there sufficient management accountability for decision making?

In line with systems methodology, further hypothesis will be identified through the integrated chronology and practitioner discussions as outlined in the approach to the SCR as identified in Appendix A.

The Independent Reviewer

24. The Independent Reviewer will be Steve Liddicott. Steve has been commissioned by the SCR Panel to draw up a report based on the information submitted about and known of the family

25. The Independent Reviewer shall be given the remit to request detailed IMRs from any agency that could provide further information or details about their involvement with the family and agreed individuals

26. The Independent Reviewer will compile a Final Report based on a review of the chronologies as provided by each agency and any additional reports requested. The Independent Reviewer will have the remit to interview staff from any agency in order to establish further details of their involvement with the family and associated individuals

27. Focus Groups will be held throughout the process of this Review and the Independent Reviewer may be invited to participate and assist discussion

28. The Independent Reviewer will advise the SCR Panel if subsequent or alternative methodologies are required in order to enable them to obtain as much relevant information and detail as is required for them to complete their report.

QUALITY ASSURANCE WITH OTHER LSCBs		Process Step	Timescale	Supporting Commentary
	⇩	Serious Case Review initiated	One month from initial notification	
	⇩	Notification to DfE and National SCR Panel		Notifications to be sent to Mailbox.SCRPANEL@education.gsi.gov.uk and cie@ofsted.gov.uk
	⇩	Integrated Chronology		Agencies to ensure the chronologies are robust, agency owned and not anonymised, in order that reviewer is able to get a full picture
	⇩	Hypothesis		Required to inform the requirement for IMRs. Independent reviewer to provide this information to Panel.
	⇩	1:1 Discussions Or Group Discussions		These will be undertaken by the Independent Reviewer along with Panel members. Panel members will not interview their own agency. This may lead to additional IMR reports being requested. Ensure interviewees are briefed as to what is required to alleviate worries to focus on positives.
	⇩	Learning Events		To incorporate learning throughout case, so we can learn all along, feeding back to agencies part way through process. These events also provide the opportunity to test findings/ analysis to support the development of the report associated recommendations and actions
	⇩	Way forward • Action Plans • Changes		Agencies will begin to change develop practice in light of learning events
		SCR Report	Six months from initiation	In line with WT 2015 SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.
	⇩	Criminal Trial		There should be a "dotted line" from the SCR report to any Criminal Trial
	⇩	Publication		SCR Reports should be published on the LSCB website for a minimum period of 12 months, and will be also available upon request.
	⇩	Multi Agency Briefing Sessions		Following publication a series of briefing sessions will be arranged, in order to disseminate learning wider across the borough.