Barking & Dagenham Safeguarding Children Board

Serious Case Review: Child C

Final Report

Published: January 2018.

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Appendices:

1.1. The Circumstances supporting the decision to undertake this SCR

1.1.1. Child C was born prematurely at 28 weeks and 5 days gestation at home; following transfer to Newham University Hospital (NUH) she was admitted to the Neonatal Unit. Child C remained in the Neonatal Unit for a period of 65 days; the mother visited the unit on only 18 occasions before Child C's discharge on 5th August 2016. Staff on the Neonatal Unit at Newham University Hospital (NUH) made a referral to London Borough of Barking and Dagenham Children's Services regarding the limited visiting of mother and engagement with the staff.

1.1.2. Ten days after Child C's discharge from the Newham Hospital Neonatal Unit she was made subject to a Child Protection Plan (CPP) in the London Borough of Barking and Dagenham under the category of 'neglect' along with her older sibling.

1.1.3. On 28th September the mother of Child C was travelling on a bus with Child C in a baby sling; the baby's head was covered with a white cloth. The sibling of Child C was also with her and was in a pushchair. The mother asked for help from the passengers saying that her baby had stopped breathing, one passenger carried out Cardiopulmonary Resuscitation (CPR) on Child C prior to the arrival of the emergency services. The ambulance crew that attended the scene were concerned that Child C's jaw was locked and called the police. Child C was taken to NUH where she was pronounced dead.

1.1.4. Child C presented at NUH in cardiac arrest, she was not breathing, was very cold to touch, and had stiffness in her neck and limbs. She also had bruising and swelling to her head and eyes.

1.1.5. The parents of Child C were arrested on suspicion of the murder of Child C and later charged with a) Murder; b) Assault/ Neglect; c) Causing/ Allowing the Death of a Child.

1.1.6. A skeletal survey conducted post death indicated that Child C had suffered multiple fractures that were old and new fractures which were considered to be consistent with non accidental injuries (NAI)

1.1.7. The case was considered by Barking & Dagenham Safeguarding Children Board (BDSCB) Serious Case Review (SCR) Panel on the 10th November 2016 to consider if the criteria had been met, under Regulation 5[1] namely:

(a) abuse or neglect of a child is known or suspected; and

[1] Local Safeguarding Children Boards Regulations 2006

(b) (i) the child has died.

1.1.8. The then Chair of the Board accepted the recommendation to conduct a Serious Case Review, in line with Chapter 4, Working Together[2]

1.1.9. In May 2017, the parents of Child C were found guilty of causing or allowing the death of Child C. They both received custodial sentences.

1.2. Family Composition

1.2.1. The family members relevant to this review will be referred to as follows:

Family member	Description used in this report	Age at time of Child C's death	Ethnicity
Subject	Child C	3months	Black British / Caribbean
Mother of Child C	Mother	25	Black British/ Caribbean
Father of Child C	Father	52	Black British
Sibling Of Child C	Sibling	Older than Child C by a couple of years	Black British / Caribbean
Maternal Aunt of Child C	Maternal Aunt	29	Black British/Caribbean
Maternal Grandmother of Child C	Maternal Grandmother	50	Black British /Caribbean

1.2.2. **Family involvement.** The involvement of key family members in a Review can provide particularly helpful insights into the experience of receiving or seeking services. Letters were sent to the mother via her solicitor and directly to the father. To date there has been no response.

[2] Working Together. HM Govt 2015

1.3. Summary of the background

1.3.1. The mother of Child C was the sixth of eight children. Following a disclosure by Child C's maternal grandmother in 2007 of domestic abuse, the family moved to a women's refuge and then to accommodation in Essex. Child C's mother returned to live in London in 2010 when her relationship with her mother (the maternal grandmother) had broken down. She had no fixed abode and was reported to live between family and friends.

1.3.2. The mother, now a resident of Newham, continued with her transient lifestyle during her first pregnancy and gave birth prematurely at 34 weeks gestation to Child C's sibling (April 2014). She avoided professionals and only engaged with services on her own terms, evidenced by sharing different information depending on which agency she was talking to. The mother denied that she was in a relationship with the father of her children but stated that he was supportive.

1.3.3. The mother approached Newham Housing Needs Service on the 7th April 2014 with a letter from the maternal aunt stating that she could no longer allow the mother to stay on a temporary basis in her flat in Tower Hamlets. The mother was offered temporary accommodation in both Forest Gate and Edmonton. She turned down both of these offers, citing proximity to her father and brother whom she had alleged assaulted her for the former, and the latter because it was too far away.

Chronology of Housing Offers/Events

Date	**Location**	**Outcome**
25 April 2014	Forest Gate	Rejected: too close to father and brother
11 December 2014	Chadwell Heath	Accepted
11 March 2015	Chadwell Health	Cancelled: not living there
17 March 2015	Edmonton	Rejected: too far away
7 April 2015	Dagenham	Accepted: Signed for on 9 June. Moved in 6th July
April 2016	Dagenham	Cancelled: not living there

1.3.4. The mother experienced a late spontaneous miscarriage (at 21 weeks gestation) on 16th June 2015, at the father's home. The mother and the baby were conveyed by ambulance to hospital. The baby

was reported by ambulance staff to have shown signs of life but subsequently died.

1.3.5. The mother also self reported a number of early miscarriages (five to seven) and had presented for fertility treatment aged 19. Three births had all been premature and home deliveries with no professional present.

1.3.6. Following nearly 16 months of tenancy arrangements, in March 2016, the London Borough of Newham cancelled the mother's tenancy for a flat in the London Borough of Barking and Dagenham (LBBD) as it transpired that she had never been resident at this address and they concluded the homelessness duty had been discharged in April 2016. The mother was pregnant with Child C, her third pregnancy in less than three years, and on 2nd June 2016 again delivered prematurely at 28 weeks and 5 days gestation at the address of Child C's siblings father. Child C was admitted to the Neonatal Unit at Newham University Hospital where she remained for a period of 65 days.

1.3.7. During Child C's time in the unit her mother visited her on only 18 occasions. Prior to Child C's discharge a strategy discussion was held and an Initial Child Protection Case Conference (ICPCC) was planned to take place in the LBBD on the 15.08.16. On 5th August Child C was discharged from the Neonatal Unit into the care of her mother who planned to stay with her sister (the maternal aunt) in Tower Hamlets (the third London borough).

Date	Event	Outcome
25 July 2016	Strategy meeting with Police	Recommends case progressed to ICPC
29 July 2016	Professionals Meeting held at the hospital	Mother to register with GP in Tower Hamlets
Tuesday 2 August 2016	Discharge Planning Meeting held at the hospital	Child C to stay with mother and sibling at maternal aunts flat in Tower Hamlets
Friday 5 August	Child C discharged from the Newham Hospital Neonatal Unit	At 6pm
15 August	Initial Child Protection Case Conference held by LBBD	Child C and older sibling made subjects of Child Protection Plans under the category of neglect
17 August	Threshold of Care and Legal Planning	Care proceedings should be initiated. If

	Meeting held by LBBD	children not seen by 19 August Emergency Protection Order to be considered
19 August	Maternal grandmother and maternal aunt offer support to directly avoid children being taken into care	Family Support Plan signed and agreed that the family will move to Essex to live with maternal grandmother

1.3.8. At the ICPCC on 15 August convened by the London Borough of Barking and Dagenham (LBBD), Child C and her sibling were made subject to a Child Protection Plan (CPP) under the category of neglect. During the conference the mother was antagonistic and stated that she would not comply; she refused to say who the father of Child C was or where he lived. In view of this further action from the ICPC meeting was for further consideration of a legal planning meeting if the mother's non-compliance continued.

1.3.9. Concern escalated as Child C had not been seen by a health professional since discharge from the Neonatal Unit at Newham University Hospital and it was unclear where the family was living. A Threshold of Care and Legal Planning Meeting (TCLPM) was convened two days after the ICPCC (17 August); the TCLPM provided a framework for how the case should be progressed and managed. This meeting was attended by LBBD Group Manager CSC, Senior Solicitor, Court Progression Officer, Social Worker and Minute Taker and concluded that care proceedings should be initiated.

1.3.10. On 19 August the maternal grandmother and maternal aunt of the children visited LBBD Children's Services with the mother and stated that the mother wished to take Child C and the older sibling to live with the maternal grandmother in Essex, who offered to monitor and support the mother as she did not want her grandchildren to "go in to care".

1.3.11. Following initial investigations, the family moved to Essex on 22 August. Essex Children's Services were advised of the children's move into their area and asked to add the names to the list of children on a CPP.

1.3.12. On 23 August the social worker contacted the maternal grandmother to check how things were going and no concerns were raised, and the mother had planned to register with the local GP practice.

1.3.13. On 24 August the safeguarding plans for both children were sent to the TCLPM to report and review the change of circumstances. The TCLPM decided not to proceed with care proceedings for the children at that time. This was to allow for a period of support with the wider family in the care of the children. The TCLPM directed that a safeguarding agreement should be put in place, specifically that if the mother moved out from the grandmother's address with the children, then the social worker and police must be informed. The Child Protection Plan (CPP) was to continue and more core groups to be held. The maternal grandmother was informed and that she must make contact with SW3 /police if the mother leaves Essex with the children.

1.3.14. On 26 August (this was the Friday of the August Bank holiday weekend) the mother rang the social worker to inform her that the maternal grandmother had "kicked her out". The maternal grandmother spoke with the social worker and stated that she could not look after her daughter and grandchildren indefinitely and that the LA needed to find accommodation for them. The mother had also forgotten to bring her bank card with her and the maternal grandmother could not continue to support her financially. The maternal grandmother gave a positive report of the mother interacting well with the children. The family had registered with a GP and had made contact with the Essex Housing Department.

1.3.15. The social worker spoke with the mother on 1 September and she confirmed that she and the children were still living with the maternal grandmother and was due to see the Housing Department the same day.

1.3.16. A joint home visit by the social worker and health visitor was carried out on 6 September. This was also convened as a Core Group Meeting.

1.3.17. On 8 September the social worker was unable to contact either the mother or maternal grandmother to get an update on the housing situation.

1.3.18. On 14 September the social worker was again unable to contact the mother but did speak to the maternal grandmother who told the social worker that the mother had taken the children back to London for three days (12-15th September). The maternal grandmother had failed to tell the social worker about the departure despite this being part of the safeguarding agreement. SW3 informed the Team Manager who instructed SW3 to tell the maternal grandmother that she must notify the police of this. SW3 was unable to speak with the maternal grandmother and left a message instructing her to tell the police.

1.3.19. Following an unannounced home visit by the social worker on the 19th September it appeared that the family were co-operating and that progress was being made in relation to: an application to housing, health appointments, outstanding development checks and immunisations for the children.

1.3.20. Shortly after the completion of the visit on 19 September, the mother and the two children again left the address in Essex returning to London; again, the maternal grandmother failed to inform the social worker. The mother sent text messages to the health visitor asking to rearrange a planned home visit scheduled for the 26.09.16.

1.3.21. It is now understood that the mother remained in London with the children. On the morning of the 28 September the mother boarded a bus with Child C in a baby sling; the baby's head was covered with a white cloth. The sibling of Child C was also with her and was in a pushchair. The mother asked for help from the passengers saying that her baby had stopped breathing, one passenger carried out Cardiopulmonary Resuscitation (CPR) on Child C prior to the arrival of the emergency services.

1.3.22. The emergency services attended and called the police, as there were suspicious circumstances. Child C was pronounced dead at the hospital.

2. Methodology

2.1. For details about the review process and methodology; see Appendix 1.

3. Details of Practice and Analysis

3.1. Introduction

3.1.1. The detail of this SCR has been divided into five time periods. A timeline of key events for each of these time periods can be found in Appendix 2. What happened, and the underlying practice, is considered alongside multi-agency decision-making, assessments and interventions. The appraisal is set out to assess the quality of the multi-agency practice at key points, and identify which are considered to provide the most significant learning. In doing so, it takes into account both the contemporary required standards and also the information that was known, or could have been known, at the time of the events. Where there is information about why practice may not have met required standards, this is explained.

3.1.2. It aims to provide an outline of what happened and how the various professionals responded or took action. This extends to give a clearer view and takes what happened into a discussion about why things may have happened in the way they did. By doing this the Review is seeking to achieve a greater depth of learning about safeguarding practice and the systems that underpin this with all the agencies that were directly engaged. This learning extends beyond the individual circumstances of this situation and will be the basis of each agency's development activity after the publication of this report

3.1.3. Some important development and learning has already commenced through the process of the SCR panel, the development of each individual Independent Management Report (IMR) and organisations have already considered developments and learning that has direct future impact. This is set out in Appendix 3.

3.1.4. The family had six different addresses in four different local authorities. When the family moved, it resulted in changes to children social care and health service provision particularly the health visiting service.

3.1.5. In order to understand where responsibility for the case rested during the timeframe for the SCR, the local authority with ongoing responsibility has been identified.

3.1.6. What is clear throughout all these circumstances are the ongoing challenges that professionals face working with transient families who have multiple or complex difficulties. This becomes even more difficult with avoidant, hard to engage and resistant families when the need to safeguard vulnerable children is a primary concern, not least the sharing of information in a timely manner when different IT systems are used and they do not align.

3.2. Period 1: October 2013 – July 2014

(Please see summary time line at Appendix 2 pages 76 – 80)

Agencies involved:

- **London Borough of Newham – Adult Services and Children's Services**
- **Newham Housing Needs Service**
- **Home to Home**
- **GP1**
- **GP2**
- **Newham University Hospital**
- **Midwifery Acorn Team**
- **Newham Intensive Hospital Intervention Team**
- **East London NHS Foundation Trust (ELFT) – Health Visiting Team**

Mother is homeless and pregnant and gives birth prematurely to Child C's older sibling, the London Borough of Newham (LBN) undertakes a single assessment.

During this period the mother presented with housing issues which did not meet the threshold for statutory intervention from children's social care however the professionals are focused on the issue of housing and pay insufficient attention to:

- *The mother's transient lifestyle,*
- *The impact that this has on her ability to parent and*
- *Her resistance to working co-operatively with professionals.*

3.2.1. In October 2013 GP1 raised an Adult Safeguarding alert concerning the mother who was pregnant, of no fixed abode and had allegedly been physically abused by her brother and her father.

3.2.2. The London Borough of Newham Access to Adult Services (ASC) team received the alert, being the first point of contact for all adult services. ASC were unable to make contact with the mother, as she did not respond to the telephone calls. A letter was sent to the mother advising her to make contact and to attend the domestic violence service for support. ASC made a referral to children's services (CSC) regarding the unborn child.

3.2.3. The mother contacted the service in November and gave her consent for a referral to be made for domestic violence support. At this point she stated that she was living with an uncle and she was assessed as not meeting the threshold for assessment and on-going support from ASC.

3.2.4. The mother gave the name, address and date of birth of the father of

the unborn baby (Child C's older sibling); this information was available to Children's Social Care (CSC) via the Care First IT record system. The contact made by ASC with the mother was by telephone; she was never seen face to face by the service.

3.2.5. The mother attended Newham University Hospital (NUH) for her antenatal booking appointment with her sister (maternal aunt) in October 2013. The mother was correctly identified for priority antenatal care and was referred to the Acorn Team[3] due to her homelessness and 'complex social history". The mother was reported to be very underweight.

3.2.6. Unfortunately, the Midwifery Acorn team records that are separate from the Maternal Hand Held Records, have not been found and there is therefore a gap in recording how the Acorn Team Midwives worked with the mother during this pregnancy, and what if any additional concerns or risks were identified. Barts Health raised a clinical incident report at the time. They now undertake regular audits to ensure that the Midwifery Acorn records, hand held records and main hospital held records all marry up post delivery.

3.2.7. The father of the baby was identified at this appointment on 29 October 2013 including his address and that he was currently unemployed. No further details were recorded or what level of involvement he would have with the baby. This could have been an opportunity to discuss the relationship and to consider whether the father provided support and stability or posed a risk.

3.2.8. The triennial review of SCRs in March 2016[4] makes the following recommendation: 'Efforts must be made to increase the visibility of fathers in practice, policy and research around neglect. Too often mothers are the focus, this can mean that the risks and protective factors that fathers bring to a child's life may be missed. Local service leaders can enable this through policy review and practice audits'. This is a key lesson for all the agencies who worked with this family.

3.2.9. At the end of October 2013 the father attended his GP2 stating that he felt anxious and depressed and had been buying diazepam[5] off the street. A Patient Health Questionnaire (PHQ-9)[6] was appropriately completed and he scored 25/27 indicating severe depression and was restarted on an anti-depressive drug and a referral was made for counseling; it is unclear as to whether this was taken up.

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[3] Vulnerable Woman's Maternity Team

[4] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 -2014 (DfE 2016

[5] Benzodiazepine – used for their sedative, anxiety- relieving and muscle relaxing effect

[6] A multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression; it is widely used in General Practice.

3.2.10. The GP practice made significant effort to follow up the review of the father's mental health. The father failed to respond to telephone calls from GP2 practice to come into the surgery for a review of his mental health; this was good practice and demonstrated that GP2 wanted to review the father's mental health. He eventually attended the GP surgery four months later.

3.2.11. When questioned by GP2 the father stated that he lived alone and this was reinforced by his records indicating that he was a 'single man' and there were no linked family members on the GP system. While it is not clear whether GP2 asked the father specifically if he was in contact with any children the information available at the time presented no contra indications Furthermore, at this point neither Child C nor their older sibling had been born. It is now known that he had children from a number of different relationships.

3.2.12. It is clear that GP2 worked on the basis of the information available at that time.

3.2.13. The case was allocated to SW1 who worked in the Newham Intensive Hospital Intervention Team at the beginning of January 2014. This was following the opening and closing of the case until the mother was 22 weeks pregnant. The allocation included supervisory direction for a single assessment to be undertaken.

3.2.14. SW1 demonstrated tenacity at attempting to contact the mother undertaking an unannounced visit and multiple telephone calls but was successful in meeting with the mother on only one occasion when she was advised to present at the Homeless Persons Unit to apply for housing in her own right.

3.2.15. Following this meeting SW1 reported, "It had been impossible to meet with mother as she disengaged from this assessment. The mother's presenting need is to find a suitable accommodation where she will live with her baby. When she realised that Social Care are not in a position to provide her need at present as she has no live child, she has not thought it necessary to continue to engage with the assessment."

3.2.16. The assessment recognised that the mother had been a victim of violence perpetrated by her own father and brother but saw the risk as being reduced by the fact that the last incident was in March 2013 and concluded 'It has been difficult to comment on all areas needed to complete this assessment to make any meaningful recommendations, however, the baby when born does not appear to be at imminent risk except the risk of homelessness and this could be assessed again when the mother presents at the hospital to have the baby'.

3.2.17. Based on the information available to Newham CSC at that time the

threshold for further statutory intervention was not met, mother reported that the risk of domestic abuse was reduced as she had moved away from the perpetrators and although she did not have her own tenancy she had found herself a temporary place to stay and was advised to present to the Homeless Persons Unit.

3.2.18. The mother failed to attend two routine ante natal appointments in a row but did attend the next one. She blamed the fact that she had no permanent address and was experiencing problems with her phone; this was a constant feature throughout the review period, when the mother would have a number of different mobile numbers and would say that she had been given the wrong time for appointments.

3.2.19. The Midwifery Service has a 'Did Not Attend' pathway in place and staff followed this in managing missed appointments. Staff need to be reminded and remain curious as to why appointments are missed and should always consider the potential for 'disguised compliance'[7] or 'non-compliance'[8] this will be will be discussed under Section 3.7.

3.2.20. In April 2014 Child C's sibling was born prematurely at 34 weeks gestation and the midwives informed the social work team as instructed; the mother had agreed to work with the social worker regarding housing.

3.2.21. Mother and baby were fit for discharge four days after the birth, but the mother refused to leave and remained in hospital for a total of 12 days post delivery. During this time the father of the baby stayed on the ward for an afternoon whilst the mother went to the housing department, however, the Housing Needs Service does not corroborate this account; it is unclear where the mother went. This was another opportunity for professionals to find out more about the father and the role he played within the family.

3.2.22. The mother had presented to the Housing Needs Service on the 07.04.14 with a letter from her sister (maternal aunt) stating that she could not stay with her any longer, as there was insufficient room at her flat in Tower Hamlets.

3.2.23. The mother also disclosed at this appointment that she had been staying with her uncle in a one bedroom flat but said her uncle did not want any visits from the 'council'. A subsequent home visit confirmed that the mother had been staying 'off and on' with the uncle, but that he had mental health problems and did not want the baby to stay in his flat because he was a smoker.

3.2.24. The mother was referred by Newham Housing Needs Service to 'Home to Home' which was a mother and baby unit for young

[7] Parents giving the appearance of co-operating with professionals to avoid raising suspicion and allay concern.
[8] Parents' lack of co-operation and /or hostile attitude of parents.

mothers. She turned this down due to the property being in the area (Forest Gate) where her father and brother lived (she had alleged they had assaulted her).

3.2.25. Following the birth of Child C's sibling a new birth notification was received by East London NHS Foundation Trust who are commissioned to provide a range of services including health visiting in the LBN.

3.2.26. The new birth visit[9] was completed on the post-natal ward as the mother and baby were still in the hospital due to the mother's homelessness and her refusal to leave the hospital. HV1 assessed the family as meeting the Universal Partnership Plus[10] and a follow up visit was planned for the 16.05.14.[11] This was conducted in line with the requirement that the Health Visitor Service is the lead agency on the delivery of the Government's *Healthy Child Programme; pregnancy and the first five years, (*DOH, 2009). This states that additional support may be needed by some parents and will depend on their individual risks, needs and choices. The aim is to identify any health or development related concerns as early as possible so that the required level of support and intervention can be agreed and if appropriate refer or signpost to another service.

3.2.27. The mother and baby were discharged to the uncle's home on 24 April 2014, 12 days after the birth, and the midwife visited the same day. The midwife was concerned about the sleeping arrangements for the baby as it was a one bed roomed flat, there was no cot in evidence, the mother was sleeping on the sofa and the flat 'stank of smoke'.

3.2.28. A duty social worker visited the property the following day. The social worker raised concerns regarding the cigarette smoke in the home, lack of space and co-sleeping arrangements for mother and baby, which the social worker advised to stop with immediate effect. The duty social worker liaised with housing and advocated on the mother's behalf and following this, housing agreed to provide mother and baby with accommodation.

3.2.29. The case was closed by Newham Children's Services on 19.05.2014 on the basis that the presenting issue was housing, which was being addressed by the housing department.

3.2.30. This decision fell below the required standard as it did not gather sufficient information about the lifestyle of the mother, the role of significant others, such as the biological father, reasons for her poor

[9] New birth visit is completed 10-14 days after the birth
[10] Four levels of health visiting intervention, Community, Universal, Universal Partnership and Universal Partnership Plus: Health Visitor Implementation Plan: A Call to Action (DH 2011).
[11]ELFT Health Visitor Operational Framework states follow up visit should take place two weeks after the new birth visit.

attendance and engagement with professionals and its impact on the baby.

3.2.31. Supervision was provided throughout this period and whilst it gave direction it did not encourage professional curiosity or ensure the assessment was completed in full. It is well documented that in working with families to safeguard children, the sense that professionals make of information they receive will inevitably be vulnerable to common errors of human reasoning (Munro; 1999).

3.2.32. The importance of regular supervision and management oversight for all professionals will be discussed under additional learning, see Section 3.17

3.2.33. The mother cancelled the planned follow up visit made by HV1 for the 16.5.14 by text as she stated that she was not at her uncle's address and the appointment was rescheduled for four days later (20 May). The mother and sibling were not at the uncle's address when HV1 attempted the rearranged visit. The mother then requested to see HV1 at the Child Health Clinic (CHC) on the 22.05.14; she arrived nearly three hours late.

3.2.34. This pattern by the mother of cancelling appointments but then wanting to rearrange may have encouraged HV1 to think that she wanted to engage with the service.

3.2.35. On 22 May 2014 The mother told HV1 that she had been 'kicked out' by her uncle and she had been staying with the father of the baby. This was the first time that the mother had shared with a professional that she was staying with the father of the baby.

3.2.36. HV1 did not record his address and did not enquire about the role and relationship; this was a further missed opportunity to gain more information and insight in to how much time the mother and sibling spent with him, and what his role and influence was.

3.2.37. The mother failed to attend a further two appointments with the health visiting service, this was despite contacting the mother directly by phone to remind her about the appointments.

3.2.38. HV1 did not share the non-engagement by the mother with GP1, the case had already been closed by Newham Children's Service (NCS) on the 19.5.14. This was an opportunity for HV1 to consider concerns about disguised compliance.[12] While HV1 made a referral back to CSC (see para 3.2.43) on the basis of neglect if the potential of disguised compliance been considered this could have added weight to the referral.

[12] This can lead to a focus on adults and their engagement with the service rather than achieving safer outcomes for children.

3.2.39. ELFT have a clear policy for how to manage missed appointments, the 'Did not Attend'[13]policy states when two appointments are missed 'The staff member has an individual professional responsibility to respond to failure to attend an appointment in a manner based on an assessment of the service user's risk and their identified needs'.

3.2.40. When children do not attend or there are repeated cancellations and rescheduling of appointments by parents, professionals should be curious about why and move away from the response 'did not attend' to 'was not brought'. Recent research into health agency 'Did not attend' policies has shown inconsistency and that they can, at times, be a systemic defensive response by agencies to help manage large workloads.[14] Non-compliance with appointments may be a parent's choice but it may not be in the child's best interest. Repeated cancellations and re-scheduling of appointments for children should be treated with curiosity. A shift away from using the term did not attend (DNA) to was not brought (WNB) would help 'maintain a focus on the child's ongoing vulnerability and dependence, and the carer's responsibilities to prioritise the child's needs. In some cases it may be considered a sign of neglect.

3.2.41. HV1 followed up with Housing Needs Service on the 24.5.14 enquiring about the progress of the case.

3.2.42. The mother approached the Housing Needs Service on the 12.6.14 stating that she was back living with her uncle. The homelessness caseworker sent a letter the same day asking the mother to submit the requested documents: proof of identity for herself and the child, proof of residence for the past five years and proof of income. The mother is advised in the letter that this information must be sent within seven days to avoid the closure of her case. The Housing Needs Service received no response within the timeframe.

3.2.43. At the end of July 2014, HV1 referred the case to Newham Children's Care Services citing concerns for the safety and wellbeing of Child C's sibling as neglectful. The mother had failed to bring Child C's sibling for developmental checks, outstanding primary immunisations and there was no clarity about where the family was living.

3.2.44. It should be noted that HV1 was a newly qualified health visitor, and it appeared that at this time the onus was for HV1 to seek

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[13] ELFT Did Not Attend policy guidance

[14] Munro, Eileen (2012) *Review: Children and young people's missed health care appointments: reconceptualising 'Did Not Attend' to 'Was Not Brought' - a review of the evidence for practice.* Journal of Research in Nursing, 17 (2). pp. 193-194. ISSN 1744-9871 and Lisa Arai, Terence Stephenson & Helen Roberts; **The unseen child and safeguarding: 'Did not attend' guidelines in the NHS;** Archives of Disease in Childhood, March 2015; http://adc.bmj.com/content/early/2015/03/16/archdischild-2014-307294

supervision; the danger being that if health visitors do not recognise risk, or the significance of these, then they may not seek out supervision.

3.2.45. ELFT have since implemented a mentoring programme[15] for all newly qualified health visitors and regular safeguarding supervision. See Section 3.17.

Learning Points:

- GPs should be reminded to "*Always ask patients with mental health difficulties, learning difficulties or drug and alcohol misuse whether they have significant care responsibilities. Consider their capacity to care for children safely. Record this information in medical records and emphasise it in referrals and correspondence about patients"*
- Impact of poverty and homelessness on the child (including pre-birth) should always be considered in cases where these issues are present
- Parents who are homeless are often the most vulnerable in society.
- Clear standards for assessment should be developed, or if they already exists re-affirmed with professionals
- All relevant family information should be recorded and appropriate follow-up questions asked. The importance/impact of the father's role should be acknowledged
- Barts Health should consider reviewing the Did Not Attend pathway to ensure that poor engagement and disguised and non-compliance are considered.
- Professionals should share experiences of non-compliance
- ELFT staff should be reminded of the 'Did not Attend' policy and consider reviewing and implementing a 'Was not Brought' policy
- Mentoring programme for all newly qualified health visitors and regular safeguarding supervision – Actioned

16 ELFT Mentoring Programme for newly qualified health visitors including monthly reflective safeguarding supervision.

3.3. Period 2: August 2014 – June 2015

(Please see summary time line at Appendix 2 pages 80 – 85)

Agencies involved:

- **London Borough of Newham – Children's Services**
- **Newham Housing Needs Service**
- **Newham Intensive Hospital Intervention SW Team**
- **Police**
- **London Ambulance Service**
- **Midwifery Service Newham University Hospital**
- **Emergency Department at Newham University Hospital**
- **East London Foundation Trust (ELFT) Health Visiting Service**
- **North East London Foundation Trust (NELFT) Health Visiting Service**

In December 2014, Newham Housing Needs Service placed the mother in Bed & Breakfast accommodation in Chadwell Health in the London Borough of Barking and Dagenham. The Intensive Hospital Intervention Team between 4 August 2014 and 10 February 2015 completes a second single assessment and the case closed in May 2015. The mother has a spontaneous miscarriage at 21 weeks gestation on 16 June 2015.

This period of time highlights the challenges encountered by multi-agencies when working with a mother who chooses when and where she wishes to engage with the services, and shares different information with different professionals. This means that information sharing by all the professionals becomes key to protect and safeguard children.

3.3.1. Following the referral from HV1 LBN triage identified issues of neglect and the case was reopened under the Intensive Hospital Intervention Team. It was less than three months since the case had been closed by SW1 working in the Intensive Hospital Intervention Team; SW2 was allocated to work with the family.

3.3.2. The mother's non-engagement with the ELFT health visiting service continued, she had failed to attend a total of five appointments between July – September (2014).

3.3.3. The failure of the mother to attend the appointments was again not shared with SW2 nor were enquires made with GP1.

3.3.4. HV1 did not follow ELFT policy. Consequently, SW2 thought that the mother did keep appointments with the health visiting service. The mother did attend on the 02.10.14 at the CHC for a follow up health review.

3.3.5. During the time (August 2014 to June 2015) that ELFT health visiting service was in contact with the mother and Child C's sibling none of the contacts took place in the home setting; there had been no assessment of the home environment. The family was initially assessed as meeting the need for Universal Plus[16] but this was then changed to Universal following attendance at Child Health Clinic in the local Children's Centre where the family was seen by HV2. The explanation provided for this was there was no access to the RIO[17] IT system in the clinic setting and HV2 did not check the records on her return to the health visiting base; had she done so then the family concerns would have been noted.

3.3.6. In September 2014 the mother provided Newham Housing Needs Service with the required documentation namely: the full birth certificate of Child C's sibling, the Child Benefit book and letters confirming Income Support (this was three months after the request to provide the documents within seven days).

3.3.7. On the 11.12.14 Newham Housing Needs Service provided the mother with B&B accommodation in Chadwell Heath[18]. However, this was cancelled in March 2015 after it was discovered that the mother had never stayed in the Chadwell Health B&B accommodation and told the HNS that she had been advised by SW2 to vacate the room because of a bed bug infestation.

3.3.8. Following the placement of the family into Chadwell Heath B&B accommodation, HV1 contacted the health visiting service[19] covering the new address and did a verbal handover. Unfortunately, the full health visiting records were not forwarded and the mother's records remained active on the RIO system for ELFT health visiting service, this resulted in the full history and contact pattern not being available to the new health visiting team in North East London Foundation Trust (NELFT). The remaining records pertaining to Child C's sibling were sent in error to Redbridge and it was almost three months before this was rectified and the records received by the health visiting team covering the Chadwell Heath area. There then followed a number of attempted visits to the family in their new accommodation by the health visiting team. At this time NELFT were experiencing a high number of vacancies and health visitors were moved to different areas at short notice to cover Child Health Clinics and New Birth Visits resulting in a fragmented management of

[16] Provides on-going support from the health visiting team plus a range of local services including Social Care, Children Centres, GPs and third sector organisations. For example: complex issues including domestic violence, health and social issues and safeguarding issues etc. Families allocated to this package of care will be offered up to maximum of 1 contact per month/minimum of 6 contacts annually dependent on planned interventions requirement.

[17] Electronic Care Record System
[18] The property was in the LBBD.
[19] NELFT; Barking and Dagenham

mother and Child C's sibling.

3.3.9. The single assessment by SW2 took 120 days to complete which falls well below the required standard of 45 days. During this time the assessment was impeded by the persistent failure of the mother to engage.

3.3.10. SW2, like SW1, was tenacious in providing support to address the issue of homelessness and persistently attempted to contact the mother, undertaking unannounced home visits, attempting to contact via telephone and chasing her whereabouts via the uncle and the maternal aunt.

3.3.11. Despite these attempts SW2 met with the mother and baby on only one occasion.

3.3.12. SW2 met with the mother and Child C's sibling on the 12.11.14 at her uncle's address and the SW noted, 'how the mother actively stimulates her child, his attachment and strong relationship with the mother and the uncle'. SW2 also noted that when the sibling was lifted from the car seat, the child was wet through, enough to wet her own clothes when the child sat on her lap. SW2 requested information from the health visiting team and received a response on the 5.2.15 (three months later) HV3 confirmed that Child C's sibling was up to date with developmental checks and immunisations but had presented with marks on his face and his weight had dropped by 1 centile. HV3 advised the mother to go to her GP1. There was no follow up with the GP by SW2 and these issues were not progressed as SW2 considered that they were health related issues and had been addressed by GP1.

3.3.13. The mother had provided no details of the child's father and he remained unknown, despite the opportunities to glean information outlined in (para 3.2.7) The absence of information about a family should always be considered in context and must include, both the reasons for the lack of information, and the significance of that information for the child.

3.3.14. The single assessment by SW2 concluded on 6 February 2015 that the mother presented as caring towards Child C's sibling and capable to meet a range of the child's needs. 'From the information gathered it is my view that the neglect of Child C's sibling's health needs are no longer a safeguarding concern at this stage'.

3.3.15. The mother had reported that she did not see a need for ongoing support as she loved her baby and would never expose the child to any harm. Her main concern continued to be housing and although she was in Bed & Breakfast (B&B) accommodation SW2 never visited her at this address.

3.3.16. On 5 February 2015, the day before the single assessment was completed, NCS requested police intelligence relating to the mother, the request stated that the information was required for an assessment regarding the mother and Child C's sibling This information was provided by the police and was known at the time that the case was closed by NCS see para 3.3.25.

3.3.17. On the 06.02.15 an ambulance was called to the address of the father of Child C's sibling where it was reported that a nine-month old child had a high temperature, rash on forehead, shivery and crying. Following an assessment at the house[20] the sibling was taken to NUH where the Co-op GP assessed the sibling;[21] Child C's sibling was discharged home.

3.3.18. SW2 contacted the NELFT health visiting team on the same day asking them to carry out a home visit, a home visit was attempted on the 12.02.15 which was unsuccessful, but a card was left inviting the mother to attend the clinic. The mother attended the Child Health Clinic with Child C's sibling the following day (13.02.15). This was the only face-to-face contact the health visiting service (NELFT) had with the mother and Child C's sibling, this included: three attempted telephone calls to book appointments, five effective telephone calls, two pre-arranged home visits (not kept) and two unannounced home visits that were unsuccessful. In all there was input from eight different health visitors.

3.3.19. At the end of March 2015 an offer of temporary accommodation through the private leasing scheme was made. The mother accepted the offer of a flat in the LBBD

3.3.20. In early March (2015) the mother self referred to the midwifery service as she was six weeks pregnant and was seen by the same midwife in the Acorn Team that had booked her for her previous pregnancy. Although mother presented for antenatal care at an early stage she did not attend for all appointments or turned up at the wrong time.

3.3.21. The father's name was recorded under two different surnames, this was not challenged or explored further, and it was identified that he was age 40 plus (in fact he was 51) and she was 24 years of age. Professionals should always carry out further checks when different names or aliases are given.

3.3.22. It was also recorded that the father had children with another partner and was unemployed. Risk factors were identified: mother's low weight, previous pre-term delivery before 34 weeks gestation, she did not smoke or drink (although at her first booking she stated that

[20] The father's address
[21] Primary care located within the Accident and Emergency Department to review patients that are deemed suitable tor GP management.

she did smoke) and she had a social worker due to her housing issues.

3.3.23. At this appointment the mother gave more information about the father including that he had other children; however, this information was not shared with the other agencies and another opportunity to assess the father of the children was lost This may have been because the midwife knew the mother from her last pregnancy and that SW2 had not flagged any concerns with the midwifery team.

3.3.24. On the 10.05.15 the mother took Child C's sibling to the Urgent Care Centre (UCC) with a head injury. The sibling was aged 13 months at the time. The explanation given was that the sibling had been jumping on the bed and fell and hit their head on a windowsill. At the time there was confusion about whether Child C's sibling was subject to a CPP as this was flagged on the IT system, they were in fact a Child In Need (CIN). Staff in the unit followed the correct procedure for dealing with a child on a CPP and informed SW2 by fax about the injury.

3.3.25. At this point the case was still open to Newham Children's Service but no further enquiries were made in respect of the incident by NCS.

3.3.26. While it is impossible to state categorically, it would be unusual for a child of 13 months of age to have the ability to jump up and down on a bed without any support and further exploration of the history should have been undertaken to ascertain his/her gross motor skills and the context of the injury in order to exclude non-accidental injury.

3.3.27. On the 13.05.15 the manager in the Intensive Hospital Intervention Team made the decision to close the case on the basis that the original concern was about the mother not seeking health input for the child and the housing issues and it was recorded that both had been resolved. It is unclear whether the fax sent from Urgent Care was seen by SW2 or the manager as there was no reference to it within the IMR for NSC. It is impossible to determine what happened to this fax though it is clear that SW2 was not aware of the head injury. This meant that an opportunity to follow this up was lost.

3.3.28. At the time of concluding the assessment work SW2 was asked by the authorising manager to establish the mother's address and send a referral to the relevant Local Authority. This action did not happen meaning that information/assessment was not made available to LBBD.

3.3.29. On the 02.06.15 an ambulance was called, again to the father of Child C's siblings address in the London Borough of Newham, where it was reported that the mother had given birth to a premature baby. It was reported that on arrival a hostile man holding a child approximately one year of age met the ambulance crew.

3.3.30. The London Ambulance Service (LAS) has in place a safeguarding adults and children policy and practice guidance which are reproduced on its intranet and website[22]. LAS report that staff come across hostile situations and people regularly, this is sometimes due to the delay in an ambulance attending and sometimes due to the nature of the call and that the people on the scene are upset and distressed. On this occasion following their assessments and attendance it was deemed that a safeguarding referral was not needed.

3.3.31. The baby/fetus was taken to the Emergency Department (ED at NUH); the baby died and a death certificate was issued[23]. A midwife on the assessment unit spoke to the father on the phone to keep him informed but it is unclear if they had been given his contact details or spoke to him using the mother's mobile phone.

3.3.32. The father was clearly more involved than the mother was disclosing to professionals.

3.3.33. This was the second time that the ambulance had attended the father's address in the London Borough of Newham yet the mother continued to deny that she knew where he lived or that they were in a relationship.

3.3.34. There were many different discussions about whether the infant who went to the ED was a neonatal death or a late miscarriage before the viable 24 weeks of pregnancy. Irrespective of whether it was classified as a death or miscarriage the process for allowing mother to spend time with the baby and having mementoes was the same. The mother was referred to the bereavement midwife and was seen for a follow up appointment on 03.08.15. The Acorn team was notified. The care received by the mother at this time was of a good standard.

3.3.35. The mother wanted to arrange for the baby to be buried, however, the Registrar Office at NUH had difficulty making contact with the mother. When contact was made the mother had failed to register the birth and said that she was not in a financial position to pay for the burial. On the 14.10.15 the mother was offered a hospital funeral, the mother turned this down stating she would be unable to attend but still wanted to arrange her own funeral for the baby.

3.3.36. Over the next few months numerous attempts were made by the Deputy Superintendent Registrar to contact the mother including phone calls, leaving messages on the voicemail and by letter. It is unclear as to whether the mother did make contact however the baby

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[22] http://www.londonambulance.nhs.uk/health_professionals/safeguarding-child_protection.aspx.

[23] Death certificate of a live-born child dying within the first 28 days of life, death was due to extreme prematurity.

was buried at the end of March 2016 in the City of London Cemetery.

Learning Points:

- The absence of information should always be considered in context and must include, both the reasons for the lack of information, and the significance of that information for the child.
- If there is concern about an injury of a child attending UCC/ A&E Departments the referral must be followed up to ensure that it has been received.
- Professionals do not always identify chaotic lifestyle and frequent changes of address as potential child protection issues. Any neglect strategy or guidance should reference these features
- Mobility and lack of parental cooperation are common factors and need to be recognised as a risk factor that should heighten concern.
- Professionals to be reminded that when different names or aliases appear to be used then further checks with agencies working with the family should be undertaken.
- The admitting address is not routinely recorded only the discharge address

3.4. Period 3: July 2015 – July 2016.

(Please see summary time line at Appendix 2 pages 85 – 91)

Agencies involved:

- **London Borough of Newham Children's Services**
- **Newham Housing Needs Service**
- **London Borough of Barking and Dagenham Children's Services**
- **London Ambulance Service**
- **Midwifery Services**
- **Neonatal Unit, Newham Hospital**
- **North East London Foundation Trust (NELFT) Health Visiting Service**

Mother is pregnant with Child C, she moves into a tenancy

provided by Newham Housing Needs Service in July 2015 in the London Borough of Barking and Dagenham. She abandoned this accommodation and the homelessness duty was discharged in April 2016. Child C is born prematurely at home and admitted to Newham University Hospital Neonatal Unit where she resides for 65 days.

This period highlights escalating concerns about the mother's engagement and her attendance on the Neonatal Unit to visit and care for Child C. Despite the concerns, Child C is discharged into the care of her mother without a period of 'rooming in' on the unit. It would appear that 'professional optimism' wins out despite the family having no fixed abode and the mother's poor history of parenting and engagement with relevant agencies to date.

3.4.1. The mother was pregnant and again self referred to the midwife on the Acorn Team in February 2016. The information the mother gave at the booking clinic with regard to the number of miscarriages differed and that she had never smoked. The mother was screened using the Whooley Questions[24] and did not disclose that she had been suffering, or had suffered with mental health concerns. The mother was now living in temporary accommodation (in LBBD) with Child C's sibling.

3.4.2. The father's name was recorded by the Acorn Team and matched the first name given at their last booking appointment in March 2015; no further enquiry was made. On this occasion, the mother did not meet the criteria for the Acorn Team as she no longer had a social worker and she was living in temporary accommodation; the plan was for shared consultant care. The mother's attendance for routine ultrasound scans and antenatal appointments was varied; she attended three scans and then failed to attend two. This pattern was repeated with the midwives clinic where she failed to attend three but not consecutively. It would appear that she was doing 'just enough' to keep the professionals at bay. The midwives managed her attendance using the Did Not Attend Pathway.

3.4.3. Evidence suggests that women who have had a premature birth are more likely to have a premature birth in subsequent pregnancies. Other risk factors include: being under weight (which may indicate poor nutrition), low income and poor housing. At the booking appointment for pregnancy, women are routinely asked about drug use; the staff did not feel that there was any evidence to suggest that the mother did use drugs, and she consistently denied using substances when asked as part of the booking process.

3.4.4. The Housing Needs Service liaised with the managing agent reference the temporary accommodation as they have a duty to visit

[24] NICE guidelines (CG192), 2014

clients once every quarter; it is now clear that they had never found the mother in on any of the visits carried out. The managing agent visited the property on 17.03.16 and a neighbour informed the managing agent that no one stayed at the property. The managing agent entered the property and noticed that there were no signs that anyone lived there; no proper furniture or food was in evidence. The managing agent notified Housing Needs Service the tenancy was cancelled and the mother was reported to have abandoned the property. Following the cancellation, the homelessness duty was considered discharged[25] in April 2016.

3.4.5. It was not known where the mother and Child C's sibling were living at this time. The information was not shared with LBN Children's Social Care, at this time the case was closed to NSC and the Housing Needs Service were unaware of any concerns regarding the family. Newham Housing appears to have worked on the assumption that the person has gone back to family, or found alternative accommodation.[26]

3.4.6. Although LB Newham had determined that the family did not meet the threshold for statutory intervention it could be argued that the mother and Child C's sibling were vulnerable given that housing had been and was now an ongoing risk. Key learning from this is that consideration should be given to implementing an information sharing agreement between Housing and CSC when tenancies are cancelled and there are young children in the household.

3.4.7. Child C was born prematurely at 28 weeks and 5 days[27] in early June at the address of the father of Child C's sibling (in the LB of Newham); this was the third time the mother had delivered at this address

3.4.8. This was the fifth time an ambulance had attended this address however they were spread over a period of more than one year. The London Ambulance Service does not flag addresses for 'Frequent Callers' this would only be done if there has been abuse/assault against attending members of ambulance staff and if LAS have been notified by CSC that an unborn child is at risk. At this time there was no flag against this address.

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[25] The council had accepted the mother's homelessness application and had provided suitable accommodation.

[26] The Homelessness Code of Guidance states: -

FAMILIES WITH CHILDREN UNDER 18

11.29. It is important that social services are alerted as quickly as possible to cases where the applicant has children under 18 and the housing authority considers the applicant may be homeless, or threatened with homelessness, intentionally. Section 213A(2) therefore requires housing authorities to have arrangements in place to ensure that all such applicants are invited to agree to the housing authority notifying the social services authority of the essential facts of their case. The arrangements must also provide that, where consent is given, the social services authority are made aware of the essential facts and, in due course, of the subsequent decision on the homelessness case.

[27] The earlier a baby is born the higher the risk is of health problems.

3.4.9. The mother and baby were taken to NUH and the baby was admitted on to the Newham Hospital Neonatal Unit; initially the baby required ventilation to assist with her breathing.

3.4.10. The mother refused to stay in hospital and took her own discharge the same day; this was against medical advice. The plan was for her to go and stay with the father of the children for a few days. The address was recorded at discharge was in fact a different flat number, she gave the number as 12 rather than 16. It is not known whether this was a transcribing error or a deliberate act by the mother to give false information. As a consequence of this error, the midwives had difficulty finding anyone at the property when they subsequently attempted a postnatal home visit.

3.4.11 The midwives also reported that it was difficult to make contact with the mother via the mobile phone number that she had provided them with. The midwives managed to make contact by phone on the third attempt and an appointment was made for the postnatal clinic,[28] which the mother kept, and the subsequent follow-on appointment. There then followed a period of non-engagement by the mother with the midwifery service.

3.4.12 The baby resided on the Newham Hospital Unit for a total of 65 days; the mother visited her on 18 occasions. The safeguarding advisor instructed the staff on the Neonatal Unit to keep a visiting record as the mother had not visited Child C from the 2-6th June and had made no telephone contact. The staff on the Neonatal Unit on the 21.6.16 made a referral to NCS as the staff were concerned about limited visiting by the mother, requesting food when on the unit and difficulty in making contact by phone.

3.4.13 The staff were advised that the referral needed to be sent to the LBBD, as this was where it was reported that the mother lived. A Multi-Agency Referral Form (MARF) was completed and sent on 27.06.16; the referral stated poor visiting, difficulty in contacting the mother by phone, unable to engage with her to offer support, and that the mother requested food when she came on to the unit, she appeared to have financial difficulties and general lack of preparation for the baby; a copy was also shared with the health visiting team in NELFT.

3.4.14 The referral was received at LDBD Multi Agency Safeguarding Hub (MASH) on the 29.06.16 and the case was considered the next day; it was recommended to be progressed to assessment, the reasoning for this was: concern about the neglect of baby, mother's lack of concern for her child, Child C's sibling's missed health and developmental appointments, the need to consider her parenting capacity and a query about mother's mental health. MASH spoke with the mother who

[28] Postnatal clinics have been in operation since 2011, all women receive an initial home visit post discharge from hospital and then future postnatal care is arranged in collaboration with the women.

informed them that she was staying with her sister (the maternal aunt) in Bow and would move back to her address in LBBD when Child C was discharged (it is now known that she no longer had this property, but professionals were unaware at the time). The mother also said that Child C's father was not involved, although she had discharged herself from hospital to the father's address; she was described as being very defensive. In fact the mother was lying to professionals about her personal circumstances.

3.4.15. Background reports, referrals and the single assessments from Newham Children's Services were downloaded from the case record system in Newham on 22 July 2016. There is no record to indicate that these records had been shared before or at the point of the case closure by NCS in May 2015 see para 3.3.28.

3.4.16. Staff on the Neonatal Unit facilitated a telephone conversation with HV3 and the mother, who agreed to attend the CHC the next day but she failed to keep this appointment.

3.4.17 Prematurity and giving birth at home with no medical assistance have been discussed in the SCR biennial reviews[29] *the impact that the needs of extra demanding pre-term baby places on parents, often compounded by the time spent apart from the new baby who is in the Neonatal Unit.*

Learning Points:

- The importance of triangulating information with other professionals and not only accepting the information given by parents must be considered where there are other parenting engagement concerns.

- The importance of checking addresses at point of discharge particularly when leaving against medical advice.

THE LONDON BOROUGH OF BARKING AND DAGENHAM COMMENCE WORK WITH THE FAMILY

3.4.18. The case was allocated to SW3 (working for the LBBD) by the Team Manager in the Assessment Service and sets out an interim safety plan with clear tasks and a timeframe. This included seeing the children, establishing the role and whereabouts of the father, setting up a discharge planning meeting as appropriate and completing the single assessment by the 04.08.16.

[29] Brandon et al, 2009:55

3.4.19. SW3 visited Child C the Newham Hospital Neonatal Unit and spoke with staff to find out more about the mother's visiting pattern and to ascertain from the staff on the unit what would be the normal pattern of visiting by parents. The exact number of times that the mother had visited Child C on the Neonatal Unit was not provided at the time. SW3 also asked staff at what point would the possible abandonment of Child C be reached.[30] The staff were unable to give any clarification at this point.

3.4.20. It is worth noting that following the allocation of the case all the work undertaken by SW3 took place out of the LBBD area, in Tower Hamlets, Newham and Essex.

3.4.21. On the 12.07.16 the mother failed to attend the Newham Hospital Neonatal Unit for a specific appointment; the mother needed to give consent for a blood transfusion for Child C and supply a blood sample.[31] SW3 and the Children's Safeguarding Advisor were present on the ward so that they could talk with the mother; she failed to arrive at the appointed time and eventually turned up nearly three hours late by which time they were no longer present on the unit.

3.4.22. SW3 contacted the mother by phone and arranged to meet with the mother the following day. SW3 heard a child crying in the background, the mother told her it was Child C's sibling and asked her not to interfere. She challenged the mother about how difficult it was to contact her and that this was not helped with frequent changes of her mobile number (this was now her third number) the mother told SW3 that she should appreciate that she had answered the phone. SW3 asked the mother where she was currently living, she responded that she was living in Manor Park but refused to give an address but said that she also stayed with her uncle. SW3 told the mother that she was concerned about the following issues: infrequent visits to Child C, living at different addresses in different boroughs, providing two different surnames for Child C's father, and that professionals had not seen Child C's sibling; the mother was reported to be defensive and agreed to meet the next day. This was a good conversation that SW3 had with the mother and identified the concerns that she had about the mother's lifestyle and her sharing different information with professionals.

3.4.23. SW3 (LBBD) did meet with the mother the next day and stated that the information gathered would be recorded as part of the single assessment that she was undertaking. The mother had brought Child C's sibling with her and it was agreed that SW3 would carry out a home visit at the mother's address in LBBD. The mother agreed to

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[30] **Child abandonment** occurs when a parent, guardian, or person in charge of a **child** either deserts a **child** without any regard for the **child's** physical health, safety or welfare and with the intention of wholly **abandoning** the **child**, or in some instances, fails to provide necessary care for a **child** living under their roof.

[31] Babies born prematurely may have a low level of red blood cells causing anaemia.

this, even though she was no longer in this property, and failed to inform the social worker; this resulted in a wasted visit by SW3 to the property although SW3 was then able to confirm that the mother had vacated the property some 11 weeks ago because it was being cleaned and cleared of rubbish. This was a clear example of the mother giving false information and continuing to insist that this was the address that she was living at. SW3 attempted to phone the mother but there was no reply.

3.4.24. At this point SW3 had clarified that the mother did not reside at this Barking and Dagenham address however it was still not known where the mother and Child C's sibling were living. During supervision of the case with the Team Manager (TM) it was agreed that the LBBD should continue to work with the family, as there was still no clear understanding of exactly where the mother and her children were living.

3.4.25. The LCPP[32] state that *in order to provide mobile families with responsive, consistent, high quality services, London local authorities and agencies must develop and support a culture of joint responsibility and provision for all London children (rather than a culture of 'borough services for borough children')*

3.4.26. The Named Nurse for Safeguarding at NUH requested a Strategy meeting outlining the ongoing concerns re the mother's minimal visits to see Child C; the visits were short, lack of provision of clothes and nappies, and multiple addresses and contact details. This is quickly followed by a request for a professional meeting; SW3 responded that she would update the staff following her assessment.

3.4.27 Child C was fit for discharge on the 19.07.16 and the Named Nurse for Safeguarding (NUH) contacted SW3 by email in order to plan a discharge meeting. The mother and Child C's sibling visited Child C; the mother had again forgotten to bring in any clothes for Child C. It was noted that Child C's sibling looked well and exhibited no apparent stranger danger awareness,[33] and would go off with any member of staff (Child C's sibling was just over two years old at this time). SW3 raised this concern with mother and that Child C's sibling was walking on 'tip-toes' and there was possible language delay; the mother dismissed the concerns and threatened SW3 that she would 'never take my children away'.

3.4.28. Supervision took place between the TM and SW3, the safety plan was reviewed; it was agreed that Child C should not be discharged from hospital until the situation about accommodation was clear and deemed safe. The mother had also failed to disclose details about the father of the children and no further information was known. It

[32] Chapter 6.1.2.

[33]Stranger danger is the danger presented to children and adults by strangers. The phrase stranger danger is intended to sum up the danger associated with adults whom adults or children do not know.

was also agreed that if the mother's pattern of behaviour continued then the case would be escalated through Child Protection Procedures. This was good practice with a clear instruction to escalate and recognition that the risks for the children were increasing.

3.4.29. The Team Manager had a telephone discussion with the police and it was agreed that the case did meet the threshold and a Section 47[34] enquiry was commenced. The London Child Protection Procedures were not complied with. Specifically:

"*The strategy meeting / discussion must involve LA children's social care, the police and relevant health professionals."*

3.4.30. The Strategy meeting / discussion should have taken place on the Newham Hospital Neonatal Unit given that Child C was still on the unit and it would allow the maximum number of hospital clinical staff to attend and make valid contributions. Given that staff on the Neonatal Unit made the referral it is difficult to justify why this did not happen and was a serious omission.

3.4.31. Discussion at the SCR panel meeting on the 28 June 2017 highlighted that East London Boroughs have adopted an approach of using an initial telephone call between CSC and police only as an initial response to Section 47 enquiries. Following this there may be a decision to call a S47 Strategy meeting/ discussion. However, there is a risk in this approach in that it can lead to an absence of multi-agency involvement in the investigation and assessment of the family.[35]The need for this is explicit in the pan London Child Protection Procedures. LBBD now use a telephone conferencing process (implemented in September 2016) so that all agencies are now routinely invited to and able to engage in strategy meetings / discussions.

3.4.32. The mother was still refusing to tell the hospital staff where she was living and accused them of lying about how frequently she had been visiting Child C. SW3 informed the mother verbally about the Initial Child Protection Case Conference (ICPCC) and also sent an invitation to the address in Tower Hamlets (maternal aunt's home) where she was supposed to be staying after the baby was discharged from hospital. SW3 also arranged to see the mother at the maternal aunts flat the next day.

3.4.33. SW3 visited the property and met with the maternal aunt, the mother failed to attend, as she could not 'drag Child C's sibling out of bed so

[34] A Section 47 enquiry means that CSC must carry out an investigation when they have 'reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm'1. The enquiry will involve an assessment of the child's needs and the ability of those caring for the child to meet them. The aim is to decide whether any action should be taken to safeguard the child.

[35] London Child Protection Procedures (2016) Chapter.3.4.11.

early in the morning', the mother refused to say where she was staying. SW3 advised maternal aunt about the concerns, she stated that she did not know where the mother was currently staying but would accompany her to the ICPCC and give her support. SW3 then phoned the mother and arranged for her to attend CSC offices the next day. The meeting was scheduled for 1.30pm, the mother eventually turned up at 4.30, three hours late and was dismissive about the concerns that SW3 had, namely: how difficult it was to contact the mother, that she refused to say where she was living and would not give any details about the father of the children. The maternal aunt accompanied the mother for this appointment.

3.4.34. A discharge-planning meeting was held on 2 August 2016 at NUH, Child C was medically fit to go home. This followed an intense period of communication between the Named Nurse for Safeguarding, staff on the Neonatal Unit and SW3. The mother attended the meeting, but the maternal aunt was unable to attend. The discharge planning meeting should have been chaired by the team manager in line with procedures. This was the first planning meeting and was crucial in setting up the Child in Need plan ahead of the ICPCC.

3.4.35. A discharge plan was put in place and the mother was told that she had to stay with the maternal aunt (in Tower Hamlets) at this address and register with a local GP. SW3 and the new health visitor covering the address in Bow were to visit weekly. The mother had been given plenty of time to register with a GP but failed to do so. Prior to discharge the baby's milk was changed from prescription milk to regular formula milk, this was because the mother still had not registered with a GP and therefore there was no ability for a prescription to be written and the milk dispensed. The Consultant Paediatrician was of the opinion that Child C's milk could safely be changed to regular formula milk.

3.4.36. The actions of the discharge planning meeting were recorded in the CSC case records however, there is no evidence that these were distributed to the professionals that attended the meeting or sent apologies. This was a significant omission. The actions of this meeting could have been framed and given the status of the safety plan due to the level of concern that had unfolded during Child C's hospital stay. This is made even more critical given that the mother was going to be living at an address in yet another authority

3.4.37. The use of a template for CIN plan: plans for children in need upon discharge from hospital should be recorded using the Child in Need plan template, distributed to the relevant professionals, and parent/s and recorded accordingly whilst also being chaired by a Team Manager is an action already taken by the LBBD.

Learning Points:

- Strategy / discussion meetings must follow the LCPP requirements and be based on multiagency engagement.

- Minutes of discharge planning meetings are critical and **must** be shared in a timely manner with all professionals involved in the care of the baby/ child being discharged from a hospital setting.

3.5. Period 4: 5th August – 22nd August 2016

(Please see summary time line at Appendix 2 pages 91 – 92)

Agencies involved:

- **London Borough Of Barking and Dagenham Children's Social Care**
- **London Borough of Barking and Dagenham Legal Team**
- **Neonatal Staff NUH**
- **Metropolitan Police**
- **North East London Foundation Trust (NELFT) Health Visiting Service**

Child C is discharged from Newham University Hospital Neonatal Unit to an address in the London Borough of Tower Hamlets, the third London borough. This was the address of the maternal aunt. An Initial Child Protection Case Conference is held and Child C and her sibling are made subject to a Child Protection Plan under the category of neglect. A Threshold of Care and Legal Planning Meeting is held two days later due to mother's expression of non-compliance.

This period of time highlights the challenges encountered by multi-agencies when working with mobile and avoidant families when trying to protect vulnerable children.

3.5.1. Child C was discharged into the care of the mother on Friday 5th August at about 6pm. Child C received the first dose of the primary immunisations after consent was obtained from the mother. The staff had initially suggested that Child C stay on the Neonatal Unit for 24 hours post immunisation but the mother was frustrated by the this and had made arrangements for a taxi to collect them. The Consultant Paediatrician was happy for Child C to leave the unit. Primary immunisations are given in the community to premature babies and are not observed for a period of 24 hours. Routine advice was given to watch for signs of a fever and to give paracetamol if required.

3.5.2. There is a discrepancy about the actual date of Child C's discharge from the Neonatal Unit; LBBD had the date of discharge as the 06.08.16 but Barts Health had it recorded as 05.08.16. This discrepancy about the discharge date is of some concern and that the discharge was over a weekend. It was planned that SW3 would visit at the maternal aunts flat on the Monday 08.08.16 where the family had agreed to stay post discharge.

3.5.3. Prior to Child C being discharged from the Neonatal Unit, it would have been beneficial for the mother to have been invited to stay on the unit overnight, 'Rooming In', thereby allowing staff to observe how the mother cared for Child C in a supported environment, i.e., whether there were signs that the mother was developing an attachment with the baby and so would be able to meet the needs of a premature baby with whom she had spent very little time. This was an omission and fell below expected practice.

3.5.4. At the point of discharge Child C was reported to be thriving and growing well but there was very little written documentation about Child C's daily routine, including whether she was an easy or difficult baby to feed, if she was difficult to settle or whether she was happy and contented or cried excessively, and how frequently she was feeding over a 24 hour period. Child C's weight was recorded as being just under the 25th centile[36] Child C's head circumference is recorded as 33.6cms but there was no record of her length. These growth measurements are an important baseline for professionals so that subsequent measurements can be recorded and plotted on the centile chart. The relationship of all these measurements will identify the need for further monitoring or investigations by professionals involved in her care.

3.5.5. On the 8.08.16 (the first working day following discharge) SW3 made a planned home visit to the Tower Hamlet address where the mother and her two children should have been living, they were not at home but the maternal aunt was and SW3 was invited into the flat. SW3 contacted the mother by phone, she stated that she was out buying milk and would be back in five minutes. SW3 observed that there was no change to the flat from SW3's previous visit. There was no evidence that the family were living at this address. SW3 waited for 45 minutes; the mother turned up as she was leaving and had a deep cut above her right eye. When questioned by SW3 the mother attributed the injury to a blackout stating that she had a history of suffering from blackouts but refused to allow SW3 to contact her GP1 for further information. The mother had reportedly been referred to the Neurology Team by GP1 to investigate the cause of her reported blackouts. However, it is unclear whether a referral was made, or the mother chose to give this information to deflect further questioning

[36] UK WHO growth charts 2016

from the professionals. The mother's GP medical records have not been available for this SCR despite numerous attempts to locate them. GP1 retired and the patients registered with the practice were allocated to other local practices.

3.5.6. The arrangements in the discharge plan quickly became problematic; the mother and children were not at the maternal aunt's address or with the uncle. The uncle reported to SW3 when she attempted a home visit that he had not seen the mother for 18-24 months (this was new information and possibly not accurate) and was also reported to say that the mother had undefined mental health issues.

3.5.7. Shortly after this visit the mother contacted SW3 by phone; the mother was aggressive and difficult and swore at SW3; the mother stated that SW3 had no right to go to see her uncle without her permission. It is now known that the uncle contacted the maternal aunt who contacted the mother immediately after SW3 left, to tell her that she had visited; this indicates that there was some level of communication between members of the wider family about professionals' visits.

3.5.8. SW3 pursued the line of enquiry as directed by the team leader to establish the whereabouts and role of the father. SW3 contacted the community midwifery team and obtained the discharge address that the mother had given the hospital on 2 June 2016 when she took her own discharge, reportedly to the father's address in Newham. SW3 made a home visit to this address but there was no response (we now know that this was the wrong flat number) The mother continued to state that she was staying at the address in Tower Hamlets with the maternal aunt to SW3. The invitation to the ICPCC was sent to this address, as this was where the mother was supposed to be staying.

3.5.9. The ICPCC was held on the 15.08.16 the mother, Child C and maternal aunt were in attendance. It was clear that the discharge plan was not working; neither Child C nor her sibling had been seen in the past ten days, by any professional, since discharge from the hospital. The Police were present at the ICPC, information was requested regarding the mother and maternal aunt. The mother who attended the conference refused to give any information about the father except his name. This made it difficult for the Police, or other agencies, to undertake checks. Further work was remitted to the social worker as part of the interim safety plan (see para 3.4.18).

3.5.10. Child C attended with her mother; a friend was reportedly looking after Child C's sibling. (The conference had to be stopped as Child C was hungry and the mother did not have any milk with her, a ready-made feed was obtained).

3.5.11. Child C and her sibling were made the subjects of a Child Protection

Plan (CPP) under the category of neglect. During the conference the mother made her unwillingness to comply with the plans very clear; she presented as resistant and antagonistic and stated that she would not comply. This was very concerning and the Chair of the conference recommended that in light of this, that SW3 and the TM review the situation within 24 hours and escalate as appropriate.

3.5.12. The London Borough of Barking and Dagenham should have shared that the children were made subject to a CPP under the category of neglect, with the two London Boroughs where it was known the mother had connections and possibly lived; namely Newham and Tower Hamlet. This was an oversight but the responsibility for the CPP remained with LBBD irrespective of where they were living at this point.

3.5.13. The Team Manager decided to convene the Threshold of Care and Legal Planning Meeting (TCLPM) following the recommendation made by the Chair of the ICPCC. This was a direct response to the escalating risks and the increased concern about how to safeguard the children.

3.5.14. The TCLPM remit is to decide based on a robust analysis of the level of assessed risk whether:

- it is in the best interests of the child to provide a further period of support for the family with the aim of avoiding proceedings;

  or

- Whether proceedings should be initiated immediately.

Child C and her sibling were referred for discussion at the Threshold of Care and Legal Planning Meeting (TCLPM) on 17th August; two days after the ICPCC, this was timely and resulted in approval for care proceedings to be issued.

3.5.15. A proposed Public Law Outline (PLO) plan identified a number of further assessments to be undertaken; including a psychological assessment and a drug test, this is the first time that drug use has been considered as a possibility, apart from the routine enquiry during her pregnancies, which she answered no to. The safeguarding plan also made it clear that the mother, Child C and her sibling must live at the maternal aunt's address in Tower Hamlets until all proposed assessments are complete, that the social worker and health visitor will visit on a fortnightly basis to assess the development and progress of the children and that the mother signs the safeguarding agreement.

3.5.16. The father of the children was named in the minutes (although the

first name is different) and the mother reported that he had Parental Responsibility[37] although SW3 stated that the mother had refused to give the father's details to professionals. SW3 had asked the mother to provide a copy of the children's birth certificates in order to see if the father is named, the mother did not provide them at this point in time.

3.5.17. The following day (18.08.16) the maternal grandmother contacted SW3 to say that she would be able to care and support the family. The involvement of the family came at a critical point when a decision had been made to instigate care proceedings and was accepted by the Team Manager and agreed by the Group Manager (a recording is made in the case files by the TM) as providing an appropriate alternative arrangement and was seen as being a positive source of support, which should be tried out.

3.5.18. As a result of this development the maternal grandmother and maternal aunt met with SW3 and the TM on the 19.08.16. At this point the mother was not with them. They left the offices and returned with mother. The maternal grandmother had put herself forward to offer accommodation and practical and emotional support, as she stated that she did not want to see her grandchildren go into care. The maternal grandmother proposed that the mother and her two children move to Essex and stay with her in her two bed roomed flat. It was made clear at this meeting that the maternal grandmother must contact SW3 and the Police if the mother left Essex at any time.

3.5.19. The TM made a case recording as management oversight about the maternal grandmother putting herself forward to offer accommodation, practical and emotional support plus monitoring. Following the initiation of safeguarding checks, the Group Manager agreed the plan for the family to move to Essex. The Group Manger reiterated in an email to SW3 that there must be a strong commitment by the mother to adhere to the CPPs and that they must remain in Essex.

3.5.20. However, given the fact that the maternal grandmother had herself been a victim of domestic abuse and that the mother had grown up in this household further questioning about whether the maternal grandmother was capable of supporting and managing the situation and working with SW3 could have been considered in more depth. It was reported by SW3 during an interview that the maternal grandmother presented as a plausible individual who understood the context of the situation and said she would be able to manage the mother and offer support to the family. It was also noted that the maternal grandmother had removed herself and her children from the perpetrator and was currently living in Essex with her youngest child (see para 3.11.5). It could not have been known at the time that this

[37] Jointly registering the birth of the child with the mother, getting a parental responsibility agreement with the mother or getting a responsibility order from a court, in the case of unmarried parents.

decision was made that the maternal grandmother would fail to inform SW3 when the mother left Essex with her two children.

3.5.21. A risk assessment of the maternal grandmother and maternal aunt was completed, and the view taken that the maternal grandmother was able to emotionally support the mother and her two children. This was a temporary arrangement and further assessments would be undertaken at a later stage. An assessment should include both the capacity and ability of the person who has put themselves forward as well as considering the potential interaction and sustainability of the relationship they already have with the birth parent (the mother); in this case daughter and sister (the maternal aunt).

Learning Points:

- Careful consideration should be given for parents with poor visiting patterns to complete a Rooming-In to allow an assessment of the ability of the parents to care for a premature baby and observe the development of bonding.

- Staff need to be reminded about the importance of recording vital measurements and developmental milestones, feeding regimes and management of babies leaving the neonatal unit in order to have a baseline to assess growth and development

- When children are subject to a CPP in one borough but known to be mobile this information **must** be shared with other boroughs or local authorities where they have previously lived/ or should currently be living.

- An ICPCC is an invaluable forum for the sharing of information especially regarding other relatives, associations or absent fathers.

3.6. Period 5: 22nd August – time of incident resulting in the death of Child C.

(Please see summary time line at Appendix 2 pages 92– 94)

Agencies involved:

- **LBBD Children's Services**
- **LBBD Legal Department**
- **Metropolitan Police**

- **Essex Children's Services**
- **Essex Housing Department**
- **An Essex Clinical Commissioning Group**
- **A local Provider Health Service in Essex**
- **London Ambulance Service**

Following the approach by the maternal aunt and grandmother to the London Borough of Barking and Dagenham Children's Social Care, the mother and her two children move to Essex to live with the grandmother.

This period highlights the challenges to safeguarding systems when family members are not transparent with the agencies involved and fail to adhere to the safeguarding plan in place; resulting in an escalation of risks to vulnerable children.

3.6.1. SW3 instigated safeguarding checks with the Police regarding the maternal grandmother and the accommodation in Essex was then checked for suitability. The maternal grandmother lived in a two bed roomed flat with her youngest 16 year old son, he was happy about his sister and her two children coming to stay. Child C's sibling was going to sleep in his room, as there were bunk beds. It was reported that the maternal grandmother worked nights but would be around during the day to offer practical and emotional support and monitor the mother with her children.

3.6.2. The family moved to Essex by taxi on 22.08.16, they were collected from a street in the Manor Park area; it was reported that the taxi driver had to wait for almost two hours, as the mother was not ready when he arrived. We now know that in fact the address that was shared with the taxi firm was the wrong address and that the mother was possibly collected from the street.

3.6.3. SW3 notified Essex Children's Services on 23 August 2016 that the children were the subject of Child Protection Plans and were now resident in their area.[38]

3.6.4. The case was reviewed by the TCLPM (24.08.16), the decision was not to continue with care proceedings and directed that the CPP continue and that a safeguarding plan be put in place in which the mother, Child C and her sibling lived at the maternal grandmother's address and that the social worker must be informed if she moved out with the children. They also considered whether this plan could be held safely as it would be at least 4-6 weeks before Essex Children's Social Care would be able to review the case, as the accommodation was temporary. It is unclear how this was communicated to the family apart from an email by the Group Manager to the TM and SW3 reiterating the fact that the mother and

[38] Chapter 6:London Child Protection

children must remain living in Essex at all times.

3.6.5. The mother registered herself, Child C and Child C's sibling with a local GP3; mother gave her last address as the flat in LBBD, despite the fact that she had never lived at the address; the mother continued to lie about her personal circumstances. The registration form specifically asked whether any other services were involved with the family or young person e.g. Social Care or Child and Adolescent Mental Health Services (CAHMS). The mother circled Yes on Child C's form for Social Care but no further details were provided or requested by the practice staff. The mother did not note any social care involvement with Child C's sibling.

3.6.6. The current patient registration form used by this practice did not specifically contain a tick box to ascertain if the children are subject to CPPs, or if they were Looked After Children (LAC). Currently there are no standard forms widely used in Primary Care when new patients register that asks specifically whether there is active social care involvement, including if children are subject to a CPP. At the point of patient registration the practice is relying on the parents sharing the information, as there may be some delay in previous records and notes being available. When families have a history of mobility and avoidance the potential for selective information to be given is increased.

3.6.7. On the 1 September 2016 a letter was sent by SW3 to the GP3 surgery that stated that the children were subject to a plan under the category of neglect at LBBD and requested that the GP surgery provide detailed information about all contacts made with the mother and children and to provide this within the next 72 hours due to significant concerns that the LBBD had regarding the children. A response was sent back to SW3, on the 5 September stating that the family were registered with the practice and had contacted the mother regarding outstanding immunisations for the children. At this point neither children had been seen by the GP in Essex nor had they attended the local Accident and Emergency Department.

3.6.8. However, the original letter was not embedded within the health records of the children or mother. The IMR author for the GP3 Practice was unable to ascertain why this was the case and surmised that the failure to scan the letter in to the notes was as a result of human error. This particular practice has different sites, all letters/ faxes and correspondence go to the main site to be scanned and then tasked to individual GP's to read and action.

3.6.9. Action has already been taken by the GP practice to mitigate against this happening and amended the Standard Operating Procedure (SOP). However, the consequence of this omission was that there was no safeguarding alert placed on the EMIS IT system alerting all professionals, within the GP practice, with access to the system that

the children were subject to a CPP under the category of neglect. Whilst practice staff were unaware of the child protection plan, the staff working within the surgery did not have any concerns regarding the care or presentation of the children; presentations were positive and the children received their outstanding immunisations.

3.6.10. The mother had been previously registered with this practice (in Essex) until 2010 when she returned to London. It would also appear that Child C's sibling was registered here in 2014 prior to the alleged move into the temporary accommodation in LBBD.

3.6.11. Previous GP records for the family were unavailable[39] from GP1 in Newham see para 3.5.5. This would suggest that Child C was never registered with a GP whilst living in Tower Hamlets at the maternal aunt's address. Despite numerous efforts to locate the records for both the mother and Child C's sibling, they have not been located; this has resulted in a gap of information that the mother may have shared with her GP1 in Newham. As a consequence of this potential key information/ learning has been lost.

3.6.12. On the 24.08.16 a transfer in telephone call was made by the health visitor (HV3) in NELFT to the duty health visitor in a local provider health service in Essex. This duty health visitor allocated the case the same day and the assigned health visitor (HV4) made contact with the mother and booked a planned home visit on the 01.09.16. The movement-in visit was required to be completed within 10 working days.[40]

3.6.13. Although health records were sent to the local community provider a copy of the CPP was not included. The minutes of the ICPCC were circulated to all professionals on the 19 September 2016, 22 workings days later. The standard is 20 working days but the period did cover a bank holiday. However, information about the family and that the children were subject to Child Protection Plan in LBBD under the category of neglect was passed on verbally to the safeguarding network in Essex. In order for health visitors to undertake a robust assessment and understand the context of the family and the rationale for the children being subject to a CPP under the category of neglect, all available information and past records should be read. If all of this information was not available to HV4 then there is an expectation that contact would be made with SW3 in LBBD to discuss the case and ask for a copy of the CPP to be sent immediately via a secure email address.[41] This did not occur.

3.6.14. The home visit on 1 September by HV4 focused on the sleeping

[39] Transfer of previous GP records should not exceed a maximum delay of 8 weeks, however NHS England was aware of a significant backlog within the contracted notes transferral service that affected a significant volume of patient records.
[40] A Local Provider Health Service Essex
[41] Each health professional has a NHS secure email address.

arrangements of Child C, there was no cot and it was reported that she either slept in the car seat or with the mother; HV4 advised the mother to line a drawer and put Child C in this to sleep until a cot could be obtained. Child C was weighed by HV4 and the weight was recorded in the Parent Held Record (Red book) as stated in the IMR for the local community provider. However the weight was not recorded in the HV records and it is therefore not known what the weight at this time was. HV4 did inform SW3 in a telephone call that the children had been weighed and there were no concerns. The importance of recording and plotting weights and measurements on the centile charts should be reinforced with all staff that come in to contact with children and young people. This was the first time that Child C had been weighed since discharge from the Newham Hospital Neonatal Unit on 5th August and was an opportunity to assess whether she was continuing to grow and thrive. This was also highlighted as a learning point for Barts Health at the point of Child C's discharge from the Neonatal unit see para 3.5.4.

3.6.15. The mother reported that Child C cried more than their older sibling; though this information was not explored any further. This was an opportunity to explore with the mother what Child C's routine was and assess whether the mother had realistic expectations of looking after a premature baby. HV4 commented on the cramped conditions within the flat and that it appeared that the maternal grandmother was not very happy that the mother and her two children were staying with her, this was useful information given that it was the family that had suggested that the mother move to Essex with her two children and stay with the maternal grandmother who was recorded as supportive of the plan.

3.6.16. HV4 contacted SW3 later that day; the only information that was shared concerned the lack of a cot and that the children had been weighed and there were no concerns as recorded in SW3 case records. HV4 requested the CPP to be sent, SW3 informed her that she would bring a copy to the Child Protection core professional group scheduled for the 06.09.16 at the maternal grandmother's flat. Although the core meeting was scheduled for five days later, it would have been best practice for the CPP to be sent that day.

3.6.17. The Core Group took place on 6th September 2016.[42] The mother, maternal grandmother, Child C and their sibling, SW3 and HV4 were present. This was the first time that SW3 saw the mother, Child C and her sibling, and the maternal grandmother in their 'home' environment in Essex. There were no minutes of the Core Group meeting. This was a significant omission. This meeting was a key opportunity for professionals to review the CPP and the safeguarding agreement whereby the mother and her two children must stay in Essex, and if she did leave then the maternal grandmother must

[42] The core group was held late due to children's change of address and family living out of borough.

notify the social worker and police immediately. It is reported that the mother and maternal grandmother were aware of this expectation. What is not clear is how this was communicated to the family - either in writing or verbally. The Core Group provided an opportunity to remind all present about the expectations and conditions set out in the safeguarding plan and CCP. This would have provided clarity to all parties involved about the rules and the escalation if the plan is not being adhered to. Because of the lack of minutes of the Core Group it has not been possible to ascertain whether the conditions of the safeguarding plan were reiterated verbally at this time. HV4 stated that she was unaware of this stipulation when interviewed by the IMR author. The importance of recording and documenting key meetings has been identified and is a key learning point for all agencies involved. The LBBD has also identified the need to strengthen the safeguarding plan/agreement by using a model template which sets out the expectations of the parent/s and any other family members involved; the services to be provided; arrangements for review; and the contingency plan if the agreement is seen not to be working.

3.6.18. During the time that the family were supposed to be living in Essex SW3 made two home visits, the 6th and the 19th September. The 6th was also when a Core meeting took place. SW3 also made contact by phone on four occasions.

3.6.19. It was noted that Child C's sibling interacted positively with the mother and grandmother, whilst Child C was asleep in a car seat. The mother confirmed that the children were due to be seen by GP3 the next day and that Child C's sibling was up to date with the immunisation schedule. The mother showed SW3 Child C's birth certificate; the father's name was not on the certificate. At this meeting it was established that the mother still had not presented herself to the housing department in Essex and it was agreed that the maternal grandmother would accompany her to the housing department in the next few days. At the end of the meeting HV4 took a signed form by mother, which allowed GP3 to share information with social care.

3.6.20. Child C was examined by GP3 on the 07.09.16, it was reported that Child C was well and had put on weight according to her mother. At this time GP3 was unaware that both children were subject to a CPP, as the records were not flagged on the IT system as outlined in para 3.6.9. It was recorded that GP3 did not have any concerns about the children. The mother did bring Child C for her routine 2nd dose of primary immunisations and an appointment was given for the 3rd dose which was due to be given in four weeks time.

3.6.21. On 8th September, two days after the core meeting (on 6.09.16) the LBBD SW3 attempted to speak to the mother by phone to get an update about the contact with the Housing Department; a voice mail

message was left for the mother to respond. Six days later on 14th September 2016, SW3 again attempted to talk to the mother on the phone; again there was no response. At this point SW3 contacted the maternal grandmother, who informed her the children had left with their mother on 12.09.16 to go to London and were due to return on Thursday 15th September 2016.

3.6.22. On Monday 12.09.16 the mother sent a text to HV4 that she needed to go out and could she come to the flat before 3pm. It is reported that the mother was relaxed and chatty during this visit. We now know that this was the day that she left for London accompanied by her two children.

3.6.23. This development was in breach of the safeguarding agreement made to safeguard the children; and after SW3 discussed the situation with her Team Manger she attempted to phone the maternal grandmother to request that she report to the Police that the mother and children were missing. As there was no one answering a message was left on her answer phone (see para 1.3.18). As a consequence, SW3 next visited on 19 September (the third working day after the breach) to make a Child Protection home visit to the family in Essex. The fact the mother had taken the children back to London and that the maternal grandmother had failed to inform SW3 called in to question whether the basis of the CPP was fully secure and safe. It might have been considered appropriate to alert the TLPCM of this development or take other action.

3.6.24. SW3 followed up this breach when she made the unplanned home visit on Monday 19.09.16. When SW3 arrived the mother was about to leave for an appointment with the Practice Nurse for Child C's Rotarix.[43] SW3 asked the mother if she could accompany her to the GP surgery but she refused so SW3 took the opportunity to meet with the maternal grandmother, with whom she felt that she had a reasonable relationship.

3.6.25. SW3 was reassured during the visit when she was shown a card with the details of the housing officer on it, by the maternal grandmother When the mother returned from the GP surgery she appeared to be much calmer, maintained eye contact, accepted that there needed to be changes made and appeared to be very positive about the situation, this was in stark contrast to any of the previous meetings that she had with the mother. Child C's sibling was observed playing with toys and was particularly fond of tractors, played 'peek- a- boo' from behind the sofa and was seen laughing and interacting well. SW3 felt that the sibling did have a relationship with the mother but was always looking for affection and would climb onto adults' laps. Child C was often asleep or sleepy on the visits that the SW3 made to Essex.

[43] Oral vaccine against rotovirus, a common cause of diarrhoea and sickness, administered at 8 and 12 weeks.

3.6.26. This was the last time SW3 saw the family. It is now known that immediately after SW3 left the maternal grandmother's home the mother left with her two children and took the train back to London (see para 3.10.6.)

3.6.27. HV4 received a text from the mother on the 26.09.16, '*I can't remember if we have an appointment but if we do can we please reschedule it. Thank-you."* HV4 responded by text, offering an appointment for the next day; there was no response from the mother. On the 27.09.16 HV4 received another text from the mother '*it is OK for you to come tomorrow anytime will be fine*" HV4 responded by text offering a 4pm appointment for the following day, the mother sent a text back at 12:19 '*Yes that's fine'.*

3.6.28. It is now known that the family were in London from the 19th and again the maternal grandmother had failed to inform SW3 as stipulated in the safeguarding agreement. HV4 was unaware that the family had left for London immediately after the previous re-arranged visit on 12.09.16. HV4 was also unaware of the safeguarding agreement that was in place (see 3.6.17), specifically that the mother and her two children must remain in Essex, and if they left or attempted to leave then SW3, or the police, must be informed immediately. This arrangement was not included within the CPP at the time of transfer in to Essex.

3.6.29. On 28th September 2016 the mother Child C and their sibling boarded a London bus. During the journey, the mother asked for help as Child C had stopped breathing. Emergency services attended the scene and Child C was taken to NUH where she was pronounced dead, non-accidental injury was suspected; the parents were subsequently arrested on suspicion of murder.

Learning Point:

- Minutes of core meetings must be shared with all professionals involved in the care of the children in a timely manner.
- Written safeguarding plans should be discussed with professionals at point of movement in to new local authority
- Staff should be reminded about the importance of sharing information/plans
- Staff should remain curious at all times particularly when the attitude or behaviour of an individual changes dramatically and may appear to become more compliant.

- The importance of uploading CPP onto GP records and putting a safeguarding alert on all the records so that all professionals with access to the records working in the practice have this information (SOP in place). This has already been actioned

3.6.30. The next part of the report provides the analysis of items set out in the Terms of Reference (TOR) agreed by the Serious Case Review Panel on 28.04.17. Due to the number of different agencies and professionals involved in the provision of care to the family, the named agency / organisation is set out for a clearer and a better understanding.

3.6.31. There is also a section where learning that has emerged from the SCR that is not covered by the TOR will be discussed and analysed. The recommendations made in this section are for all the Safeguarding Children's Boards involved with this case, unless specifically directed to an individual Board. The individual recommendations made within the Independent Management Reviews are included in Appendix 3.

3.6.32. The areas set out for analysis by the original TOR are:

1. The level and extent of agency engagement and intervention and whether his was appropriate to the assessment of parent's ability to provide adequate care and supervision of Child C and her sibling.

2. The recognition of safeguarding factors by all agencies and how these were addressed.

3. 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.

4. The quality of assessments on which decisions and actions were taken.

5. Whether there were any factors in the history of any adults that indicated they posed a risk to children.

6. Whether race, religion, culture was a factor in this case and had been fully considered.

7. The extent and quality of partnership working among key agencies and across local authority borders.

8. The effectiveness of working arrangements and information

sharing and communication between all professionals and whether this could have been improved.

9. The existence of any factors relating to the 'capacity and climate' within agencies which may have impacted upon practice in this case (i.e. vacant posts or staff on sick leave etc

10. In addition to the above the review should consider learning for both the individual agency and how agencies work together through the BDSCB.

3.7. The level and extent of agency engagement and intervention and whether this was appropriate to the assessment of parent's ability to provide adequate care and supervision of Child C and her sibling.

3.7.1. Throughout the period under review, there was a pattern of poor engagement by the mother with all agencies; the mother engaged almost entirely on her own terms or when professionals informed her that the concern had increased to such a level that further intervention was deemed necessary e.g. the concerns raised by the staff on the Newham Hospital Neonatal Unit that resulted in the Initial Child Protection Case Conference and the intervention of the extended family to prevent care proceedings for the children. At the very least this demonstrated that the mother did not lack an understanding of what was required but showed a very significant will not to work with professionals in the best interests of her children.

3.7.3. In this case the mother's behaviour included: avoidance,[44]ambivalence,[45] confrontation[46] and deceit. To employ appropriate support, and challenge parents when non-engagement or disguised compliance occurs, professionals need to be supported through: adequate supervision, training and management oversight. The way in which the mother sought to "manage" professionals in this situation included:

- Cancelling and re-booking appointments
- Early self-referral to Midwifery Services and then not attending appointments
- Attending appointments at the incorrect time
- Doing just enough to keep professionals at bay
- Moving from one address to another and refusing to give details

[44] When a parent fails to turn up, is unavailable for planned visits or cutting visits short.
[45] When a parent is late for appointments and repeatedly make excuses for missing them
[46] When a parent disputes the facts and argues with the professional.

- Lying about living in LBBD even when the tenancy had been cancelled

- Frequent changes of mobile phone numbers

- Agreeing to live with maternal aunt following Child C's discharge from the Newham Hospital Neonatal Unit and then failing to do so.

- Failure to disclose father's details

- Giving a variety of reasons why it has been difficult to keep appointments, Child C's sibling sleeping, unwell or couldn't find anyone to look after them

- Aggressive / defensive responses to professionals and calling them liars

- Becomes more compliant when threatened with more invasive action

3.7.4. Although professionals challenged the information that they were being given, the meetings and telephone conversations quickly became hostile and aggressive and the mother was verbally abusive on more than one occasion. The danger of this is that the focus moves to trying to maintain a relationship with the mother and in doing so the 'lived experience' of the child(ren) becomes lost or diluted.

3.7.5. Brandon et al (2008)[47] note that disguised compliance, by its very nature, makes it difficult for professionals who are involved with a family to maintain an objective view of progress in safeguarding the welfare of a child. Disguised compliance 'wrong foots' professionals and can prevent or delay understanding of the severity of harm being experienced by children in the family.

3.7.6. At the most basic level, disguised compliance harms children as it prevents professionals being able to properly assess the risks to children in the household. Professionals are unable to progress work due to a lack of access or where the level or quality of contact with the family is so limited it makes ongoing work impossible. All disguised compliance involves resistance to change and an inability or unwillingness on the part of parents and carers to address risks to their child. Assessments of the parent's capacity and willingness to change should therefore be carried out alongside assessments of the child's life.

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[47] .(http://webarchive.nationalarchives.gov.uk/20130401151715/ https:/www.education.gov.uk/publications/eorderingdownload/dcsf-rr023.pdf)

3.7.7. The mother appeared to try and control different relationships with the professionals involved with her and her family. A range of factors including: experience of seeking help in the past which will influence the present, trust and attachment, experience of authority, any cultural racism/ discrimination or something to hide will all have an influence on how a family or individual will engage. The influence of other adults who are 'behind the scenes' including 'shadowy males' must also be considered. With the benefit of hindsight what might have been perceived by professionals as disguised compliance or non-engagement at the beginning; it is now evident that the mother and her extended family were giving false information and on occasions lying directly or failing to pass on information in the best interests of the child(ren).

3.7.8. There is a significant need to consider the appropriate levels of support, guidance and challenge for front line professionals (in all disciplines) to ensure that they are protected and supported to recognise and work with the often overwhelming feelings that working with families such as this may evoke.

3.7.9. Professionals need to be able to distinguish between disguised compliance and typical behaviour in families with complex/chaotic needs. Within the context of family intervention work, multiple and complex needs is sometimes used to refer to families who have often reached the stage where they are presenting with externalised behaviours which have negative and very disruptive consequences for themselves and those around them such as persistent offending behaviour or persistent anti-social behaviour. Other terms such as troubled families and families with multiple problems are also used to describe families with multiple and complex needs.[48] Front line workers need particular support and to be advised of strategies and practical approaches to cut through any deliberate obfuscation. Policy needs to be clear and followed to both safeguard children and workers in these situations.

3.7.10. The quality of the assessments undertaken by both Newham and LBBD were significantly hampered by the lack of engagement by the mother. Her resistance to work co-operatively with professionals made it difficult to fully grasp the lived experiences of the children.

3.7.11. When LBN were undertaking the assessments the level of concern for the mother, the unborn child and subsequent sibling of Child C was at a lower level and it was determined that it did not meet the threshold for statutory intervention. Though the pre-emptive closure of the case on 15th May 2015 was regrettable

3.7.12. Following the birth of Child C and the referral by staff on the neonatal

[48] **Providing intense support for families with multiple and complex needs**

unit at Newham Hospital to the LBBD the concerns escalated about the mother's behaviour and in particular the refusal by the mother to come to the hospital to give blood, the poor visiting pattern and short duration of these visits and most importantly the perceived lack of interest/ urgency in taking Child C home.

3.7.13. The mother denied any on-going relationship with the father and refused to say where he lived. She shared the name of the children's father with the midwifery service, albeit two names were given, and she also stated that they were no longer in a relationship but that he was supportive. Further exploration of the relationship and of the expected role of the father did not occur. The father's shadowy presence continued throughout the review period, though he visited the post-natal ward to care for Child C's sibling and came to see Child C on one occasion whilst she was on the Neonatal Unit. It is assumed by the ambulance crew that it was the father that was seen when they attended his home address in response to a 999 call; this may suggest that this was where the family lived for most of the time. This information was recorded by the single agencies working with the family, but was not shared, analysed or properly pursued. The two names provided by the mother for the father had the same first name and one of the second (family) names corresponded to that of Child C's sibling. The potential risks the father posed (and possible strengths he offered) remained unassessed for the duration of the professionals involvement. This was a significant omission.

3.7.14. Engagement by the mother in the antenatal period was poor for all three of her pregnancies. During Child C's pregnancy the mother attended three out of a possible 14 appointments; though she knew that the risk of having a premature birth was higher, yet she still failed to attend. As previously discussed the mother was not being cared for by the Acorn Team at NUH for vulnerable women during this pregnancy because it was thought that she had been given temporary accommodation and there was no longer involvement from Newham CSC. Poor antenatal attendance is of concern and should have been flagged, the mother appeared to do just enough to convince the professionals that she was complying with her care and that she had mitigating circumstances to explain why she failed to attend her scheduled appointments.

3.7.15. This pattern of poor engagement continued with the health visiting service, firstly in ELFT and continued in NEFLT. Contact was mainly by phone or attendance at CHC, pre-planned visits were either cancelled or there was no reply. As a consequence of this, there was no assessment within the home environment. The initial assessment made by the HV1 (ELFT) was for the highest level of support; this was quickly changed to the Universal Service following attendance at the child health clinic (where she was seen by HV2). When the family moved to the LBBD this resulted in the health visiting service being provided by NELFT. The poor engagement continued and any

contact that was made was either by phone or at the clinic (a total of eight health visitors were involved) because of staff shortages, the use of bank staff and that there was no named health visitor for the family. Consequently, there was no assessment of the home environment or consideration of the lived experience of the child.

3.7.16. Following the premature birth of Child C and her subsequent admission to the Neonatal Unit at NUH, staff became increasingly concerned about the lack of visiting by the mother and difficulty in contacting her. The staff correctly identified that the mother's ability to provide adequate care to her children needed to be further assessed. A referral to LBBD Children's Social Care was made by staff on the Neonatal Unit and was appropriately responded to. SW3 was allocated to the case and agreement via a strategy discussion with Police, to take the case to an Initial Child Protection Case Conference within the 15 days time frame. There was an opportunity to make some assessment of the mother's parenting ability, in particular caring for a premature baby, by inviting her to 'room-in' on the Neonatal Unit and care for Child C for a period of time prior to discharge, this did not happen and was an omission. It is unclear as to whether the mother was asked to 'room-in' and declined or the mother was not asked. The ability to carry out a robust and meaningful assessment was sabotaged by the mother by avoiding planned visits by SW3 following discharge from the hospital and prior to the ICPCC but was not assiduously pursued by the concerned professionals at the time. Both children were made subject to a CPP under the category of neglect; and due to the mother's behavior and expressed view that she would not comply with the plan an urgent review was carried out 24 hours later to ensure that the children were safeguarded.

3.7.17. The Team Manager decided to convene the Threshold of Care and Legal Planning Meeting (TCLPM) held on 17 August 2016 due to the escalating risks and the increased concern about how to safeguard the children. The meeting resulted in approval for care proceedings to be issued. This was timely and met practice standards.

3.7.18. When the mother and the children moved to Essex there appeared to be some initial better engagement by the mother with the health services. The health professionals worked with the mother to ensure that the children received their outstanding immunisations, and in the case of Child C's sibling a developmental assessment. A family health needs assessment was not completed whilst the family resided in Essex; they were there for just under five weeks.

3.7.19. What is clear over the course of the time period of this review is that the mother was prepared to lie to the professionals working with her. This included denial of knowing where the father lived, pretending that she was still living in the flat In LBBD 11 weeks after the tenancy had been cancelled. It would also appear that the maternal aunt and

grandmother did not inform the professionals engaged in safeguarding the children when the mother was not living at the agreed address.

3.7.20. Mobile or transient families are often able to avoid contact with professionals and as a result individual agency's systems do not always enable sufficient focus to be maintained on the needs of vulnerable children. When parents are also rude and verbally aggressive to practitioners the management of the case becomes even more challenging. The use of a chronology identifying missed appointments and untruths should have formed part of the historical information available to professionals working with the family so they could triangulate such information and at least catalogue the extent and nature of the "non-compliance". While this historical information should not determine current thinking it should have significant impact on decision making.

Learning Point:

- The use of chronologies to identify missed appointments and untruths should be used in cases to support the management and decision making to better safeguard children.
- The inability to complete a meaningful assessment when parents do not engage means that the risks to the children cannot be properly assessed
- The focus of the professionals must remain on understanding the lived experience of the children, what was their everyday life like?

3.8. The recognition of safeguarding factors by all agencies, with the exception of police and how these were addressed.

3.8.1. There were a number of safeguarding factors evident in the mother's history and her lifestyle choices that she made. These included:

- The mother presented as a young homeless women living between extended family and friends in East London.
- The mother had moved with her own mother (maternal grandmother) and two younger siblings to a Women's Refuge in Essex due to domestic abuse and she had also alleged that her father and brother had assaulted her when she returned to live in London.
- The mother also made an allegation against 'her boyfriend' (the

father of the children) in 2013.

- At the time of her first pregnancy she reported that: she was no longer in a relationship with the father of the unborn child, unemployed and in receipt of benefits.

- She already had a poor attendance at health appointments and chose what information she was prepared to share with professionals involved with her care.

- She had three premature births at home in the space of three years. It is unclear as to whether the professionals considered whether there was any link between these and an environment of domestic abuse.

3.8.2. It is acknowledged that this list is drawn up with some elements of hindsight, though many of those issues were known about, sometimes in individual settings, at the critical decision making opportunities.

3.8.3. During two of the mother's pregnancies she was under the care of the 'vulnerable women' midwifery team at NUH. Her attendance was poor and she seemed to ignore advice given by the midwives. It is difficult to comment further about whether safeguarding factors were considered by the team, due to the unavailability of the records. However, there were a number of factors including:

- the mother's history including self reported early miscarriages

- chaotic and mobile lifestyle

- poor attendance at antenatal appointments

- history of domestic abuse

that were significant enough that professionals should have made plans as to how the case would be managed and escalated as appropriate. There was no referral made to NCS by the midwifery team, but this may have been due in part to the premature birth of Child C.

3.8.4. The staff on Neonatal Unit at NUH were very proactive in identifying safeguarding factors and communicated well with the Named Nurse for Safeguarding within the hospital and the subsequent referral to MASH in LBBD. The staff also identified concerns around the discharge plan for Child C and in particular the fact that the family were moving into another London Borough (this was the third) and that the mother had failed to register with a GP in the area prior to the discharge of Child C. There had also been difficulty in identifying the health visiting team that would take on the case in Tower Hamlets. We

know that when mobile families move, the current case transfers between health visitors does not guarantee that contact will be maintained with the family which can potentially lead to vulnerable children's needs being overlooked. The Named Nurse rightly challenged LBBD CSC about health not being included in the Strategy Discussion/ meeting and followed up her concerns by email, The Named Nurse from NUH also attended the ICPCC; this was good practice.

3.8.5. The LBBD identified the concerns following the referral to MASH and allocated a social worker to complete a single assessment by the 4.08.16. The instructions and timeframes were clear and there is good evidence of communication and supervision with the TM. Following the children being made subject to a plan for neglect the CPP were of a good standard with clear timelines and expected outcomes for the children. The Chair of the ICPCC was sufficiently concerned about whether the safeguarding plan would work due to the behaviour of the mother when she attended that she directed the SW to review and escalate the case as required. This showed a firm and clear grasp of the issues of safeguarding at this early stage.

3.8.6. When the family moved to Essex, there was a clear safeguarding plan in place, the focus being that the mother and her children had to remain living with the maternal grandmother, and if she left the house with the children then the maternal grandmother must notify the social worker immediately. The lack of Core Group minutes has already been identified as a significant issue see para 3.6.17. The safeguarding plan needed the full cooperation of the maternal grandmother and when she failed to inform SW3 the first time that the family returned to London it was reasonable to think that this may happen again and should have merited a review of whether the safeguarding plan was robust enough.

3.9. 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?

'*Neglect can be difficult to define because most definitions are based on personal perceptions of neglect. These include what constitutes 'good enough' care and what a child's needs are. Lack of clarity around this has serious implications for professionals in making clear and consistent decisions about children at risk of neglect' (NSPCC.2012)*

3.9.1. It is well known that neglectful parenting is almost inevitably a sign of complex and longstanding problems such as mental ill health, domestic abuse, a poor physical environment or entrenched behaviour by a parent or parents. The understanding of neglect is a partnership requirement and must not just be the responsibility of

Children's Social Care. In this SCR the initial assessment carried out by NCS had focused on the issue of housing and did not fully explore the chaotic and poor engagement in a wider context and assess the parenting capacity of the mother in a meaningful way. The absence of information about the father was a feature throughout. Different information was held by the agencies attempting to work and support the mother and was not pulled together until the third assessment undertaken by LBBD.

3.9.2. The Intensive Hospital Intervention Team in NCSC initially identified potential safeguarding concerns under neglect, in relation to the mother failing to safeguard the health of her unborn child. There was an absence of evidence within the case files of a robust assessment of risk for neglect. The focus continued to be supporting the mother to secure housing with little exploration of the impact on the transient, chaotic lifestyle on the mother's ability to meet the needs of her unborn child. The sibling remained as a Child in Need (CIN) in Newham until the case was closed in May 2015. During this time there was no Team Around the Child (TAC) Meeting or multi-agency consultation and planning around the decision to close the case, and a missed opportunity to consider the need to update the assessment following the report that Child C's sibling had suffered a head injury allegedly caused by jumping on a bed. When the social worker requested information from the health visiting team in NELFT it took over three months for the response. There was a lack of urgency and case drift, in part due to the high volume of referrals, high caseloads held by social workers and an over reliance on agency staff see section 3.15.

3.9.3. Staff on the Neonatal Unit at NUH clearly identified risk factors and neglectful parenting and appropriately referred the case to the LBBD.

3.9.4. The work undertaken by the LBBD social worker kept a clear focus on the needs of the children and identified that the mother's parenting capacity showed indicators of neglectful parenting. The mother's behaviour had implications for the welfare of the children and the social worker escalated the case, which, resulted in the children being made subject to a CPP under the category of neglect and then consideration of safeguarding action through the court. However, professionals in Essex did not know about the safeguarding plan and specifically the requirement that the mother and the two children must not leave the maternal grandmother's address. The GP practice in Essex did receive the information about the children being subject to a CPP under the category of neglect in the LBBD. However, this was not uploaded onto the Information Technology system and as a consequence of this the records did not have a safeguarding alert applied see para 3.6.8.

3.9.5. At the time of this review there was no overarching tool to support professionals in assessing and gathering evidence about possible

indicators of abuse or neglect. Since then both Newham and Essex have worked on the positive benefits of having a Neglect Strategy and both have one in place. LBBD Care Profile tool[49] is in place for social care staff who have received briefings on its use.

3.9.6. Ofsted commented that '*those local authorities providing the strongest evidence of the most comprehensive action to tackle neglect were more likely to have a neglect strategy and /or systematic improvement programme across policy and practice, involving the development of specific approaches to neglect*[50]

3.10. The quality of assessments on which decisions and actions were taken.

3.10.1. A good assessment, including family history and identification of risk factors, is fundamental to ensuring that a strong and appropriate plan for the level of required intervention is put in place. Professionals need to maintain a healthy curiosity and continually assess at each professional intervention in order to detect any changes in the family dynamics. Risk factors are cumulative, the presence of more than one increases the likelihood that the problems experienced and the impact on the (unborn) child and parent will be more serious. Research evidence from SCRs [51] suggests that history is an important part of assessing current and future parenting capacity. A safe child protection system needs to deal proficiently with risk, probability and impact; it is not enough to respond reactively after an incident of significant harm has been caused to a child.

3.10.2. Risk should be assessed from the perspective of the children and should not be unduly influenced by sympathy for the adults' experience. In this case the number of opportunities that the professionals, who were attempting to work with the family, had to undertake an assessment was limited. However, the assessments that were completed were not child centered, and crucially did not explore the attachment between the mother and child(ren) or indeed question how she was meeting the basic needs of her children given the chaotic lifestyle she was leading. Perhaps as a consequence of this, the potential and actual risks to the children were not clearly understood. For example, the safeguarding network of professionals did not acknowledge the possible additional impact of poverty and homelessness on the lived experience of the children.

3.10.3. The quality of the assessments undertaken by professionals in this SCR were seriously impeded by the lack of engagement and avoidance and duplicitousness by the mother. The assessments completed by Newham CSC were impeded by mother's sabotaging

[49] Graded Care Profile is an assessment tool used to assist in the identification of neglect.
[50] In the Child's time: professional response to neglect.
[51] Brandon et al, 2008

of visits resulting in only two successful face to face contacts and this compromised the extent to which holistic assessments of parental, environmental and social factors could be undertaken. The assessments were not sufficiently child centered therefore the focus remained in supporting the mother to secure accommodation and did not explore complex safeguarding issues.

3.10.4. The importance of and need to support social workers to determine how long to spend on individual cases, and to balance 'thoroughness and depth' and 'timeliness and proportionality' is a crucial part of management oversight and supervision. Assessments must be outcome focused, the plan reviewed regularly and evidence collected to determine that progress is being made. The analysis of each assessment should be strengthened by critical reflection in supervision and reduce case drift.

3.10.5. As already highlighted in the appraisal of practice the health visitor in ELFT initially assessed the family as meeting the needs of a Universal Partnership Plus and arranged a follow up visit with the mother at home two weeks later (the new birth visit was undertaken on the postnatal ward). This appointment was not kept and there then followed a period of time when the mother either re-arranged a scheduled appointment or turned up late, the result being that there was drift in the case and the mother and sibling were not being assessed. HV1 referred to NCSC when Child C's sibling was seven months old as she had been unable to assess the mother and child and had missed various health checks and immunisations.

3.10.6. When the case was referred to the LBBD SW3 there were clear concerns about the mother and her avoidant and manipulative behaviour. As previously stated in para 3.3.28. SW2 did not pass on the information to LBBD when the case was closed and the family had moved into accommodation in LBBD. Information held by Newham was provided to LBBD on 16 July 2016. SW3 worked tirelessly to engage with the mother in order to carry out a meaningful assessment. SW3 visited the numerous addresses that were on file for the family in order to see the children and complete an assessment. SW3 showed persistence, flexibility and commitment in her role and was not afraid to challenge the mother's account despite being verbally abused by the mother. Although the assessment did begin to surface some issues there could have been a firmer focus on the mother's ability to parent and her bond/attachment to Child C, particularly as the key reason for the referral was attachment and parenting. Nonetheless, the assessment did lead to the escalation of the case and a plan to safeguard the children.

3.10.7. Professionals are dependent on what individuals choose to disclose and this is shaped by the awareness, perception of the workers, and the candour of the individual. There were a number of issues that the mother was not candid about, or actively tried to conceal. These

included:

- The mother not disclosing the information to all professionals about the father of the children; this may have been because she was unwilling or felt too scared, was unaware of her partner's background or denied its significance.

- The self-reported number of miscarriages experienced by the mother; the 'blackouts' and the cut over the right eye may have been as a result of domestic abuse. With the family history of domestic abuse, the maternal grandmother, her own father and brother assaulting her. Professionals had considered the risk of domestic abuse but thought that it had diminished as there had been no reported incidents since 2013 and the mother denied having a partner or being in a relationship.

- The mother's reluctance to allow her GP medical records to be accessed during the assessments undertaken may suggest that there was information that she did not want other professionals to know.

3.10.8. The role of the professional is to remain curious and intrusive about what information is not being shared, and the possible reasons behind this.

Learning Point:

- Robust systems of management oversight and supervision to allow reflective analysis and development of outcome focused plans to evidence real change for the children

- Remind staff about the importance of history, the past may be a significant pointer of the future.

3.11. Whether there were any factors in the history of any adults that indicated they posed a risk to children.

3.11.1. The absence of any checks as to whether the father of the children posed any risk to the family or whether he was supportive and provided stability has already been discussed under the appraisal of practice. The lack of knowledge about him or the drawing together of the various strands or fragments of information left a significant and ultimately defining gap in professionals' knowledge. Work has commenced in ELFT to ensure that the father's details are recorded and what role it is understood that he has within the family unit.

3.11.2. It is imperative that fathers do not remain invisible and that

investigations are pursued despite reluctance, resistance or any self-reporting that there is no ongoing relationship with a father.

3.11.3. In this case information about where he lived, his possible names and that he had visited both his children following their births in the hospital was known by some of the professionals working with this family but it was not shared or acted on in a meaningful way.

3.11.4. As set out in para 3.2.11, GPs need to do all that they can to establish the circumstances of any adults who present with anxiety, depression and/or substance misuse whether they care for children and in what capacity. In the absence of a national framework setting out GP responsibility to consider the dependents of patients it is useful to reflect on learning gained by the National Society for the Prevention of Cruelty to Children (NSPPC) from a number of serious case reviews in which they state GP's must:

'Always ask patients with mental health difficulties, learning difficulties or drug and alcohol misuse whether they have significant care responsibilities. Consider their capacity to care for children safely. Record this information in medical records and emphasise it in referrals and correspondence about patients'[52]

This is repeated here to reinforce good practice

3.11.5. Safeguarding checks were undertaken to assess the suitability of the maternal aunt and grandmother in providing accommodation and general support to the mother and her children. However as discussed in (para 3.5.20.) there was no individual assessment of the maternal grandmother or maternal aunt in relation to their own capacity and ability to act in the best interests of the children and not to be unduly influenced by their relationship (or lack of it) with the mother. Given that both the maternal aunt and the maternal grandmother had not co-operated with the safeguarding plan that was put in place, and had in fact chosen to be complicit with the mother when she returned to London on 12th September 2016, there should have been more exploration of why the maternal grandmother failed to inform the social worker and whether she could be relied on if it happened again. The decision to allow the mother and children to go to Essex was not wrong. In any event it would have been difficult for the local authority to pursue another course in the face of the maternal grandmother's determined statement to provide care and avoid the children entering the care system. It was however an on-balance decision that the extended family, and in particular the maternal grandmother, would offer support and stability and allow more time for the LBBD to complete further assessments.

3.11.6. There was also little known about whether the mother posed any

[52] https://www.nspcc.org.uk/preventive-abuse/child-protection-system/casereviews/learning/gps-primary-healthcare-teams/.

risks or any exploration about whether she would be able to protect her children from harm. This is of particular significance given some of the family background of intergenerational domestic abuse. The mother reportedly lived with different friends and family but the exact whereabouts or who the other adults were in the house was unknown. Her mobile and chaotic lifestyle was a feature throughout the whole time period of this review and despite securing accommodation chose not to live in it. It is well recognised that when families are homeless they experience difficulty in accessing benefits; the mother often made reference to financial difficulties. The mother's financial situation was not explored in any real depth, nor why she was always hungry on the occasions that she did visit Child C on the Neonatal Unit.

3.11.6. The extended family were viewed as supportive when they came forward at a point of crisis to assist the mother in caring for her two children. When the maternal grandmother 'stepped in' to provide accommodation for the family at the time it was seen as a positive and allowed a further period of time to support the mother in demonstrating that she was capable of meeting the needs of her children. SW3 was reported to feel that she had a good working relationship with the maternal grandmother and that she had demonstrated good insight. In light of this it would have been very difficult for the local authority to purse legal proceedings to remove the children from the mother. It could not have been foreseen that the grandmother's expressed concern and apparent agreement with the arrangements would have been so shallow. There was little to suggest that the maternal grandmother would fail to inform SW3 if the mother left Essex with her two children but having failed to do so on the first occasion it is unclear what reassurances were obtained from the maternal grandmother by SW3 that she would fulfil the agreement to do so if the family left Essex and returned to London. In point of fact on the day that this meeting took place (19.09.16) the mother left for London and was away until the events of the 28th September.

Learning Point:

- It is imperative that father's do not remain invisible and investigations pursued even when there is denial or resistance from the mother.

- The importance of requesting police information on father's when undertaking assessments.

3.12. Whether race, religion, culture was a factor in this case and had been fully considered.

3.12.1. There is very little reference made to the self-identity of the family or what pivotal role it might play in the day-to-day life of the family and extended family. It was recognised that a detailed assessment of the family was needed, though not possible in the immediate need to secure mother and children in what appeared to be an available and more stable setting. By understanding the cultural background of the family, professionals can get beneath the surface of assessments of risk by gaining an understanding of risk and resilience, strengths and vulnerabilities. Using this as a starting point, how best to provide services to meet their needs may be better facilitated. There is nothing to suggest that culture or ethnicity was considered in any of the assessments undertaken.

3.13. The extent and quality of partnership working among key agencies and across local authority borders.

3.13.1. The quality of partnership working demonstrated in this case is variable and to a significant extent reflects the difficulties that key agencies experience with mobile and avoidant families. This is further complicated when service provision changes due to the family residing in another London Borough or moving to another local authority. When another layer of different health providers is added it becomes increasingly difficult for professionals within the key agencies to maintain strong working relationships. This becomes even more challenging and difficult when there is no shared IT system even within the health services.

3.13.2. When the initial assessment was instigated by NCS there was some evidence of partnership working between health, housing and social care. However, when the family moved into temporary accommodation in the LBBD this necessitated a change of health visiting provision and NCS found it increasingly difficult to speak to the family health visitor (NELFT) allocated to the family. It is now known that eight health visitors were involved (NELFT site a combination of agency, bank and different clinic attendances as a contributing factor). In these circumstances co-ordinated and close partnership working was almost impossible.

3.13.3. There was good partnership working between the staff on Neonatal Unit at Nehwam Hospital, who liaised with LBBD CSC and the health visiting service in NELFT. There continued to be difficulty in establishing the health visiting team that would provide services whilst the family were living in Tower Hamlets, as a consequence of this Child C was not seen by a health professional until the move to Essex.

3.13.4. There was some good partnership work when the family moved to Essex but it is evident that partners in Essex were not all aware of the full facts of the case, as outlined in the appraisal of practice. This mitigated against professionals in Essex being able to fully conduct their roles.

3.14. The effectiveness of working arrangements and information sharing and communication between all professionals and whether this could have been improved.

3.14.1. Throughout the time period of this review there was a great deal of information that was shared, however because there was no key worker for long periods, an overall plan with clear measurable outcomes was missing. Recent published SCRs [53] highlight the difficulties professionals face with mobile and avoidant families in sharing timely and critical information. Professionals need help to *'analyse and assess the risks that arise when a vulnerable family moves across boundaries and all professionals change.*[54]

3.14.2. As previously discussed in the appraisal of practice and the specific TOR, professionals working with the mother were not always clear about why NCS had been involved and what the status of Child C's sibling was. When Child C's sibling presented with a head injury there was confusion about whether the child was the subject of a CPP or was a Child In Need. The attendance was shared with SW2; GP1 and NELFT health visiting team but no follow up of the family was carried out. This omission was discussed in the appraisal of practice.

3.14.3. There are no prescribed systems in England for case transfer across local authority boundaries for Children in Need (CIN) but there is an expectation that professionals share information. There are however no standards for professionals working within the new local authority to contact or see the child(ren) and once the case is passed on there is no obligation on either LA to keep the case open.

3.14.4. Health visiting services shared information at the point of transfer with a telephone call prior to the transfer of records. The midwifery service completed a communication form and forwarded to the health visitors. However, there was still no clear plan and little evidence that professionals had comprehensive and necessary information about the known or potential risks.

3.14.5. The staff in the Newham Hospital Neonatal Unit and the Named Nurse were clear about the concerns and made an appropriate referral to MASH that resulted in the case being allocated to a senior social worker and an ICPP.

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[53] Oxford, Tri-borough and Luton LSCBs

[54] http://www.oscb.org.uk/wp-content/uploads/Child-Q-SCR-Summary-sheet.pdf

3.14.6. When the children became subject to a Child Protection Plan on the 15 August 2106 the information was not shared with Newham or Tower Hamlets despite the fact that the children were supposed to be living in Tower Hamlets and it was known that they also had been living in Newham, this should have happened. This has been highlighted as a learning point under section 3.5 of this report.

3.14.7. Information was shared with the health agencies in Essex and CSC were also informed that the family had moved in temporarily and the children were subject to a CPP. We now know that this information was not uploaded on to the GP IT system, which meant that professionals working within the practice did not have this information when they family attended for appointments. The previous GP records were not available to the Essex GP practice as previously discussed.

3.14.8. The Core meeting held at the maternal grandmother's home was an opportunity for professionals to meet and review the Plan, and understand the conditions that the family had agreed to. The minutes or any recording of this Core Meeting, the areas covered including the safeguarding plan, and the actions that each agency agreed were not circulated. Nor have they been made available in this SCR process. This falls below expected practice. Health understood that their focus was to ensure that the children completed any outstanding immunisations and developmental assessments.

3.14.9. Communication and information sharing is vital in ensuring that the professionals working with families understand the full picture and are clear about the issues and concerns that need to be addressed. This becomes even more important with a mobile family where there is evidence of intentional deceit about where they are living and with whom. It is far easier for mobile families to avoid contact with professionals particularly when they move across local authority boundaries, which means that the case is transferred on and other partner agencies such as health visiting are provided by different organisations.

3.14.10 Although the London Child Protection Procedures (LCPP) were generally followed in this case, it is clear that there were gaps in information shared and the identification of the concerns surrounding the family (these have been previously identified in the report see 3.3.1). In the triennial review of SCRs published in 2016, it states: 'Our reviews of serious case reviews spanning more than ten years suggest that, despite national guidance and legislation, there are deep cultural barriers to effective information sharing among professionals.' The additional learning is that all staff have a duty to read the records prior to a contact, so that they are clear about what the purpose of their intervention is, and what information is missing in order for them to identify what may be required to ensure a robust

assessment is completed.

3.15. The existence of any factors relating to the 'capacity and climate' within agencies which may have impacted upon practice in this case (i.e. vacant posts or staff on sick leave etc)

3.15.1. Caseloads in the Intensive Hospital Intervention Team were high, at 30, with additional pressures on the team to support the referral and assessment team. At the time it was reported that the numbers of referrals was high and the through- put was slow. This had a direct impact on the length of time that cases were open and in this case clear case drift. This was recognised in the Single Inspection by Ofsted in 2014, as was the fact that the LBN were also aware of the issues and had a comprehensive plan in place. The implementation of the improvement plan commenced in 2015; resulting in a move to work in locality teams, and the work of the Intensive Hospital Team was subsumed into locality teams. A hospital liaison manager was appointed to ensure that the close working relationship with Newham University Hospital continued. There was also increased management capacity, improvements to the MASH and a new comprehensive quality assurance and performance programme.

3.15.2. NELFT identified the high numbers of health visitors involved with the family whilst living in Dagenham. There were considerable staff shortages and there was a reliance on bank and agency staff that were moved at short notice to cover Child Health Clinics and caseloads in other area of the borough. This had a direct impact on how this family was visited and assessed. There were eight health visitors involved in delivering the service. The health visitors reacted to either information being shared or enquiries being made and an attempt to determine where the family was living. There was no overview of the possible risks and concerns within the family due to the high number of health visitors working on the case.

3.16. In addition to the above the review should consider learning for both the individual agency and how agencies work together through the Safeguarding Children's Board.

3.16.1. This case highlights the difficulty of 'keeping track' of a mobile and avoidant family. All LSCBs should give consideration as to how information sharing across boroughs particularly with housing and health service provision can be strengthened.

3.16.2. The case was accepted by the LBBD as at the time there was an understanding that the family were residents of the borough. At the point that is was clarified that the family were in fact not residents of the borough, the decision was made to keep the case, as it was unclear as to the exact whereabouts of the family. This was a sound

decision made in the best interests of achieving continuity.

3.16.3. The lack of focus on the children's lived experience is stark in this report. In part due to the non-engagement of the mother and therefore the opportunity to assess the children was limited. When professionals did meet the family the focus was very much on dealing with the problems presenting and trying to keep the mother engaged. The 'voice of the child' was lost.

3.17. Additional learning identified during the course of the Serious Case Review, the importance of supervision and management oversight.

3.17.1. Brandon and colleagues (2008) stress the importance of effective and accessible supervision. This helps staff put into practice the critical thinking required to understand cases holistically, complete analytical assessments, and weigh up interacting risk and protective factors.

3.17.2. Supervision was provided throughout the period of time that the case was open to the LBN. However, due to the difficulties in parental engagement the case drifted and there was insufficient consideration and analysis of the implications of the mother failing to engage with the process and a lack of a child focus. There was no professional curiosity about where and with whom the mother and her child was living, what risks they may present of if there were protective factors. The decision to close the case, which was supported by the supervisor, was based on a partial assessment. The LBN have identified the need to strengthen supervision within their IMR. A follow up on this action should be a local SCB priority.

3.17.3. The supervision and management oversight provided to SW3 in the LBBD was of the expected standard, with good clear instruction and timeframe from initial allocation of the case. There was regular supervision by the TM to SW3 and also met with the mother and SW3 to agree a plan when the concerns were escalating. When they discovered that the family was not residing in the borough they decided that there was a danger that the family 'might get lost' within the system if they transferred the case, and they were still unclear about where the family were actually living. The Team Manager should have chaired the Discharge Planning meeting in line with procedures as this was the first planning meeting and should have been seen as setting up a CIN plan ahead of the ICPCC. There is evidence in the records and through an interview with SW3 that she felt well supported by her manager.

3.17.4. Comments have been set out in para 3.2.44 on the situation for HV1 with regard to accessing supervision in the appraisal of practice. ELFT provide regular safeguarding supervision and use 'Signs of

Safety'[55] to support the practitioner to reflect on the strengths and risks present in the case

3.17.5. Primary Care and in particular GP's have a unique role in working with families. The mother's GP medical records from GP1 have not been located despite attempts by Newham CCG to trace the records for the mother and sibling. As a result there is a gap in the information and understanding of how and when the mother attended her family doctor and what information she gave to GP1.

3.17.6. As previously discussed, professionals working within Primary Care should be supported to ensure that they consider the possible impact on the adults ability to care for children or dependents when they themselves may be vulnerable due to drugs or alcohol misuse, or suffer from mental health issues.

3.17.7. One other issue that has emerged in this review is that despite very extensive professional contact over the whole period, there was no understanding of the mother's ability or capacity to read and understand documents, letters or reports. It seems to have been assumed that in light of her somewhat streetwise demeanor/use of texts etc that she was able to read and understand. Though the use of texts and apparent level of articulation may cover considerable difficulties in really understanding official documents.

4. Conclusion and Recommendations.

4.1. Among many lessons this case highlights the difficulties that professionals experience when working with non-compliant, chaotic, mobile and duplicitous families. This family lived at six different addresses (these were the addresses that the professionals knew about), and in four local authority areas, three of which were in London. The mother engaged with the different agencies and professionals on her terms. She often managed to do 'just enough' in terms of attending health appointments to suggest she was complying and trying to keep her appointments. She shared different information with different professionals and was verbally aggressive and abusive, she accused professionals of lying or giving her the wrong appointment times.

4.2. The mother made it difficult for social workers to complete meaningful assessments and as a consequence the voice of the child was not always captured. To some extent the professionals got caught up in managing the more immediate impact of her behaviour and responding to her transient lifestyle and very difficult attitude, and an enormous amount of time was taken up by trying to pin the mother down to where and with whom she and her children were living.

[55] Framework for the Assessment of Children in Need and their Families, DH, 2000.

4.3. At the point when the LBBD had made the decision to commence care proceedings for the children, her extended family stepped in to support the mother. The maternal grandmother was seen as supportive and suggested to the social worker that she had insight in to the issues that needed to be addressed by the mother. The realistic child protection plans and safeguarding agreement with the additional caveat that the maternal grandmother must report immediately to the social worker if the mother left the address in Essex with the children, was reasonable but undermined by the mother's actions and the failure of the maternal grandmother to alert the authorities.

4.4. The father of the two children remained a 'shadowy, invisible' presence throughout the review period. The mother denied that they were still in a relationship and refused to give details to all the professionals involved with the family. There was information about the father in the single agencies but it was never shared. The consequence of this was the father and his considerable role and influence remained unknown throughout the period under review. Consequently, there was no assessment completed of whether he posed a risk to the children or was a protective factor.

4.5. The mother had grown up experiencing domestic abuse and had moved with her mother (maternal grandmother) to Essex before returning to London at the age of 17. The mother reported that she had been assaulted by her own father and brother and received support for this. There is also a reference to an incident of domestic abuse by her boyfriend in 2013. The SCR panel discussed the possibility of the self-reported miscarriages, the premature births, history of blackouts and an injury to her face as possible signs of domestic abuse; there was no evidence to support this.

4.6. There was concern about the care of Child C and her sibling by the mother, and in particular her transient lifestyle, avoidance of engaging with services and failing to put the needs of her children first. But there was no specific evidence that Child C would experience serious physical harm. In these circumstances, it is reasonable to say neither Child C's death nor her injuries could have been predicted. However, there was a constellation of factors both in the history of Child C and the older sibling that presented a cumulative picture of risk, neglect and poor understanding of the mother's wish or capacity to care for Child C. The issue of the father was a singularly significant factor in the risks to both children.

4.7. **The recommendations arising out of the learning from Child C's experience are:**

Recommendation 1:

That LB of Newham consider the most appropriate way of ensuring an information exchange between housing and CSC when a tenancy is cancelled, and when there is a reason to believe that there is a neglect or risk to a child to ensure that wider issues of safeguarding and possible neglect and risk to children are evaluated

Recommendation 2:

Barts NHS Trust must ensure that staff are made aware about the importance of recording vital measurements including weight, height and head circumference. When babies and young children have been in hospital for extended periods and there are any concerns about parental engagement with child(ren), developmental milestones as well as a summary of feeding and sleeping patterns must be recorded and where considered necessary should be shared at the point of discharge with all community staff and social care.

Recommendation 3:

The Safeguarding Children's Boards involved in this case must assure themselves that single and multi-agency training for staff working with avoidant and hard to engage families include the identification of disguised compliance, collusion and deception as part of any existing training programmes, or devise new modules as necessary.

Recommendation 4:

All agencies need to consider whether the arrangements they have in place, including strategies/policies, procedures, training and supervision for staff and managers, are adequate, specifically to identify neglect and assess its likely impact and risk to children. This must include support and guidance to staff on practical approaches that can be used.

Recommendation 5:

The relevant LSCBs must seek assurance that all agencies can demonstrate how fathers or absent parents are included in any assessments that are undertaken. This is to ensure that consideration of risks or protective factors are evaluated in order to ensure that practical steps are put in place to safeguard any children.

Recommendation 6:

The relevant LSCBs need to be assured that a full and robust assessment is undertaken on family members (or anyone that puts themselves forward) to provide support or care for children who have met the threshold for care proceedings. The assessment must include the capacity and ability of the individual and consider the interaction and sustainability of the relationship they have with the birth parent. This must include realistic and frank assessments of any background factors that may have an impact on current behaviour and attitudes.

Recommendation 7:

The LSCBs need to be assured that systems are in place so that minutes of any Core Group Meetings are shared with all the relevant agencies involved in the protection of the named children concerned.

Recommendation 8:

Relevant LSCBs must assure themselves that procedures and arrangements are in place to ensure that Child Protection Plans (CPPs) are shared with all key agencies who have a role with either parent(s) or children in relation to the CPP.

This must include ensuring the timely distribution of the CPP in the most appropriate way (electronic, fax, uploading to shared systems, or paper copies etc) to ensure that all key managers and staff concerned are sighted on agreed CPPs.

Recommendation 9:

The relevant LSCBs concerned need to be assured that at their own local level procedures are in place, and are followed, to ensure that health agencies are fully involved in strategy meetings and fully informed of the outcomes. This is already a requirement from the London wide Child Protection Procedures.