

**Serious Case Review under Working
Together 2013**

In respect of Child D

Agreed at the Serious Case Review Panel

May 2014

Authored by: Ann Duncan and Ghislaine Miller

Independent lead reviewers

CONTENTS

SECTION 1: INTRODUCTION

Succinct Summary of the Case

Methodology

SECTION 2: FINDINGS

Timeline of Significant Events

Appraisal of Practice: a Synopsis

Summary of Findings

Findings in Detail

1. Introduction

1.1 Why this case was chosen to be reviewed

On 29th April 2013 Child D's mother noticed that Child D, then aged 11 weeks, was not moving their left arm and contacted her GP who advised her to attend the Accident and Emergency Department (A&E) Child D was admitted and was found to have a fractured left radius and ulna. A referral was made to Children's Social Care (CSC). Child D had a skeletal X-ray that showed a number of old fractures. These included probable fractures of the 7th and 8th left ribs and of the 5th, 6th and 7th ribs. There was also a possible fracture of the left tibia. These injuries had been sustained when Child D was approximately one month old. Both Child D's mother and her partner, Mr H, were arrested and were charged with neglect and causing or allowing Grievous Bodily Harm (GBH) to take place.

The Named Doctor from the hospital made a referral to the Serious Case Review Panel (SCRCP) of the LSCB to consider whether this case met the criteria for conducting a review under Working Together 2013, namely, where:

*(a) abuse or neglect of a child is known or suspected; and
(b) there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. (Working Together to Safeguard Children, 2013:68)*

On the 29th May 2013 the Independent Chair of the LSCB agreed that a Serious Case Review should be undertaken.

1.2 Family Composition

Family member	Date of birth
Child D	11 weeks old at time of admission to hospital
Miss F (mother)	18 years old
Mr H (father)	35 years old
Mr J (maternal grandfather)	47 years old
Child L (maternal uncle)	14 years old

1.3 Review Timeframe

The period for review in the case chosen was 1st June 2012 to 29th April 2013 - a period of just over 11 months. This covers the period from the beginning of Miss F's pregnancy with Child D, until the admission to hospital and the discovery of multiple injuries.

1.4 Succinct Summary of the Case (a table of key events is included in this section)

This case involves a family with complex needs that had been well known to CSC and the Police over a number of years. The family has a history of violence and crimes involving several family members; namely, Child D's uncle (Child L), maternal grandfather (Mr J) and Mr H. Some of these acts of violence may have been gang and/or drug related.

Miss F was taken into care at the age of ten, as a result of neglect and physical abuse by her father. She remained in foster care for a period of two years. Miss F's half-brother, Child L, and two half siblings were later taken into care and remain subject to Full Care Orders.

At the time of her pregnancy with Child D, Miss F lived with her father in a two bed roomed maisonette. Miss F, then aged 17, was pregnant, and the father of her baby, Mr H, was 17 years older than her. He had two children from a previous relationship that were known to CSC in another local authority. Miss F's father, Mr J, was unhappy about the pregnancy and along with his mother (Miss F's paternal grandmother) wanted Miss F to have the pregnancy terminated, in part because the baby would be of mixed heritage. (Miss F told us this when we interviewed her)

Miss F refused to have a termination, stating to the Teenage Pregnancy Midwife (TPM) that she was happy and wanted to have the baby. Mr J did not want Miss F to stay in the family home once the baby was born, so she applied for re-housing and was advised to wait until after the baby was born when she would be offered a two bed-roomed flat.

Miss F attended all her antenatal appointments and engaged with the Health Visiting Service. She was referred to the Family Nurse Partnership¹, but turned down their offer of support, despite two contacts with the Family Nurse, stating that she had a wide circle of friends all of whom had babies and they would give her all the support that she needed.

There is evidence that Miss F was vulnerable: from the neglect and physical violence that surrounded her most of her life; from her separation from her family when placed in care; and from the care experience itself. She had self-harmed just prior to the review time line. She was also completely deaf in one ear and had only 20 per cent hearing in the other, and relied on lip-reading to communicate.

Miss F's half-brother, Child L returned to the family home in November 2012 under a Placement with Parents Agreement: he had been repeatedly absconding from his care home in the south of England and was involved in criminal activity. Miss F was 29 weeks pregnant at this point and was not consulted about the return of Child L to the

¹ The Family Nurse Partnership is an intensive, structured, home visiting programme, which is offered to first time parents under the age of 20. A specially trained family nurse visits the mother regularly from early pregnancy until the baby is 2 years old and builds a close, supportive relationship with the family.

household, nor included in the assessment that underpinned the Placement with Parents Agreement.

Baby D was born in February 2013, following a normal delivery. Following the birth Miss F and Child D received home visits by the Midwifery Service and one visit from the TPM who discharged them into the care of the health visiting service at ten days post delivery. The health visiting service completed the new birth visit and mother and Child D attended their GP for the postnatal and six-eight week developmental assessment. Child D was invited to attend a baby massage clinic.

There was an incident at the family home in early March 2013 in which four men came to the house looking for a stolen mobile telephone believed to be in the possession of a friend of Miss F's who was visiting her. The men were threatening, and according to family members returned later in the day to 'rob the house' and later threw a brick through the window. Mr J and Child L spent the night with friends, whilst Miss F stayed in the flat with Baby D, despite being advised to leave and continuing to receive threatening telephone calls from the men.

On 29th April Child D's mother noticed that Child D, then aged 11 weeks, was not moving their left arm, and contacted her GP who advised her to attend the Accident and Emergency (A&E) Department of the local hospital. Child D was found to have a fractured left radius and ulna and was admitted. A referral was made to Children's Social Care (CSC). Child D had a skeletal X-ray that showed a number of old fractures. These included probable fractures of the 7th and 8th left ribs and of the 5th, 6th and 7th ribs. There was also a possible fracture of the left tibia. These injuries had been sustained when Child D was approximately one month old. Both Child D's mother and her partner, Mr H, were arrested and placed on bail for neglect and causing or allowing Grievous Bodily Harm (GBH) to take place.

This case was investigated by officers from Haringey CAIT. Despite an initial reluctance to prosecute the suspected perpetrators the CPS finally authorised charges of Cause or Allow serious physical injury, Contrary to S5 Domestic Violence, Crime and Victims Act 2004 in relation to Child D's mother and father. Mother and Father were charged on 7th October 2013.

On 1st May 2013, CSC made an application for a care order to safeguard Child D. On 2 May 2013, Child D was discharged from hospital and placed in foster care. On 7th May 2013, the County Court granted an interim care order which continued for the duration of the care proceedings. On 18th December 2013, there was a fact finding hearing by the Court to determine the cause of the injuries. The Court found that:

"Paragraph (P) 246 "Having reviewed all the evidence, I am unable to find, on the balance of probabilities, who inflicted the injuries on Child D"

P 250 "I have considered separately the positions of Ms F, Mr J, and Child L. I find that there is a real possibility that each of them may have inflicted all or some of the injuries on Child D. I cannot exclude any of them from the pool of perpetrators".

P 251 "...I find that there was no medical explanation found for the injuries. The parents have not provided any or any reasonable explanation for the injuries. The parents (Miss F and Mr H), Mr J and Child L, have either caused the injuries or failed to protect Child D from the injuries. The parents failed to seek medical attention for Child D in respect of the leg and rib fractures."

On 28th November 2014, there was the final hearing of the application for a care order and the Court made a Special Guardianship Order to Mr and Mrs XX, the foster carers for Child D.

In parallel with CSC application for a care order, the Police undertook an investigation that led to the parents Miss F and Mr H being charged on 7th October 2013 with the criminal offence of causing or allowing a child to suffer serious physical injury, contrary to S5 Domestic Violence, Crime and Victims Act 2004. On 22nd September 2014, at the Crown Court, the case against the parents was dismissed (no case to answer) because the trial could not go ahead due to the non-availability of a key witness. The CPS appealed this decision. On 17th December 2014, the Court of Appeal dismissed the appeal and upheld the Crown Court decision.

There is no dispute in any of the court papers or any other papers or evidence that the child did suffer the injuries as outlined.

Timeline of Significant Events

Date	Significant Event
12.4.12 (Prior to review period)	Referral to CAMHS from Mental Health Liaison Services at A&E NMUHT from Mental Health Liaison Nurse. Miss F presented with a stab wound to her leg, this was self inflicted and followed an argument with her father over a boy.
18.6.12	Case closed by CAMHS following three appointments with Miss F. GP informed.
22.6.12	Mr H receives a fixed Penalty Notice for smoking cannabis and in possession of a small bag.
22.6.12	Child L is missing from his Care Home and turns up at the family home. He is returned to the Care Home.
27.6.12	Miss F attends booking appointment with Teenage Pregnancy Midwife. Pressure from her father and paternal grandmother to terminate pregnancy. Housing issues.
28.6.12	Referral to CSC made by TPM due to housing situation and age of partner and family background.
28.8.12	Pre-Birth Core Assessment completed within the

	timeframe. Case closed. Professional network to be asked to re-refer if there are any concerns nearing the birth
31.8.12	First antenatal visit by health visiting service
7.11.12	Second visit by the health visiting service
15.11.12	Mr J accompanies Children In Care Social Worker CIC SW to look for Child L who has absconded from placement. He is returned to care home, but SW discovers that Child L and Mr J are on the same train back to London. Placement with Parent Order agreed and Child L to live at home (2 bedroom house). Miss F not consulted: 29 weeks pregnant.
23.11.12	Housing appointment, Miss F advised to wait until the baby is born: will then be offered two bed roomed flat, does not tell the housing officer that Child L is already at the family home.
27.12.12	Child L arrested for breach of bail conditions. Police serve drug warrant at family home, information not shared with other agencies.
10.02.13	Baby D born, BW 3.02Kg
21.02.13	New birth visit by agency health visitor.
First 2 weeks in March	Consultant Radiologist indicates first fractures are likely to have happened during this period.
11.03.13	Incident at family home, four men demanding a stolen mobile phone back. Return later according to family members to rob the house and hold a knife to the throat of a friend. Brick thrown through the window. Mr J and Child L go to another house. Miss F and Mr H stay with Baby D despite being advised to leave the home.
14.03.13	Strategy Meeting held: health agencies not invited. Outcomes from the meeting are: joint visit to family home with SW for Child L and Miss F, complete initial assessment by 25.03.2013, advise Mr J to remain at friend's address, obtain update from HV, explore housing options, special scheme to be put on Police System.
27.3.13	Miss F visits GP: post natal check, plus 6-week baby

	check. Weight 3.48 Kg
16.4.13	Joint home visit by HV and SW invited to CHC for weight check.
23.4.13	Attended CHC for weight check; 3.92 Kgs, length 54cms
29.4.13	Child D taken to A&E: painful left arm. Admitted. CP referral to CSC. Skeletal X ray showed several fractures, some 6-8 weeks old, as well as broken arm.
29.4.13	Strategy Meeting. Parents arrested.

1.5 Methodology

Statutory guidance² requires SCRs to be conducted in a way that:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

The following principles should underpin all reviews³:

- There should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;

² Working Together 2013: page 67

³ Working Together 2013: page 66-67

- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process.

In addition, SCR reports should “Be written in plain English and in a way that can be easily understood by professionals and the public alike”⁴ To help ensure that this report is accessible to all readers, a guide to acronyms and terminology is provided as **Appendix 2** of this report.

Haringey LSCB has chosen to use the Learning Together systems model, developed within the Social Care Institute for Excellence (Fish et al., 2008) to comply fully with the requirements of Working Together 2013. The Learning Together review process is based on the following key principles:

1. **Avoid hindsight bias.** In order to understand why people acted as they did, it is important to avoid hindsight bias – judging their actions from the standpoint of knowing what happened later, when it is easy to see which bits of information were significant and which were irrelevant. Therefore this systems model seeks to understand the experience and the reasoning of the workers and managers who were working with the family at the time, in particular, to explore what sense they were making of the case, and the contributory factors in the work context that were influencing their practice at the time;
2. **Provide adequate explanations.** The model requires reviewers to appraise and explain decisions, actions and inactions in professionals’ handling of the case, and to view performance as the result of interactions between the context and what the individual brings to it.
3. **Move from individual instance to the general significance.** The case provides a ‘window on the system’, finding out whether weaknesses visible in the management of an individual case are widespread, and so leading to a broader understanding about what supports and what hinders the reliability of the multi-agency CP system.
4. **Produce findings and questions for the Board to consider.** Some findings lead to the simple recommendation of a new rule or specific action; others may require the Board to consider how to balance identified needs with other demands on agencies’ resources.

⁴ Working Together 2013: page 70

5. **Analytical rigour.** Qualitative research techniques are used to underpin rigour and reliability, alongside a very open process so that others can see how conclusions were reached.

Full details of this review process are contained in **Appendix 1** of this report.

1.6 Reviewing expertise and independence: Lead Reviewers

The review was led by two independent SCIE Lead Reviewers; Ghislaine Miller and Ann Duncan. They both have extensive experience in writing SCRs/IMRs under the previous 'Chapter 8' framework, and have received training and accreditation in the SCIE Learning Together model. Neither has any previous involvement with this case, or any previous or current relationship with Haringey council or partner agencies.

The Lead Reviewers have received supervision from SCIE as is standard. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

Review Team

This comprised **8 senior professionals** (a full list is in Appendix 1 of this report) from the multi-agency services involved with the family. Their role was to provide a source of high-level strategic information about their own agencies, as well as professional expertise in their fields. Together with the Lead Reviewers, they collected data about this case, including a review of records from the organisations involved, and produced and agreed the content of this report.

Full involvement of practitioners

The second important group taking part in the case review was **18 front-line professionals and first-line managers** (a full list is in Appendix 1 of this report) who had worked with the family in different capacities, known as the Case Group (CG). They provided a detailed picture of what happened in this individual case, and also their knowledge of the systems as a whole, to help us understand whether practice in this case had been typical or otherwise. To elicit their involvement and experiences of this case, members of the Review Team (RT) held individual conversations with the Case Group professionals. Some members of the Case Group attended two multi-agency meetings to contribute to the analysis and findings from the Review Team and Lead Reviewers.

1.7 Methodological comment and limitations

1.7.1 Participation of professionals

At times during this review the lead reviewers felt that there was not always an effective response by the RT and CG members. It has been difficult to get any momentum going and attendance at the Follow on Meetings with the CG was poor. This may have been due in part to the re-organisation of CSC during this timeframe when members of staff were under threat of losing their jobs and different agencies sending new personnel. By the end of the process there were only 4 of the 8 original RT members remaining and

there have been 3 different representatives on the RT from the hospital. This has impacted on consistency and ownership. Despite these set backs the content and quality of the conversations and background documentation provided credible and important information in order to understand the case.

The 18 conversations that took place provided rich information and proved to be a positive experience for most practitioners. The RT members embraced the conversations as a new learning tool and were impressed by the level of understanding about the development of the case that emerges from them. One social worker commented:

“This was one of the best processes I have taken part in. I learnt a lot”.

1.7.2 Perspectives of the parents

Child D’s parents have contributed their views to the review via a meeting held on the 7th February 2014, with the two Lead Reviewers. The purpose of the meeting was to hear the parents’ views on the services they had been provided during the period under review.

1.8 Structure of the Report

The next chapter (Chapter 2) of this report begins with a summary of what happened in the case. This leads on to a presentation of the **6 priority findings**. Each finding concludes with some key questions that the finding raises for the LSCB and member agencies. **It is the responsibility of the LSCB to decide how best to respond to the findings, with the aim of reducing the recurrence of poor practice. The questions are intended to support their considerations.**

2. FINDINGS: WHAT LIGHT HAS THIS CASE REVIEW SHED ON THE RELIABILITY OF OUR SYSTEMS TO KEEP CHILDREN SAFE?

2.1 Introduction

Statutory guidance requires that SCR reports ‘...***provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence. These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong.***’ (2013: 65)

This section firstly explores the ways in which features of this particular case are common to other work that professionals conduct with children and families, and therefore how this one case can provide useful organisational learning to underpin improvement.

This is followed by a synopsis of the appraisal of practice, provided for the reader. This sets out the view of the Review Team about how timely and effective the interventions with Child D and the family were, including where practice fell below expected standards. Where possible, it provides explanations for this practice, or indicates where these will be discussed more fully in the findings.

Finally, this section discusses **6 priority findings** that have emerged from the SCR. The findings explain why professional practice was not more effective in protecting Child D in this case. It also outlines the evidence that indicates that these are not one-off issues, but underlying patterns – which have the potential to influence future practice in similar cases. We also consider what risks they may **pose to the wider safeguarding of children**.

2.2 What is it about this case that acts as a window on practice more widely?

2.2.1 Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including serious case reviews (SCRs) states:

‘Reviews are not ends in themselves. The purpose of these reviews is to identify improvements that are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.’⁵

2.2.2 Haringey Safeguarding Children Board (LSCB) identified that the SCR of this tragic case held the potential to shed light on particular areas of practice:

What has this case told us about what was known about the family

- Mother was a care leaver; historical abuse within the family; history of “scapegoating” of Child L, and that Miss F was pregnant and the father of the baby was 17 years older than her
- Miss F’s refusal to engage with appropriate support services
- Difficult relationship between the parents

What has this case told us about communication between agencies?

Was there information that agencies knew that could have prevented the injuries to Child D?

What contact did agencies have with Child D during this period?

What assessments were carried out to support the decision to return Child L to the household during this period?

2.3 Appraisal of Practice in this case: a synopsis

⁵ Working Together, 2013:66

This synopsis summarises what we learned about professional practice in this case and forms a context for the findings that follow in Section 2.5. It aims to capture the appraisal (or judgement) that the Review Team made about how professionals handled this case: what was good practice and what was poor practice, given what was known and knowable at the time. The findings that follow provide the explanations of the ‘why’ questions, defining what got in the way of providing more effective help.

Overview

In summary, the Review Team’s appraisal of how professionals handled this case was that despite the plethora of information, risk factors and family history, professionals treated this as historical and not relevant to the current situation, and consequently that this information did not appear to influence current judgements of risk. It appears that the professionals concentrated on the present and gave little weight to the past, evidencing a pattern of practice often known as ‘start again syndrome’,⁶ combined with a high level of professional optimism based on very little substance.

Evidence from SCR’s⁷ and research suggest that history is an important part of assessing current and future parenting capacity and should be considered as a potential risk factor. In this case, the family dynamics were not explored and the agencies appeared to work in silos, with little information and challenge between and across agencies.

Perhaps what is the most challenging for the child protection system is that, despite the presence of risk factors, professionals did not take them seriously enough, judging that the case did not meet the threshold for ongoing CSC intervention, either under section 17 (child in need) or section 47 (child protection) and so the case was closed by CSC following the Pre-Birth assessment. The family had contact with health professionals during this time focusing on maternal health and housing support, but the family told us that they felt “let down” by professionals and feel they could have “done a lot more to help them, particularly with housing issues”.

The key features of how the case was handled by professionals are detailed and appraised below.

1. Lack of appropriate response by all the agencies involved to the high level of violence within and around the family, and consideration of the impact of this on a small baby.

The family, well known to CSC and the Police, had a complex and violent history. Professionals in CSC had access to these documented facts but did not consider that they were of significance to the current situation, or how they might impact on the family dynamics particularly when Child L returned to the family home. When we spoke to Child D’s mother, she described Child L as being “*all over the place. He came home when I was 29 weeks pregnant and that was a big risk, as he was so violent and*

⁶ Brandon 2008

⁷ Brandon et al, SCR Biennial Review, 2009, DfE.

aggressive. [Professionals] should have thought about that before they put him back into the house". The family did not raise this concern when the case was active.

The Professionals involved in placing Child L back to the family home did not involve the police and therefore the opportunity for background checks to be carried out every person living at this address was lost.

Despite these risk factors, professionals from CSC considered it safe for Miss F to live at the family home alongside Child L and his escalating anti-social behavior.

When an incident happened at the family home in March 2013 involving four men (the family thought that they were members of a gang), the family was subjected to threats of violence and a brick being thrown through a window narrowly missing Child L. The family was advised to stay with friends or family at another address overnight. Mr. J and Child L did leave the family home but Miss F remained with Child D. (CSC thought that Miss F and Child D were going to spend time at the Grandmother's home) Mr. J refused help from the police and was unwilling to give them any information on the incident. This must have been very frightening for the family and in particular Miss F with her new born baby who was one month old at the time. A Merlin was completed by the police officers and shared with Child L's SW.

Following the incident, a strategy meeting was held, the purpose of which was to share information and establish the facts about the circumstances that were giving rise to the concerns. The decision to hold a strategy meeting was appropriate, however health agencies were not included in this meeting, and it did not consider whether there was a need for a Section 47 enquiry. In discussion with the CG they were clear that the outcome of the meeting was to gather more information and hold a review meeting in one month's time, this did not happen. This was another missed opportunity to review and assess the information and changing circumstances of this family. There appeared to be little recognition of the underlying violence that they were exposed to both inside and outside the family home. **This will be explored further in Finding 4.**

2. Superficial assessments carried out by professionals who appeared to be impressed with Miss F's resoluteness, determination and aspirations for her baby and her apparent resilience to family life. However, this was a naïve approach and lacked signs of professional curiosity and healthy scepticism.

The initial referral to CSC from the Teenage Pregnancy Midwife (TPM) in June 2012 was because of her family background, and because Mr. J was unsupportive of the pregnancy, he did not like the father of the baby, did not want Miss F to live in the family home after the birth of the baby, and wanted Miss F to have a termination. The TPM also noted that there was a large age difference (17 years) between Miss F and Mr. H, but there was little exploration of what this may indicate or whether there was cause for concern. This was an appropriate referral, albeit one, which did not outline sufficiently clearly the causes for concern.

A Pre-Birth Assessment was initiated; the assessment was completed within the timeframe but lacked analysis and impact of her past experiences. Although the SW

commented on her immaturity during the first meeting, at the follow up meeting the SW was impressed with Miss F's aspirations for her baby and determination that her baby was going to have a better life than hers. Miss F was very positive about being pregnant and spoke of going back to college after the birth of the baby. Miss F was initially wary of the SW due to her own experiences and was fearful that her 'baby would be taken into care'. Miss F was unable to give her partner's surname at the first meeting but did know that he had two children from a previous relationship and had been in prison.

A follow up meeting was arranged with the social worker and Mr. H, accompanied by Miss F. He gave the social worker his missing personal details including his children's names. Mr. H gave the wrong spellings of the children's names, and the social worker thought he had done this deliberately. The SW showed tenacity in tracking down the children who were known to CSC in a neighbouring London Borough and in making a request for more information. The RT found no evidence that this had been followed up by Haringey CYPS and this should have happened to understand what involvement there had been with his previous family and if it was ongoing.

Despite all of these factors; (a pregnant 17 year old leaving care, her partner 17 years older than her, and having suffered neglect and physical abuse from her father, pressure from her family to have a termination and the background of the family), the case was closed. It was deemed too early to carry out a parenting assessment and the view of the SW was that there were no current concerns. The TPM accepted this as she also felt that Miss F was engaging well with the service and the concerns were all in the past. The SW informed the Midwife and Health Visitor that the case was closed and that they should re-refer if they had any new concerns.

The Review Team's view was that this decision showed a lack of understanding of how Miss F's past experiences, as well as current issues relating to her mental health, housing and family situation could impact on her and her child's welfare. However, there was evidence that this is a norm in cases of this kind: the Case Group was of the view that the family circumstances were typical of many families they deal with and would not automatically meet the thresholds for intervention.

There was a thread running through the assessments made by health and social care that the risks were historical and therefore not relevant to the present. Professionals failed to consider the impact of the past on Miss F and her ability to parent. The RT thought that it was poor practice that it was deemed too early to commence a parenting assessment particularly in light of Miss F's own childhood experience of being in care herself and her lack of support and guidance; where was her 'parenting compass'?

This was a missed opportunity to build up a relationship with this young mother in order to carry out a fuller and more robust assessment of risk to herself and the baby. Information from CG members during the conversations and at the Follow On meetings identified that there is an expectation in Children's Social Care (CSC) that staff should complete the assessments within the timeframe and close cases as quickly as possible. The timescale and organisational pressure appears to be the driver, as opposed to an

understanding that an assessment is an iterative process that takes time (this was confirmed by members of the RT). (**See Finding 6**).

3. Professional responses to Miss F's refusal of support services resulted in an increased risk to her and her baby.

The Teenage Pregnancy Midwife (TPM) had referred Miss F to the Family Nurse Partnership. This was an appropriate referral, however Miss F refused the service as she felt that she would get all the support and advice from her friends all of whom had babies. In view of Miss F's past history and her refusal to engage with the FNP, the RT were of the opinion that a Common Assessment Framework (CAF) should have been completed by the TPM.

Following her refusal to engage with the FNP she was referred to the Health Visiting Service for antenatal visits. This was good practice. The Health Visiting Service targets families with identified risk factors to carry out antenatal assessments. Miss F received two antenatal visits, HV1 and HV2 and there was a plan for a third visit, this did not take place due to workload. HV1 had correctly identified the risk factors but then shortly left the service. HV2 appeared to treat the information and assessment by HV1 as historical factors and felt that Miss F was preparing well for her baby and had no current concerns. (**See Finding 6**).

Miss F attended all her antenatal appointments and the pregnancy was progressing well. There was no liaison between the HV and TPM during the pregnancy, both the TPM and HV2 worked with the family but did not share information. The explanation given by TPM (during her conversation) was that Miss F was fully engaged with the service, and there were no new concerns during the course of her pregnancy. HV2 referred Miss F to a variety of support services, including HARTS, Family Outreach and Family Support all of which she turned down apart from Homesafe (a service for care leavers), which she was refused as she did not meet the criteria. Families often refuse other support services but given the vulnerability of this young mum it is disappointing that the professionals were unable to persuade her to engage with these targeted services.

4. Lack of information sharing between the agencies involved, particularly when Child L returned to live in the family home under a Placement with Parent Agreement.

During the review period, a number of agencies had contact with different members of the family, including CSC, the Police and health visiting. Information was not shared between these professionals, meaning that a holistic view of the risks within the family was not achieved.

Child L returned to the family home under a Placement with Parent Agreement in November 2012, at which time Miss F was 29 weeks pregnant. The Children in Care (CIC) SW carried out the risk assessment but this was carried out from the perspective of Child L, who was then aged 14. There appeared to be little analysis of the possible impact that Child L might have on the family dynamics, it was known that Miss F and

Child L used to fight when they were younger and he was aggressive towards his half sister. This information was not shared with the Health Visitor or the First Response Team (CSC).

The fact that Child L had returned to the family home was treated in isolation and because the other agencies were unaware of his return there was no opportunity to explore the changing circumstances or consider whether there were any risks for the safety of Miss F and her unborn baby. The RT felt that a professionals' meeting should have taken place on Child L's return. This would have allowed the professionals involved with the family to have a full understanding of the situation, explore what the potential risks might be and develop a robust plan including a police check on all members of the household.

The Youth Offending Team (YOT) did not share information with other agencies involved when: Child L had breached his bail conditions. The Police did not share the information when Mr. H was caught in possession of a gun and driving without insurance (he was arrested and charged in January 2013, however the Police would be unaware of his relationship with Miss F and he gave the police a different address). A MERLIN was completed when they were called to the family home at the request of Miss F, as Child L was being very aggressive towards her, and this was shared with the SW for Child L which is the normal practice if the case is open rather than going via MASH. However given the age of the Child D the threshold to undertake a separate assessment under MASH protocol would have been reached.

5. Inadequate responses to identified needs at the new birth visit

The purpose of a new birth visit carried out by health visitors is to: develop a relationship with the family; assess the growth and development of the baby, and assess the family situation. This informs a decision about the most appropriate level of intervention that will be required - universal, enhanced or enhanced plus. The visit is usually carried out between 10-14 days post delivery and takes place in the family home.

The health visiting service has corporate caseloads⁸. The allocation of work is done by the team manager electronically and entered directly into the practitioner's diary, the usual practice would be that this is done during an allocation of work meeting allowing face-to-face discussion and a pooling of information known about the family. However, in this case, team meetings did not take place.

In this case the team manager of the health visiting service allocated the new birth visit to an agency health visitor. Given that HV2 had already visited Miss F and started developing a relationship it would have been more appropriate for the new birth visit to be carried out by HV2. Agency health visitors were being used to manage capacity, as there were vacancies within the team and a high number of births, as a consequence of this, the permanent staff held more safeguarding cases and worked with families requiring a higher level of support.

⁸ Corporate caseloads is when a team of health visitors work together on a shared caseload.

Prior to the agency HV3 undertaking the new birth visit she did not check on the electronic records⁹ and was unaware of the antenatal contacts. Following completion of the new-birth visit HV3 had no concerns but having read the records and in discussion with the team manager agreed that the family required further assessment, and an enhanced service. Although this case was identified correctly as requiring ongoing support this failed to happen (due to workload and no agreed follow up time from the new-birth visit) and the next home visit by HV2 was a joint visit with the SW in April.

6. Lack of attention to indicators of safeguarding issues within primary care.

After birth, Child D showed a pattern of weight gain that had fallen from the birth centile, and although this was recorded by primary care there was no follow up or referral to the health visiting service and no consideration of whether there were any safeguarding concerns. Child D's parents also told us that they had expressed concerns to health professionals about Child D's health, but that these were not followed up. It was unclear whether these views were expressed (and if so to which professionals) as there is no recorded documentation of these concerns.

Child D was taken for a six-eight week review with the GP in March 2013. It is unclear whether the GP examined the baby naked and there is no reference made to whether Child D became distressed on handling or if any blue pigmented naevi were present.¹⁰ Child D had multiple blue pigmented naevi in the following areas (as listed in the independent Medical report): left wrist, over the left elbow, over both right and left shoulders and over the upper thoracic spine, the right ankle and over both buttocks. (These blue spots can sometimes be mistaken for bruises and should be recorded to exclude NAI.) It is now known that at the six-eight week assessment Child D would have already sustained fractures to the leg and ribs¹¹.

In our conversation with Child D's parents, they expressed a view that they wished that Health professionals had found out about Child D's injuries earlier. It is difficult to conjecture whether Child D's injuries could have been detected at this stage. However, the recording does not give evidence to suggest that appropriate examinations were conducted which could have facilitated identification of these injuries.

At birth, Child D weighed 3.022 Kg (9th centile), length 47cm and head circumference 34.5cm. At the six-eight week review the weight was 3.48Kg (2nd centile i.e. a fall of one centile space) and head circumference 33cm. These measurements were recorded in Child D's Personal Child Health Record (PCHR) known as the Red Book. However, there is no evidence to suggest that the weight was plotted on to the centile¹² chart: **this**

¹⁰ Electronic record keeping systems (RIO) introduced in 2011 has enabled robust management of work. Systems are now interrogated on receipt of the Birth Notification so that historical information forms part of a pre-visit risk assessment.

¹⁰ Blue pigmented naevi are a type of birthmark that are present at birth or appear soon afterwards, either single or multiple in number and are common in children with pigmented skin.

¹¹ Radiologist report

¹² Centile chart WHO growth charts

is poor practice. We also found no documentary evidence recording the feeding regime at the six-eight week review or how Miss F was coping given that she was a young mother. During the conversations it also emerged that all babies were weighed with their nappy on in this GP practice; **this is poor practice and needs to be addressed urgently.**

The failure of Child D to maintain the birth weight trajectory, and the implausible head circumference measured by the GP, did not trigger further analysis. However, after the six week review, the GP recorded that no follow up was required. The RT were struck by the fact that little or no consideration was given to the growth of this baby and were of the opinion that a referral should have been made to the HV for further exploration and monitoring. Our scrutiny of the records suggest these checks were a tick box exercise with no analysis or consideration about the possible reasons for slow weight gain in a baby that is being bottle-fed.

The apparent slowing down of Child D's weight gain was picked up by HV2 in April when she did a joint home visit with SW, but HV2 did not discuss this discrepancy with the GP. HV2 recorded the feeding regime, that the baby had green stools and had 'colic'. Miss F showed concern about Child D's weight gain and attended the child health clinic as advised by the Health Visitor. **Child D's weight on this occasion was satisfactory. The reasons why health professionals did not pick up safeguarding indicators are discussed further in Finding 3**

7. Inadequate Management Oversight and lack of Supervision

During this case there were key opportunities for those professionals in management posts to give direction and guidance to front line staff. In particular the RT felt that the Pre-Birth Assessment should not have been signed off (the manager spoke about it being a poor assessment during the conversation but signed it off due to the pressure of meeting the target, see **Finding 1**). When Child L returned to live in the family home there appeared to be a lack of management oversight and no rehabilitation plan for Child L.

The team manager for the health visiting service allocated the new-birth visit to be carried out by an agency health visitor rather than waiting for the health visitor who had already visited Miss F in the antenatal period to return from one days annual leave. This coupled with the fact that this case was not taken to supervision by the SW at all and the health visitor only after the joint visit with the SW in April 2014.

Supervision within the arena of child protection is an important opportunity for front line clinicians to have protected time in order for them to explore any fixed thinking that they may have on the case. Health Visitors receive Child Protection supervision every three months, but can also access supervision more frequently if required. Management supervision is received monthly but can be cancelled due to pressure of work. Social Workers receive monthly supervision on their caseloads.

During this case, clinicians talked openly about the importance of supervision but also felt that there was insufficient time to review cases adequately. The caseworkers spoke of supervision becoming more directive; checking that plans had been followed and less focused on the emotional demands of working with children and their families. It was felt that this was due to the sheer numbers of families that needed to be brought to supervision, rather than the supervisor being unwilling to provide supportive, reflective and challenging supervision.

The CG also highlighted that many families like this would not be discussed in supervision, either because the case worker did not identify the need for the case to be discussed or because the case had been assessed and closed before an opportunity to discuss in supervision presented itself. Furthermore, HV2 was a newly qualified health visitor and had a named mentor who had only been qualified a year, so was also unable to provide expert advice and guidance.

The RT felt that if caseworkers had received better quality supervision it might have supported the individuals in recognising risk factors and planning interventions to mitigate against them (**see Finding 6**). We know that individuals cannot police their own biases or fixed views; supervision is therefore key in helping to support staff, not just with the volume and demanding pace of work but with its nature, which regularly brings them into face-to-face contact with vulnerable adults. **This will be explored further in Finding 5.**

8. Good professional responses to admission of Child D to A&E.

Miss F attended the hospital A&E department with Child D on 29th April. She had noticed that Child D's left arm was 'floppy' and the child cried when Miss F touched the arm or tried to change the child's clothes. An X-ray of the child's left arm confirmed a fracture of the ulna and radius. Child D was admitted to the hospital, as there was no clear history of how the injury to the arm happened. A skeletal survey, CT head scan, ophthalmology review, blood tests and plotting of the baby's weight and head circumference were undertaken. A referral was made to CSC. This was good practice and demonstrated that the safeguarding system worked well when a baby presented with a physical injury.

2.5 Findings

The final stage in a Learning Together review is to use the case as a 'window on the system' (Vincent, 2004) and identify what this case has told us about more general weaknesses in the multi-agency safeguarding system. These are set out as a series of findings, which represent the main learning from this case review for the LSCB and partner agencies. Each finding is set out in a way that illustrates:

- How does the issue feature in this particular case?
- How do we know it is not peculiar to this case? What can the Case Group (those who worked with the family) and Review Team (the senior managers from each agency appointed to help with this case review) tell us about how this issue plays

out in other similar cases/scenarios **and/or** ways that the pattern is embedded in usual practice?

- How prevalent is the pattern? What evidence have we gathered about how many cases are actually or potentially affected by the pattern?
- How widespread is the pattern? Is it found in a specific team, local area, district, county, region, national?
- What are the implications for the reliability of the multi-agency child protection system?

The evidence for the different ‘layers’ of the findings comes from the knowledge and experience of the Review Team and the Case Group, from the records relating to this case, and other documentation from agencies, and from relevant research evidence.

Six priority findings were chosen because they represented areas of practice which were significant in how this case was managed, but which also reflected wider patterns of practice and the systems which underpin that practice.

Finding	Category
Finding 1. A culture of meeting targets and timescales has resulted in a lack of critical analysis when conducting assessments: “hitting the target; missing the point.	Management Systems
Finding 2: A potential pattern where Looked After Children and Young People who move placements on a regular basis are not appropriately assessed each time, resulting in a missed opportunity to review and amend the care plans in place.	Multi-agency working in longer-term work.
Finding 3: A potential pattern by which postnatal checks and developmental assessments undertaken in General Practice do not always consider issues relevant to safeguarding.	Multi-agency working in response to incidents and crises.
Finding 4: A pattern whereby practitioners have become accustomed to working with families surrounded by high levels of street and drug-related violence, meaning that this does not lead to a consideration of impact on parents and children.	Multi-agency working in response to incidents and crises.
Finding 5: A pattern whereby practitioners do not bring a case to supervision either because they fail	Human Biases

<p>to identify the need for supervision, or the case has been closed, resulting in a lost opportunity to challenge the interpretation of facts and the plan for intervention.</p>	
<p>Finding 6: A pattern whereby practitioners superficially identify risk factors but do not consider the significance or impact they might have, resulting in inappropriate levels of intervention to safeguard children.</p>	<p>Human Biases</p>

Findings in detail

The remainder of this section discusses the **six priority findings** in more detail.

Finding 1. A culture of meeting targets and timescales has resulted in a lack of critical analysis when conducting assessments: “hitting the target; missing the point”.

Assessment is a vital stage in any professional relationship with a family. It is at this point that a holistic picture of a family’s needs and strengths should be formed, and any potential risks to children identified, as a robust basis for making decisions about future service provision. This case identified a pattern in which assessments appear to be undertaken in a superficial manner, apparently driven by a need to meet prescribed timescales. This leads to an incomplete consideration of family circumstances, which can in turn mean that families experiencing high levels of risk and need do not receive the appropriate services.

1. How did this manifest in this case?

Throughout this case, assessments and visits were undertaken as required, and within timescales. However, they were frequently of a superficial quality, missing out on key risk factors and opportunities to intervene. This suggested that the emphasis on timeliness of assessment has not been accompanied by an emphasis on quality. At worst, efforts to meet timescales appeared to exacerbate superficiality of engagement with the family.

A Pre-Birth Assessment was undertaken by the social worker which identified some of the risks: a previously looked-after child with a history of physical abuse and neglect and, whose partner is 17 years her senior, facing a lack of support for her pregnancy from her family. However, these were treated as historical factors and the SW was reassured by the positive response and aspirations the mother had for her un-born child. Although the Manager of the SW felt that the assessment was inadequate she still signed it off in order to meet the 35-day time-scale. The view at the time of the assessment was that it was too early to undertake a full parenting assessment and as there were no current issues the case was closed and the other agencies involved

informed to re-refer if there were any new concerns. This short-term involvement of CSC in cases at the “front door” leaves them with a fragmented view of cases.

Secondly, following the birth of the baby the health visiting service undertook the new birth visit. This should be done within 10-14 days after the birth and there is an expectation that this target is reached. The case was allocated to an agency health visitor, as the family health visitor was on one day’s annual leave. The agency health visitor was not aware of the family background and was unaware that the family had received two antenatal visits from the health visiting service. The use of agency health visitors as a way of meeting targets therefore, in this case, meant that the quality and relevance of the assessment was weakened.

The six –eight week post natal check and infant review of the baby were completed within the timeframe. Sadly, in this case the poor weight gain and the discrepancy in implausible head circumference were not queried or analysed in any way, or a referral made to the HV.

When the incident happened at the family home in March, a strategy meeting was held within 48 hours; unfortunately there was no health representation at the meeting despite the fact that they were involved on an on-going basis with the family and may have had relevant information to share.

2. What makes this an underlying issue?

Both the Case Group members and the Review Team were very clear that there is still pressure to meet the targets across all agencies. Each organisation is monitored on a monthly basis against agreed performance indicators. During the conversations practitioners spoke about the drive to complete the assessments within the 35 day timeframe even if the resulting assessment was deemed to be poor, or lacked in-depth analysis. Health Visitors are expected to visit 95 per cent of all new births by day 14.

3. What is known about how widespread or prevalent the issue is?

Members of the Review Team reported that there is evidence of significant pressure from all agencies to meet monthly targets. Within CSC there is added pressure to close cases and put the emphasis back on the other agencies to re-refer, resulting in a fragmented view of the family, little or no analysis of the family background and at times a failure to recognise the significance of the risk factors and the impact that they may have on family dynamics. This is often described as the ‘revolving door syndrome’

¹³There is evidence that this is a national issue: this was something that was picked up in the Munro Review.¹⁴

¹³ ¹³ June Thoburn et al, 1999, cited in Enhancing the wellbeing of children and families through effective intervention, Jessica Kingsley Publishers, 2006

¹⁴ ¹⁴ The Munro review of Child Protection, Department for Education, June 2010

4. What are the implications for the reliability of the multi-agency child protection system?

All agencies have finite resources, and must make 'trade-offs' to meet priorities with the resources they have. Placing a high level of emphasis on meeting timescales means that this may be 'traded off' against the quality of work – meaning there is insufficient emphasis on, and time allowed for, undertaking a thorough assessment of risk and need. This means that vulnerable families may be left without support.

Finding 1. A culture of meeting targets and timescales has resulted in a lack of critical analysis when conducting assessments: “hitting the target; missing the point.

Whilst timescales are important to ensure that cases do not drift, there needs to be a sense of proportionality, to ensure that cases are assessed rigorously, rather than being closed prematurely. This case has suggested that the emphasis on timeliness of assessment has not been accompanied by an emphasis on quality. At worst, efforts to meet timescales appeared to exacerbate superficiality of engagement with the family.

ISSUES FOR THE BOARD AND MEMBER AGENCIES TO CONSIDER:

- Is information provided to the LSCB only on meeting timescales and performance targets, masking underlying issues about the quality and effectiveness of interventions?
- The LSCB needs to be assured that cases are allocated in a timely way to ensure that workers have sufficient time and capacity to undertake the assessment.
- The practice of allocating cases by e-mail (even when workers are on leave) needs addressing.
- Given the National and London problems with recruitment and retention of health visitors, is there an opportunity to use the money allocated to address this problem in a more effective way?
- The use of agency health visitors in conducting new birth visits should be reviewed

Finding 2. A potential pattern where Looked After Children and Young People who move placements on a regular basis are not appropriately assessed each time, resulting in a missed opportunity to review and amend the care plans in place.

Placements for Children and Young People in care should be made on the basis that it is in the best interest of the child or young person to move and that the placement will provide a stable and nurturing environment to allow the child to reach their full potential. It should not be made on the basis of poor planning and resource shortfalls. This case suggested evidence that the return of the young person to the family home appeared to be driven by expediency rather than being needs led, and based on thorough assessment. In this case, this meant that the potential risks to other family members were not considered.

1. How did this manifest in this case?

Child L, Child D's uncle, was subject to a Care Order and had his own newly allocated social worker, who was overseeing his placement in residential care. After frequent episodes of going missing, and becoming involved in criminal behavior, it appears that Child L "voted with his feet" and returned home with his father, unbeknown to the social worker. This fait accompli resulted in Child L remaining at home, under the Placement with Parents (PWP) regulations, and the allocation of an additional student social worker. The PWP assessment that should have underpinned this agreement did not take account of the fact that his pregnant sister (29 weeks) was also living there, in a 2-bedroom maisonette. There was no assessment of this "re-constituted" family (the children both now living with their father, whose care they had been removed from in the first place) or the potential risk to the (unborn) baby, either from the overcrowding, or from Child L's "out of control" behavior, which included drinking, drugs and criminal activity.

2. What makes this an underlying issue rather than a particular issue to the individuals involved?

The RT and CG members were clear that, due to the high number of children and young people in care, time constraints meant that a full assessment was not always done for children who move frequently. The fact that this did not happen in this case and the opportunity to review all of the occupants of the household may be replicated in other cases.

3. What is known about how widespread or prevalent the issue is?

The information above suggests that this issue was not restricted to this case, however it is unclear how widespread this is in terms of other Looked after Children and Young People in Haringey.

4. What are the implications for the reliability of the multi-agency child protection system?

The risk is that there is an assumption that all Looked After Children and young people will have a robust assessment undertaken at each placement that clearly identifies the health needs and risks to allow rehabilitation plans to be put in place. If this does not happen there is a danger that the wider safeguarding network remains unaware of the potential risks in the current placement.

Finding 2: A potential pattern where Looked After Children and Young People who move placements on a regular basis are not appropriately assessed each time, resulting in a missed opportunity to review and amend the care plans in place

We know that Looked after Children and Young People are vulnerable and that it is imperative that a placement is selected on the basis of providing a stable and nurturing environment. For those children that become difficult to 'place' it is even more important that a rigorous and full assessment is undertaken especially when the placement is back in the home that they were removed from.

ISSUES FOR THE BOARD AND MEMBER AGENCIES TO CONSIDER:

What steps will the Board take to ascertain whether this is a more common pattern in practice? For example, an audit of Looked after Children and young people that have changed placements in the past six months could shed further light on this issue.

Is the Board aware of any other children that have been placed back in the family home in the last year?

Finding 3. A potential pattern by which postnatal checks and developmental assessments undertaken in General Practice do not always consider issues relevant to safeguarding?

Postnatal checks and infant reviews should be part of the safeguarding 'safety net' by checking key indicators such as growth and developmental milestones as well as mother's well being. This case suggested evidence that these are not being carried out and recorded thoroughly and in accordance with best practice, meaning that opportunities to identify children at risk are missed.

1. How did the issue feature in this particular case?

Miss F and Child D attended their GP practice for their respective postnatal check and developmental assessment. Child D was seen first by the practice nurse who weighed and measured the baby (with nappy on, see section 6 in Appraisal of practice). The weight and head circumference were recorded in the PHR, but not on the centile charts. The practice nurse did not pick up the head circumference discrepancy at the time, although during the conversation she thought that she had recorded it inaccurately, as she was aware that in particular the head circumference was very small and might be indicative of microcephaly. The baby was then redressed by the mother and was seen by the GP for the physical examination.

The GP completed the physical examination and recorded that 'no follow up was required'. Again there was no analysis of the growth and weight gain of Child D, the measurements were not recorded on the centile charts and there was no exploration of the feeding regime and how this young Mum was coping with her new baby. It is unclear whether the GP examined the baby naked and there is no reference made to whether Child D became distressed on handling or if any blue naevi were present.¹⁵ Child D had multiple blue naevi in the following areas: left wrist, over the left elbow, over both right and left shoulders and over the upper thoracic spine, the right ankle and over both buttocks. (These blue spots can sometimes be mistaken for bruises and should be recorded to exclude NAI.) The GP failed to pick up that Child D's weight gain appeared to be slowing down and should have made a referral to the HV to monitor the weight of this baby particularly in light of Miss F's age and background.

2. What makes this an underlying issue rather than a particular issue to the individuals involved?

Postnatal checks and developmental assessments are routinely carried out in General Practice. The staff involved in these assessments must always consider the possibility that there may be safeguarding issues and must remain vigilant to them. The RT were concerned that some GP practices were isolated and did not always communicate effectively with the health visiting service. The lack of communication of potential safeguarding issues seen in this case may therefore be replicated in other GP practices. The Review Team were also aware of other cases where GPs have failed to either identify safeguarding issues or pass on relevant information to the other agencies involved with the family, including another current SCR.

3. What is known about how widespread or prevalent the issue is?

The information above suggests that this issue was not restricted to the GP practice involved in this case. However, it is unclear how widespread this is in terms of other practices within the Borough or more widely.

4. What are the implications for the reliability of the multi-agency child protection system?

The risk is that there is an assumption that all consultations, developmental assessments that are carried out in General Practice, by GPs, will always consider the possibility that there may be safeguarding issues and the need for referral in to CSC. This relies on the professionals working within the practice to be confident in recognising and acting on what they have observed.

¹⁵Blue pigmented naevi spots are a type of birthmark that are present at birth or appear soon afterwards, either single or multiple in number and are common in children with pigmented skin.

Finding 3: A potential pattern by which postnatal checks and developmental assessments undertaken in General Practice do not always consider issues relevant to safeguarding.

We know that families use the services of GPs in varying ways and that the GP has at times a unique position in being able to assess and monitor the health and well being of the family (in some cases the extended family). Whilst acknowledging that GPs and practice staff have attended the requisite Safeguarding training there needs to be more challenge in how they are applying the learning into their every day practice. In particular, postnatal checks and developmental assessments should be part of the safeguarding 'safety net' by checking key indicators such as weight, growth and developmental milestones and mother's well being. The safeguarding system is reliant on GPs and practice staff identifying and referring cases into CSC.

ISSUES FOR THE BOARD AND MEMBER AGENCIES TO CONSIDER:

- This case has suggested that GPs may not be picking up indicators of abuse and neglect as part of postnatal checks. Could the Board take action to investigate the extent of the problem, for example through audit?
- How well do GPs engage with safeguarding in Haringey?
- Are 6-8 week reviews of babies in General Practice simply a 'tick box exercise', rather than including an opportunity for analysis and consideration of safeguarding?

Finding 4. Practitioners have become accustomed to working with families involved in, and surrounded by, high levels of street and drug-related violence, meaning that this does not lead to a consideration of impact on parents and children.

Risks to children may not just come from within the home or their immediate family. Other adults with whom the family are involved, or the community at large, can also present a safeguarding risk to children, particularly where involvement is street or drug-related. It is important for the reliability of the safeguarding system that professionals are able to recognise and take steps to mitigate threats to children's safety arising from these influences. However, this case has suggested a pattern whereby professionals do not consider risks posed by street and drug-related violence. This appears to be partly due to professional 'desensitisation' to this problem in some geographical areas.

1. How did the issue feature in this particular case?

Child D's environment contained significant levels of violence and criminal activity, yet these did not appear to be considered to be a risk factor for this young baby, and did not

lead to child protection measures being taken, or more urgent steps being taken to re-house Miss F.

There were several occasions on which Police were involved with members of the family in relation to violence and criminal activity, including:

- Arrest of father (Mr. H) for possession of a firearm (January 2013 prior to the birth of Child D and he gave a different address, at this point it would not be known about his connection)
- A drug warrant served on the family home in December 2012 (before Child D was born)
- Police called to the house to deal with an incident of aggression by Child L towards Miss F and completed a MERLIN (see appraisal of practice)

There was also an incident at the family home in which four men turned up looking for a mobile telephone, returned later possibly looking for drugs, held a knife to the throat of a friend of the family, and then threw a brick through the window narrowly missing Child L. Mr. J and Child L left to stay with friends because of the danger, but Miss F remained in the house with her young baby despite reportedly receiving death threats on her phone; CSC had advised her to leave and were under the impression that she was going to stay with her grandmother for a few days.

After this incident, a strategy meeting was held. The purpose of this meeting was to share information and establish the facts about the circumstances that have given rise to the concerns, understand the level of risk which was deemed to be a low level and decide what was required. The decisions taken at the strategy meeting were to undertake a single assessment on Miss F and Child D, liaise with the HV and continue to advise Mr. J and Child L to stay away from the family home, a follow up meeting to take place in one month, this did not happen as Child D was admitted to hospital.

The levels of violence in the family could also have potentially posed a risk to staff, yet these were not raised as a concern. Only one caseworker identified the potential dangerousness of the situation and refused to do a home visit. This is indicative of workers getting used to levels of violence and failing to recognise the potential risk to themselves when visiting clients homes.

2. What makes this an underlying issue rather than a particular issue to the individuals involved?

The Case Group were very clear that there were many families like this on their caseloads and the circumstances were not unusual. Indeed when the case group were questioned about the incident at the family home they thought that it 'wasn't that bad, it was only a brick through the window'. One RT member commented that it is considered "par for the course in Haringey".

There is also evidence from recent SCR's where violence within the family and gang affiliation is also a feature.

3. What is known about how widespread or prevalent the issue is?

There is a high level of crime associated with drugs and gangs in this area of North London. It is unclear what numbers of children are placed at risk by this criminal activity.

4. What are the implications for the reliability of the multi-agency child protection system?

A culture in which practitioners accept high levels of violence as being relatively frequent and almost “normal” potentially results in lack of identification of risk to children and contradicts the notion of safeguarding being “everybody’s business”. This increases the risks of harm to vulnerable families.

Finding 4: A pattern whereby practitioners have become accustomed to working with families surrounded by high levels of street and drug-related violence, meaning that this does not lead to a consideration of impact on parents and children

In this particular area of Haringey drug and street violence are so common that they have become perceived as normal. Front line members of staff are in danger of failing to fully comprehend the levels of danger and risk in some families. This not only exposes professionals to potential danger, but also leads to a minimisation of risk to some of those living in the household.

ISSUES FOR THE BOARD AND MEMBER AGENCIES TO CONSIDER:

- Does the board know if professionals are aware of gang activity?
- Does exposure to gang- and drug-related violence form part of safeguarding assessments? If not, should it?
- Do members of the LSCB consider it necessary to find new ways of raising awareness amongst agencies of the continuing high levels of violence (including gang violence) drugs and crime in the borough?

Finding 5. A pattern whereby practitioners do not bring a case to supervision either because they fail to identify the need for supervision, or the case has been closed, resulting in a lost opportunity to challenge the interpretation of facts and the plan for intervention.

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). As Munro (2008) notes:

‘Psychological research has shown that people are very bad at policing their own biases. Social workers need regular critical supervision to ensure that their biases are not distorting their assessments.’

Supervision is a key mechanism by which practitioners can be challenged on the sense they are making of a case, and helped to avoid. This case suggested a pattern whereby supervision is not fulfilling this role, leaving practitioners vulnerable to predictable errors and biases in their thinking, such as the tendency to allow families to ‘start again’ (¹⁶).

1. How did this manifest in this case?

The SW carrying out the Pre-Birth assessment did not take the case to supervision although she did seek guidance and direction from her line manager on an ad hoc basis. The case was closed and therefore there was no opportunity to review the case and consider all the presenting facts to determine what should be considered as historical and what was current.

HV2 again did not identify this as a case that she wished to take to CP supervision during her antenatal contact but did seek supervision following the joint home visit with the SW in April; this was two weeks before Child D was admitted to hospital.

2. What makes this an underlying issue?

The Review Team and Case Group are very clear that the practitioners carry a high number of families with concerns that do not meet the thresholds for intervention but continue to give cause for concern. Through further discussion with the core group it became evident that these cases were seldom taken to supervision as they already had high numbers of cases of Children with a Child Protection Plan or Children In Need. Health staff referred to there being insufficient time available in the supervision sessions to discuss the families in a meaningful way and supervisees are reliant on staff identifying and bringing the right cases to the supervision sessions. SW’s often carry out initial assessments and due to the time constraints may not receive formal supervision on the case as it has been processed and closed.

3. What is known about how widespread or prevalent the issue is?

Members of the Review Team are clear that professionals from all agencies do receive supervision on a regular basis, but the time constraints and robustness are variable.

Several practitioners felt the need to regularly seek “informal” supervision from their manager on an ad hoc basis; but from the managers’ perspective this was not viewed as supervision and would not have been recorded.

¹⁶ Brandon (2008)

There was concern expressed by the RT that a case like this one would not routinely be taken to supervision and therefore the opportunity to challenge the view or perception that the risk factors are historical and therefore not relevant is lost.

4. What are the implications for the reliability of the multi-agency child protection system?

Much has been written on the benefits to both the individual and the organisation when regular supervision is given and received. It is therefore surprising to find that supervision is not always viewed positively, and indeed many of the case workers could not identify with “reflective”, “challenging” or “supportive” supervision. Professionals working with difficult and complex families need protected time to make sense of the information and changing circumstances. This can become even more important when a family has been known to agencies for “years” to provide a critical and challenging view / perspective that allows the facts to be viewed from a different perspective. It also allows professionals to be able to communicate and express their anxieties about the work that they are undertaking with the family, and identify gaps and risks within the multi-agency system.¹⁷

Finding 5. A pattern whereby practitioners do not bring a case to supervision either because they fail to identify the need for supervision, or the case has been closed, resulting in a lost opportunity to challenge the interpretation of facts and the plan for intervention.

Good supervision is fundamental to good practice: in providing support, challenge and reflection, particularly with difficult and complex families. Some complex cases do not get discussed in supervision, either because the case has been opened and closed (the complexity of the case has not been appreciated) or the choice of what cases are discussed is left to the supervisee.

There is evidence of managers being under considerable pressure, with limited time to provide robust and good quality supervision, and many workers rely on ad hoc informal conversations with their manager, seeking affirmation that they are making the right decisions. Whilst this is good, there is a danger that this replaces full discussion within a formal supervision setting, where time is devoted to reflection and appraisal of practice and its effectiveness.

ISSUES FOR THE BOARD AND MEMBER AGENCIES TO CONSIDER:

- Is the LSCB assured that professionals receive timely and qualitative supervision?
- How will the Board review the cases that are discussed in supervision and those that are not?

¹⁷ Brandon (2008)

- What do members of the LSCB consider needs to change in supervision to ensure that is used effectively for reflection and challenge?

Finding 6: A pattern whereby practitioners superficially identify risk factors but do not consider the significance or impact they might have, resulting in inappropriate levels of intervention to safeguard children.

A good assessment including family history and identification of risk factors is fundamental in ensuring that a strong and appropriate plan for the level of intervention is put in place. There is a danger that when professionals from the key agencies fail to identify the risks or understand the significance of them, children are left living in risky situations.

1. How did this manifest in this case?

Throughout this case the professionals working with the family, SW's and Health Professionals, listed the risk factors present within the family and family home but appeared unable to consider the impact that these may have on Miss F's ability to parent, or whether the family home was a safe place for her to be. The family were well known and had a complex history (see paragraph 1.2). Miss F was a young person leaving care who was pregnant and living with her father Mr. J who wanted her out of the family home before the birth of the baby. Miss F attended for all her antenatal care, engaged with the health visiting service but turned down any additional support that would have been available through the Family Nurse Partnership. **This links to Findings 1 and 5.** Following the initial assessment by the SW in the First Response and the subsequent closing of the case the health visitors were reassured by her preparation for the birth of her baby and her attendance for all her antenatal appointments. The HV was unaware that Child L had been returned to the family home or that Mr H was arrested in possession of a gun in January. It is always difficult to get the balance between historical information and current presentation correct in assessing the risk but in this case the professionals appeared to be swayed by the optimism and determination of Miss F who was going to give her baby a better life than the one that she had.

2. What makes this an underlying issue rather than a particular issue to the individuals involved?

Members of the Case Group were asked routinely in conversation whether they were aware of the LSCB Pre-Birth Assessment tool which was developed by the LSCB and launched in July 2012 to help professionals assess and identify risks to unborn children;

none were aware of it. This suggests that it is not routinely used to assess risk to unborn babies across all the agencies and therefore indicates an underlying pattern.

3. What is known about how widespread or prevalent the issue is?

This is a continuing professional problem whereby professionals are constantly balancing risks and making a judgement between what is known about the family against the 'here and now'. Inevitably getting the right balance is not always possible at the time.

Research (Burton 2009)¹⁸ suggests that the human brain struggles to make sense of contradictory data, and the more incremental it is, the harder it is to make sense of that data. In this case the professionals appeared to overlook the lessons of history. Research evidence from SCR's (Brandon et al¹⁹) suggests that history is an important part of assessing current and future parenting capacity, and should be considered as a potential risk factor. It is apparent that 'the past is the best predictor of the future'²⁰. This view of the family was coupled with a rule of optimism and a failure to revise judgments in light of new information. Reder et al²¹ have written about a cognitive error, which results in disregarding new evidence that might challenge the current direction or concept of the case (e.g. family support as opposed to child protection). In looking at 35 cases which ended in children's deaths, they found that, once workers have formed a view of what was going on, they typically fail to notice or give weight to evidence that challenges that picture. In some cases the behaviour springs from a pervasive belief about a family, within which new information is slotted into that version of a family's functioning.

4. What are the implications for the reliability of the multi-agency child protection system?

A fixed view of a family can permeate across agencies and regardless of the information available that should challenge this view; the view can remain set over an extensive period of multi-agency involvement. There are clear implications for effective partnerships in how children are safeguarded.

Finding 6: A pattern whereby practitioners superficially identify risk factors but do not consider the significance or impact they might have, resulting in inappropriate levels of intervention to safeguard children.

A safe child protection system needs to deal proficiently with risk and probability; it is not enough to respond reactively after an incident of harm has been caused to a child.

¹⁸ Burton 2009

¹⁹ Brandon et al: 2008

²⁰ Reder and Duncan 1999.

²¹ Reder et al 1993

Time and time again through this review practitioners have failed to act on the risks to this vulnerable mother and her baby, despite all the evidence being available. Indicators of risk were ignored and assumed to be historical in nature.

ISSUES FOR THE BOARD AND MEMBER AGENCIES TO CONSIDER:

- Are members of the Board surprised that the Pre-Birth Risk Assessment Tool is not being used?
- Does there need to be an audit of pre-birth assessments?
- How can members of the LSCB be assured that professionals fully take into account family history when assessing current risk?

Appendix 1 – Methodology

1. This SCR has used the SCIE Learning Together model for case reviews. This is a 'systems' approach, which provides a theory and method for understanding why good and poor practice occur, in order to identify effective supports and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high risk areas of work, such as aviation, it was taken up in Health agencies, and from 2006, was developed for use in case reviews of multi-agency safeguarding and CP work (Munro, 2005; Fish et al, 2009). National guidance in the 2013 revision of *Working Together to Safeguard Children* (2013) now requires all SCRs to adopt a systems methodology.
2. The model is distinctive in its approach to understanding professional practice in context; it does this by identifying the factors in the system that influence the nature and quality of work with families. Solutions then focus on redesigning the system to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.
3. Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit.
4. The basic principles – the 'methodological heart' – of the Learning Together model – are described in summary form below:
 - a. **Avoid hindsight bias** – understand what it was like for workers and managers who were working with the family at the time (the 'view from the tunnel'). What was influencing and guiding their work?

- b. **Provide adequate explanations** – appraise and explain decisions, actions, and in-actions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it
- c. **Move from individual instance to the general significance** – provide a ‘window on the system’ that illuminates what bolsters and what hinders the reliability of the multi-agency CP system.
- d. **Produce findings and questions for the Board to consider.** Pre-set recommendations may be suitable for problems for which the solutions are known, but are less helpful for puzzles that present more difficult conundrums.
- e. **Analytical rigour:** use of qualitative research techniques to underpin rigour and reliability.

5. Typology of underlying patterns

5.1 To identify the findings, the Review Team has used the SCIE typology of underlying patterns of interaction in the way that local child protection systems are functioning. Do they support good quality work or make it less likely that individual professionals and their agencies can work together effectively?

They are presented in six broad categories of underlying issues

1. Multi-agency working in response to incidents and crises
2. Multi-agency working in longer-term work
3. Human reasoning: cognitive and emotional biases
4. Family – Professional interaction
5. Tools
6. Management systems

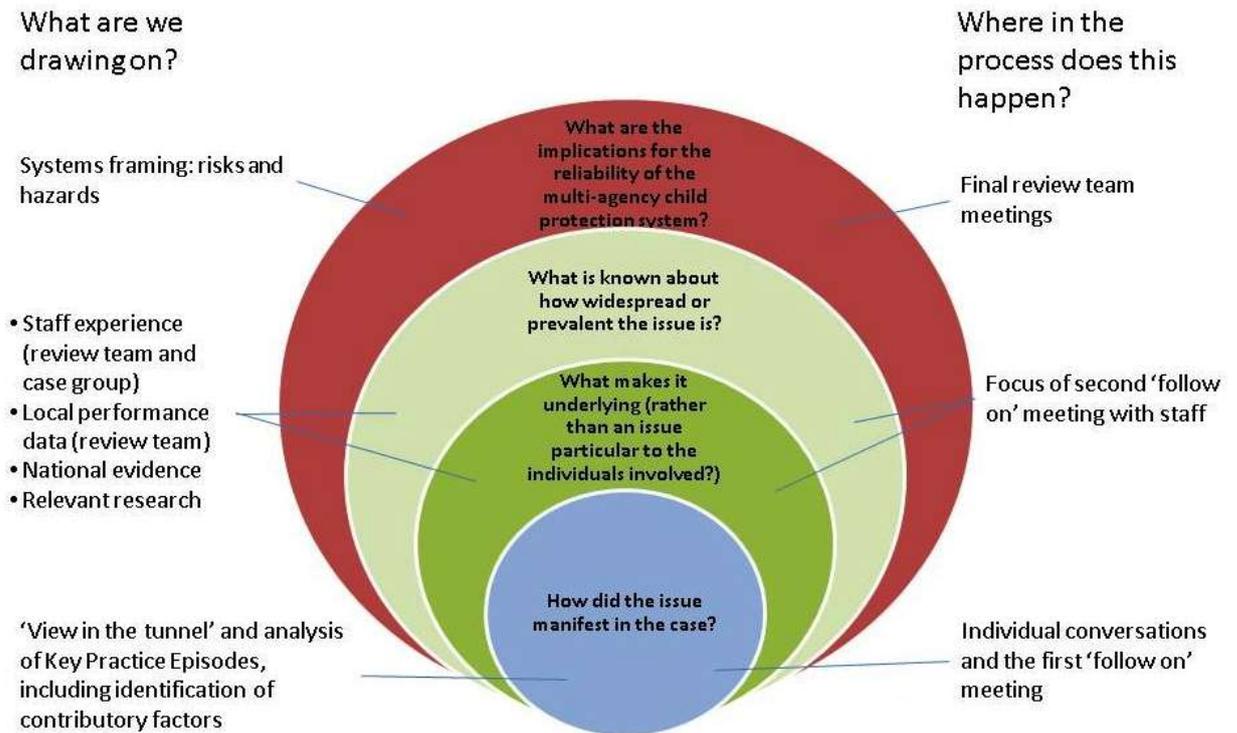
Each finding is listed under the appropriate category, although some could potentially fit under more than one category.

6. Anatomy of a finding

For each finding, the report is structured to present a clear account of:

- How the issue manifests itself in the particular case
- In what way it is an underlying issue – not a quirk of the particular individuals involved this time and in the particular constellation of the case?
- What information is there about how widespread a problem this is perceived to be locally, or data about its prevalence nationally?
- How the issue is usefully framed for the LSCB to consider relative to their aims and responsibilities, the risk and reliability of multi-agency systems. This is illustrated in the Anatomy of a Learning Together Finding (below).

'Anatomy' of a Learning Together finding



22

7. Review Team and Case Group

7.1 Review Team

The Review Team comprises senior managers/professionals from the agencies involved in the case, who have had no direct part in the conduct of the case. Led by two independent Lead Reviewers, they act as a panel working together throughout the review, gathering and analysing data, and reaching conclusions about general patterns and findings. They are also a source of data about the services they represent: their strategic policies, procedures, standards, and the organisational context relating to particular issues or circumstances such as resource constraints, changes in structure, and so on.

The Review Team members also have responsibility for supporting and enabling members of their agency to take part in the case review.

The two Lead Reviewers in this SCR are both accredited to carry out SCIE reviews, and have extensive experience in writing SCRs/IMRs under the previous 'Chapter 8' framework. Neither has any previous involvement with this case, or any previous or current relationship with Haringey Council or partner agencies.

Ann Duncan, Independent Lead Reviewer

22

Ghislaine Miller, Independent Lead Reviewer
Head of Safeguarding, Quality Assurance and Practice Development, Haringey Children's Social Care (CSC)
Interim Assistant Director Quality Assurance (CSC)
Acting Head of Service, including First Response Team, Haringey CSC
Designated Nurse for Safeguarding, NHS Haringey Clinical Commissioning Group (CCG)
Consultant Paediatrician and Designated Doctor for Safeguarding, NHS Haringey CCG
Named Nurse Safeguarding Children (Primary Care), NHS Haringey CCG (shadowing DN)
Named GP, NHS Haringey CCG
Acting Director of Operations Woman, Children's and Families Division (SCR Panel member only) Whittington NHS Trust
Interim Head of Safeguarding Whittington NHS Trust
Head of Housing Support & Options, LA Housing Service
Named Nurse for Safeguarding, Whittington NHS Trust
Review Officer, SC&O 21(2) Crime Academy & Review group, Metropolitan Police

7.2 Case Group

The Case Group are the professionals who were directly involved with the family. The Learning Together model offers a high level of inclusion and collaboration with these workers/managers, who are asked to describe their 'view from the tunnel' – about their work with the family at the time and what was affecting this.

In this case review, the Review Team carried out individual conversations with 17 Case Group professionals.

<p>Health:</p> <p>GP</p> <p>Practice Nurse (PN)</p> <p>Teenage Pregnancy Midwife (TPM) Whittington Health</p> <p>Health Visitor Whittington Health</p>

Agency Health Visitor (has now left) Nursery Nurse (has now left) HV Manager Whittington Health
CYPS: Social Worker First Response Team x2 Manager of First Response Team Children in Care Social Worker x2 Children In Care Manager X2 Social Worker x2
Housing Support Case officer

8. Structure of the review process

A Learning Together case review reflects the fact that this is an iterative process of information-gathering, analysis, checking and re-checking, to ensure that the accumulating evidence and interpretation of data are correct and reasonable.

The Review Team form the 'engine' of the process, working in collaboration with Case Group members who are involved singly in conversations, and then in multi-agency 'Follow-on' meetings.

The sequence of events in this review is shown below.

Timeline to completion

29th May 2013

Extraordinary SCR sub group held - took decision for SCR to be undertaken

12th June 2013

SCR sub group – decision SCR methodology should be blended approach

2nd July 2013

1st SCR panel with lead reviewer held

2nd August 2013

2nd SCR review panel held – Briefing from Lead reviewer on process

Decision taken not to have blended approach and to continue review as SCIE review, second lead reviewer to be identified.

2nd August 2013

1st Practitioners group meeting held – Briefing from Lead reviewer on process

12th September – 2nd October 2013

Information gathering: conversations and documentation submitted

21st October 2013

3rd SCR review panel held – Consider “view from tunnel” and “KPEs”

29th November 2013

4th SCR review panel held – Considering “findings” and explore prevalence

29th November 2013

3rd Practitioners group meeting held - Considering “findings” and explore prevalence

18th December 2013

Lead Reviewer and LSCB chair meeting – discuss key lines of enquiry

20th December 2013

Findings to be circulated to review group

Wk of 20th January 2014

Lead reviewers to meet with family

Wk of 20th January 2014

5th SCR review panel held – to review final report

Wk of 3rd February 2014

Governance meeting for Agency leads (TBC - new)

5th March 2014

SCR sub group to sign off report

26th March 2014

LSCB Meeting

Report to be made public date to be confirmed

8.Scope and terms of reference

8.1 Taking a systems approach encourages reviewers to begin with an open enquiry rather than a pre-determined set of questions from terms of reference, such as in a traditional SCR. This enables the data to lead to the key issues to be explored

8.2 The time frame for the SCR was decided as follows:

1st June 2012 to the 29th April 2013 - a period of just over 11 months. This covers the period from the beginning of Miss F’s pregnancy with Child D, until the admission to hospital and the discovery of multiple injuries.

9.Sources of data

9.1 Data from practitioners

- Conversations with members of the Case Group; these were recorded and discussed by the whole Review Team.
- Two Follow-on meetings in which members of the Case Group responded to the analysis of the case and gave feedback about accuracy and fair representation of their views. In relation to the emerging findings, the Case Group were asked to comment on whether these were underlying and widespread/prevalent. In other words, could we draw conclusions about whether, and in what way, this case provides a 'window on the system'?

Members of the Case Group have also helpfully responded to follow-up queries and requests from the Lead Reviewers and the Review Team for clarification or further information, where this has been needed.

9.2 Data from documentation

The Lead Reviewers and members of the Review Team reviewed the following documentation:

The records of the agencies in the case, which were then translated into an integrated chronology

Referral and information records (CYPS)

Placement with Parents Agreement / Assessment

Letter to housing from Young People In Care Team

Child D's Personal Child Health Record (Red Book)

Whittington Health Supervision Policy

Whittington Health Protocol for Joint Working between Children's Community Health Services and Haringey General Practice February 2009 (amended May 2011)

Whittington Health Visitor teams, by establishment and caseload size.

Whittington Health protocol for managing Children with a CP Plan and Children In Need

Written report from Consultant Paediatrician on Child D's admission and copy of report from Consultant Paediatric Radiologist.

9.3. Key Practice Episodes and Contributory Factors

The data from the conversations with the Case Group translates into their 'view from the tunnel' and thence into a selection of Key Practice Episodes (KPEs) which enable us as reviewers to capture the optimum learning from the case. These KPEs are significant points or periods in relation to how the case was handled or how it developed. Case Group members are also an invaluable source of information about the why questions – an exploration of the Contributory Factors which were affecting their practice and decisions at the time.

9.4. Participation

The Lead Reviewers and the Review Team are grateful for the willingness of the professionals to reflect on their own work, and to engage so openly and thoughtfully in this SCR.

9.5. Data from family, friends and community

As in traditional SCRs, the Learning Together model aims to include the views and perspectives of family members as a valuable element in understanding the case and the work of agencies. The two lead reviewers met with the parents of Child D on the 7th February 2014.

Appendix 2 – Guide to terminology

Acronyms used and terminology explained

10 Statutory guidance requires that SCR reports

‘...be written in plain English and in a way that can be easily understood by professionals and the public alike.’ (2013: 70)

Writing for multiple audiences is always challenging. An appendix (Appendix 2) on terminology aims to support readers who are not familiar with the processes and language of safeguarding and child protection work.

2. Haringey LSCB and SCIE are both keen to improve the accessibility of SCR reports and welcome feedback and suggestions for how this might be improved.

3. Acronyms

A&E	Accident and Emergency Department (hospital)
CAF	Common Assessment Framework
CSC	Children’s Social Care
CYPS	Children and Young People’s Services
HARTS	Health Access Resource team
FRT	First Response Team (CSC)
TPM	Teenage Pregnancy Midwife
FNP	Family Nurse Partnership
PCHR	Personal Child Health Record (Red Book)
HV	Health Visitor
LSCB	Local Safeguarding Children Board
LT	Learning Together
NBV	New Birth Visit
SCIE	Social Care Institute for Excellence
SW	Social Worker
CIC SW	Children in Care Social Worker
NAI	Non Accidental Injury

MASH	Multi Agency Single Hub
MERLIN	Form completed by police and shared with other agencies (formally Form 78)