CHILD T

A SERIOUS CASE REVIEW

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On behalf of the Haringey Safeguarding Children Board
Completed September 2013
1. INTRODUCTION

1.1 Child T, born in 2007, was the subject of two child protection investigations after suffering extensive injuries, first in the summer of 2010 and then in February 2011. On both occasions he returned from hospital to the care of his family and was subsequently subjected to further physical abuse. He, and his siblings, were then brought into the care of the local authority, where they remain.

1.2 In 2011 the Haringey Safeguarding Children Board (HSCB) considered whether these circumstances required that a Serious Case Review (SCR) be conducted. It was initially judged that the statutory criteria indicating that a SCR was necessary were not met. Nonetheless the HSCB arranged for the relevant agencies to consider their involvement with Child T and his family, and to report back on that involvement.

1.3 Those reports were independently evaluated. In the light of that evaluation the Board decided that in fact the statutory criteria for conducting a SCR were met, (although it was now some considerable time after the events to be considered). The agencies reviewed and re-submitted their original reports against revised Terms of Reference. This is the Overview Report from the SCR. Details of the Terms of Reference and the organisational arrangements for the SCR are at Appendix A of this report.

1.4 This report has then been finalised some years after the events under review. During that time there have been major changes to the way in which services have been configured and how they are delivered, locally and nationally. Some of those changes and their relevance to the matters under review are detailed in Section 10 of this report.

1.5 This report was largely written before the publication of Working Together to Safeguard Children (2013). Comments on guidance relate to the guidance in place at the time of the matters under review, unless otherwise indicated.

2. FAMILY COMPOSITION AND BACKGROUND

2.1 This table sets out brief details of the family composition at the point when the children were brought into care.

<table>
<thead>
<tr>
<th>Relationship to subject</th>
<th>Name</th>
<th>Age at June 2011</th>
</tr>
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<tbody>
<tr>
<td>Subject</td>
<td>Child T</td>
<td>4</td>
</tr>
<tr>
<td>Mother</td>
<td>Ms B</td>
<td>26</td>
</tr>
<tr>
<td>Father1</td>
<td>Mr D</td>
<td>25</td>
</tr>
<tr>
<td>Sister</td>
<td>Child V</td>
<td>2</td>
</tr>
<tr>
<td>Mother’s partner and father of Child Y</td>
<td>Mr C</td>
<td>35</td>
</tr>
<tr>
<td>Half-sister</td>
<td>Child W</td>
<td>7</td>
</tr>
</tbody>
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1 There has been no current reference to Mr D (or Mr E) in the information submitted. They are presumed to be in Poland.
2.2 Child T’s mother, Ms B, was born and grew up in Poland, coming to the UK in 2009. Her relationship with Mr D, Child T’s father, had broken down and she had left the marital home to live with her mother (MGM). When she came to the UK her three children initially stayed with MGM but joined their mother in the UK in March 2010, by which time she had formed a relationship with Mr C. His mother, PSGM, was also part of the family in the UK but left around the time of the first injuries to Child T. MGM also came to the UK in June 2010 and lived with the family.

3. **CHRONOLOGY**

3.1 **The first injuries: June – July 2010**

3.1.1 On Wednesday 30/6/10, at 10:30 pm, Child T was taken to the Accident & Emergency Department (A&E) at North Middlesex Hospital (NMHUT) by his mother and Mr C. He had bruising around the eyes, forehead and nose. Bruising and swelling was said to have become worse during the day. Mr C said that Child T often ran around the house and “bangs and hits himself on the wall”. He was admitted to a paediatric ward for investigations and “discussions with social services”. Apart from the immediate injuries he was said to appear well.

3.1.2 A weekly multidisciplinary meeting to discuss all hospital referrals to the hospital-based children’s social care services, and children who are inpatient with child protection concerns, was being held the following day, 1/7/10. Child T was discussed and was subsequently reviewed by a Consultant Paediatrician, CP1. She felt the situation should be formally notified to children’s social care services, because of the likelihood that the injuries had been deliberately inflicted. A referral was faxed to the London Borough of Enfield Children’s Social Care Services (ECSC) as it had been mistakenly understood that the family lived in that local authority area. The referral described the injuries and the causation suggested by the family, and said that no one had seen any incident which might have caused the injuries.

3.1.3 ECSC considered the information they had been sent. On 2/7/10 the hospital has a record of receiving a request from ECSC for more information. (No record of making this request has been found in the ECSC files). In any case by this time it appears that ECSC had already decided, on the basis of the content of the original referral, that no further action was necessary. They did not carry out any checks with other agencies or notify police. They decided to write to the hospital explaining that they were not going to take any further action. There is no indication that they did so. (Police have subsequently confirmed that the circumstances of the child at this time were such that would expect to have been notified by the local authority, so that they could jointly decide how to follow this up).
3.1.4 A further written referral was made to ECSC by a second Consultant Paediatrician, CP2, on 3/7/10. It consisted of the original referral plus additional information describing “unexplained bruising in other areas, left hand side of chest on lateral aspect, in mid axillary line 2 lesions, over hip on the back (sic) of lateral aspect of vertebrae, which may or may not be due to finger tips” No action was taken by ECSC in response to this referral (which they record as received 5/7/10). It was described by ECSC as a “duplicate referral”.

3.1.5 On 4/7/10 a Polish speaking doctor, PR1, spoke to various family members who were visiting the hospital. He was told, by Child W, that Mr C had hit her so as to cause bruising to her bottom. PR1 spoke to CP2 who subsequently spoke to the Enfield Emergency Duty Team (EDT) as it was now the evening. It was agreed that there were no grounds to keep Child W in hospital that night but that the concerns raised should be followed up the next day. The following day, 5/7/10, before any follow-up action was taken, Child T was removed from hospital by his mother and Mr C, without the agreement of medical staff. Over the previous days Mr C had increasingly expressed his annoyance at the child’s prolonged stay in hospital, because, he said, of the disruptive consequences for family life.

3.1.6 A referral was now made by the hospital to police and, for the first time, to Haringey Children and Young People’s Services (CYPS). Around the same time – the sequence of events is unclear – ECSC realised that the family did not live in Enfield and also made a referral to Haringey CYPS. ECSC played no further part in the events under review.

3.1.7 Police visited the family home without delay and saw the family, who were initially hostile. Mr C (presenting as the only English speaker in the family) said that the family felt that being in hospital was not assisting Child T, who was himself spoken to directly by police. Police had no concerns about the child’s presentation, nor about the home conditions. Police had some discussions with staff at NMUHT, and, feeling that medical advice offered was inconclusive, decided to take no immediate action.

3.1.8 During the course of the day there were discussions between police and CYPS and it was agreed that there should be a Strategy Meeting\(^3\), to be informed by a report from the hospital. Later in the day there was a further incident involving police. They were called to the family home by Mr C’s mother, PSGM, who had had a dispute with her son. Police attended but she was not present so they returned the following morning. PSGM was again not present but eventually it was judged that no further police action was necessary. Police recorded this as a domestic violence matter but did not complete a MERLIN\(^4\) notification to CYPS. Police attending the Strategy Meeting (which took place at the same time as the second police visit) were not aware at that point of this other set of problems in the family.

3.1.9 The Strategy Meeting was attended by the hospital’s Named Nurse\(^5\) for Child Protection, a Haringey social worker (SW1), team manager (TM1) and police officers from the Child Abuse Investigation Team (CAIT). There were no decisions or actions formally recorded except that the Consultant

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\(^2\) The "out of hours" children’s social care service.

\(^3\) A formal inter-agency meeting held under child protection procedures to share information and plan any investigation.

\(^4\) The routine notification to local authorities of children coming to police attention.

\(^5\) The Named Nurse has a lead role on safeguarding children issues for their organisation.
Paediatrician was to be asked by the Named Nurse to provide a definitive opinion on the injuries. CP1 had been unable to attend the meeting but had provided photographs and a report expressing concern that the injuries had probably been inflicted.

3.1.10 Police attending noted that the doctor had “... not said the injuries are (non-accidental) but that she was concerned. She ... was questioning the parents’ explanation as it was the medical view that they would have heard the child cry out and that the torso bruising would not be caused by falling off the bed”.

3.1.11 No date was set for a subsequent meeting. It was agreed that if CP1 came back with even more concrete information, the meeting would reconvene. CYPS understood that they would investigate the injuries on a single agency basis with police assistance. Conversely, police understood that they and CYPS were to be equally involved in a formal joint investigation. In any event police officers and social workers visited the home that day.

3.1.12 When police and CYPS went to the home members of the family, including Child W and Child T (through an interpreter), were spoken to. They denied that any injuries to Child T had been deliberately caused. The parents were seen together, with Mr C replying in English and the questions being translated for Ms B. Mr C denied any responsibility for the injuries but said that Child T bruised very easily. The alleged smacking of Child W was not explored. There was clearly still bad feeling from MGM towards PSGM and MGM suggested that PSGM might have hit Child T. This was not explored further during the interview and subsequently police made no attempt to interview PSGM.

3.1.13 Following the visit police and CYPS agreed that the police involvement should be terminated at that point. The rationale for this decision was that there had been no disclosure of abuse by the child and that there was not unequivocal medical advice about the causation of the injuries. The home environment and the conduct and presentation of the children had not given cause for concern.

3.1.14 This was followed on 9/7/10 by a joint visit by SW1 and a Health Visitor (HV3). Both professionals took on various tasks to assist the family. The involvement of the Health Visiting service then lapsed, until a Health Visitor, HV5, was allocated in mid-September.

3.1.15 On the same day as this visit Ms B attended a booking appointment at NMUHT Maternity Services. She made no reference to the recent events. She was 18 weeks pregnant. She had previously attended A&E on five occasions because of concerns about her pregnancy but had failed to attend two scheduled appointments.

3.1.16 On 14/7/10 CP1 wrote to community health services and CYPS expressing strong concern that Child T’s injuries had been inflicted. She said that “I would like to highlight that this child had an injury to his forehead resulting in a haematoma... that could only have occurred if there was a large amount of force on impact... The second fact that concerns me greatly is the presence of bruising on the

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6 When considering concerns about a child a decision will be made by police and children’s social care services as to whether the matter should be followed up by a joint investigation – involving both agencies – or, where concerns are less significant and it may be that no crime has been committed, as a single agency investigation by children’s services.
left side of the rib cage. This is an unusual place for bruising to be found in a child and implies a second mechanism of injury taking place, once again for which the parents claim to have no knowledge. My concerns here are that this is a 3 year old boy who has had two separate injuries for which there have been no explanations and each injury individually is concerning and in an area which is quite uncommon in a child of this age.”

3.1.17 This letter is marked as having been received at CYPS on 29/7/10. It is not known who saw it although TM1 is clear that she did not. There is no record of any response to the letter by CYPS. The case was then discussed or mentioned at six subsequent weekly liaison meetings at NMUHT but this did not lead to any further action.

3.2 Ongoing contact: July 2010 – February 2011

3.2.1 SW1 began to liaise with the Haringey Education Department about a school place for Child W. There was a partial response from Education which did not clarify how SW1 might proceed.

3.2.2 On 9/8/10 Mr C attended NMUHT with self-inflicted cuts to his arm, saying that he was worried about debt and housing problems. He was treated and sent home with advice to see his GP. There were no checks with children’s services.

3.2.3 Ms B had continuing but inconsistent contact with maternity services in the community and at NMUHT. On 11/8/10 a midwife noted that she appeared unhappy and Mr C said that they had family problems and were in touch with CYPS. Ms B was not spoken to directly. The midwife did not subsequently share this disclosure with the Named Midwife, or complete a LINK form.

3.2.4 SW1 completed a Core Assessment on 24/8/10. She was asked by TM1 to write to other agencies advising that no safeguarding concerns had been identified, that the agencies should monitor the children and refer back to CYPS if there were any new concerns, and that the case would be closed once the family members were registered with a GP and Child W was settled in school. The Core Assessment was signed off by the manager on this basis. SW1 would continue to see the family until these actions were completed. On 27/8/10 SW1 noticed that Child T had facial bruising. She accepted a (mimed) account from the children and MGM that this had been accidentally caused. There is no record of her advising TM1 of this or causing any further enquiries to be made.

3.2.5 On 30/8/10 Ms B went to NMUHT, in connection with her pregnancy. An obstetrician noticed bruising on her arms. The explanation given by Ms B was that she had done this at work. The obstetrician noted that the maternity records mentioned possible domestic abuse and the involvement of “social services” and suggested admission for observation, which Ms B declined.

7 A specialist midwife with similar responsibilities for safeguarding, similar to the Named Nurse, as described above
8 This is an information sharing and planning tool that is completed by maternity staff where social, medical or psychological concerns have been raised ante-natally, regardless of whether a referral has been made to children’s services. The LINK form is kept on the labour ward and retrieved when the mother is admitted in labour so that the plan can be initiated.
She was noted to be very anxious and it was also noted that Mr C was “keen for her to be discharged”. No further action was taken by the obstetrician, (although this would have been another opportunity to flag concerns through the completion of a LINK form).

3.2.6 On 31/8/10 Mr C took Child T to the GP, saying that he was concerned that the child bruised easily. He had bruises to his back and legs. The GP (GP1) arranged blood tests which indicated no medical explanation for the bruising. On 17/9/10 Child T was seen by a nurse (PN1) for immunisations. She noticed bruises on his arms, legs and back and asked a GP (GP2) to see him. GP2 examined the child and arranged for him to be seen for follow-up on 22/9/10.

3.2.7 The family attended on 22/9/10 and saw a GP who made a referral via ‘Choose and Book’ for a paediatric outpatient appointment, so that the bruising could be explored further. It was anticipated that the parents would book the outpatient appointment as would be usual for the ‘Choose and Book’ system. However the parents did not follow this up and no contact was made with the hospital. The GP notes do contain a copy of the referral letter which would have been sent electronically but was not linked to an appointment as the parents did not make one. The GP practice took no action when they received no response to the referral.

3.2.8 Meanwhile on 14/9/10 Mr C himself saw a GP (GP3) to say that he both smoked and injected heroin every day – the first reference to continuing use of illegal drugs. He was referred to the Drug Advisory Service Haringey (DASH) and went there for assessment on 16/9/10. He was then booked to see a doctor on 30/9/10 and he attended for this appointment. Unfortunately the appointment had to be cancelled, to which Mr C responded angrily. The appointment was rearranged for 4/10/10. He attended that day and was seen by a specialist doctor and nurse. Arrangements were made to start a programme of medication to support his withdrawal from drug use. On 6/10/10 he failed an appointment and then did not initiate any further contact with DASH. The service contacted him at the end of that month and he said that he was drug-free and wanted no continuing contact. He was consequently discharged from DASH.

3.2.9 In October 2010 Child W started attending School 1. The school was not made aware of the history of the family’s contact with agencies.

3.2.10 On 2/11/10 HV5, who had been allocated the case in September, telephoned the family and spoke to Mr C who said that the family were doing well. This was the first direct contact from the Health Visiting service since July. HV5 asked him to make contact as necessary. Apart from a subsequent telephone call HV5 had no other contact with the family.

3.2.11 Child Y was born on 11/12/10. Delivery was normal and Mr C was present. Mother and baby were discharged the following day. Midwives visited five times post-natally, although there was no reply on two occasions. There were no medical concerns for mother or baby but on two of the three successful visits a midwife felt Mr C was

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10 Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. It relies on patients to follow the GPs advice and use the Choose and Book system.
argumentative and unpleasant to her, and that the atmosphere in the home was tense. She left a message with the health visiting team advising of her concerns. This should have prompted the health visitors to contact maternity services but the message was filed without being actioned.

3.2.12 Another health visitor, HV6, made the New Birth Visit\(^{11}\) on 19/1/11. She had not seen the midwife’s message and was consequently unaware of the midwife’s concerns. However during the visit she was told by Mr C of the previous unexplained injuries to Child T. HV6 observed that Child T was pale, smiled and made eye contact when spoken to, but appeared slightly watchful and wary. She noted that this should be further explored on the next contact and that previous health visiting records were to be checked.

3.2.13 She discussed the family’s presentation with the health visitor, HV3, who had been briefly involved the previous summer. HV3 explained the concerns at that time. She said that the case had been left as a “blue folder case” (meaning it was for enhanced health visitor input). It was now clear that it had not been followed up in this way immediately or by HV5, when she became responsible for the case. The family were again assessed by HV6 as a ‘blue folder’ case because of her current concerns. HV3 spoke to SW1 to advise of her colleague’s concerns and SW1 said that she had only continued to see the family to assist them in accessing universal services – education, welfare benefits and healthcare.

3.2.14 The family failed to keep two clinic appointments for the baby in January. On 10/2/11 HV6 made a home visit with a Polish Link Worker. All family members were present. HV6 recorded that the visit was dominated by Mr C, who was complaining angrily about SW1 not supporting the family, and who would not listen to advice from HV6. HV6 recorded that Ms B did not intervene and made no effort to calm Mr C. HV6 planned to discuss nursery placement for Child T with SW1 and to refer the family to a children’s centre outreach worker for benefits advice. She planned another contact on 15/2/11 to complete health assessments on the children and follow up outstanding dental and orthoptist referrals.

3.2.15 On that date, 15/2/11, a meeting was held with the family. Professionals present were SW1, HV6 and the children’s centre outreach worker. SW1 intended to terminate the CYPS involvement and the purpose of the meeting was to determine continuing input from other services. The meeting agreed:
- SW1 would close the case, and advised the family that Child T should attend nursery;
- The Health Visitor would monitor the situation
- The outreach worker would support the family and arrange for a Polish speaking worker to assist with benefit entitlements

3.3 February 2011: the second and third sets of injuries

3.3.1 Three days later, on 18/2/11 (a Friday) police were called to the family home by Ms B who made allegations of violent conduct by Mr C to her and to Child T. Police could see that the child was extensively bruised and they arrested Mr C. Child T was left overnight with his mother. There was no recorded consultation with the local authority’s EDT at that point.

\(^{11}\)Births are routinely followed up with a visit from the health visiting service. This service is provided throughout the country.
3.3.2 The following day Child T was taken by police for medical examination and was seen by a paediatric registrar (PR2). The EDT had been made aware of the situation in the morning and both police officers and an EDT officer, EDT1, attended the medical. Child T was found to have more than 50 bruises of varying ages and sizes. He told the doctor of having been hit with a belt and a stick by Mr C. The doctor judged that many of the injuries were caused by physical abuse and that others were “highly suspicious”.

3.3.3 Mr C was interviewed by police and denied causing any injury to Child T, suggesting that the children’s mother and maternal grandmother hit the children with a slipper. He also denied any violence towards Ms B.

3.3.4 The doctor spoke to Ms B who described how she had been the subject of repeated physical assaults by Mr C. She also said that she had suspected that Child T was being abused by Mr C and that Child T had told her this. She further said that Child W had now also spoken of being physically assaulted by Mr C. Child W disclosed to police that Mr C had “tried to drown her” whilst bathing her a few weeks previously. She said she had not told Ms B at the time as Mr C had made her promise not to do so. PR2 noted that Child T appeared comforted by his mother’s presence.

3.3.5 The CAIT officers, EDT1 and PR2 discussed how to keep the children safe and ensure their well-being. EDT1 confirmed that that foster care could be provided for all the children if appropriate. There was a shared view that Ms B was fearful of Mr C and had herself been subject to abuse. The young age of Child T and the view that the perpetrator of his injuries had apparently been identified were decisive factors in a conclusion that Child T should return to the care of his mother and MGM, provided Mr C remained in custody. Should he be bailed there would be further discussions. Mr C was in fact remanded in custody.

3.3.6 On 21/2/11 a Strategy Meeting was convened from which the principal outcomes were decisions to initiate care proceedings but not to seek immediately to remove any of the children from the care of their mother. There were some misgivings about this. There was a polarisation of views about the weight to be given to the failure of Ms B and MGM to protect the children, or to speak out in any way, as opposed to the debilitating effects of domestic abuse on Ms B, which might have intimidated her and prevented her from coming forward.

3.3.7 The case was reallocated to another social worker, SW2. On 22/2/11 the other children were all medically examined. No evidence of injury was found, and skeletal surveys were normal, but Child W again spoke of being physically assaulted by Mr C. Child V was described as very “wary” and “distraught” throughout the examination. An interpreter reported that Ms B had told her that all three of the older children had been physically assaulted by Mr C. The doctors’ recommendations from these examinations were:

- All the children should be removed from the family as the mother and grandmother had failed to protect them. This would also help prevent any attempts at pressuring the children to change their account of events
• Child W should have an Achieving Best Evidence interview\textsuperscript{12} as soon as possible.
• In view of Child V's presentation, her social worker should consider a referral to Child and Adolescent Mental Health Services (CAMHS).

3.3.8 Ms B was interviewed, through an interpreter, at home the next day by SW2, who explained to her that care proceedings were to be initiated. Ms B repeated her account of life with Mr C but was more equivocal about what had happened to the children and how much she knew about it. She denied that Child T had told her about being hit. The social worker interviewed Child T again and he said that he had told his mother about being hit. He also said to SW2 that “daddy” had hit him with a belt and a cable.

3.3.9 Meanwhile police also interviewed Ms B, as well as MGM and Child W. Child W said that Child T was hit most often but that she herself had once been hit with a rod. Ms B said that she knew that Child T was hit more frequently when Mr C was taking drugs. MGM said that she had seen bruising to Child T but had decided this had been accidentally caused. At the same time she said that she wanted to seek police assistance but did not know how to do so.

3.3.10 A Strategy Meeting was held on 25/2/11. Information had been gathered from the various health services involved and, for the first time, the facts of Mr C’s substance misuse and the GPs' knowledge of repeated bruising to Child T were drawn together with the knowledge of the current and previous injuries. Agencies were concerned that Ms B and MGM were aware of the abuse and had not acted to prevent it. It also appeared that there may have been discrepancies in the accounts they had given to various agencies. However there had been no evidence that either of them was responsible for any previous physical abuse and there was no indication that the children might be directly harmed by them, or did not wish to be with them. It was confirmed that care proceedings were to be initiated but that there should be no immediate attempt to remove the children.

3.3.11 On 28/2/11 Ms B told SW2 that Child T had new bruising. Ms B claimed that she had asked Child T about this and he had said that the injuries had been inflicted by that social worker, SW2. Later that day Child T was taken to Accident & Emergency, NMUHT, in the company of his mother, a different social worker and an interpreter. Child T said that “the lady” hit him. When asked what the lady looked like and how she did it, he was unsure. Following a medical examination, where new bruising was confirmed, and some new bruising was seen on Child W, all four children were brought into the care of the local authority.

3.3.12 During subsequent investigations there was disagreement between doctors as to the extent of the “new” bruising, whether it was indeed “new” and whether it might to any extent be accidentally caused. The balance of medical evidence, as eventually decided in care proceedings, indicated that there was new bruising, likely to have been caused by Ms B and/or MGM. Further enquiries later revealed that the children had previously been injured in Poland when in the care of Ms B and MGM.

\textsuperscript{12} Government guidance to assist those responsible for conducting interviews with and supporting vulnerable witnesses, including children, in criminal proceedings.
3.3.13 Mr C was sentenced to 4 years in prison in October 2011 for “wilfully assaulting a young person under the age of 16”. Mr C appealed this sentence, but the court dismissed his application. In 2012 full Care Orders were made in respect of all the children.

4. THE FAMILY

4.1 There has been no contact with any family member to inform this report. Child T’s mother and maternal grandmother are now believed to be in Poland. Mr C was to be deported after completion of his prison sentence.

4.2 Because of this, and because of the weakness of the agencies’ assessments, many questions about the family, their relationships and their conduct remain unanswered. There is no explanation of the circumstances in which PSGM left the family. There is no “feel” for what sorts of community supports the family had, or whether they were isolated. Their financial arrangements, including the consequences of Mr C’s drug addiction, are unexplained. These are all matters which would have added to an overall understanding of what this family were like, how they operated and what it was like “to be that child”.

5. THE AGENCIES

5.1 North Middlesex University Hospital Trust

5.1.1 This was the first agency involved. The hospital had four broad areas of contact with Child T and his family:
- Child T’s presentation in July 2010
- Ms B’s pregnancy
- Mr C’s presentation with self-inflicted injuries in August 2010
- Child T’s presentation in February 2011

5.1.2 The principal concern arising from Child T’s first admission is the way in which the hospital’s early recognition of child protection concerns became diluted and was eventually lost. The referral made in error to ECSC was significant and was compounded when the A&E notification was picked up by the Enfield liaison nurse and sent to the health visiting team in Enfield. This A&E notification was never received by the Haringey Health Visitors (and they did not seek it out when they subsequently became aware of the case).

5.1.3 There is no sense of urgency in the actions taken while Child T was an in-patient. The disappointing input from other agencies is important – administrative weaknesses in both local authorities, the lack of rigour in the investigation by police and CYPS, and an overall failure to analyse the situation accurately. Nonetheless hospital doctors had well-founded concerns, from the outset, that Child T’s injuries had been inflicted. They could have escalated those concerns in the face of the inadequate responses of other agencies. More could have been learned from the direct contact which ward staff had with Child T but there is no sense from the report of how the child presented in hospital, or how he was seen by staff.

5.1.4 Instead the IMR identifies
“a muddled and inappropriate use of the Escalation Procedure”.
CP1’s concerns should have been addressed to a more senior officer than the social worker and could also have been raised with a professional within the hospital who had lead responsibility for safeguarding. The letter sent by CP1 to the local authority was copied to the Named Doctor for Child Protection but did not clarify whether this was for information only or whether any action was expected of the Named Doctor. The Named Doctor did not respond, when they might have been proactive and contacted CP1 to discuss the concerns. The Health Overview Report maps out the steps which should have been taken:

Had the escalation guidance been followed, the named doctor or nurse for child protection should have contacted the social worker directly for a discussion and if no resolution was found then the case should have been escalated to the Designated Doctor or Nurse for child protection to discuss with a more senior social work and police colleague. Had this occurred there may well have been a very different outcome as there would have been a senior management review of the case”.

5.1.5 CP1 also sought to follow this up by raising the matter at the hospital’s weekly Link (liaison) meeting. The communication between the Link meeting and social care was ineffective and no actions arose from these discussions. In the face of a lack of response over a period of weeks, the energy went out of CP1’s concerns and the matter was allowed to drop. The IMR comments on the role and function of that weekly meeting at which both local authorities, Enfield and Haringey, were represented:

“(this) calls into question the effectiveness of the meetings. If this matter had been resolved and the injuries taken more seriously, outcomes for Child T may have been better and (this might) have prevented the serious injuries that he presented with some seven months later”.

5.1.6 The inaccurate identification of the responsible authority, the way in which the hospital worked with the family during the admission as well as the follow-up post-discharge are all areas from which concerns and learning points arise. Professionals need to accept that there are times when well-grounded fears for the safety of a child become mired in organisational inertia. To ensure that those concerns are adequately investigated, real determination may be necessary. This was a situation in which medical staff felt there was clear evidence of serious physical abuse. It is unacceptable that such well-evidenced concerns did not lead to a vigorous safeguarding response across the agencies.

5.1.7 This failed investigation was a turning point, the key event which left Child T unprotected. The Health Overview report summarises the position. Child T had “experienced a physical injury, the professional assessment of which by a paediatrician was that it was likely to be non-accidental and yet a junior social worker, her manager and a police officer – none of whom are qualified to assess causation of injury - dismissed the paediatrician’s view. This decision coloured much of the rest of the work with Child T and his family”.

5.1.8 There was a more satisfactory response and, initially at least, outcome to Child T’s second presentation:
“A good medical and social history assessment was undertaken by the on call Paediatric Registrar who conducted the child protection medical on
Child T... on 19 February 2011, including observation of attachment... good engagement of Child T through the interpreter, and awareness of her role and responsibility (in) a child protection investigation and (of) ABE procedures.”

This was assisted by input from the other agencies which was more clearly planned and reliable.

5.1.9 The Registrar’s response was thorough and effective in supporting the investigation. Subsequent medical involvement was delivered by the Community Paediatric Service and is discussed below. The IMR does comment on a resourcing / organisational issue:

“Child Protection medicals... (outside normal working hours) were not carried out by a Consultant Paediatrician”.

Updated information submitted to this review in 2013 indicates that this is no longer a problem.

5.1.10 There were missed opportunities in Ms B’s involvement with Maternity Services during her pregnancy with Child Y. The first scheduled contact, in July 2010, was very soon after the first child protection investigation. This investigation was not disclosed by Ms B and information systems did not alert the midwife to these events.

5.1.11 The IMR points out a weakness in the arrangements around the subsequent weekly liaison meetings in the hospital:

“It is likely that these meetings were aware that Ms B was pregnant. The Named Midwife is a member of the weekly meeting group for the purposes of receiving minutes. She does not attend the meeting on a regular basis. It would be normal practice where a child was discussed and the mother was found to be pregnant that the case would be passed to the Named Midwife. Had this happened in this case then there may have been an opportunity to better link the presentations together”.

5.1.12 During her second contact in August the midwife identified strains in the couple’s relationship and Mr C confirmed that this was the case. Ms B said nothing and, although there were language difficulties, the midwife felt that this raised further concerns. However

“The midwife did not share any of this information with the Named Midwife or complete a LINK form, or consider a referral to social services”.

At two subsequent contacts midwives allowed the presence of Mr C to deter them from making enquiries about domestic abuse, when they might have engineered a way to communicate privately with Ms B.

5.1.13 The IMR explores the difficulties of enabling disclosure when a woman attends with an abusive partner and refers to initiatives such as “the use of the “red sticker on the bottle”...a simple tool, so that when a woman is asked to go to the toilet to give a urine sample there is a notice that asks her to stick a red dot on the bottle if she is being abused by her partner”. Language difficulties may have defeated such an initiative in this case but it is clear that a great deal of effort has gone into raising awareness about domestic abuse and its significance in pregnancy. The Health Overview report emphasises the link, quoting the London Child Protection Procedures:

“In almost a third of cases, domestic violence begins or escalates during pregnancy” and “everyone working with women, teenage girls and
children should be alert to the frequent inter-relationship between domestic violence, substance misuse and mental ill health.\textsuperscript{13}

5.1.14 At the same time, as the Health Overview report also notes, “The midwife who had concerns about domestic violence should have sought supervision or had a management discussion but did not”. It is therefore reassuring that after the birth the visiting midwife “did make an assessment that there were family problems, with possible domestic abuse and safeguarding concerns for the children. She alerted the health visitor, which was good practice”.

5.1.15 There was poor information sharing and communication within the health visiting team, and between the health visiting team and NMUHT, around the birth of Child Y. The birth notification from NMUHT states correctly that Child Y is “1 of 1” meaning that this is a single baby (rather than the first baby born of a multiple pregnancy, such as twins). The Whittington Health IMR suggests that the HV misinterpreted this information and understood that this was Ms B’s first child. This led to a new set of records being created for Ms B rather than linking her to the information already held following Child T’s injuries in June 2010. This has now been addressed and is a good example of how the very detailed examination of practice which is carried out during an SCR can identify entrenched organisational weaknesses.

5.1.16 Mr C’s presentation in A&E with self-inflicted injuries did not prompt a sufficiently inquisitive response. “Earlier in the day his partner had attended the Maternity Triage department of the hospital with concerns about a possible miscarriage. He told staff that he had family problems, including financial problems and the threat of eviction. It was noted that (he) had liver damage as a result of alcoholism and intravenous drug use”.

5.1.17 In that context it would have been appropriate to think about the welfare of the children in this family, explore any concerns about them and consider, in liaison with specialist advisors, whether a referral to children’s social care services was indicated. It may be that Mr C would have sought to block this or divert concerns but the key learning point is the lack of alertness by A&E staff to the possibility of child protection concerns.

5.2 London Borough of Enfield, Children’s Social Care Services

5.2.1 The IMR from ECSC does not address all the issues in the Terms of Reference for this review as the agency’s involvement was limited. However, the report does identify some very basic safeguarding concerns arising from that involvement.

5.2.2 The response from ECSC to the initial referral was, without discussion with any other professionals or exploration of the family background, that they would take no further action. There is no adequate explanation for this. As their IMR notes

\textsuperscript{13} The London Child Protection Procedures 4\textsuperscript{th} Edition (2010) section 5.12.12 & 5.12.6
“The nature of the injuries, the lack of clarity about the causes, and the apparent delay in presenting to A&E (at 10.30pm) were sufficient grounds for social care intervention”.

5.2.3 When a further written referral was made to ECSC by NMUHT, as doctors had identified further injuries, this was not recognised as containing new information, but was treated as a duplicate of the initial referral.

5.2.4 On 4/7/10 Enfield’s out of hours team (EDT) was contacted by a Consultant Paediatrician from NMUHT who reported the conversation between the Polish doctor and Child W, in which she said that she had been slapped. No child protection investigation followed from this incident and “the Out of Hours Social Worker in his recordings commented that he was concerned that the hospital had made a unilateral decision to interview Child W who was not their patient”.

It is surprising that the EDT officer should attribute so much weight to the propriety of the interview, in a situation where the doctor had fears for the safety of the child.

5.2.5 Finally, once it was established that the family lived in Haringey, the IMR advises that “the case was referred to Haringey as it had been established that the family lived there. The only evidence of this is a front fax sheet, which had been scanned on the electronic records. There is no indication that the hospital had been informed of this” and “there is no evidence of any discussions with Haringey”.

5.2.6 Overall this was not an adequate response to Child T’s presentation in hospital and the subsequent concerns. Child protection procedures were not followed, especially in failing to contact police. The judgment that no child protection action was necessary was not based on sufficient evidence. There were administrative errors in failing to identify new information in the second referral and failing to identify in the first place that this was not an Enfield family.

5.2.7 The IMR advises that “As a result of a recent OFSTED inspection, an Improvement Action Plan has been drafted which addresses both the thresholds and responses to referrals, and how decisions are communicated to referrers”. Further information about extensive changes and service improvements since this time in Enfield, and the other agencies, is detailed at section 10 of this report.

5.3 London Borough of Haringey, Children and Young People’s Services

5.3.1 The IMR very thoroughly identifies the weaknesses in practice within and between agencies which allowed Child T to remain in a situation where he was being repeatedly injured by the adults responsible for his care.

5.3.2 The initial assessment was flawed – it failed to take adequate account of the explicit concerns expressed by CP1. Both police and CYPS too readily accepted that the case was best followed up on the predication that Child T’s
injuries were accidentally caused. The IMR pinpoints the importance of these discussions taking place after the removal of the child from hospital, so that the input from staff who had been looking after the child was diminished. A quote from SW1’s Core Assessment demonstrates how the facts of the case were being shaped to fit with the way that the social worker thought best to proceed:

“given the responses of all the adults and children it was not felt by the social worker that there was any future benefit of dealing with this case as one of ongoing investigation for (partially) unexplained injury, but rather social work involvement would continue to consider the family support needs.”

5.3.3 The principal consequence, as the IMR describes, is that any investigative thrust to social work involvement was lost:

“the social worker appears to have seen her role as ensuring that the family were linked with key services such as health care, education and benefits, rather than undertaking a rigorous assessment”.

5.3.4 Having adopted that mindset, which was never adequately challenged by managers or supervision processes, SW1 did not respond appropriately when noticing bruising again in August. She accepted without any investigation that this was accidental. A further matter of concern is the lack of any response to CP1’s letter which explicitly expressed a view that there was evidence of inflicted injury. There is no evidence that either of these matters were brought to the attention of a manager. The case then drifted for seven months, during which time it was discussed with a supervisor once. This discussion did not lead to any changes in the way the case was being managed. There is no evidence of a formal, structured “child in need” approach to the management of the case.

5.3.5 The immediate CYPS response to the second set of injuries was provided by the EDT. The response was thorough and appropriate and the decision jointly agreed by the agencies not to seek to bring the children into care over the weekend was understandable.

5.3.6 The subsequent Strategy Meeting decided to confirm that arrangement and to continue to assess the situation. There was predictably some disagreement between professionals about this. Some felt that Ms B had repeatedly and knowingly failed to protect Child T, though there is no indication of anyone considering that anyone other than Mr C might have been directly physically abusive. The IMR picks up the way in which the analysis of the situation drifted into considering the possible outcomes of any legal proceedings rather than focussing principally on whether the children needed to be immediately protected. It also highlights the way in which “the rule of optimism” prevailed:

“Once a judgment has been formed about a family or a parent there is a reluctance to revise that judgment. This means that other evidence which may conflict with that judgment can be ignored or distorted to fit with the perceived judgment. There is a tendency to persist in initial judgments, and to dismiss, distort or minimise discordant and challenging new information”.

14 The former Framework for the Assessment of Children in Need would have provided a statutory basis and organisational arrangements for managing the multi-agency input to the case.
Having taken the decision not to seek to remove the children, the follow up by SW2 was very thorough and systematic. There is clear evidence of determined attempts, for the first time, to establish a full understanding of the family situation. The response of the agencies, when the allegation was made that this social worker had gone on to injure the child, was robust: “There is further evidence of good practice in ensuring that the new bruising was taken seriously (and) that the allegations against SW2 were resolved without her involvement (in the child protection investigation)”.

The IMR is thorough in analysing the weaknesses in staffing and support arrangements prevailing at the time. The report demonstrates that there were serious staffing problems in the team managing the case, including serial changes of manager and consequent lack of supervision, while that team which was receiving some 50 referrals each week.

There is good consideration in the IMR of the fact that practice did not consider racial, cultural, linguistic or religious issues. Most importantly, because of the language problems, “the world was interpreted through Mr C and his view was unchallenged and held sway”.

The report explains the way in which it was possible in an over-stretched system that the important letter from CP1 would be seen only by SW1 and not a manager (although this does not explain SW1’s lack of response to that letter). There were also “significant budgetary pressures” and “enormous political pressure on the front line”.

Some of those pressures will have their roots in the difficulties underpinning the case of Peter Connelly, the 17 month old child who died in Haringey in 2007, following sustained physical abuse. This IMR demonstrates the need for continuing vigilance, identifying the following features which are common to the two cases:

- Absence of authoritative child protection practice and lack of challenge
- Flawed inter-agency communication and the role of the Chair in child protection meetings
- Over-reliance on medical and criminal evidence
- Weaknesses in joint working between police and CYPS
- Over-readiness to place children with family and friends without adequate analysis
- Weaknesses in first-line management and supervision

**5.4 Metropolitan Police Service**

Police became aware of Child T when he was removed from hospital on 5/7/10. The officers who visited the home felt they could not get a definitive medical opinion on Child T’s injuries. They had no concerns about the home environment or the way in which the adults presented. There was no liaison with CYPS at that initial visit. Police decided that no immediate action was necessary at that time. The weaknesses in joint working across the agencies are of concern but the decision not to seek immediately to remove the child, now that he was at home and apparently well is understandable.
5.4.2 A written referral had been sent to police from CYPS, noting their principal concerns that

- Child T had unexplained bruising to the face and chest wall. Consequently the hospital was suggesting that the injuries were likely to be non-accidental.
- The original referral to Enfield Children's Services had not been followed up.
- Due to the suspicious nature of the injuries, the hospital did not want to discharge him until child protection enquiries had been completed but the parents against medical advice had removed him from hospital.
- Mr C had become angry and had been making threats to hospital staff.

CYPS also provided information about the second referral from CP2 which added more medical information, described action taken, and referred to the head injury on Child T as 'unexplained'.

5.4.3 On the basis of all this information a police officer completed a standard assessment, the Child Risk Assessment Model (CRAM). The IMR judges that this assessment was unsatisfactory in that it did not set out the potential risks to the children or consider measures to tackle those risks. This assessment was then never reviewed and updated, as it should have been, once the investigation commenced and the subsequent home visit had been completed. The IMR notes that there were widespread problems of compliance with the CRAM at this time, which were recognised and tackled by the MPS. In relation to the service in Haringey the IMR notes that an inspection in 2011 found that

"research appeared generally consistent, formatted and comprehensive. The CRAM on referrals was present in all cases reviewed and (staff)... were identifying risk factors from the intelligence presented from the research...so that there is a marked improvement in the CRAM completion."

5.4.4 Police then attended the Strategy Meeting on 6/7/10 and, as described above, there was a lack of clarity and consensus across the agencies as to whether or not the follow-up to this was in fact a formal joint investigation. The police IMR appropriately notes some weaknesses in the police management of this investigation, in that Mr C and Ms B were not interviewed separately, and police did not seek to interview PSGM, who had left the home.

5.4.5 The police report broadly concludes that, apart from the above, the overall police investigation was adequate. However, at the point at which police (jointly with CYPS) decided that there need be no further police involvement, there were clearly important unresolved matters of concern. The investigation had not fully considered the very explicit indications of inflicted injury described in the correspondence from CP1 and the further information from Child W.

5.4.6 The medical report considered at the Strategy Meeting had stated that

"I am very uncomfortable with the amount of bruising this child has and with the injury on his forehead. I do not accept that a 3 year old child would bang his head with such severity and not cry out. In addition, bruising on the left side is in a very unusual place and this cannot be incurred either from falling
or from play. I cannot exclude the possibility that some of these may have arisen from pressure from fingers.”

5.4.7 This is not an unequivocal medical confirmation of inflicted injury but it is very nearly that. The police enquiries into the concerns raised by this doctor were not sufficiently thorough. The possibility that this child had been the subject of assault can not be said to have been excluded after the visit by police and SW1. The management of this case should have continued to involve police until the investigation was concluded satisfactorily.

5.4.8 The next significant police involvement relates to the injuries to Child T in February 2011. Police responded promptly to the initial concerns raised by Ms B. The decision to leave the children with their mother overnight, following Mr C’s arrest and detention, was appropriate although police should have notified the CYPS “out of hours” service of the situation on the Friday evening and involved them in the decision.

5.4.9 Police and CYPS then worked very effectively together throughout the weekend, ensuring a thorough investigation of the home and assessment of any continuing risk to the children. Police also worked productively with the Crown Prosecution Service to progress the charges against Mr C.

5.4.10 Police and CYPS again worked together well when the possible evidence of new inflicted injuries came to light. The decisive action to exercise police powers of protection was appropriate. The IMR describes subsequent events including the outcome in relation to Ms B and her mother.

“*In April, the Crown Prosecution Service decision was that no further action should be taken against Ms B and MGM .. There were mixed views (in the police investigating team)... as regards this decision...which led to... a request for it to be reviewed by the CPS ... This decision was reviewed by the CPS in June and it remained no further action to be taken*.”

5.4.11 It is relatively uncommon for police to challenge CPS decisions in this way and, despite the final outcome, this action demonstrates police commitment to ensuring that these matters were now followed up thoroughly.

5.5 Health Visiting Services – Great Ormond St Hospital

5.5.1 Throughout the period of time that the injuries to Child T were sustained, health visiting services in Haringey were commissioned by the Haringey Primary Care Trust (PCT) and provided by Great Ormond St Hospital. From June 2011 Whittington Health took over the responsibility for providing the service. The family were not known to health visiting services before the initial injuries to Child T in June 2010. Health visitors became involved after police and CYPS had agreed the arrangements for the ongoing management of the case.

5.5.2 After the initial joint visit by HV3 and SW1 the case was not allocated to a named health visitor until mid-September. HV5 then managed the case for some four months between September 2010 and February 2011. During that time she did not visit the family and did not liaise effectively with other health and social care professionals. She did not respond to an invitation from SW1 to visit the family together and appears to have assumed that the social worker was covering tasks such as liaising with the GPs.
5.5.3 There was a key failure not to recognise, after the injuries to Child T, that this should be followed up as a “blue folder” case. The Health Overview report explains that there would then have been recognition of “an enhanced level of need and a requirement to discuss the case at child protection supervision and six weekly GP liaison contacts. These cases are also subject to a monitored contact regime, usually requiring face to face contact with the family on a monthly basis”. The IMR judges that HV5 “applies no adequate risk assessment, fails to make this a ‘blue folder’ despite it reaching the threshold, and seeks no management review or supervision”.

5.5.4 The lack of alertness to the background of child protection concerns is placed in a context of weak basic practice: “there is no active involvement in assisting the family to achieve the health outcomes identified” and “Very little effort was used to engage the family and no effective communication occurred outside of her role”.

5.5.5 Another Health Visitor, HV6, then became responsible and carried out the New Birth Visit for Child Y. This visit was made at 39 days when the expectation was that visits be made within 28 days. Even 28 days was an unusual target as most areas of the country aim to visit within 14 days. Moreover this case should have been a priority as Ms B was perceived (in error but the HV service did not know this) as being a first time mother and because social concerns had been raised by the midwife.

5.5.6 HV6 was more alert than HV5 to cause for concern. At her first visit she noted that Child T seemed “watchful and wary”. She did not liaise with the GPs, as she might have done, but she did recognise the need for advice and promptly sought and received supervision from HV3. She then went on correctly to designate the case as a ‘blue folder’ case, making one subsequent visit before the events leading to the second child protection referral.

5.5.7 There were further weaknesses in the health visiting service’s response to these events, in that “There was no health visitor attendance at the strategy meeting on the 21/2/11. Attendance at this meeting should have been prioritised…” The Health Overview report advises that “This should have been a priority”.

5.5.8 These weaknesses were not the consequence of lack of training or experience. The IMR is clear that “All staff involved in this case had completed the required level of child protection training with some being trained to a higher level. In addition to a specialist child protection health visitor, the staff also have access to a Named and Designated health professional for advice and support”. And “All the staff involved in this case carried case responsibility for child protection cases and would therefore have been accessing frequent supervision”.

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5.5.9 However there were major organisational problems in that health visiting team at the time. There had been a change of office location and storage space was difficult with files kept in various places. An electronic recording system had been partially implemented, and records were filed so that it could be difficult to link and cross-reference family records. There were staffing difficulties including long term sickness absence and problems covering part-time posts. Caseloads were dominated by complex and chronic child protection cases. Supervision for the team was being carried out by a consultant who did not link into the wider management network.

5.5.10 As with CYPS the key issue was an overall lack of management oversight so that the way in which the serious child protection concerns had become dissipated was not picked up.

“there does not seem to have been any management follow up by the team leader or health visitor specialist for child protection, as to the progress of health visitor engagement with the family”.

While these events were taking place the health visiting service in Haringey was still being managed by GOSH. GOSH was implementing a major programme of service improvements following the Peter Connelly case. GOSH have advised that

“At the time of the incident the changes and learning from the second SCR for Peter Connelly were still being brought into the service and were not fully embedded”.

5.6 General Practitioners

5.6.1 The review has identified repeated failures by GPs to consider the possibility of non-accidental injury in the family. The family were registered with GP Practice 2, where Child T was seen on three occasions (31/8/10, 17/9/10 and 21/9/10) with bruising variously to his arms, legs and lower back.

5.6.2 These injuries prompted medical investigations which suggested no medical causation for the bruising. However, as the IMR says

“There is no evidence that the two doctors…and the nurse who saw Child T…considered non-accidental injury as a possible diagnosis. They were falsely reassured by the apparent good relationship between Mr C and Child T”.

It is striking that there was apparently no consideration of inflicted injury as a differential diagnosis - the nature and pattern of the bruising was not necessarily suggestive of accidental injury. In fact the Health Overview report describes how

“some of the bruising seen on Child T on these occasions was in suspicious sites”.

5.6.3 There was no communication from General Practice 2 to the HV service. The Health Overview report notes that

“It would have been good practice for General Practice2 to have checked the family were engaged with the health visiting service given that the practice was aware Ms B was pregnant, had 3 young children, was newly arrived in the UK and had Child T whom Ms B and Mr C were expressing concerns about”.

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15 Core information

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5.6.4 The IMR describes how Mr C was known by the GPs to have a history of misuse of drugs and alcohol. He saw a GP in connection with his use of heroin. The GP failed to consider the wider potential consequences of this issue. Moreover, the contact about drug usage came shortly after the bruising to Child T was being followed up by the GPs. The two presentations were not considered together:

“no enquiry was made into (the family’s) well being and the impact of his drug misuse on them and their notes were not reviewed. There was a lack of awareness of the possible impact of drug misuse regarding child protection”.

5.6.5 The report acutely identifies how the various staff were disarmed by Mr C’s relaxed presentation and his willingness to talk about the child’s injuries. This exemplifies the extent to which professionals can adopt a mindset in which they can become closed to the possibility of other explanations. “The Practice discovered in February 2011 that Child T had been admitted to hospital with more than 50 bruises and child abuse was considered. This was mentioned at the weekly doctors meeting but not considered a significant event for the Practice. ...When the practice was asked for information ...the report sent... notes that Child T had easy bruising with minor trauma and that Mr C was a drug abuser. The writing of the report does not trigger any further reflection of the case”.

5.6.6 This very thorough report also identifies a range of organisational issues in GP Practice 2 which affected their ability to provide a safe child protection service. These ranged from having no identified child protection lead doctor to weaknesses and inconsistencies in administrative systems. However the report is clear about the most significant learning point:

“The doctors involved in the care of Child T were reassured to such a point by the apparent openness of the parents and the good relationship witnessed that they didn’t seriously consider child abuse. They should try and understand their own psychological position on this. Child abuse was not (as it should have been) the diagnosis ..., which they then had to seek to disapprove”.

5.7 Barnet, Enfield & Haringey Mental Health Trust

5.7.1 This agency provides a very detailed examination of Mr C’s involvement with drug and alcohol services. That contact consisted of an initial assessment in September 2010, an appointment with a specialist doctor in October 2010 and two subsequent meetings with a specialist nurse. Mr C did not then maintain contact with the service, which formally closed the case after he informed them in November that he was drug-free.

5.7.2 The scrupulous analysis provided by this IMR identifies no serious concerns about their direct service provision. In fact there is evidence of good practice in relation to team working, record keeping and service user involvement. The report also demonstrates a very positive approach to identifying and implementing issues which can serve to improve practice, and details a number of specific changes and improvements which have already been made.

5.7.3 Those service improvements relate to their adopting a broader approach to their work, one which more explicitly recognises the safeguarding of the children of service users as part of their “core business”. The report
recognises the context, evidenced frequently in SCRs and similar exercises, of adult substance misuse services not working well with children’s services. This is often because of a lack of clarity about agency responsibilities and perceived conflicts of responsibility:

“There has been a long standing belief that those working in the drugs and alcohol service are protective of their clients and less likely than other health staff to share information with others either within health or outside agencies. There is likely to have been an element of this within DASH’s historical working patterns and practice which may influence current practice. Therefore it is important to acknowledge this and build in the structures that make communication failures less likely”.

5.7.4 The IMR acknowledges that there was a very obvious gap in their assessment, which was almost entirely adult-focussed and should have raised concerns about the wider family circumstances:

“the knowledge that the father was spending £30-40 a day on heroin, was not working and had three children should have triggered them to have asked more questions and consider the (children). This is the single most important oversight…”.

5.7.5 The Health Overview report further comments on the lack of consideration of the day to day implications for the children of living with someone who might be using drugs intravenously:

“Neither the GP or DASH considered the impact of Mr C’s drug addiction on his parenting capacity either in terms of his behaviour, where he might be injecting heroin and the impact of that on the safety of the children”.

5.7.6 The IMR identifies factors which may have contributed to the weaknesses in their approach. The level of spending on drugs (and cigarettes) was, for the DASH service, not unusual. Mr C’s presentation was disarming – he was well dressed, made an easy rapport with staff, and was credible in relation to his drug use. Consequently

“there appears to have been a combination of staff in the service having a lowered threshold for concern because of their client group and unrecognised disguised compliance which is a frequent feature within serious case review learning”.

5.8 Whittington Health – involvement in 2011

5.8.1 This IMR principally deals with the medical response to Child T on 19/2/11, and the subsequent events. Since 2010 the management arrangements for some services had changed and Whittington Health had become involved. The report describes NMUHT’s management of his second presentation with multiple injuries which were very thoroughly assessed and documented before he was discharged into the care of his mother. His sisters were then referred for assessment at the Community Paediatric Service, where they were all seen on 22/2/11, accompanied by MGM.

5.8.2 The report deals with the differences of medical opinion on the nature and causation of the injuries to Child T examined on 19/2/11, 28/2/11 and on 1/3/11. On 28/2/11 he was seen at NMUHT, coincidently by the same paediatrician who had examined him on 19/2/11, who recorded that he had “20 new bruises”. He was subsequently seen, on 1/3/11, by more senior doctors who found that there were
“some new marks, since the last medical on the 19/02/11 ... although less than recorded...on 28/02/11. It was thought that these were not diagnostic of abuse. The apparent discrepancy between the two examinations was felt to be due to two factors. Some of the injuries that occurred on 19/02/11 may not have been separately recorded due to their number and overlapping nature and these were then recorded as new injuries on 28/02/2011. Some of the marks noted ...on 28/02/11 may not have been bruises and may have faded by (the date of the review).”

In fact we know now that it was determined in the care proceedings that there were new injuries between 19/2/11 and 28/2/11, when he was in the care of His mother and MGM.

5.8.3 The IMR finds generally that the involvement of the various medical services provided by this agency had been appropriate throughout.

“The medical aspects of the case were, on the whole, managed appropriately. There was good communication between the acute and community paediatric services”.

5.8.4 The report considers the issue of the concerns raised by doctors after the medical examinations on 28/2/11 and notes that, despite the doctors’ recommendation that they be separated from their mother, the children were returned to her care. The IMR accepts that there was no immediate reason at this stage to suspect Ms B of harming the children.

“The risks... had to be weighed against the distress of separating the children from their mother, who, although she had not protected the children, was not thought to be an abuser”. However, it is unclear what discussions, if any, actually took place between medical staff and CYPS (and other agencies, especially police) in order to reach this conclusion. This issue is not considered in the CYPS IMR (which is otherwise very thorough), suggesting that CYPS staff may have been unaware of the degree of concern felt by the doctors.

5.8.5 The written recommendation made by the paediatricians at that time after seeing the children is unequivocal:

“All the children should be removed from the family as the mother and grandmother had failed to protect them. This would also help prevent any attempts at pressuring the children to change their account of events”. As the IMR states, if discussions had not persuaded the paediatricians that this was the appropriate course of action, or if no discussions had taken place, the matter should have been escalated to more senior or specialist colleagues.

5.9 Health Overview Report

5.9.1 The Health Overview report (HOR) has been prepared by the Haringey Clinical Commissioning Group. The report is drawn up in line with the guidance in Working Together 2010 (8.3) that:

“Designated safeguarding health professionals, on behalf of the PCT as commissioners, should review and evaluate the practice of all involved health professionals, including GPs and providers commissioned by the PCT area”.

5.9.2 The report reminds us of the considerable extent to which health agencies contributed to the management of this case, which involved:

- A GP practice
• A hospital providing paediatric services to child T, midwifery services to Ms B, and accident and emergency services to Ms B, Mr C and child T
• A tertiary hospital trust commissioned to provide children’s health services in Haringey which included a health visiting service to the family and community paediatric services to all the children
• A mental health trust providing a drugs advisory and treatment service to Mr C

5.9.3 The report, which is thorough and systematic, largely echoes the themes and findings in this report. It is clear that there are, from a health perspective, “key missed opportunities which might have made a difference to the outcome of the case”:
Those missed opportunities include:
• Lack of escalation of concern following the response by children’s social care and police to the medical opinion about Child T’s injuries.
• Inadequate information sharing between the paediatric service and the midwives, so that, when the midwives suspected domestic abuse, they might have responded more decisively if they had known about Child T’s injuries.
• Failure by the health visitors to define the case as one with unresolved child protection concerns, which would have automatically ensured supervision took place and provided an independent assessment of work being carried out
• Delay in allocating the case to a Health Visitor after the first investigation
• Poor follow up by HV5, who never saw the family
• Inadequate assessment of the causation of Child T’s bruising when seen in general practice
• Lack of liaison between the health visiting service and General Practitioners
• Insufficient consideration of the impact of drug misuse on parental capacity by the GP and DASH
• Lack of consideration by hospital staff of the impact of Mr C’s self-harm on the rest of the family when he attended A&E
• Dissatisfaction of the paediatricians when the children were returned to their mother after the child protection medicals, but failure to take further action on that dissatisfaction.

5.9.4 The report notes that
“If appropriate referrals to social care had been made by the midwifery service, A&E staff, DASH staff and GP staff there would have been at least five further contacts with social care” - and consequently five further opportunities to intervene and protect these children.

5.10 London Borough of Haringey, Education Services – report for information

5.10.1 Haringey Education Services have reported on the family’s contact with one school in Haringey. The report deals initially with the admission of Child W to school, picking up some delay and inefficiency in the admission arrangements. The report advises that, since that time, new, centralised arrangements have been introduced which should prevent these problems.
5.10.2 The principal issue identified in the report is poor sharing of information. The Head Teacher at Child W’s school was unaware of the initial injuries to Child T and the consequent involvement of CYPS with the family until after the second set of injuries came to light. The report notes that “The main lesson to be learned in this case is that information about the involvement of CYPS with this family was known by some professionals and should have been shared with all professionals involved with the children”.

6. ISSUES IDENTIFIED FOR CONSIDERATION IN THE TERMS OF REFERENCE

6.1 Introduction

6.1.1 This section of the report considers each of the issues specifically identified as Terms of Reference for this Review.

6.2 Were there any issues, in communication, information sharing or service delivery, within or between services including those with responsibility for working out of hours as well as those working in normal office hours with particular reference to their knowledge of the process of escalation of intra and inter agency concerns in accordance with paragraph 18.5 of the London Child Protection Procedures.

6.2.1 The general issues in respect of communications and service delivery are set out in detail above. Most importantly

- The investigation in June / July 2010 was seriously flawed. Responsibility sat with the wrong local authority for four days. Insufficient weight was given by police and CYPS to medical evidence which was clearly suggestive of inflicted injury. Police terminated their investigations too quickly.
- There was no sense of purpose to SW1’s work after the initial investigation. She did not ensure that other key agencies were aware of the injuries to Child T and did not respond to the important letter from CP1.
- GPs did not consider non-accidental injury as a diagnosis for injuries in August / September 2010.
- The Health Visiting service lost sight of the child protection concerns in the case and, after the first injuries, did not see the family until Child Y had been born.
- DASH were insufficiently alert to child safeguarding issues arising from their work.

6.2.2 Paragraph 18.5 of the London Child Protection Procedures deals with “Professional Conflict Resolution”. It sets out straightforward arrangements, when professionals or agencies cannot agree, for resolving those disagreements. The arrangements require the involvement of senior or specialist colleagues - escalation. Ultimately, and unusually, the LSCB can arbitrate.

6.2.3 In this case the issue of escalation arises principally in respect of the response to the first set of injuries. However with the exception of NMUHT
there was no need to escalate, because the other agencies involved agreed that the injuries should be regarded as non-accidentally caused.

6.2.4 Although CP1 wrote to the social worker setting out the evidence for her concerns, she did not seek to involve any senior colleague or advisor. Her letter was copied to the Named Doctor for Child Protection but not with any express intention – it could have been regarded as for information only. There was no escalation of her concerns to more senior staff in CYPS or police.

6.2.5 The Haringey EDT was contacted on the day after the second set of injuries came to police attention. The EDT response was of a high standard – attending the examination, contributing to the decision-making process and making it clear that they could provide placements if the children were to be brought into care. The thinking behind the agencies’ decision is clear and understandable in the circumstances.

6.2.6 There was not a unanimous view between the agencies following the second set of injuries. There was disagreement as to whether it was safe to leave Child T, and the other children, in the care of his mother and MGM. Some professionals felt that Ms B and MGM could have done more to protect Child T. Others felt that the domestic abuse Ms B had suffered had been significant and, with Mr C in custody, the children would be safe. We know now that it would have been appropriate to ensure that the children were also protected from their mother and MGM. However, it appears that at the time no professional felt so dissatisfied with the decision taken that the need for escalation arose.

6.3 Was the work in this case consistent with each organisation’s and the LSCB’s policy and procedures for safeguarding and promoting the welfare of children and with wider professional standards?

6.3.1 The essential concern arising from this review is that a child twice returned from hospital, having been deliberately seriously harmed, to the care of abusive adults and was further abused. All the key agencies in the case have found weaknesses in their practice which will have contributed to those events.

6.4 What were the key relevant points/opportunities for assessment and decision making and effective intervention in this case in relation to the children and family? What was the quality and timeliness of decision-making and did subsequent assessments and decisions appear to have been reached in an informed and professional way? What was the quality of multi-agency risk assessments?

6.4.1 The principal points for intervention are Child T’s two presentations at hospital with multiple injuries. The first presentation was mishandled initially by ECSC in making a decision which was inappropriate and relied on inadequate information. NMUHT could have done more to ensure that their well-founded concerns were directed to the right agencies and escalated as necessary. No doctor attended the Strategy Meeting held when Child T had been removed from hospital. Police did not take adequate account of all the evidence. CYPS should not have accepted the responsibility for conducting
a single agency investigation (which they thought was the case, though police have a different view).

6.4.2 All of this set the scene for continuing work with the family by health and social care agencies which was based on a faulty assessment and was allowed to continue with no clear plan and no effective supervision, on a misdirected course. Neither the GPs nor the school were informed by CYPS about the child protection concerns which arose in July 2010. The GPs missed opportunities to re-focus concerns when they did not question the causation of a number of injuries to Child T. The Health Visitors did not give the case sufficient priority. Maternity Services did not adequately explore the issue of domestic abuse - all agencies relied too heavily on Mr C as the conduit for exchange of information. Agencies failed to share information adequately or effectively about Mr C’s substance misuse.

6.4.3 The response to the second presentation, in February 2011, was better. However police initially left the children overnight with their mother and MGM before other agencies were involved. There is a lack of consensus about whether agencies gave adequate weight to their knowledge of Ms B failing to protect Child T in the past. There is no evidence that the GP practice was contacted about or invited to the Strategy Meeting when, as the Health Overview report notes, “By this time the GPs held a lot of information about Mr C’s drug addiction and the presentation of Child T in August and September with bruising...[all of which]...which may well have influenced the decision to return the children to the mother’s care.”

6.4.4 As well as the misjudgements of the individual agencies this review demonstrates a worrying failure of agencies to work together. The response to the first presentation was explicitly marked by a lack of effective collaborative work across the agencies. Continuing information sharing was poor and remains unexplained – it is not clear why SW1 did not carry out the basic task of ensuring that the GPs (and subsequently the school) were aware of the initial child protection concerns. A very thorough risk assessment by DASH was weakened by a failure to cross reference reports with other agencies.

6.4.5 Effectively there were no satisfactory multi-agency risk assessments. The ongoing contact with the family lacked any sense of a process of assessment and review. Determining the appropriate response to the second set of injuries was more difficult for the agencies but, ultimately, they did not seek to prevent Child T from returning to an abusive home. This decision, as the CYPS IMR states, “was not based on any adequate assessment of the mother and her attachment to an abusive partner”.

6.5 What did the agency know about the history of each of the parents? Consider whether both the mother’s and the father’s experiences in the light of their childhood and previous relationships was appropriately identified, acted upon and has any relevance.

6.5.1 The CYPS IMR sets out their position with clarity: “There is no evidence that there was any exploration of the background of the mother, her mother, her previous partners, including the father of Child T,
or Mr C and his mother, until SW2 began to undertake a thorough Section 47 investigation”.

It is a serious weakness in the agency’s earlier management of the case that there was no attempt to draw together a comprehensive understanding of the family history. It again reflects a hurried, non-analytical approach which was not subject to challenge. The confusion over responsibility between the two local authorities, and the consequent delay, fed into a significant missed opportunity to initiate a proper assessment – when Child T was in hospital and, as chance would have it, was being looked after by a Polish doctor.

6.5.2 The Health Visitors had only the most basic background knowledge “Ms B disclosed that she had arrived in the UK from Poland, having left an alcoholic partner who was violent towards her. She had left her three children with their maternal grandmother in Poland. Shortly after arriving in the UK, she and Mr C formed a relationship. She moved in to live with Mr C and his mother (and) returned to Poland in March 2010 to bring her children to live with them in the UK”.

The direct involvement of the Health Visiting service with this family was minimal, and HV5’s input lacked purpose and direction. Although risk factors were documented they do not appear to have been taken into account by HV5, who did not seek supervision or guidance in managing the case.

6.5.3 The BEHMHT report sets out what they knew about Mr T which of course principally reflects the focus of their involvement on him - “... unable to work because of his current dependency on heroin (and) had had an alcoholic father and a mother and brother living in Poland with whom he had little contact (and who had) had alcohol problems in the past”.

6.5.4 The agency which demonstrates the best understanding of the family background is the police – their IMR contains quite full accounts of the history of the various adults coming to their attention. This may have only been drawn together after the detention of Mr C – but, if available then, it could equally have been found and used to inform earlier involvement.

6.5.5 There is no evidence that the parents’ previous histories were explored and used to inform the management of this case. There are indications of long-standing problems, including substance misuse and previous domestic abuse. Information has emerged about previous abuse of these children. It would have been appropriate to take a detailed family history at an early stage, and to consider ways of establishing what might be known in Poland about the family. It does not seem that Child T’s father was ever considered by any agency.

6.6 What training has been provided in adult-focused services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children?

6.6.1 This question applies to BEHMHT, the only agency participating in this review which is for adult service users only. The IMR sets out an impressive list of training arrangements and details the extent to which the members of staff involved in this case had been trained.

6.6.2 The agency has readily recognised that, despite the training in place, there was an insufficient focus on the children in this case. It sets out the ways in
which lessons have already been learned and the changes that have been made accordingly. This agency has demonstrated a vigorous response to the issues arising from this case.

6.7 Were practitioners aware of “what it was like to actually be that child”, sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse, specifically physical abuse or neglect and about what to do if they had concerns about a child’s welfare?

6.7.1 Outside school there was virtually no attempt to communicate with the children and, as the Education IMR points out, “the school (in Haringey) had no knowledge “what it was like to actually be that child” in reality as the school had no knowledge of the involvement of Haringey Children’s Social Care and the reasons for this involvement”.

6.7.2 During Child T’s first admission to NMUHT there is no evidence of any attempt by hospital staff to work directly with him, to understand his wishes and feelings and feed that information into a process of assessment. This is particularly disappointing on a specialist children’s ward.

6.7.3 The agencies which should have been communicating directly with the children at home were the Health Visiting Service and CYPS. There were three direct contacts between health visitors and the family. Observations were made and recorded of the children’s demeanour and presentation. Attempts were made to communicate with them but language or Mr C’s presence prevented successful communication. HV5 failed to meet the family during her period of allocation and therefore never assessed the children. Similarly there is no evidence of SW1 interacting with the children in any way.

6.7.4 This is of concern and is not adequately explained by the failure of agencies to identify abuse. Professionals should be seeking to understand a child’s experience at all times. SW1’s understanding of the purpose of her contact with the family is unclear, but any such involvement should include direct observation and interaction with the child.

6.7.5 The GPs did not know about the first evidence of abuse. However they missed opportunities to explore subsequent evidence. They “saw a ‘happy’ child on the knee of Mr C, who they assumed to be the father and were falsely reassured by this. There is no indication in the records that any attempt was made to speak to Child T. He was 3 years old and should have had reasonable language skills albeit probably speaking in Polish. There was no consideration of what it might be like to be a child within a household where the adult male (whom the practice took to be the father) had a drug addiction and financial problems”.

6.7.6 The only evidence of positive and purposeful engagement with any of the children (outside school) emerges from the involvement of the Polish speaking doctor at NMUHT. “the Polish speaking Registrar spoke in Polish to Child W and she was able to talk about life at home and that Mr C did slap them. When she told the doctor that she was not afraid of Mr C, the doctor was astute enough to
observe that her words contradicted her body language and non-verbal communication”.

6.7.7 However, as the IMR points out, the fact that her disclosure, which was observed by Mr C, did not lead to effective professional intervention may then have placed her at further risk. There is no evidence of anyone trying to communicate purposefully with Child T during his stay in hospital or at any time until the case was re-allocated to SW2 in February 2011.

6.7.8 The CYPS IMR discusses the false reassurance given to professionals by the warmth of the interactions between the children: “They were observed….as being reassured by both Mr C and Ms B and going freely to them for affection. It is difficult for professionals to believe that children are being abused when they also show lack of fear and positive attachments to the adults”.

6.8 Did actions accord with assessments and decisions made? Were opportunities for effective intervention, such as Section 47 investigations, multi-agency strategy meetings, Family Group Conferences, Child Protection conferences or effective Looked After Child reviews taken? Were appropriate services offered/provided and/or relevant enquiries made, in the light of assessments?

6.8.1 The issue of Looked After Reviews does not apply in the period under consideration. Otherwise these questions have been answered throughout this report. Assessments were weak and largely unevidenced. The first Strategy Meeting failed to draw together and evaluate all the available evidence and then came to an unclear conclusion. Consequently there were no Child Protection Conferences. There were no formal “child in need” arrangements. The agencies’ view of the family, until the second set of injuries, would not have indicated that an intervention such as a FGC was necessary. The final set of injuries led to the immediate removal of the children into care, so that formal child protection processes were not necessary.

6.9 Did practice in the period show any lessons learned from previous Serious Case Reviews? If not, what were the barriers?

6.9.1 The CYPS IMR notes: “Re-reading the SCR for Peter Connelly to identify whether lessons from that review had been incorporated into practice, I was struck by some similarities with this case: different incidents of bruising seen by different professionals; willingness to believe the adults; a failure to focus on the needs of the child; the absence of key medical staff at key meetings; a failure to act authoritatively or challenge…”

6.9.2 Most of the agencies similarly find evidence of lessons not learned. For Education, the key issue relates to an earlier review (Family Q 2010) “information about the involvement of Haringey Children’s Social Care with this family…should have been shared with all professionals involved with the children”.

6.9.3 The GP IMR notes how Peter Connelly, like Child T, was presented to the GP with bruising and explanations that he was a clumsy child. The Health
Visitors also note the corresponding evidence in this case of children not being seen or frequent missed contacts. The NMUHT report identifies a number of lessons which have been learned from previous SCRs, although these largely relate to improved administrative practice in support of child protection processes.

6.9.4 Peter Connelly died three years before the first detected injuries to Child T. The picture of organisational change and disruption, workload pressures and staffing and budgetary problems, which is evident in a number of the IMRs, may to some extent provide an explanation for the weaknesses in the agencies’ practice in this case. Nonetheless it is worrying to find compelling evidence of individual and systemic failures within and between services so soon after that high profile case. One might expect, if anything, that agencies would be over-sensitive to the possibility of abuse going undetected.

6.9.5 This is the issue of most serious concern arising from this review. How could agencies, particularly in this locality, so fundamentally fail to recognise and respond to a child being repeatedly and seriously abused? The review has found the answers to that question in

- An overall weakness in collaborative investigation and follow-up across all the agencies
- A failure to focus incisively on the children of the family and what life was like for them
- A reluctance to “think the unthinkable” and recognise all the adults in the family as perpetrators of abuse
- A lack of alertness to the prevalence of child abuse as a diagnosis
- Weakness in joint working between children’s and adult services
- A lack of planning and focus in case management
- Organisational instability and budgetary reductions
- The effects of ill-managed organisational change

6.9.6 It is now more than three years since the initial concerns arose for Child T. The key agencies have set out in Section 10 of this report the ways in which they have sought to improve services since then, and the evidence of that improvement.

6.10 Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?

6.10.1 There are no apparent issues of disability or religious identity in this situation. However this was a Polish family where, ostensibly, only Mr C (and increasingly the children) was able to communicate effectively in English. Ms B may have had more grasp of the language than was admitted but it is clear that her ability to communicate with the various agencies was limited. She was consequently less able to feel confident that she could take effective action to protect herself and the children. There was limited use of interpreters and the CYPS IMR describes how “the world was interpreted through Mr C and his view was unchallenged and held sway. Not only did this allow him to wield all the power within the household, but with external agencies too. Furthermore it failed to offer any voice to Ms B and meant that there was no attempt to build a relationship with the children”.

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6.10.2 However analysis in the IMRs of the meaning and consequences of the family’s ethnicity and language skills is limited. There is little sense of exploration of what community supports were available or of how far the family was part of a community. SW1 tackled issues around getting the children into education without apparently assessing the extent to which the family might need broader support. It is perhaps more evidence of displacement – by immersing herself in activity aimed at getting the children into school the social worker was able to set aside the issues of harm that had led to her involvement in the first place.

6.10.3 The role of the children’s grandmothers, and the extent to which they either alleviated or aggravated the problems in the family, is unclear. It does not seem that there was any attempt to understand their significance for the family dynamics, or even to establish the basic facts of the composition of the family. There may have been an easy but un evidenced assumption that a grandparent would necessarily be a protective factor. The Education IMR makes an interesting observation about how the family presented and / or were understood by agencies:

“no-where does Mr C give his designation as step father” referring to research findings about the heightened incidence of harm perpetrated by men who are not biologically related to the abused child. All these observations bring us back to the lack of basic fact-finding to enable thorough assessment.

6.11 Was there sufficient management accountability for decision making? What was the quality of supervision? Were senior managers or other organisations and professionals involved at points in the case where they should have been?

6.11.1 The position taken by police in response to the first set of injuries was not adequately challenged. The police IMR comments that “The supervision merely accepted the officers’ conclusions and closed the investigation without appearing to provide a dispassionate review of the findings”.

6.11.2 The position in CYPS was similar “There is no recorded management decision, instruction or supervision…. hence no recorded challenge to the view of this as a family support, child in need case, and no need to pursue the Section 47 enquiries”.

6.11.3 The extent to which professionals were able to set aside the injuries Child T had sustained is a sharp reminder of well recognised themes in the management of child protection. Abusive adults can be convincing but the personal and organisational pressures which lead staff to take fixed views are an even greater concern. In this instance there was no managerial challenge or review of the evidence which had led staff to take a particular view.

“In this case, once allocation had happened, there does not seem to have been any management follow up by the team leader or health visitor specialist for child protection, as to the progress of health visitor engagement with the family”.

In CYPS
“there is no evidence of management involvement in the case from (9/7/10 - the date of the joint visit with HV3) apart from the signing off of the Core Assessment on 24th August and supervision from the temporary manager in November 2010”.

6.11.4 The BEHMHT report describes a number of steps taken to enhance the resilience of their child protection arrangements, including twice daily team meetings where safeguarding issues are discussed. All the agencies involved in this review need to be able to demonstrate a greater reliability and effectiveness in their supervision arrangements.

6.12 How effective was management support and supervision in countering the impact of parental hostility and deflection. What evidence is there of reflective and authoritative practice of both supervisors and supervisees?

6.12.1 There is relatively little evidence of significant parental hostility towards professionals in this case. Mr C angrily took Child T out of hospital and there are isolated instances of his losing his temper. Much more significant is his use of deflection. As BEHMHT note in their IMR “He is reported by those interviewed to be articulate, appeared well kempt and was thought to be easy to engage with. This may have had the effect of lowering the threshold of concern in a service that deals with many more challenging clients”.

6.12.2 His confidence in his ability to deceive professionals is displayed most explicitly in his dealings with the GPs. He succeeded in entirely displacing any thoughts of physical abuse, while apparently proactively seeking a medical explanation for Child T’s presentation. SW1 was similarly misdirected into focussing her interventions into financial support rather than parental care of the children. The CYPS report explains how this became a sort of self-fulfilling prophesy “Since she did not undertake a rigorous assessment of the family functioning and decided at an early stage that this was a family support case, there was no acknowledgement that the adults in the household were preventing her focusing on the needs and wellbeing of the children”.

6.12.3 It is more difficult to be clear about Ms B’s contribution to the deceit of professionals by the family. She largely presented as unable to speak English although there is some scepticism about the extent of that communication problem: “midwifery staff …all separately thought that Ms B’s …English was better than she gave the impression that it was, and that perhaps the reason she did not communicate and appeared withdrawn on occasions was more an indication of the relationship with Mr C”

6.12.4 Ultimately there is compelling evidence that she had knowledge of the nature and severity of abuse suffered by Child T. She chose not to have recourse to the services which could intervene to protect her son. Subsequently evidence has emerged linking her directly to the abuse of Child T and previous child abuse concerns in Poland. There was a lack of critical thinking which would encompass the fact that mothers may be actively engaged in or collusive with the abuse of their children. The correspondence with the abuse of Peter Connelly cannot go unmarked.
6.12.5 There is no evidence of reflection resulting in a challenge to the general view that these were poor and troubled immigrant parents, struggling to provide for their children and promote their well-being. The CYPS IMR accepts that there was no “focus on how the family had deflected the social worker, and others, from an emphasis on investigation to supporting the family with their practical difficulties”.

6.12.6 There is little evidence of effective supervision being used to challenge assumptions about family functioning – assumptions which became regarded as established facts. The CYPS IMR again captures the weakness in practice: “The team manager in this case for the first 3 months was both competent and knowledgeable (but) there was no regular supervision ... and this meant that the family support approach was never challenged, nor the assessment of the safeguarding risks in the household. Key questions were not asked; the supervision approach reflected the case work approach” (my emphasis). This report also points out that escalation of difficult situations to more senior managers needs to be a rigorous process. Senior managers were very ready to become involved in the second investigations, but their involvement was not documented in any way.

6.12.7 The IMR from the health visiting service accepts that there was a failure in management throughout their involvement in the case – a lack of management oversight allowed an undue delay before the case was allocated to HV5. HV5 then did not follow up the case and that was not identified, although her managers were aware of the circumstances in which the case had presented.

6.12.8 Police involvement in the first referral was ended too quickly, without taking full account of the medical evidence and the continuing concerns of senior doctors. There was no need to terminate contact immediately after the joint visit with CYPS and no evidence that this decision was critically scrutinised by police managers / supervisors.

6.13 Evaluate the impact of any organisational change and challenge over the period covered by the review and establish the capacity of front-line services for effective response.

6.13.1 Child T came into hospital for the first time at the very end of June 2010. Arrangements at NMUHT had changed significantly that month when the management of in-patient children’s services was transferred back from Great Ormond St Hospital NHS Foundation Trust (GOSH) to NMUHT itself. It would not be right to extrapolate from the one case under consideration here to comment on the overall effects of these revised management arrangements. However we can say that while the response to Child T’s initial presentation appropriately identified cause for concern, there was then a loss of urgency. When ECSC failed to accept the concerns of hospital staff, the problem was not escalated effectively by those staff to more senior managers or clinicians with specialist child protection responsibilities.
6.13.2 The CYPS IMR spells out the organisational context for the management of this case. This is deliberately quoted at length as it starkly illustrates the pressure which staff and services will have been under at that time:

"the team...had an establishment of 15, consisting of 9 social workers, 2 social work assistants and a practice manager. Of these, 3 of the social workers were from an agency (including SW1), 1 was newly qualified and one was part-time. One of the social work assistants was from an agency, as was the practice manager and the manager herself. In addition, there was one social worker who was suspended, another with serious capability issues and nearing suspension, as well as 2 social workers from the United States – well qualified, experienced and competent, but needing significant support to make the adjustment to the Haringey / English legal and cultural context. Although SW1 was an agency worker, she had been in Haringey for more than a year and was seen by her manager as her most experienced and competent worker. The Practice Manager, although a very experienced worker, was newly in the Practice Manager post and learning the role. The team manager left at the end of September 2010, and her role was taken by an agency team manager, who left (after) a few weeks having (displayed) low levels of competence. The permanent replacement started in mid January; a team that was already struggling was left without effective first line management in reality between October and the end of January".

6.13.3 The IMR goes on to give evidence of other pressures. In response to budget reductions the authority had introduced an arrangement whereby approval was needed by a Director or Assistant Director before minor amounts of expenditure could be committed – such as arranging the use of an interpreter. This was clearly a practice which may have had implications for the management of this case, and one which is likely to have had a stultifying impact on the quality of work generally.

6.13.4 The IMR robustly challenges the findings of Ofsted inspections in February and August 2010, which had generally reported positively on the situation in CYPS. There is of course only one case under consideration in this report but the concerns arising in this review mark the dangers of "believing your own press". The inspectors flagged up as particular strengths that "performance management arrangements and case auditing systems (are) firmly in place (and) staffing capacity (is) responsive to need". The challenges facing front-line staff are compounded if judgments like this are allowed to mask the reality of day to day work pressures.

6.13.5 The Health Visiting service accepts that there were serious problems in the team at that time and that management arrangements failed to identify the way in which the case had become seen as less worrying, and the consequent low priority given by HV5. For the other contributing agencies there are no "headline" issues relating to organisational robustness, particularly in front-line services.

6.14 Did agencies make gender-based assumptions about the likelihood that women would prevent abuse rather than perpetrate it?

6.14.1 This question arises principally from the decision, taken after the second set of injuries, that no immediate legal action was necessary to protect the children once Mr C was in custody. The account, given by Ms B and her mother, that the injuries had been inflicted by Mr C, was broadly accepted. In so far as there were concerns about the safety of the children in the care of
their mother and MGM, these arose from the women’s failure to protect them from Mr C.

6.14.2 The medical evidence about what happened to the children in the few days before they were removed into care is not straightforward and does not unambiguously demonstrate fresh injury. However there was a finding of fact in the care proceedings that there had been physical abuse during that time, which is supported by evidence from Poland about previous abuse of the children before Mr C was part of the family.

6.14.3 The agencies which were directly involved in identifying and responding to abuse are all satisfied that the judgments made after the father had been arrested were reasonable. They have scrutinised these events and have not found any evidence that their decisions were influenced by assumptions about the women as unlikely perpetrators of abuse.

6.14.4 Some agencies or staff within the agencies were worried that the women’s previous failure to protect Child T amounted to significant harm in its own right. The CYPS IMR describes the Strategy Meeting where “views were polarised between Ms B as a victim and therefore powerless against the perpetrator but not dangerous in her own right (my emphasis) and as a parent who had failed to protect her children”. This does suggest that a view had been taken that Ms B was “not dangerous” and did not pose an active threat to the children.

6.14.5 Police report that they would have routinely considered the possibility that the women may have been directly responsible for abusing Child T: “risk assessments considered the mother (and maternal grandmother) as possible suspects for abuse and also considered them for neglect for not protecting the children”. Other than this there is no evidence that agencies, apart from police, considered MGM as either a victim or a perpetrator of abuse.

6.14.6 The relationship between domestic abuse and child abuse is complex and individual situations will require careful consideration: “When a woman who is being abused is also involved in the abuse of her children, assessments need to explore her capacity to acknowledge the abuse and her capacity to change her mothering when she is no longer being abused herself. Recovery work will also need to recognise that domestic violence also constitutes an attack on the parent-child relationship (usually mother) and that intervention is needed to strengthen this relationship in the aftermath of violence”.16

6.14.7 A decision needed to be made for the immediate care of the children. There was no indication that they might come to any direct harm from their mother or MGM and, on that basis, the judgment about arrangements made for their care was reasonable. However, if a thorough Core Assessment had been carried out after the initial injuries in 2010, the information of previous concerns about injuries inflicted in Poland should have come to light. That should have affected analysis and decision making throughout the case and this situation may have been avoided.

16Every Child Matters: Research and Practice Briefing – Humphries, Dept of Health 2006
6.15  Is the “quality assurance” of decision-making in child protection sufficiently resilient, with particular reference to the processes and outcomes of Strategy Meetings?

6.15.1 There were three Strategy Meetings in the period under review – one in response to each set of injuries. The principal reason for concern about these meetings arises immediately from the responses of the two key agencies: CYPS advise that “the strategy meetings, of which there were 3, were reasonably well-recorded” whereas the police report that “As there have been no meeting minutes available to review against what the officers have recorded, it is not possible to comment further”.

6.15.2 The police position is corroborated by NMUHT whose report in respect of the first meeting states that “There was no written record of the meeting or decisions reached and actions to be taken”. The reference to the meetings as “well-recorded” probably means that a good record was placed on the CYPS file by the officer attending. It seems clear that no formal minutes were taken.

6.15.3 It also appears that minutes were not taken of the subsequent Strategy Meetings, even though we know that there was a spirited discussion, when Mr C was first in custody, as to whether it was appropriate to seek to prevent Child T returning to his mother’s care.

6.15.4 Strategy Meetings are often held at short notice and it would not be realistic or always necessary to have arrangements for full minutes to be taken. More usually a note of decisions will be made and circulated. A “minimum requirement” should be agreed and it may then be useful to develop some arrangements for quality assuring the processes and outcomes of Strategy Meetings.

6.16  What could or should agencies have done to gather information about the family from Poland?

6.16.1 For most of the agencies the question of gathering information from Poland would not arise. Health agencies do not normally seek information from abroad unless there is a specific indication that this is advisable. There were no health concerns for any member of the family which would have prompted overseas contact.

6.16.2 On the other hand police regarded this as a routine issue once they were involved in a continuing investigation: “it is now a standard practice in criminal investigations that research in (foreign nationals’) country of origin will be completed”. It appears that most of the background information which is now held has been derived from police enquiries.

6.16.3 However there is no indication that the assessment carried out by SW1 looked further back than the arrival of the family in this country, other than re-stating the information disclosed by the adults. The IMR suggests that
such research would have been carried out if the case had not been “re-framed” so as to discard the possibility of injuries having been inflicted. “The mechanisms are available to local authorities to make such enquiries... The question of whether these services are utilised is very much down to how seriously the case is viewed and how the risk to the child is assessed”.

6.16.4 Once the local authority was involved to the extent of carrying out a Core Assessment it is difficult to see any rationale for not making such enquiries as a matter of routine. In a locality as diverse as Haringey this will not be an unusual situation and it may be helpful for the authority to develop more specific guidance on this issue.

7. **GOOD PRACTICE**

7.1 OFSTED\(^{17}\) has suggested that the “best” SCRs will identify “Good practice... with... potential for wider implementation”. As well as having this potential, good practice must mean something more than meeting the basic expectations of a professional body, and / or an employer.

7.2 Some of the reports contributing to this review suggest, as good practice, systems or practices which should already be routinely in place. However the response of agencies to the final set of injuries in February 2011 was impressive. Agencies were not deflected by the allegations that the injuries had been perpetrated by a member of staff. Agencies can become paralysed and ineffective in the face of allegations against staff. It is encouraging to see here that agencies responded swiftly to safeguard the children.

7.3 Perhaps the best example of good practice arises not from the management of the case but in the decisive way that BEHMHT used it as a learning opportunity: they “reviewed their service chronology alongside that of other agencies ... as a team and agreed a set of fourteen actions to enable practice to be more focussed upon the welfare of the child. The DASH built this into the everyday operating framework of the service to ensure that this is achieved and have set up audit systems to monitor this”. More detail is provided in section 10 of this report.

\(^{17}\) OFSTED SCR Descriptors January 2009

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8. KEY FINDINGS

8.1 Within both health and social care services there was evidence of organisational confusion. For the health visitors that led to a situation where there was no input for several months. The involvement of CYPS was misguided and lacked focus. There were also specific weaknesses of individual professional practice – the unevinanced decision taken by ECSC that the injuries did not need investigation, the wrongheaded response of police officers and social workers to the evidence of abuse put before them from the hospital, the lack of any action by HV5, the GPs’ failure to make a differential diagnosis of inflicted injury. Checks and balances between agencies and management arrangements within agencies were insufficient.

8.2 The agencies’ response to the first injuries raises grave concerns. This was not a “borderline” case. Child T had multiple injuries. There was medical evidence which was highly suggestive of child abuse. However this did not prompt a thorough child protection investigation. CYPS thought they were undertaking a single agency assessment with police support whereas police viewed this as a joint investigation. Both agencies responded inadequately to a strongly expressed medical view that these were inflicted injuries. Police were premature in terminating their involvement after one visit, when further medical evidence had been invited.

8.3 There was, following the first injuries, no systematic process of assessment and review. There were simple failures to collect information, including information from Poland, and more challenging failures to “think the unthinkable” – for example, that the mother and grandmother of these children may not have been protective agents but may have colluded with abuse or been abusive in their own right. The readiness to accept an arrangement where there was insufficient use of interpreters, and Mr C provided the main conduit for information about the family, further allowed for a skewed presentation of the family to professionals.

8.4 Weak communications and information sharing arrangements contributed to the lack of effectiveness in the overall response. Substance misuse services and children’s services did not communicate with each other. Concerns within maternity services about domestic abuse were not communicated to other agencies. Within the GP practice there was a failure to link the implications of Mr C’s substance misuse with the presentation of a child of the same family with repeated and unexplained injuries. There was not anything approaching a well-informed view of the family until after the second set of injuries.

8.5 This list of concerns sounds like a textbook presentation of frequently found weaknesses in the protection of children, so it almost inevitably culminates in failures to listen to the “voice of the child”. One of those failures was immediate – Child W told a Paediatric Registrar, in the context of a high level of concern that Child T had been abused and that she had also been hit by Mr C. Yet her disclosure did not lead to any investigation when the doctor reported it to ECSC, or subsequently.

\[18\] See, for example, the HSCB website Key Messages
8.6 There was a continuing weakness in the involvement of CYPS, who, over a period of months, had minimal contact with any of the children of the family. “Simply seeing a child is not protection against harm. Workers need to try to understand what the world looks and feels like for that child”. Health visitors have particularly important knowledge about the health and development of children. This was entirely missing from the management of the case until shortly before the second injuries.

8.7 In the three key agencies – social work, police and community health services - there was no effective management oversight to challenge the course that was being taken, either on the specific mistakes in the investigation of the first injuries, or on the lack of thoroughness or process in ongoing work.

8.8 It is unavoidable that any examination of services to children in Haringey will be carried out in the context of the death of Peter Connelly. Weaknesses in child protection arrangements are of concern anywhere but it is a reality that the delivery and oversight of services in Haringey must be particularly robust and resilient. Consequently it is important to be clear that this Review, which of course considers only one case in 2010/2011, evidences serious failures of management and professional practice at that time within and between the three key child protection agencies – police, health and children’s social care services.

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19 Key Messages
9. CHALLENGES

9.1 Because the events under review are not recent, this section of the report does not suggest immediate actions to be taken, but sets out issues arising from this Review on which the Board might wish to be reassured.

A. Is the “quality assurance” of decision-making in child protection sufficiently resilient, with particular reference to the processes and outcomes of Strategy Meetings?

B. Do agencies understand arrangements for escalation of concerns? Some agencies can present as particularly authoritative and decisive by virtue of their societal role and status – most obviously police and the medical profession. Is there a particular need to enable challenge and escalation in respect of those agencies.

C. Is there sufficient clarity for practitioners about the role and availability of specialist support, such as might be provided by the Named Doctor for Child Protection?

D. Are the agencies satisfied that information-sharing arrangements, where there are child protection concerns, are sufficiently robust, so that, for example, it would not again be possible for children’s social care and substance misuse agencies to be unaware of each other’s involvement with a family?

E. Are supervision arrangements systematic and challenging so that they will identify and tackle both immediate errors and a continuing lack of purposeful involvement?

F. Two of the key services - children’s social care and health visiting – were significantly affected by budget restrictions and / or organisational pressures. Do those agencies have the resources and organisational stability to meet their child protection responsibilities?

G. Is it necessary to re-assert to GPs the need to consider child abuse as a differential diagnosis or even, as the IMR argues, the “prime significant diagnosis one is seeking to prove or disprove”?

H. Maternity services are increasingly aware of the incidence and implications of domestic abuse and there has been investment in ensuring that they can provide appropriate advice and “signposting” to potential victims. Is there a need to reinforce awareness within those services of the associations between domestic abuse and the safeguarding of children?

I. It is an unusual feature of this case that Child T was physically abused again in the care of his mother and MGM after Mr C had been removed into custody. How reliable was the assessment which led to the decision not to seek to prevent his return to his mother’s care? Did that assessment challenge any gender-based assumptions about
the likelihood that women would prevent abuse rather than perpetrate it? Did the assessment robustly consider the probability that all of the adults of the family had been complicit in the abuse of Child T?

J. There were missed opportunities to hear the “voice of the child”. That does not seem to have been the guiding principle in the agencies’ work. The Board will need to be reassured that this has changed.

K. The most serious concern arising from this review is the weakness of the initial investigation, where compelling, medically substantiated evidence of inflicted injury was not given enough weight. The Board (and the Enfield Board) should be absolutely satisfied that there is a sufficient understanding of this across all the agencies to provide a reassurance that it would be unlikely to happen again.

9.2 The LSCB has accepted the need to respond to all these concerns and sets out the steps taken to do so in a separate document.
10. SERVICE IMPROVEMENTS

10.1 Introduction

10.1 Since the events reviewed in this report there have been many changes to the way in which services have been configured and how they are delivered, locally and nationally. This section of the report summarises the information provided by the agencies about those changes and how they would have affected the management of this case.

10.2 North Middlesex Hospital University NHS Trust

10.2.1 In response to the findings in this serious case review and as a result of a number of other developments within the hospital a number of changes have taken place in the paediatric service and the child protection team.

10.2.2 The child protection team at North Middlesex is being strengthened and enlarged. Previously it was comprised of a whole time equivalent nurse, a whole time equivalent midwife and 0.4 of a consultant Paediatrician’s time with a whole time administrator. In future there will be 2 nurses and 2 midwives in addition to the medical input. The deputy named nurse post will be based in A&E. The whole team will be managed by the Matron for Paediatrics; previously the midwife was managed by the Midwifery matron.

10.2.3 In addition the weekly child protection meeting is run differently – cases of children who are no longer in the hospital are not left on the list awaiting actions. The actions are done between meetings and the children are rapidly followed up and then removed from the list. Copies of the discussion from these meetings are now routinely sent to GPs.

10.2.4 North Middlesex University Hospital NHS Trust introduced a new child protection policy in 2012. This explicitly gives a clear plan for case escalation to senior officers in other agencies.

10.2.5 North Middlesex University Hospital NHS Trust is investing in new Information technology and is introducing a new unifying patient administration system, system C. This will allow all appropriate staff to access the systems used in different parts of the hospital. The hospital is exploring whether it is possible using this system to print the responsible borough for each child on casualty cards in order to decrease the chance of a referral being sent to the incorrect local authority.

10.3 London Borough of Enfield, Children’s Social Care Services

10.3.1 ECSC have reported a number of changes and service improvements, since the events under review. Some arise directly from the lessons learned from this case. Two members of staff have been assigned to be the key point of contact within ECSC with N MUHT. ECSC has developed a multi-agency ‘Single Point of Entry’ (SPOE) that accurately screens all referrals concerning vulnerable children. (As part of this process, addresses on referrals are carefully scrutinised to ensure that the referral has been sent to the correct local authority).
10.3.2 The Department has monitored and reviewed thresholds for statutory intervention. This has incorporated both an internal and external process (by Ofsted within a pilot inspection) and guidance has now been re-issued in light of the development of the SPOE. There is a commitment to an annual external review of work in this area.

10.3.3 ECSC has participated in a ‘Pilot Inspection of Early Intervention and Child Protection services’. They have also developed a rigorous and extensive series of specific themed audits of case-work; recent audits have included:-

- Responses to referrals
- Contacts leading to referrals
- Cases resulting in a decision of ‘No further action’

10.3.4 More generally there has been investment in a comprehensive training programme for our qualified social workers, and a new programme of ‘staff observation’ by managers has been developed. The supervision policy has been re-designed to incorporate better consideration of the need for practitioners to have ‘Reflective Supervision’.

10.4 London Borough of Haringey, Children and Young People’s Services

10.4.1 During the 3 years following this case changes have been made at both a strategic and operational level. These include steps to improve management, enhance information sharing and to strengthen the ability to manage cases with international links.

10.4.2 In response to issues relating to supervision arrangements and communication between managers and staff, CYPS has:

- Introduced a new supervision model, with improved policies, agreements and templates to support learning and monitoring. It recognises the importance of management challenge and will help ensure staff at all levels receive reflective but also authoritative supervision. This has been introduced in all frontline children’s services, and it is monitored through regular supervision, surveys and audits.
- Established a Quality Assurance Board to oversee and scrutinize the quality of practice and compliance with best professional practice and procedure. This is embedded within a Quality Assurance Framework and Strategy for the Directorate.
- Recruited a Principal Social Worker to provide support to both frontline staff and managers on professional best practice and to reinforce the line of accountability for the quality of practice from the frontline through to the senior leadership team. This was in line with a recommendation of the Munro Review and further strengthens the capacity to consistently deliver higher quality social work and practice.
- Ensured that all learning and development activities for CYPS staff incorporate findings from Haringey and other local authority Serious Case Review findings.

10.4.3 The impact of these measures is integral to the tracking and management of organisational risk and performance; for example CYPS has improved its

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ability to recruit and retain permanent staff. In April 2010, permanent staff figures were at 72% whereas this had increased to 87% in April 2013. Having a stable and committed, permanent social work staff group significantly improves the capacity to deliver a high quality service.

10.4.4 CYPS has also made changes to improve communications, the sharing of information and the escalation of concerns. It has:

- Established a Multi-Agency Safeguarding Hub that brings the council, police and health professionals to work together in one secure location to best ensure vulnerable children are identified and protected. Most London authorities now follow this arrangement and it has strengthened the impact of interagency safeguarding arrangements in Haringey.
- Put in place a Local Safeguarding Children’s Board escalation policy to ensure any professional can raise concerns where there may be a disagreement about how to best manage risks and help safeguard children.
- Introduced processes and standards to ensure all social workers who undertake assessments for vulnerable children always speak to children alone. This is routinely audited for compliance.

10.4.5 Haringey CYPS is now an active member of the UK branch of Children and Families Across Borders (CFAB). Links have been established with Romania and Bulgaria and work is now underway strengthening similar relationships in Poland. Currently contact is made via the consulate or by contacting social work departments directly in the family’s area of origin. The CYPS employs a number of social workers fluent in other European languages and has recently visited Poland to develop a plan to work more effectively on inter-country safeguarding issues. Budgets and access to resources for interpreting and translating were delegated in 2011 and are held at practitioner level.

10.5 Metropolitan Police Service

10.5.1 A number of significant changes have been implemented since the events reviewed in this report commenced.

10.5.2 The CAIT team at Haringey has changed numerous members of key staff including the team lead (Detective Inspector) and regional lead (Detective Chief Inspector). The team has increased focus on safeguarding and performance and through the Multi Agency Safeguarding Hub (MASH) has closer ties with key partners ensuring transparent information sharing and enhanced decision making.

10.5.3 The CAIT team have re-located to a more central location within the Borough bringing them closer to police and local authority partners.

10.5.4 All new members of the CAIT team are provided with bespoke training. This training includes the learning from this and other Serious Case Reviews and includes input on risk assessment and the use of CRAM.

10.5.5 The MPS Continuous Improvement Team has reiterated to every officer within the Child Abuse Investigation Command that witnesses must be
spoken to individually and in private when criminal culpability and discrepancies in individual accounts are being explored.

10.6 **Whittington Health – the Health Visiting Service**

10.6.1 Responsibility for the health visiting service was held by Great Ormond Street Hospital until June 2011 when it transferred to Whittington Health (WH). WH has reported a very wide-ranging programme of service developments and improvements since the events under review here, supported by an overarching workforce strategy and action plan.

10.6.2 Leadership development has been a priority with a strong management and professional development structure incorporating clearer lines of accountability. There is an ongoing significant investment in numbers of new health visitors as part of the national expansion of health visiting, alongside a structured training and development plan for the service. This builds on recruitment and training initiatives for health visitors which have established a stable workforce.

10.6.3 Appropriate levels of child safeguarding supervision are in place, alongside the implementation of a quality practice audit tool and strengthened line management systems. Where poor practice has been identified appropriate measures are being taken using improvement and disciplinary procedures as appropriate. The work of Health Visitor 5 has been reviewed by the professional lead for health visiting and the specialist child protection health visitor and her performance is being managed under the Trust’s disciplinary procedures.

10.6.4 WH has recognised that the delay in carrying out New Birth Visits was unsatisfactory. Since coming under the management of WH, a review of processes has led to significant improvements in performance and in 2012 the standard was changed to 14 days, in line with national standards. From a baseline of 18.8% in April 2012 the service was seeing 85% of families within 14 days by April 2013 and an action plan is in place to achieve the 95% target.

10.6.5 The introduction of an electronic record keeping system in 2011 has enabled far more 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.

10.6.6 There are improved arrangements to support the process of information sharing across agencies:

- GP/HV liaison meetings, to support early sharing of concerns and identification of risk, are monitored on a monthly basis by managers and are reviewed by the service manager.
- Work is being undertaken with the midwifery service to improve the antenatal to postnatal pathway with particular reference to the management of vulnerable clients.
- New referrals are processed through the Multi Agency Safeguarding Hub (MASH) to ensure speedy allocation to a health visitor or school nurse.
10.7 General Practitioners

10.7.1 In May 2012 all practices were notified of the learning for General Practice from the case. This specifically addressed minor injuries in children and advised that best practice would be to consider a minor injury to be non-accidental injury until decided otherwise. A flow chart and a risk assessment checklist in cases of injuries to children were developed by the child protection team and provided to all GPs.

10.7.2 A further notification was sent in October 2012 advising that:
- an induction programme for new staff regarding child protection (CP) should be instituted.
- a checklist should be used to help identify high risk cases to be discussed with a GP Trainer or GP Child Protection Lead
- significant events relating to CP and their concomitant actions are disseminated within the Practice and shared anonymously with the Child Protection Team, who can disseminate and incorporate them in training to the wider GP community. Examples of systems or practices working well would be shared in the same way.

10.7.3 A “vulnerable child” guidance document was disseminated to all practices in 2011 and 2012. Meetings for GPs were attended by the Named GP and Designated Nurse in January 2013 and a presentation made of this case and the learning points for General Practice.

10.7.4 Bespoke Level 3 training is offered to Haringey GPs, alongside external multi-agency training, via the LSCB. The Level 3 child protection training, which ran from July 2012 to June 2013, used a fictitious case study based on Child T. It was designed to reiterate the learning from the case and increase confidence in recognising and taking appropriate action regarding potential physical abuse.

10.7.5 The Protocol for Joint Working between the Haringey Health Visiting Service and Haringey General Practitioners was reviewed – it states GPs should provide HVs with a list of families with children under 5 years of age who have registered or de-registered with the practice in the previous month. All practices and the HV team leaders have been reminded to ensure this happens.

10.7.6 The London Deanery agreed to implement the suggestions made and advise GP trainers accordingly. They will use the Haringey case to demonstrate the challenges faced by GPs. The GP practice concerned was visited by the Medical Director who was satisfied that areas of poor practice had been identified and the appropriate action had been taken. The recommendations were made at the presentations to the collaborative leads and the CCG Governing Body Children’s Lead.

10.7.7 The Named GP has reviewed and updated registration information asked at registration of those under 10 to include whether children have attended A and E and also whether they have ever had a social worker, at any time. Most General Practices have been transferred to the EMIS Web IT system. A registration template has been produced, which will be advocated as a Haringey model for improving practice and disseminated to all practices.
10.8 Barnet, Enfield and Haringey Mental Health Trust

10.8.1 BEHMHT responded very promptly to the lessons from this review, making some swift and significant changes so as to achieve a clearer focus on their child safeguarding responsibilities. They report that there is evidence of service improvements which are embedded in practice:

- Use of a revised, shorter parenting assessment at the triage stage
- The triage worker contacting Children’s Services within 24 hours for an information sharing discussion with each new client who has parenting/caring responsibilities.
- Allocation of a key worker the following day if a client is a parent/carer;
- The addition of a safeguarding item within the daily handover meeting and the weekly Clinical Team Meeting.
- Accountability for referral to Children’s Services with the team manager.
- Robust discharge arrangements where the GP is notified at assessment and discharge and Children’s Services are notified even if a client is referred but doesn't engage.
APPENDIX A: Recommendations made in the Individual Management
Reviews of the contributing agencies

London Borough of Haringey, Children and Young People’s Service

1. Monitor the procedure for accepting post into the service and find mechanisms to ensure that all letters are seen by the addressee and their manager.
2. Explore with staff and managers how supervision can become more robust and challenging and less focused on the computer and case records.
3. Consider imaginative and creative ways to ensure that lessons are learned from SCRs and research, especially those messages which are counter-intuitive.
4. Review the arrangements for accessing interpreters, and the budget for interpreters.
5. Ensure that managers and staff are aware of the “latent conditions for error” both within the organisation and within individual cases, and that systems are developed to alert senior managers when the levels of organisational risk rise, and front line staff develop a check list for risk assessing cases prior to the assessment.
6. Discuss with other local authorities and central Government developing a process for finding out background information about children who have come to this country from abroad.

Metropolitan Police Service

1. It is recommended that the SC&O5 CAIC remind all investigative officers and team managers to ensure that investigative strategies in joint investigations are compliant with Standard Operating Procedures and ensure that witnesses are spoken to individually and in private when criminal culpability and discrepancies in individual accounts is being explored.

Whittington Health – Health Visiting Service

1. All new birth visits should be carried out within 10-14 days.
2. To improve health visitor communication with both midwifery services and GPs
3. Health should be consulted prior to child protection strategy meetings and attend meetings when relevant.
4. A review of systems within the health visiting team regarding communication and allocation of work generally and more specifically analysing leadership of the team and the individual practice of HV5.
5. The electronic patient record system (RIO) should be used to link families and mother’s records should be viewed regarding siblings on receipt of a new birth notification.
6. Health Visitor Specialists within First Response (now known as MASH) will allocate referrals to the Monthly Team Planner to ensure speedier allocation to a health visitor/school nurse. A MASH protocol will be developed regarding case allocation and regular audits will monitor its effectiveness.
7. Internal mechanisms within Whittington Health to be developed for feeding back early learning from IMR/SCR’s

Whittington Health – Haringey Community Paediatric Service
1. All external reports, correspondence, etc should be date stamped on receipt in the department, including correspondence from another service that is printed off in the department. Once read, they should be signed by the clinician with their name clearly written and dated.
2. All cases of suspected child abuse seen by a trainee paediatrician should be discussed with the supervising consultant in the relevant service at the time of the examination or soon after, and the medical report approved and signed by the supervisor before distribution.
3. Where recommendations are made, but not followed by another agency, the agency making the recommendations should be informed of this and an opportunity for discussion made.

London Borough of Haringey, Education Services

1. Where staff in Haringey Admissions are made aware that a child has involvement with an allocated Social Worker, staff in that department to ascertain via discussion with the Social Worker if there are any grounds for prioritising this case in the admissions procedures, and also to ensure that adequate tracking of cases is in place.
2. School A to ensure that only the revised admission form is used with immediate effect for all new admissions and where a family has English as a second language, the family is supported with interpreters as appropriate, to complete such forms correctly.
3. School B to be advised to use with immediate effect, a standard recording proforma for communications with professionals about vulnerable pupils.
4. Where staff based in a Children’s Centre are aware of the existence of school aged children and involvement of staff from Children’s Social Care with that child, staff from the Children’s Centre must check that the Designated Teacher with responsibility for Child Protection at the school is fully aware of the involvement of Children’s Social Care and the reason for it.
The General Practitioners

1. Consideration should be given to developing a system in general practice whereby:
   a) Non-accidental injury is considered as a differential diagnosis in all cases of injuries to children and action taken (to discount or pursue) is clearly articulated in the records.
   b) there are prompts to guide professionals in describing and recording each injury clearly.
   c) the decision affirming or rejecting NAI is clearly articulated.
   d) all unusual or multiple injuries to children are discussed routinely.

2. Child Protection training delivered to General Practice Staff in Haringey should have continued emphasis on:
   a) diagnostic skills applied to identifying suspicious signs and symptoms
   b) awareness of the challenges, myths and barriers associated with working with child protection.

3. The use of the Vulnerable Children Template, Read codes and alerts should be established in all GP practices in Haringey:
   a) the alert system should be organised so that concerns relating to risk of abuse are routinely entered on all relevant records. This would include conditions such as drug misuse or severe and enduring mental health conditions in adults being added as an alert to children’s records.
   b) information as described above should also be entered on the summary of the children and family members concerned using the suggested Read codes. The use of the vulnerable child template will aid this by presenting the correct codes.

4. Review (and amend if necessary) the system in place between GP practices and the Health Visiting service with regard to informing the Health Visiting service of new patient registrations of children under 5.

5. Review the system of training GP Registrars:
   a) Develop a checklist of cases that should always be discussed with a trainer. This does not have to be limited to Child Protection related cases and could include a range of conditions. The Child Protection cases could be parents/carers or household members of children who have significant mental health issues or drug and alcohol problems.
   b) Liaise with the Deanery regarding governance systems to assess and ensure the standard of training experience particularly, but not exclusively, with regard to safeguarding children.
   c) Consider how General Practice recognise, act on and learn from significant events
Barnet, Enfield and Haringey Mental Health NHS Trust

1. DASH work with primary care and other significant referrers to develop a referral pathway which enables them to receive timely information about previous medical and social history.
2. Develop and deliver a half-day safeguarding children supervision course for adult mental health and substance misuse staff.
3. Ensure written harm reduction information in relation to parenting, including avoiding the risk of using violence, is available for staff and clients.
4. The lessons learnt from this review are shared with Barnet Children’s Services and the Barnet Drugs Advisory Service and any necessary changes to the BDAS practice operating framework are made.

London Borough of Enfield, Children’s Social Care Services

No recommendations made

North Middlesex University Hospital Trust

1. NMUHT staff are to be reminded of their responsibility to ensure that a referral is sent to the appropriate local authority (Haringey or Enfield) and to check the PAS system to find out which local authority covers the address before faxing the Inter-Agency Referral form. The IARF needs updating to include a note to that effect. Further developments could include integrating the form within the CIP (clinical information portal) system as this would enable it to be automatically populated with demographic data including the correct local authority. Further IT developments could ensure that the form is sent electronically to social services.
2. Escalation Policy: ensure that NMUHT staff are clear about its purpose and appropriate use.
3. Domestic violence/abuse screening: Maternity to explore introducing the “red sticker on the bottle” tool.
4. Midwifery and Domestic Violence: NMUHT to explore whether IT systems that are in place are able to interface with each other so that additional information such as A&E attendances can be shared between systems.
5. Allocation of Booking Appointments: consider if there is a way of the booking appointment being done by a midwife from the local community team that is responsible for antenatal and postnatal care.
6. Role, Membership and Purpose of Weekly Child Protection and Children in Need Meetings: Terms of reference to be reviewed and compliance ensured.
7. Voice of the Child: staff need to be reminded to seek the voice of the child and record observations for all children.
8. Role of Adult A&E: Where an adult presents with mental health, substance abuse or domestic violence problems, the question must be asked regarding children in the home and the practitioner must make a decision as to whether these children are at risk of harm.
9. The impact of information being held in different parts of electronic databases: This has not been satisfactorily resolved within the hospital’s IT systems. There are currently 4 main hospital information systems that do not adequately interface. This needs further exploration.
The Health Overview Report

1. Exploration of how correct GP registration is confirmed by hospital staff
2. Improve information sharing between hospital departments
3. All actions planned in response to referrals to HV service with potential child in need or child protection concerns (to include all referrals from the multi-agency safeguarding hub & social care) to be discussed with supervisor or team leader within 2 weeks
APPENDIX B: Terms of Reference

These Terms of Reference have been redacted so as to preserve the anonymity of the family.

PURPOSE OF THIS REVIEW

The Serious Case Review aims to:

- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- identify clearly what those lessons are both within and between agencies, how and within what timescale they will be acted on, and what is expected to change as a result; and
- improve intra and inter-agency working and better safeguard and promote the welfare of children.

ISSUES TO BE CONSIDERED

1. Were there any issues, in communication, information sharing or service delivery, within or between services including those with responsibility for working out of hours as well as those working in normal office hours and with particular reference to their knowledge of the process of escalation on intra and inter agency concerns in accordance with paragraph 18.5 of the London Child Protection procedures.

2. Was the work in this case consistent with each organisation’s and the LSCB’s policy and procedures for safeguarding and promoting the welfare of children and with wider professional standards?

3. What were the key relevant points/opportunities for assessment and decision making and effective intervention in this case in relation to the children and family? What was the quality and timeliness of decision-making and did subsequent assessments and decisions appear to have been reached in an informed and professional way? What was the quality of multi-agency risk assessments?

4. Did actions accord with assessments and decisions made? Were opportunities for effective intervention, such as Section 47 investigations, multi-agency strategy meetings, Family Group Conferences, Child Protection conferences or effective Looked After Child reviews taken? Were appropriate services offered/provided and/or relevant enquiries made, in the light of assessments?

5. What did each agency know about the history of each of the parents and or any other significant adults in the household? Consider whether both the mother’s and the fathers presentation and experiences in the light of their childhood and previous relationships was appropriately identified, acted upon and has any relevance.
6. What training has been provided in adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done with regard to the duties to safeguard and promote the welfare of children?

7. Were practitioners aware of “what it was like to actually be that child”, sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse, specifically physical abuse or neglect and about what to do it they had concerns about a child’s welfare?

8. Did practice in the period show any lessons learned from previous Serious Case Reviews? If not, what were the barriers?

9. Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored, taken on board and recorded?

10. Was there sufficient management accountability for decision-making? What was the quality of supervision? Were senior managers or other organisations and professionals involved at points in the case where they should have been?

11. How effective was management support and supervision in countering the impact of parental hostility and deflection. What evidence is there of reflective and authoritative practice of both supervisors and supervisees?

12. Evaluate the impact of any organisational change and challenge over the period covered by the review and establish the capacity of front-line services for effective response.

13. Did agencies make gender-based assumptions about the likelihood that women would prevent abuse rather than perpetrate it?

14. Is the “quality assurance” of decision-making in child protection sufficiently resilient, with particular reference to the processes and outcomes of Strategy Meetings?

15. What could or should agencies have done to gather information about the family from Poland?

CONTRIBUTING AGENCIES

- Metropolitan Police (Borough)
- Police CAIT
- General Practitioners;
- North Middlesex University Hospital;
- Whittington Health (Health visiting and Paediatrics);
- Barnet Enfield & Haringey Mental Health Trust (DASH)
- LA Children & Young People’s Service (Haringey);
- LA Children & Young People’s Services (Enfield)
- LA Education Welfare Service (Haringey)
- LA Housing (Haringey)
- Children’s Centres, Early Years services
THE PERIOD UNDER REVIEW

1st April 2010 – 1st December 2011.

SCR PANEL MEMBERSHIP

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<thead>
<tr>
<th>NAME / DESIGNATION</th>
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<td>Mr Graham Badman</td>
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<td>Director of Nursing</td>
<td>North Middlesex University Hospital Trust</td>
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<td>Great Ormond St Hospital</td>
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IN ATTENDANCE

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<tr>
<td>Mr Kevin Harrington</td>
<td>Independent Overview Report Author</td>
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<tr>
<td>Manager</td>
<td>Haringey Safeguarding Children’s Board</td>
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APPENDIX C: Biographical details of Independent Chair of this review and the author of this report

Independent Chair: Graham Badman, CBE

Graham Badman CBE has been engaged for many years in the safeguarding of children and young people. He had been the Chair of an Area Child Protection Committee before being appointed Chair of the Haringey LSCB in 2008 by the Secretary of State. He was subsequently reappointed by the Haringey Board. Mr Badman had been a Director of Education in three local authorities and Director of Children’s Services in Kent. He is a member of the Unicef Board, and is well known for his strong views and support for the UN Convention on the Rights of the Child.

Independent Author of Overview Report; Kevin Harrington, J P

Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has a particular interest in Serious Case Reviews, in respect of children and vulnerable adults, and has worked on more than 40 such reviews. Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council. He has served as a magistrate in the criminal courts in East London for 15 years.