A report of the Serious Case Review of the

Baby John case
commissioned by

Essex Safeguarding Children Board

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1 Introduction

John was admitted to hospital on July 4th 2013 because he was suffering from fits. Tests indicated that he had suffered a brain injury and that the likely cause was non- accidental injury received in unknown circumstances while in the care of one or other of his parents. He was 10 weeks old. The long term consequences of his injury are not yet clear although at the time of this review he is described as "developing well, within the context of his considerable developmental needs".

At the time of the injury, John was subject to a Child Protection Plan under the category of neglect.

John was born in spring 2013 to A (mother) and B (father) who had been in a relationship for under a year. Both parents come from a Gypsy, Roma, Traveller culture. There had been concerns about risk to John before he was born and a referral was made to social care in November 2012 because of A's previous history of drug use, her criminal history including a prison sentence and her four older children being removed to care by another Local Authority in 2008 and now being subject to full care orders with plans for permanency.

Concerns were also raised about B and his criminal history including domestic violence, drug use and the fact that he had two older children who had been subject to Child Protection Plans.

John was placed on a Child Protection Plan for neglect in spring 2013 at a pre-birth Child Protection Conference. Legal proceedings were recommended at a Legal Planning Meeting held prior to his birth, but were never progressed, as it appears that social care changed the direction and planning for this unborn child, for reasons that are explored at length in this review but which have remained unclear.

John experienced one visit and two admissions to A&E following his birth. The first visit was because of poor feeding and irritability. The first admission was because B, who was sole carer at the time, reported that John had stopped breathing and had been resuscitated. The second admission in July 2013 was because he was fitting as a result of the non-accidental injuries that he had received. This was the significant factor that prompted the commissioning of the Serious Case Review.

It is the reviewer's opinion that the injuries to John were not predictable but were preventable if all the information known about his family had been assessed and had resulted in a decision to remove him from his parents care.

2 The Decision to hold a Serious Case Review (SCR)

A referral for a Serious Case Review for this case was made by Essex Social Care on July 8th 2013 and by Essex Police on July 18th 2013. This was considered by Essex Safeguarding Children Board SCR Consideration Panel on 13th August 2013. A recommendation was made to the Independent Chair of ESCB that the SCR panel had met and had agreed that the threshold for a Serious Case Review was met.

It was agreed by the ESCB Chair that this case would be suitable for a Serious Case Review and that the Essex Multi Agency Facilitated Case Review (MAFCR) methodology should be used.

3 Family members to be considered within this review:

Mother (A) date of birth 1984

Father (B) date of birth 1985

Subject John date of birth April 2013

4 Terms of Reference (Sections 4.1-4.6)

4.1 Time frame for the Review

6 months to complete the SCR

MAFCR Meetings in November 2013

1st Draft of report – December 2013

2nd Draft of report – January 2014

3rd and subsequent drafts of report – February 2014 – November 2014

Final draft of the report – November 2014

4.2 Methodology

A Practitioners' Forum and a Managers' Forum were held on two separate dates

An Independent Author/Facilitator (Laura Eades) jointly facilitated the Practitioner and Manager Forums and wrote the SCR report

An Independent Chair (Kevin Harrington) chaired the SCR Panel

An Internal Co-Facilitator (Kathie Clibbens) jointly facilitated the MAFCR sessions with the Independent Author

4.3 Reporting Arrangements

Following the two Forums the 1st draft report went to the standing Serious Case Review Sub Committee, which was independently chaired

The 2nd draft went to a feedback forum of participants in the Practitioners and Managers Forums

The 3rd draft report went to the SCR Sub Committee with a broader panel of senior representatives from participating agencies

The final report was presented to the ESCB for adoption

4.4 Participants – a list was co-ordinated by the Essex Safeguarding Children Board support team

Both the agency and participants of this review were sent an outline of the review process. All participants had had a written briefing about the process before the Practitioners and Managers Forums took place

Participants were split into two groups; practitioners and those with direct involvement with the family and line managers and those who provided the supervision for practitioners

4.5 The time frame

The period to be reviewed was agreed as from the referral to Children's Social Care made on 29th November 2012 (by the Drug and Alcohol Team) up to and including the incident leading to criminal and child protection investigations.

4.6 Key Episodes

i) It was agreed that the Serious Case Review would consider the following issues which are considered to be key decision points in the case. :

- The legal planning meeting on 5th February 2013 where there was a decision to remove baby at birth

- The pre-birth Child Protection Conference 10th April 2013 where the risks to John's safety were acknowledged as high but the apparent strengths in the family led to a consensus in the conference that A and B were committed to him and were showing capacity and intent to change. The Police were particularly concerned about B's criminal history including threats to kill, actual bodily harm, battery and cocaine use (on-going). He had previously been recalled to prison for an assault against his former partner.

ii) Where and how the decision that the baby would be removed at birth was made

iii) Whether and to what extent A's history with her other children and the impact of the relationship she had with their father on her parenting was sufficiently understood, assessed, highlighted and borne in mind by agencies undertaking the monitoring and assessment of John's care.

To what extent, decisions made in this case were influenced by children's social care's view of;

- the evidence of positives in the physical and emotional care of John by his mother after his birth
- her commitment to stay drug free
- the fact that home conditions were good, the apparent co-operation of parents with professionals and their seeming ability to put John's needs before their own.

iv) The first discharge planning meeting held a day after birth.

v) GP involvement – in particular;

- No GP had been invited to the Child Protection Conference
- The discharge summary that went to the GP after John's post-natal admission to an Essex district general hospital with a possible apnoea attack did not refer to any child protection concerns
- The two GP Practices concerned had no record of the unborn child being subject to a Child Protection Plan despite both having clear arrangements for the discussion of key cases with the midwife and health visitor.

vi) Care of John and particularly the involvement of B

vii) The apparent lack of clarity about B's visits to John (parents were said to be living separately), whether these were to be supervised and a reliance on A to oversee this.

viii) Why there weren't firmer arrangements in place about supervised contact after B alleged the child had suffered from an apnoea attack and was subsequently admitted to hospital whilst in B's sole care.

ix) Parenting Assessment and in particular;

- Part of the child protection plan was to be an assessment of the parents' relationship including their capabilities in respect of their parenting, but by the time of the incident in July this had not started.
- Some work was to be done with A about domestic violence suggesting that there were sufficient concerns about the current relationship to warrant this but this had not started by the time of the incident.

x) There was an apparent lack of rigour in the implementation of the Child Protection Plan despite the fact that significant risks had been identified and there had been a decision to remove the child at birth only a few months previously.

5 Preparation for the Review

Laura Eades an Independent Consultant who had chaired the Serious Case Review Consideration Panel[1] for this case was appointed as lead reviewer and independent author. Kathie Clibbens Professional Lead Consultant Designated Nurse Safeguarding Children for Southend, Essex and Thurrock Clinical Network was appointed as the second reviewer.

The ESCB Practice Development Manager prepared a chronology of key events to cover the timeframe to include activity by the agencies involved.

6 The Process of the Review

6.1 Initial Process

As previously stated, the Serious Case Review Panel decided that this review should be conducted using the ESCB methodology for a Multi-Agency Facilitated Case Review (MAFCR)

The process identifies 'key episodes' in the case which are derived from an examination by the reviewers of the integrated chronology and these form the basis of exploration by practitioners and managers in the forums. These episodes then form the structure of the analysis and this report.

[1] The Serious Case Review Consideration Panel in Essex was the panel that considered referrals to the LSCB for a SCR and made a recommendation to the LSCB Chair as to whether one should be commissioned.

6.2 Changes to the process

The draft report was presented to the SCR Panel in accordance with the agreed process and the Panel felt that there were too many questions that had not been able to be answered through the review so far.

As a result of this discussion it was agreed that a number of areas would be followed up in more detail with children's social care and with health services.

The period for completion of the Review was extended to accommodate this additional work.

Social Care commissioned a service manager to make the appropriate contacts and review the necessary records to provide more detail in response to these questions that had not been answered by the process so far.

Health commissioned the Second Reviewer for this Serious Case Review to undertake a number of interviews with health staff and to review any records as necessary.

The service manager and Second Reviewer produced reports of their findings to the Serious Case Review Panel which have been incorporated into this report.

7 The Practitioners Forum attendees 11th November 2013

Lead Reviewer
Second Reviewer
Interim ESCB Manager
ESCB Project Officer
Community Drug & Alcohol Team Worker 1
Community Drug & Alcohol Team Worker 2
Choices Open Road Drug Services Worker
Solicitor Legal Services Essex County Council
Housing Worker 1
Housing Worker 2
GP 1
GP 2

Essex Police Detective Constable
Essex Police Detective Sergeant
Essex Police IOM Sgt
Child Protection Coordinator
Health Visitor 1
Midwife 1
Social Worker 1
Essex Probation Offender Manager 1
Essex Probation Offender Manager 2

8 The Managers Forum attendees 18th November 2013

Lead Reviewer
Second Reviewer
ESCB Project Officer
Essex Police IOM Sgt
Operational Investigations Manager, Essex Probation
Manager, Offender Management Essex Probation
Team Manager Family Support and Protection, Essex Social Care
Team Manager Assessment and Intervention Essex Social Care
Service Manager, Choices, Open Road
Senior Practitioner local Drug Project
Housing Manager, local District Council
Head of Dept. People Legal Team ECC
Detective Inspector, Child Abuse Investigation Team, Essex Police
Service Manager Quality Assurance and Safeguarding Essex Social Care

Safeguarding Lead, an Essex District General Hospital
Head of Universal Services SEPT
Named Nurse Safeguarding Children SEPT

9 Information Sources for the review

Integrated chronology

Notes from Practitioners Forum

Notes from Managers Forum

Record of the Legal Planning Meeting

Record of the Strategy Meeting

Decisions of the Child Protection Conference

Notes of the Core Group Meetings

Review Child Protection Conference notes

Information provided by Neighbouring County Z Children's Services to Essex.

The judgement in the final hearing of the care proceedings for John

10 Parental involvement

The review did make serious attempts to include both parents of John in the review. Each was sent a letter of introduction by the Local Safeguarding Children Board Business Manager explaining the review purpose and process and inviting them to indicate how they would like to be involved. Neither A nor B responded to those letters which were shared with them by practitioners that they were working with. As B cannot read, the content of the letter was read to him.

Both parents have been charged in respect of the injuries caused to John. Neither parent engaged with the process of the care proceedings for John. Both are believed to have resumed a more chaotic lifestyle and are disengaged from services available to support them.

11 John's story

John's story is summarised here up until the first meetings in the process of assessing risk to him began. The rest of his story is told through the events of the case, the experiences of his parents and the actions that professionals took in response to events.

B had lived in a stable community in Essex for most of his life and he was well known to local agencies in the local area. He would travel around the country often becoming involved in criminal activity.

He was known for domestic violence to a previous partner with whom he had two children. Both children were known to social care services and had been subject to Child Protection Plans in 2010 and restricted contact with B. He now had unrestricted contact with them. B was known to Probation in Essex and was serving a Community Order with supervision and drug rehabilitation requirement in addition to unpaid work.

He was believed by Probation to have ‘educational deficits’ in reading and writing. He was also known to local drug agency, the Community Drug & Alcohol Team where he was on a treatment order and being seen by the drugs agency as a statutory part of his order.

He obtained prescriptions for substitute medication to address his addiction to heroin and cocaine.

A had previously lived in various adjacent counties. She was known to social care in neighbouring County X because she had four children who had been removed from her care with plans to place them for adoption. This was a consequence of her and her partners (the children’s fathers) drug addiction, criminal behaviour, domestic violence and consequent neglect and physical abuse (believed to have been perpetrated by the father according to information from neighbouring County X files). The youngest child of the four was born in 2008 with drug withdrawal symptoms necessitating the child remaining in hospital for a month after birth.

A had committed a serious offence and received a custodial sentence, which she had finally completed after being recalled for breach of her licence.

In June 2012 A moved to Essex. She told agencies that she was escaping domestic violence and threats from her former partner in neighbouring County Z and she was known to have relatives amongst the Gypsy Roma Traveller community in the local area and other parts of Essex. Her care was passed from neighbouring County Z drug agencies to Essex Community Drug and Alcohol Team (CDAT). She registered with a local GP where she received treatment for depression.

A reported her pregnancy with John to the community midwifery service in August 2012 and told the midwife that her older children had been taken into care because she had to serve a prison sentence. She said she was fleeing domestic abuse by her former partner. Her ante natal care was booked at an

Essex district general hospital on the same day and the records state that ‘all (previous) children adopted - letter box contact’ as this had been reported by A.

A frequently did not attend (DNA) her antenatal appointments though she was under Consultant led care because of previous complications. A social worker from the Assessment and Intervention service called the midwifery services on 22nd November 2012 and the midwife reported these DNA’s but she did not need to make a formal referral as the case was already known to social care, CDAT having made a referral to social care on 19th November 2012 because of A’s pregnancy and drug use.

Social Care started a 10 day assessment on 29th November and before this was completed, the team manager triggered a pre-birth assessment on December 3rd. By this time A was about 20 weeks pregnant.

CDAT and the Essex district general hospital shared the information provided by A that the reason for her children going into care was that she served a prison sentence.

On December 4th 2012 the health visitor and midwife decided to do a joint home visit but A was not present. The health visitor decided not to try to visit again as she believed that the baby would be removed at birth and there would be no role for her at the present time. B was not seen by any service at this time as he was reported to be away in Kent. A gave her address as being the same as B’s local area address.

The social worker met with A at the CDAT on the 18th of December, and explained to A that she was undertaking a core assessment, which would include finding out about B’s background and why A’s older four children had been removed

There was a joint visit to A on 28th December by the midwife and the social worker. There are no notes of the content of this visit. By January 9th 2013 the case was escalated from a pre-birth assessment to a Section 47 enquiry on review by the social care manager. B had informed Probation that the baby was not his, although he later told his probation officer that he was the father. Local authority records showed that there were previous concerns about B’s violent behaviour.

By January 2013, A was living with B at his mother’s home but A expressed concerns to CDAT that B was still taking drugs and she was considering moving out. She did approach Housing services expressing her concerns about B’s drug use and violence and that he was in and out of prison. A appeared to be very open with agencies about her circumstances and was clearly presenting B as the problem in relation to her caring for the baby. It was at this point, 10 days after the Section 47 enquiry had been triggered that the pre-legal discussion took place in social care on 24th January 2013.

John was born to A and B in the local area in April 2013.

12 Key Episode 1 - Parents history and culture

12.1 Relevant area of enquiry from Terms of Reference (see section 4.6)

iii) Whether and to what extent A's history with her other children and the impact of the relationship she had with their father on her parenting was sufficiently understood, assessed, highlighted and borne in mind by agencies undertaking the monitoring and assessment of John's care.

12.2 Background to and context for this issue.

12.2.1 **A's history**

A summary is contained in section 11 above. Much of the detail was not known to the Serious Case Review until later in the process when the legal file was made available to Essex by neighbouring County Z for the purposes of care proceedings for John.

12.2.2 **Subsequent information provided by the Service Manager Social Care**

In response to the care proceedings for John, additional information was provided by adjacent Borough Council X to Essex children's social care. This included a legal file containing statements and reports concerning the care proceedings for A's four older children in 2008, a single social care file for eldest siblings 2005-2008 (108 pages) and five files (3,882 pages) for all four children from 2008 onwards.

Although none of these files provide a detailed and comprehensive history of A and the children they do indicate that the family moved frequently between adjacent counties and others in the eastern region. They were often homeless and sometimes the children were temporarily accommodated by local authorities. Some of the moves seem to be associated with periods of trying to avoid Children's Services and other agencies and other moves are associated with domestic violence and imprisonment of a parent. The children were made subject to Child Protection Plans in two adjacent local authorities between 11.07.2007 and 21.01.2008 and again from 21.01.08 until the children were accommodated in August 2008.

The mobility of the family made it impossible for any local authority to undertake thorough assessment or effect any change. However, the social care records tell a graphic story of severe and frequent domestic violence, drug taking and alcohol misuse by both parents, frequent moves, unstable accommodation (including drunken gatherings leading to eviction) and for the children chronic physical neglect, neglect of their education, health and supervision needs.

Both parents were involved in significant criminal activity and A is noted to have co-operated with criminal justice/legal requirements only at a minimal level in order to avoid imprisonment.

A's previous partner did not engage with supportive services and A herself engaged in a limited way when her own social and family networks failed. At times she accepted a place in a refuge or offers of housing.

There were two instances of statutory intervention; an Emergency Protection Order was made in 2002 with A's eldest child being placed in the care of his grandmother for a week and Police Protection action in December 2007 when A was arrested.

The only sustained attempts to support and help the family occurred between January and July 2008 when the family settled in neighbouring County Z . It is not clear from the records what, if any, intervention was effective but chaos resumed in July 2008 and the children were accommodated with A's consent.

The only useful parenting assessment information on these files is an Initial Assessment by adjacent council Y social care in November 2004 (A had her first child and was expecting her second). It comments on her practical parenting skills, her emotional warmth towards her child but her uncertain attempts at stimulating him. It demonstrates her poor awareness of the impact of her drug use on the child and the unborn baby. Later recordings regarding A's parenting, comment on her inability to provide a stable home, to protect her children from exposure to domestic violence and drug misuse or at times to meet basic practical and safety needs.

Available records show there were no recorded concerns about previous physical injuries to the children prior to them becoming accommodated on 08.08.2008. On accommodation, various marks consistent with cigarette burns and pinching were noted on the oldest two children and A claimed that their father had been regularly hurting the eldest child and hitting the second and third child.

It is particularly concerning, that there were no reports or minutes from either Child Protection episode on the neighbouring County Z files.

12.2.3 B's history

A summary is contained in section 11 above.

12.3 Individual Agencies knowledge of the family history before the commencement of the Serious Case Review

What became clear at the beginning of this review and even more evident as the review progressed, was that there was a very different level of knowledge and understanding of the parents' histories by the agencies in Essex who were working with the family at the time of the review Forums.

This history of A unfolded during the course of the SCR Practitioners' and Managers' Forum discussions. There was no single place where it was articulated in full and analysed. However, it was long and concerning.

More was known by the Essex agencies about B's criminal history. Social care knew that he had two children from a former relationship who had been subject to child protection plans because of neglect caused by primarily domestic abuse of the mother of the children by B.

A significant amount of discussion during the review was about what individual agencies did or did not know about A's and B's past history, how much it had been taken into account in their work with the family and how such information had been shared and understood by all involved. It became clear in the Practitioners' Forum that there were considerable differences in the information that was known by individual agencies or rather that was believed to be known about the history of John's parents.

The main differences were to do with the apparent lack of knowledge or awareness by agencies of A's criminal history, her lengthy prison sentence and recall while on licence and the circumstances surrounding her older children going into care and subsequently placed permanently.

12.4 The Core Assessment

The social worker who was responsible for the case at this early stage and until the transfer to Family Support and Protection Services, on 28th May 2013, had since left Essex and was not at the Practitioners' Forum. At the SCR Managers' Forum the differences between agencies in their knowledge and understanding of the parents' history was demonstrated when the social care team manager read out information from the Core Assessment completed by the social worker. This contained information about the injuries suffered by A's older children and the fact that the youngest child had been born drug dependent. Managers from other agencies reacted with surprise as this was not information that they were aware of.

Information was also shared at the Forums about both parents' criminal history and particularly details of the offence for which A received a prison sentence. Some agencies knew that A had been to prison but did not know what for.

At the SCR Managers' Forum, the social care team manager was surprised that the partner agencies involved in the case were not aware of these two crucial pieces of A's history as she stated that it was usual practice for the Core Assessment to be used as the social workers report to a Child Protection Conference.

This was confirmed by the Reviewers at the Managers' Feedback Forum when the social care team manager checked to see what report had been submitted to Conference and confirmed it was this Core Assessment. The version of the Core Assessment that was shared with the Initial Child Protection Conference (ICPC) was completed on 13th February 2013 when it was signed off by the team manager and an updated version was signed off for presentation at the ICPC on the 10th April – the same day as the Conference. It seems clear that the report was only tabled at the conference. No other evidence to the contrary has been presented. The explanation for the apparent lack of awareness of the parents' histories by partner agencies during the course of the Serious Case Review is clearly concerning. Without a verbatim transcript of the discussions at the ICPC it is not possible to come to a conclusion about the reason(s) for this. A possible explanation is that the people from agencies other than social care and midwifery attending the Conference were not actively involved in the case and probably made an assumption that this background information was already known by their practitioners. It does beg the question as to how well reports are shared within a Child Protection Conference particularly when they are tabled at the meeting, and how they are considered and understood in terms of individual agencies' responsibilities. Child Protection Plans are intended to be a reflection of the totality of the risks to the child. The potential risks that might be identified from an analysis of the parents' capacity to parent were not identified because that analysis was not done at this crucial stage of decision making.

It also became clear following the SCR Managers' feedback forum on 25th February 2014 that the Strategy Meeting held on 18th February 2013 had discussed the parents' criminal background. This meeting was attended by the social worker, the social care team manager, the Community Drug & Alcohol Team and the midwife. The Police Child Abuse Investigation Team (CAIT) sent apologies as did adjacent Borough Council X social care services. The record of the discussion at the strategy meeting does not note the sharing of information about the parents' history and background. The outcomes of the strategy discussion were to book a legal planning meeting and for social care to discuss the need for a Child Protection conference with the Child Protection Chair.

The Initial Child Protection Conference was attended by; social care team manager, Police CAIT representative, Safeguarding Nurse, midwife, A and the Conference Chair. The allocated social worker was on annual leave – this was known when the conference was arranged. Essex Probation and Community Drug & Alchol Team did not attend. The only person who worked directly with the family (in fact had seen A on only two occasions) who attended the conference was the midwife

In accordance with local practice, the Named Nurse Safeguarding attended on behalf of the Health Visiting service and fed information back to the health visitor. The GP did not attend as they had not been invited. There is no clear explanation for the delay in calling the Child Protection Conference so late on in the A's pregnancy other than the plan by social care was for removal at birth up to an unknown point where the plan changed to an intention for the baby to return home with his parents.

12.5 What was understood by agencies about the parents' culture and the impact on their lifestyle, relationship and parenting?

The SCR Practitioners Forum identified a number of features of the impact of Gypsy Roma Traveller (GRT) culture on the family.

They had an expectation that A and B would be very mobile – that families from this culture moved around a lot and that the impact of this on parenting was often a lack of consistency in education and health care. In fact A had lived a great deal of her life in neighbouring County Z where her father still lived. Her mother had died when she was a teenager. B had lived in the local area all his life but with his mother and with other relatives. Both parents did move around, B more than A, but returned to established bases.

Some practitioners commented on the strong family orientation of people from this culture and that they often lived in or around large extended families who provided child care and social interaction and support. However when neighbouring County Z took A's children into care (legal order) there were no family members either available or suitable to be assessed as carers for the four children.

Legal services at the first legal planning meeting in this case suggested that the input of a GRT specialist would be helpful in understanding the impact on parenting, but there is no evidence that this was followed up.

12.6 Analysis and findings from Key Episode 1 Parental History

12.6.1 **The significance of parental history was not adequately recognised.**

The information about parental history during the course of the case being worked in Essex was incomplete. The files held by adjacent borough council X in themselves carried a fairly superficial account and analysis of parental history but even this limited amount of information would have assisted the assessment of risk by Essex social care. The information was available at the time A returned to Essex and was pregnant with John but was not accessed at that time.

The issue of what background information about the parents' history agencies involved in this case knew or rather what they assumed they knew is fundamental to the way in which the case progressed. As John was born a week after the Initial Child Protection Conference, crucial discussions and decisions were being made about a care plan for a child where the only basis for a decision about whether it was safe to leave him in his parents' care at all was what agencies knew about the past.

Whatever information about the parents had been shared, whether verbally at the Strategy Meeting in February 2013 or in a written report tabled at the Initial Child Protection Conference, agencies other than social care were of the view that social care had made a decision to remove the child at birth. This was the working assumption and hypothesis that was described in detail at the SCR Practitioners Forum (and by some of the agency managers at the SCR Managers' Forum) by Probation, Midwifery Service, health visitor, Drugs Services and Police.

This working assumption and hypothesis was so firmly accepted and understood, that any information about the parents' backgrounds that was presented only served to reinforce the agencies' view that removal from parental care was necessary.

It begs the question about whether the report for the Initial Child Protection Conference was read by those attending or those who received it afterwards and if so how much attention was paid to that information in formulating a view of the case.

The impression this leaves is that agencies were almost completely dependent and reliant on the assessment of risk carried out by social care in relation to A and B's histories and contributed very little to the multi-agency child protection process. It begs another question as to whether partner agencies understand the impact of parental history on parenting or whether social care are considered the experts in this field. If this is the case, there appears to be very little research that assists professionals to weigh up the impact of history in the case of previous children being removed to care, or of previous violent offences by parents on the risk of significant harm to a child as yet unborn.

The significance of the history is underlined by the judgment in the final hearing of the Local Authority's application for care and placement orders in respect of John on 22.11.2013.The fuller information from the adjacent borough council X's files was of course available to the Judge.

The Judge comments;

‘The picture painted by the previous care proceedings in relation to the mother’s four children is a fairly desperate one. Those children were removed from the care of their parents amidst allegations of extremely chaotic lifestyle, significant illicit narcotic and excessive alcohol use, allegations of neglect, domestic violence and very significant levels of criminality.’

And

“Given the history the Guardian makes the point …that it is objectively somewhat surprising at least, I think she describes it in rather more strident terms, that the Local Authority took the decision it did in relation to John, for him to be placed in the care of the mother, or these parents, after his birth. It is, no part of my task to indulge in second guessing any Serious Case Review, but it does seem to me that given the pretty shocking history in relation to the older four children of the mother at least, and the concerns which had been raised in relation to the father’s children, that the decision was taken in relation to John that it was safe, without fairly detailed investigation, for him to be placed in the care of either of these parents. Of course, perhaps with the benefit of hindsight to some extent, nonetheless it is unfortunate that we find ourselves in the position that that decision having been taken in respect of John’s he now comes before us having suffered very significant injuries in the care of his parents”

Clearly, much of the detail of this history was not known and was not sought by Essex social care during the course of the work with A and B. Certainly there was no understanding at this time of the degree of their mobility and its impact on the older children. However, there was no real evidence of professional curiosity about the background despite the knowledge by the local authority that four previous children had been subject to care proceedings and permanent placement plans.

The significance of this history was not grasped by any single agency nor by the multi-agency network. Despite the fact that the history for both parents was relatively recent and that even in outline it painted a truly concerning picture, the focus was on parental drug use. There was no focus on the parents’ capacity to change, capacity to parent successfully and capacity to develop healthy relationships. Had this case been managed within the context of a legal framework, the detail of the previous history would have been sought earlier and would have informed the assessment of risk and the laying out of expectations of change within specified timescales. The outcome may well have been different for John. This is not to suggest that what happened to him could have been predicted but perhaps could have been prevented by removing him from his parents' care until they had been properly assessed and had or had not demonstrated a commitment to change for his sake.

12.6.2 **There was a lack of engagement and assessment by other agencies which resulted in an incomplete understanding of the risks to John.**

General Practitioner (GP)

As the GP did not receive an invite to the meeting they did not then receive the minutes of the Initial Child Protection Conference and so had no information available to them that would alert the GP to any particular risks.

The GP was "out of the loop" as far as the Child Protection process was concerned. Primary health services in Essex would normally be expected (but are not yet required) to have shared and discussed information about children subject to Child Protection Plans in order to co-ordinate their response. This is usually carried out through a Primary Health Care Team (PHCT) Meeting based at GP Practices. There were no PHCT meetings that considered this case. The reason given by health practitioners is that PHCT meetings tended to cover all issues at the GP Practice and so could take up considerable amounts of time for health visitor and community midwife rather than have a specific focus on safeguarding concerns. However although these meetings are not mandatory, the job description for a community midwife does state that they must 'liaise with the PHCT over a woman's care.' There is a lack of clarity in practice as to what is required.

Once the health visitor became aware of the family, and the transfer from midwifery service to the health visitor 28 days after John's birth had occurred, it would seem essential to check with the GP to ensure that all were up to speed with an understanding of the plans for the child and the risks associated with that plan. It seems that no professional had that conversation with the GP practice.

The initial GP who A was registered with advised the SCR that a routine assessment is carried out when a new patient registers at the Practice. At this assessment, A did not provide any information about B nor did she advise the GP of her drug use. This was a Practice that did not accept patients who needed drug services as they did not have the necessary expertise. This compounded the fact that the Community Drug & Alcohol Team did not carry out its own assessment of A which would have been shared with the GP so alerting them.

The GP did not have any information about A's health while she was in prison. There are no national arrangements for the routine sharing of such information and the health records are retained by the prison unless specifically requested. This information would obviously have alerted the GP to concerns in A's background and may have led the GP to ask more questions of the PHCT. Child Protection concerns noted on previous paper records are reviewed by any new Practice and given appropriate codes so they are then 'flagged' on the computer system. The initial GP surgery was using an older system of 'alerts' which noted any concerns on the local database rather than on a network. When A changed to a new GP in a new practice, the concerns did not transfer to the new practices' recording system. This is an IT anomaly which has now been brought to GP users of this systems attention.

Community Drug & Alcohol Team (CDAT)

CDAT did not carry out its own assessment on transfer in of the case from neighbouring county Z This was an oversight as it is usually standard practice. CDAT are unable to offer any other explanation for this. The diversity of providers of drug and alcohol services makes monitoring of consistent practice across service provision more complex and there was a change of worker for A as her previous worker went on maternity leave. This meant that local Essex agencies did not have access to A's full history of drug use and the consequences for her parenting capacity. If they had had this, they may have been more robust in pursuing a full assessment and using this to contribute to the child protection process. The lack of an assessment also meant that limited information was passed to the GP for A. She was able to continue to get her medication without speaking to an advisor. The GP was restricted to the information provided by A who was economical with the truth about her addiction.

Midwifery service

Other sources of information about A's previous history are via the initial booking of pregnancy but the current practice of direct/community bookings does not allow for the generation of previous history on electronic systems. Midwives and GPs are reliant on the social and obstetric history as given by A, particularly so if previous children have been born in other geographical areas. In cases where there is significant and concerning history, this practice does not allow these professionals who may be the first professionals to know of the new pregnancy to be proactive in making contact with other agencies at this early stage. It also allows for information recorded or shared by parents with midwives and GPs to result in assumptions based on this information to be reported as facts e.g. the assumption that she had left neighbouring county Z as she was fleeing domestic violence.

12.6.3 **There was a lack of assessment and understanding of A's motivations and there were mistaken perceptions and assumptions about A's and B's presentation.**

There was no real curiosity as to why A had moved to Essex when her support structure was in neighbouring county Z and she was involved in care proceedings with her older children (and contesting the Care Order on the youngest child). A had been released from prison in 2011. It is possible that she knew B prior to her move, through the Gypsy Roma Traveller community. It was known by one agency that A had a relative in the local area. It seems likely that she moved to escape from the past and attempt a new start and a new family. There was almost no time between her arrival in the local area, the claim that she had just started a relationship with B and the announcement of her pregnancy. It was very soon after this that A announced she was no longer in a relationship with B and implied that he was controlling and she was fearful of domestic violence (for which at that stage there was no evidence). A had also left the impression with health services that her older children went into care because she had to serve a prison sentence.

No information seems to have been shared about the precipitating event for the entry to local authority care of the older children. There are no statements about this in any reports although the date of this event in August 2008 suggests that it was likely to be triggered by the birth of the youngest child in May 2008 who was born dependent on drugs and who spent a month in hospital recovering from withdrawal.

12.6.4 **There was a lack of assessment of the parents**

No psychiatric assessment or parenting assessment of A in relation to the care proceedings for her older children has been produced or shared in the course of this review. This is unusual in a case where 4 young children were removed with a plan for permanent placement. The social worker only saw the youngest child's file when she went to neighbouring county Z to read the previous files. It is not clear whether the legal documents were part of the youngest child's file or were requested before John was injured. Since the care proceedings have started for John, extensive information on the family has been sent to Essex from adjacent borough council X the former local authority. As a result of this review prompting further enquiry about what information neighbouring county Z held, a disc containing 4000 pages of relevant documents had been provided. These include an assessment by a Clinical Psychologist prepared for the care proceedings on A's older children.

12.6.5 There were perceptions that A was a competent parent and that B was a safe parent

A picture of A emerged during the Serious Case Review of a person who was very much in control of her circumstances and was not a helpless victim. There is no information about her childhood and upbringing that helped professionals form a rounded view of her. Her self-presentation was confident and seemingly competent as opposed to B's who was not very articulate. A was being treated for depression by her GP but this information does not appear in any assessment and was not seen as being significant.

There was no reference in the Forums to an assessment of B in relation to the child protection plans for his two children with a previous partner and this being considered in respect of John. Probation said that they had understood him to be a safe parent in relation to these children. Their assessment was informed by the fact that they knew that his contact with his children was supervised by a family member and that the case was closed to social care.

12.6.6 The transfer of records between Essex and neighbouring county Z was not prioritised and this lead to a lack of analysis of risk and communication of this to other agencies.

These findings raise questions about the transfer of social care records from one local authority to another and how effective current practice is. It cannot be acceptable that in a case where four previous children have been subject to full care orders in one authority, the new authority does not have immediate access to all relevant papers/assessments in order to carry out their statutory responsibilities to assess risk of significant harm. There should be a responsibility on both the authority seeking the information and the authority providing it to ensure that relevant information is passed on. The Essex social worker made an attempt to view the files held by neighbouring county Z but seemed satisfied by seeing only one file of the youngest child while being aware that there was much more information available.

It is possible that there is some confusion by Essex and other local authorities about the implications of the 'Haringey Judgement' [2] for sharing information about families between local authorities. There are no obstacles to the full sharing of information between authorities without parents' consent where there have been child protection enquiries and children subject to Child Protection Plans, in a previous local authority and section 47 enquiries are initiated on an unborn child in a new local authority.

If it is possible to share chronologies and electronic files between social care information systems this should be standard practice. If not electronic then

[2] Haringey Judgment; (R (AB and CD) v Haringey London Borough Council (2013) EWHC 416 considered the lawfulness or otherwise of not seeking parental consent before accessing information about families

consideration should be given to the files of all children subject to care proceedings – when there is a new child born to either parent - being scanned or even physically copied.

12.6.7 **Information that was held by agencies was not shared appropriately**

Although there was a great deal of useful information within Essex agencies about the parents' family background at the early stage of the assessment, it was not gathered or presented in any systematic way. Information was held by neighbouring county Z drug agencies but was not updated by the Essex agencies. Essex housing services had information about both A and B but their service was not included in social care's section 47 enquiries. Essex social care held information about B because of his other two children who were subject to child protection plans.

A pre-birth assessment should be a significant prompt for bringing together all relevant information. Once collated, the multi-agency network would need to know that information in order to participate effectively in decision making to keep the child safe. Otherwise practitioners were starting with a fairly blank slate and were heavily reliant on the lead given by social care in the assessment of risk.

The process for this Serious Case Review did not include the preparation of Individual Management Reviews and so participating agencies had not necessarily undertaken a thorough analysis of the written information they held. This resulted in the information being shared at the Practitioners' and Managers' Forums coming largely from the recollection of the Practitioners and then the Managers being informed by what they had read in preparation for their Forum. In both the Forum meetings there was a good deal of discussion about the information that had been shared between agencies. and it seems that individuals attending the Forums trusted their colleagues' version of events as presented there. There was very little challenge between agencies at these meetings and the questions that were raised were primarily about the lack of awareness of the history of the family.

There was no locus in the case for the development of a shared understanding between the agencies of the key concerns until the Child Protection Conference (CPC). The Core Assessment process does not allow for multi-agency case formulation and neither does the Legal Planning or Public Law Outline process. The introduction of a CPC was confusing in itself to agencies partnering with social care who expected care proceedings to be in process. Previous practice in Essex had been not to hold a CPC if care proceedings were in process.

12.6.8 **There was a negative impact of the mobility of the family on effective information sharing between local authorities**

The additional information available from adjacent borough council X provided the Serious Case Review with a much clearer understanding of the impact of the mobile culture of this family and in particular A, on the sharing of information between local authorities. A had spent time in other local authorities as well and yet no information from these was present on the file. While Essex social care can be criticised for not pursuing more detailed information, it seems unhelpful that the sole onus to share information concerning children at risk is on the 'receiving' local authority. It is concerning that despite many Serious Case Reviews where mobility of families (sometimes due to culture, sometimes due to families avoiding contact with services) is a feature; there are no requirements for regional agreements about information sharing.

12.7 Summary and recommendations arising from Key Episode 1

In summary, the key factors that seem to have prevented the Essex agencies other than social care, from making an effective evaluation of risk to the child from their own professional perspective and therefore to make an effective contribution to multi-agency decision making are;

1) The late sharing of information about parental history by social care with the partner agencies and the fact that there was no mechanism in place in either the Child Protection process or the Public Law Outline process for a multi-agency planning meeting to bring all the information together and formulate a view of risk.
2) The Community Drug & Alcohol Team did not carry out its own assessment of A

The lack of assessment of B or the consideration of any previous assessments in relation to his own criminal and drug taking activity and his parenting of two children who were subject to child protection plans

12.7.1 **Recommendations**

Essex Safeguarding Children Board (ESCB)

The ESCB should raise with the Department for Education the need to improve practice in sharing historical information about parents of new children whose older children have been at risk of significant harm, between local authorities and consider how this can be reinforced and monitored.

Essex Children's Social Care

Essex children's social care should clarify the criteria for and requirements of the assessment of parental history for all core and pre-birth assessments to ensure that they specifically address concerns about the risk of physical harm to young babies/children and how the resultant care plans might ameliorate those risks.

Essex children's social care should consider creating clear guidance for the sharing of historical information about children and their families where there are safeguarding concerns with other local authorities in discussion with regional and national bodies

Essex children's social care should consider the way in which it shares such historical information with the multi-agency network especially where there has been significant history of previous criminal activity, and/or care proceedings/child protection concerns about older children. The criteria for and place of a Multi-Agency Planning Meeting within existing processes should be considered

Essex children's social care should ensure that assessments of parenting capacity are a feature of all core assessments and pre-birth assessments so that potential impact of parents' history, particularly that of parents who have older children who have been removed to care is understood, shared and addressed within any work with their children

Essex Health Commissioners

All Health service commissioners and providers in Essex should re-evaluate current methods and expectations of sharing information (both internally and externally), regarding children for which there are Child Protection or Child in Need concerns. Following this NHS England Area Team, the Clinical Commissioning Group and NHS England Public Health (Essex) together as commissioners should act on these findings to advise, alert or commission (as appropriate) revisions to these methods to ensure that the deficiencies in existing IT systems supporting information sharing do not hinder the sharing of information between professionals which is essential to keeping children safe. The outcome of this work to be reported to the ESCB within 6 months.

13 Key Episode 2: The Legal and Statutory Framework – Pre legal discussion 24th January, Strategy discussion 18th February and Legal Planning Meeting 5th March

13.1 Relevant area of enquiry from Terms Of Reference (see section 4.6)

The time frame to be looked at will start from the referral made on 29th November 2012 (by the Drug and Alcohol Team) up to and including the incident investigation and consider the following points:

i) The legal planning meeting on 5th March 2013 where there was a decision to remove baby at birth ‘

13.2 Working assumption by agencies of removal of the baby at birth

In considering the process of decision making during this period of key meetings, it is essential to understand the mind-set of the practitioners involved. This was illustrated powerfully in the Practitioners’ and Managers’ Forums and is a feature of the methodology used for this review. It is unlikely that case records and the understanding of what written information was transferred between agencies would have shown just how entrenched this assumption was across the agencies.

A reported her pregnancy to the community midwifery service in Essex in August 2012 and the midwife understood from information provided by A that her four older children had been taken into care in adjacent borough council X because she had to serve a prison sentence and that she had left adjacent borough council X for Essex to get away from the threat of domestic violence posed by her ex-partner and father of these children. An initial assessment was started on 29th November. The records show that the social care team manager triggered a pre-birth assessment on 3rd December before the initial assessment being completed. This did not in turn trigger a date for a pre-birth conference which according to procedure should have taken place at about 30 weeks of pregnancy i.e. 10 weeks later.

Even at this early stage there was an assumption circulating amongst agencies working with A that the baby would be removed at birth. The social worker in a phone call with Probation on 14th January to gather information for her assessment, told the Probation officer that there were concerns in relation to A’s parenting and that she was looking to remove the baby at birth. There is no written evidence that this was the agreed plan although the social worker acknowledged that in essence this was what she was working to at this point. It may be that the social worker had reflected this view to other professionals in conversation although it is not formally recorded until a conversation between the social worker and the Community Drug & Alcohol Team in January 2013 where the social worker stated that she was 'looking at removing the baby at birth'

This assumption appears to have continued right up to the time of the Pre Birth Child Protection Conference on April 10th 2013.

One consequence of this assumption was that the professionals working with the case tended to respond to the adults' individual needs rather than to work with them as future parents and address issues such as their relationship and their parenting capacity. One significant example of this is how the health visitor was not involved in planning for support to A after the baby's birth. At the beginning of her involvement in the case, she understood that there would be no role for her to play because the baby was to be removed at birth. The focus of the health agencies was on ensuring that A got the best possible ante natal care and support and abstained from street drugs so that the baby would be healthy at birth. An example of how this played out was the unsuccessful joint visit by the health visitor and midwife to A at home on 4th December 2013. A had not attended any contact with her named midwife or consultant but had attended for a scan in October. There was a successful joint visit between a midwife and social worker on the 28th December 2013. The midwife was able to carry out the routine physical checks and assess the home. The social worker stated that they were still investigating but there was a significant history of violence and drug use.

Probation worked with the offending and drug abusing behaviour of both parents and the Community Drug & Alcohol Team continued to provide scripts for substitute medication and to carry out court ordered drug tests. Housing services responded to A's request for independent accommodation and the Police services responded to any criminal activity by A and B.

13.3 Pre-legal meeting discussion 24th January 2014

A is circa 25 weeks pregnant

13.3.1 Pre-legal meeting outcome

A pre-birth assessment had been triggered in social care's IT system on December 3rd 2012. There was a discussion between the Council's legal services and social care on 24th January. This was 14 days after the case had been escalated to a Section 47 investigation by social care. The reasons for the escalation as a result of a management review, at this point are unclear in that A was maintaining her contact with social care (intermittently in truth - 18/12, 28/12 and then 28/01) but there was more information available about B's chaotic lifestyle, domestic violence towards a previous partner and that his two older children of this relationship had been subject to Child Protection

Plans. This information was not shared with other agencies at this stage. The decision to escalate this to a pre-birth assessment was an appropriate one

B was also reported as testing positive for street drugs and had not attended his recent routine court ordered drug test.

The meeting is referred to by the participating agencies as a ‘pre-legal discussion’ designed to consider whether a formal Legal Planning Meeting (LPM) should be booked.

The reason given by social care for having the pre-legal discussion was concern about A’s capacity to parent in the light of the removal to care of A’s four older children and her significant prison sentence for a violent offence.

The outcome of the pre-legal discussion was based on the limited information that was available from neighbouring county Z about A’s history. The recommendation from the discussion was that a LPM was necessary and that a Child Protection conference should also be arranged. The overriding assumption of the Social Worker was that the baby would be removed from A’s care at birth. However the case was progressed from this point on twin tracks; route 1 being a plan to remove the baby at birth through instigation of the Public Law Outline and route 2 being a plan to hold a Child Protection Conference to plan to keep the baby in the parents’ care under a Child Protection Plan.

13.3.2 **Public Law Outline (PLO)**

Along with the multi-agency network’s working assumption that the baby would be removed at birth, there was an expectation that a PLO would be followed to provide a formal legal structure for social care and the parents to work together while there was an assessment of the risks to the child..

The pre-legal discussion about legal action in response to concerns is not part of a multi-agency process and yet the assumption of removal at birth existed amongst partner agencies so strongly even before a LPM had taken place. It is likely that the social worker was expressing this as the plan to partner agencies as seen above. The assumption that a PLO was being instigated seems to have given reassurance to partner agencies that there was a plan to remove the child at birth even though; in fact the instigation of PLO does not have a direct correlation with removal of a child. This had considerable impact on the way in which agencies other than social care continued to work with the case. They tended to treat the parents as independent individuals with their own needs rather than as potential parents. There was a lack of focus on the unborn child.

13.3.3 **Heightened concerns**

Following the pre legal discussion, concerns regarding A as a parent were heightened. She did not attend consultant appointments on February 5th and 12th 2013 and in a phone conversation with the midwife, she appeared to be under the influence of drugs or alcohol and said that she was in neighbouring county Z.

The difficulty in locating her resulted in the social worker sending an alert to local hospitals to advise that the plan for the baby was removal at birth. The social worker also confirmed that A had been told that the baby was to be removed at birth. On reflection at the SCR Practitioners' Forum the midwife considered that moving around and presumably returning to her father's home neighbouring county Z was a feature of her culture. Although the midwife records that she contacted social care, this incident is not recorded on social care files.

This action reflects the understanding of the midwifery professionals that the plan was removal of the baby at birth rather than ongoing assessment under Public Law Outline or Child Protection Plan.

13.4 Strategy Meeting

A is 28 weeks pregnant

13.4.1 A Strategy Meeting was called on 18th February 2013 and was attended by the team manager, social worker, Community Drug & Alcohol Team and the midwife. The purpose of this meeting was explained by social care as a response to the heightened concerns of the midwife for the wellbeing of A and the baby, the fact that her whereabouts were unclear and she was not in contact with social care. There had been some reports of domestic incidents between A and B at B's mother's address and some doubts had been raised by A and by B about B's paternity.

In the SCR Practitioners' Forum however it became clear that in order to initiate a Child Protection Conference on the social care IT system Protocol, there needed to be the trigger of a Strategy Meeting first. The purpose of this is to ensure that everything is completed before moving the case on to the next stage. In this instance however, the purpose was a 'workaround' with the intention of proceeding as soon as possible to an Initial Child Protection Conference. It meant that the Strategy Meeting was not managed as effectively as it could have been to analyse the risk to this unborn baby or engage the police and social care in a shared understanding of the criminal and child protection histories of the parents.

The Strategy Meeting was not attended by the Police although there was a phone conversation between Police and the social worker about their concerns. The Police had no record of the content of this discussion. The health visitor was not invited – reinforcing the idea that future planning for A as a mother was not necessary

The outcome of this meeting was that the Police decided to issue alerts for the removal of the baby if A was to go missing – they created a 'Storm' incident which would ensure that duty officers would consider the need for Police Protection of the baby. This was in line with the action taken by the social worker in relation to contact with hospitals.

The midwife recorded the outcome of the meeting in her notes (presumably as conveyed to her by the social worker) that the baby was to be removed at birth and that A was aware of this plan and that a legal case discussion was booked for 2 weeks' time.

13.4.2 The Strategy Meeting did address the immediate risks presented by A's disappearance. In other respects it acted primarily as a trigger on the IT system to allow a Child Protection Conference to be booked on the system.

The social care manager's understanding of the plan for the child was that 'the fate of the child was not decided at this point' (or previously presumably) and so could not explain why partner agencies thought that the baby would be removed at birth.

There is not much content in the social care record of this Strategy Meeting so it is not possible to balance these views. Though no one from health services received the minutes of this meeting, the midwife recorded her understanding from the meeting as "*currently arrested for shoplifting. Living with B, SW knows the family and their long history of numerous domestic violence incidents between B, his mother and his brother. B has supervised contact with his 2 children from a previous relationship. A has history of prison sentence for wielding a sharp object. A is currently in neighbouring county Z is trying to leave B and is back up to 4mg Subutex*."

13.4.3 Despite all the meetings that took place it has not been possible to track decisions. Some discussions seem to be ad hoc rather than part of a considered co-ordinated process. There was no forum for the agencies to develop a shared understanding through mutual sharing of information and challenge of what was going on in this case.

In terms of procedure, the pre-birth assessment triggered on the IT system on December 3rd should have at this stage and with all the concerns, triggered a pre-birth Child Protection Conference. It is unclear why this did not happen but it is likely that the parallel planning processes overlapped.

13.5 Legal Planning Meeting (LPM)

A is 32 weeks pregnant

13.5.1 Information provided to the LPM

The LPM that followed on 5th March was attended by social care service manager, social care team manager, social worker, Essex County Council legal officer and a minute taker. The main purpose of the meeting was to determine whether the threshold for care proceedings was met and for legal services to make a recommendation to their clients the local authority about what action to take.

The meeting had information about A's history of using Class A drugs and that a previous child had been born dependent on drugs in 2008. Information about B was shared in that there was a question about whether he was the father of the unborn child or not. Information about his drug use, domestic violence and older children subject to Child Protection Plans was also shared. The social worker presented a summary of her records not a completed assessment.

During the SCR Practitioners' Forum the legal practitioner said that the LPM had never had independent sight of other agencies' information as all their information was provided via their client. The full social care and legal records had not transferred to Essex from neighbouring county Z in line with practice nationally. Neighbouring county Z did provide a chronology but it is not clear what opportunities or time was made available to interrogate the chronology and establish the nature of risks to the unborn child.

The social worker at the LPM expressed concerns about the violent relationship between A and B despite the fact there had not been any reported incidents. There were concerns about her transient lifestyle with A moving between at least 4 local authorities.

Police would not routinely attend a LPM although their information on previous criminal activity by both A and B was available to the meeting.

The LPM also heard information that B's mother had asked to be considered as a carer for the baby if neither parent was assessed as able to do so, but police checks had 'revealed that her home environment was not suitable' There were also concerns about anti-social behaviour from the family. B and his brother were well known offenders who used their mother's home as a base and B's brother's children were recently placed on a Child Protection Plan.

The LPM recorded that a parenting assessment had not been undertaken on A because her lifestyle had been too chaotic; although in essence this would be the very reason to ensure that the assessment was undertaken. The view of social care expressed in the SCR Practitioners' Forum was that a parenting assessment would not be undertaken unless A had addressed all the historical issues of concern.

The notes of the LPM state that 'unless there are assessments that confirm parents have addressed all of the issues of concern the plan will be to remove the baby'

13.5.2 **Outcomes of the Legal Planning Meeting (LPM)**

The agreed action was for the social worker to book a Child Protection conference to ensure that the baby was subject to a Child Protection plan at birth. This was in response to the high risk of A and B taking flight with the baby after birth. The agreed recommendation of the LPM was to make application to remove the baby at birth. While this is not particularly clear from the notes of that meeting, it was the view of the legal advisor in the Practitioners' Forum that this was the core of their advice. The Public Law Outline (PLO) which is a method of managing the pre-care proceedings to work with the parents on changes that might reduce risk and allow the case to be managed outside of legal proceedings, was to be instigated as the framework for work with the family.

13.5.3 **Following the Legal Planning Meeting**

Social care managers continued to oversee this case without ensuring that the PLO process with its rigid and tight timescales for action was started. The Child Protection process appeared to supersede the legal process although the multi-agency network was not aware of or involved in the LPM. As the LPM is not a decision making meeting, there is no requirement for a dissemination of outcomes however, there was no other multi-agency forum where the decision of the local authority in response to the LPM recommendation could be communicated until the Initial Child Protection Conference on 10th April – more than a month later.

Housing services were subsequently advised by the social worker that A was making good progress and was being regularly monitored. This information did not reflect the level of concern for the unborn baby that had resulted in the recommendation of the LPM to seek to remove the baby at birth. Following the couples' eviction from B's mother's house, A made a housing application in her own right which B was not part of and on 21st March A contacted Housing to tell them that she was no longer in a relationship with B.

Probation however, always understood A to be in a relationship with B and A was used to pass messages on to B.

A had disclosed concerns to the midwife that B might make it difficult for her to leave him but that she was not happy in the relationship. The midwife gave her information about 'Safer Places'[3] but no domestic abuse risk assessment (DASH)[4] was completed because A had made it clear she was competent to remove herself from any risky environment. This was accepted it seems without question. The next midwife contact was 2nd April when A was living at a different address and she reported she was still 'in touch' with B

The Community Drug & Alcohol Team noticed improved engagement with A following this LPM and a perceived change in her attitude suggesting that A had been made aware of the recommendation. The pre-proceedings letters had not been sent to her however so it is unclear what she understood as the intentions of the local authority. She was regularly testing clean for street drugs.

13.5.4 **Framework for management of the case**

The multi-agency network consisting of the midwife, Community Drug & Alcohol Team, social worker, Police and Probation still did not have a working model of risk to this child to work with. Other agencies such as Housing, GP and health visitor were unaware of any of this process. The main concerns seemed to be A's potential to misuse street drugs and that she might resume her relationship with B although there are really no indicators that she and B were not in a relationship.

It became clear from both the Practitioners' and Managers' SCR Forums that agencies outside social care who are not familiar with the process for care proceedings would not necessarily understand how decisions about child protection are made under legal processes.

The case was added to the agenda for review at the next LPM planned for early April 2013 to update and clarify information for the issuing of proceedings. This review never took place although legal services attempted to get updates from social care but there was no response until 29th April 2013.

13.6 Analysis and Findings from Key Episode 2

13.6.1 **Pre legal meeting: progressing the Public Law Outline**

While there is no written outcome or actions from this meeting other than to proceed to an LPM, it became clear during the SCR Forums that twin tracking of the case seemed to have started soon after this meeting although there

[3] Safer Places is an independent domestic abuse charity dedicated to supporting adults and children affected by domestic abuse. http://www.saferplaces.co.uk/

[4] Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model http://www.dashriskchecklist.co.uk/

was no written evidence of where or even if, such a decision had been made. The Public Law Outline was to progress, providing a possibility of removing the baby and starting proceedings, alongside a child protection process with plans for A to keep the baby, though this was not specified to any agency outside social care

While such a way of working may be familiar and common to social care practitioners, the thinking and rationale for progressing in this way does not seem to have been made clear to key members of the multi-agency network. Either that or the agencies working with social care are not as clear about the process as is assumed. The existing assumption of removal of the child and care proceedings, appeared to lead to a deference by the multi-agency network to the legal process, minimising the necessity for a robust assessment of A's and B's parenting capacity and their assessment as a couple. There was a great deal of ambiguity about whether they were even a couple with A giving information that she was not in a relationship and then acting as if she was.

The assumption that B was the 'bad guy' in the relationship and that A on her own without B would manage and cope well was faulty at its core. B did not have a great profile as a parent but A had had 4 children removed and those in her care had suffered physical harm as well as neglect and serious consequences for a new born drug dependent baby.

13.6.2 **The LPM and parallel planning**:

There is no protocol in place for the sharing of decisions made in a LPM with the wider multi-agency network. It is not clear at which point social care decided not to actively pursue the instigation of care proceedings. The SCR Forums were unable to establish this and there are no documents that record such a decision. To all intents and purposes the case management was proceeding along twin tracks without anyone being clear about the purpose of the twin tracking. The case progressed in a very muddled and uncoordinated way from this point. It is not possible to see a clear process of decision making and implementation of actions to support those decisions.

It just seemed to happen without question or challenge from any of the participants.

Any case where removal of a child is under consideration should ensure that there is an up to date and thorough assessment of parenting capacity. If legal proceedings had been progressed this assessment would have been an essential component of the local authority's case and yet it was never commissioned or questioned. A requirement to consider this is not included in the Pre-Birth assessment guidance for Essex.

The unwritten and unstated plan appears to have been to wait and see how the parents coped once the baby was born. This of course may have been a perfectly reasonable course of action within a tight framework for monitoring over a period agreed with the multi-agency network. In fact this happened without a clearly stated rationale and was not communicated to the other agencies involved.

Legal services had concerns about the lack of information they had about progress with the PLO or why a decision had been made not to progress the PLO. There was no formal feedback to legal services by social care about progress until an email from the Service Manager on 29th April.

In fact the PLO process had stalled. There were no efforts to progress it until after the injuries to John.

The explanations given by the social worker and the manager were that the social worker's workload was too great and that she was overwhelmed with work. There is no clarity about who is responsible and accountable for ensuring that legal processes agreed at an LPM are progressed. Legal services made efforts to ask social care for an update on progress and in the SCR Forums, they expressed concern that they could not get a response to e mails on this matter. There is no formal written escalation process between social care and legal services and no cross departmental oversight or tracking of this area of decision making currently.

The rationale for the timing and the status of all these early meetings was not clear to the SCR Practitioners' or Managers' Forum. The reason for not having a pre-birth conference at an earlier stage in the pregnancy was never made clear.

The work with the practitioners and managers and the information available to the review do not clarify this.

13.7 Summary and Recommendations

The most significant feature of this period is the way that planning for the case became less and less clear for the multi-agency network. The assumption by agencies that care proceedings would initiate at the baby's birth and would almost inevitably lead to the removal of the baby did not match the thinking of the local authority – that no decision had yet been made. There was a lack of clarity about the interface between the multi-agency Child Protection process and the local authority specific PLO process. Agencies other than the local authority did not understand how one process did or did not inform the other.

The fact that all the relevant information in the Core Assessment was not taken on board by key agencies made a multi-agency discussion much less useful in providing a holistic picture of the way the family was functioning. This led to an overdependence by other agencies on the assessment of the local authority and a loss of focus and momentum in work with the family. For the local authority, there was a lack of robust challenge and questioning of the plans that unfolded in the Initial Child Protection Conference by the partner agencies

The PLO process was allowed to stall with no effective mechanism in place to bring this to the attention of senior managers in either department or no agreed protocol about accountability for follow up.

13.7.1 **Recommendations**

Essex Safeguarding Children Board

Essex Safeguarding Children Board should ensure that all agencies involved in assessment of risk of harm are aware of and familiar with the Public Law Outline and how it interfaces with the Child Protection system so that they are equipped to ask appropriate questions, to deliver consistent messages to families and to staff and to make the fullest possible contribution to decision making.

Essex Children's Social Care

Essex children's social care should ensure that a formal escalation process is in place to review the implementation of decisions/agreements made at Legal Planning Meetings.

Essex children's social care should consider whether there is a need to make Legal Planning Meetings/processes open to the multi-agency child protection network.

Essex children's social care should clarify the role of the Child Protection Conference in recommending or challenging the need for a legal framework such as the Public Law Outline for cases that carry high levels of risk.

Essex Legal Services and Essex Children's Social Care

Legal Services and children's social care should together review the way in which they communicate to ensure that the best possible advice based on current circumstances of a case is available and that the decision to proceed or not to care proceedings is based on the merits of the case rather than the likelihood of a successful application.

In cases where the Public Law Outline is recommended and there is a history of older children of either parent being removed to care, children's social care and Legal Services should work together to seek all available information and assessments if carried out by another local authority, at the earliest possible stage. The need for and commissioning of parenting and/or psychological assessments of the parents should also be considered at an early stage. A requirement for this should be included in the Pre-Birth practice guidance.

14 Key Episode 3: Initial Child Protection Conference 10th April 2013

14.1 Initial Child Protection Conference

A is 37 weeks pregnant.

Relevant areas of enquiry from Terms Of Reference (see section 4.6)

i) The pre-birth Child Protection Conference 10th April 2013 where the risks to John's safety were acknowledged as high but the apparent strengths in the family led to a consensus in the conference that A and B were committed to him and were showing capacity and intent to change. The Police were particularly concerned about B's criminal history including threats to kill, actual bodily harm, battery and cocaine use (on-going). He had previously been recalled to prison for an assault against his former partner.

ii) Where and how the decision that the baby would be removed at birth was made

vi) No GP had been invited to the Child Protection Conference

The two GP Practices concerned had no record of the unborn child being subject to a Child Protection Plan despite both having clear arrangements for the discussion of key cases with the midwife and health visitor.

14.2 The Initial Child Protection Conference took place very late on in A's pregnancy (37 weeks) and five weeks after the Legal Planning Meeting. There is no clarity about why the conference was so delayed particularly after the holding of the Strategy Meeting two months previously in February 2013. which unlocked the system allowing a date to be set for a Child Protection Conference. The social worker believed that the delay in holding the conference was due to the policy at the time i.e. that if the plan was for removal there was no requirement for a Child Protection Conference. However, the risk that the parents might move away once the baby was born was believed to be high and hence a Child Protection Conference would ensure that all agencies could be instantly alerted to the fact that a child subject to a Child Protection Plan had gone missing**.**

Some members of the SCR Practitioners' Forum were confused as to why an Initial Child Protection Conference had been called at all considering their understanding that the plan was to remove the baby at birth. At the time of this Initial Child Protection Conference it was usual practice not to hold a Child Protection Conference when the plan was removal. However, prior to this

Essex had arrangements in place in its procedures for holding a Child Protection Conference even when the plan is to progress the Public Law Outline process. This was originally arranged as a way of alerting partner agencies to the risks to a child if their family disappeared with the child – i.e. to ensure swift and decisive action to find and protect the child. The purpose of this Child Protection Conference seemed to be to cover both the eventuality of the child being removed and yet vulnerable to abduction and to the child remaining with the parents whether under a legal order or not.

Probation and Community Drug & Alcohol Team were not represented and the child's social worker did not attend due to pre-arranged leave. The social care team manager did attend. The health visitor was not invited. A standard invite to the Named Nurse for Safeguarding in the community was received and she attended, later giving feedback to the health visitor that "legal steps to protect the baby had been taken". The team manager and the midwife were the only 2 people at the conference who had a working knowledge of the case and the midwife was the only professional with direct contact with the family.

There was no GP at the conference and it became apparent during the Serious Case Review that the GPs for both A and B had not been invited. This was not identified as an omission within the conference and no actions were agreed to address this. There was therefore no report from the GP which might have brought to light his treatment of A for depression and the GP's lack of awareness of her drug treatment. It might also have clarified for the GP service the concerns about the unborn child. The GP did not receive any conference minutes and as their IT system is different from community services the GP remained unaware of any history that might have assisted him to provide appropriate care for A and John.

The conference was attended by A but not B.

14.3 The content of the Conference and the change in plan

This was the first of the new Strengths based Child Protection conferences[5] in this quadrant of Essex. All members of the SCR practitioners' forum agreed that there had been extensive briefings and opportunities to learn about the new model including opportunities to attend a mock Child Protection conference. The midwife was not trained but had been briefed (training for staff at the Essex district general hospital did not start until September 2013)

It was noted by the assessor in attendance to assess the new style conference, to be a comprehensive and thorough conference with the discussion taking over 2 hours.

[5] Strengths based practice in Essex is based on an approach developed by Andrew Turnell among others in New Zealand in early 2000's where relationships between worker and family are characterised by collaboration and empowerment

Legal services did not attend this conference and it is not clear whether the discussion and considerations of the pre legal meeting strategy meeting and legal planning meeting were conveyed verbally to the meeting.

The chair of the conference was aware that a Legal Planning Meeting had taken place and that there were significant risks raised by the case. She also was briefed by the social worker before the conference that the plan was to keep the baby with A after birth and thought this was a reasonable decision as the case would be managed under the Public Law Outline and any relevant evidence of risk would be collected through this process. This was the first real evidence that the plan for the baby had changed.

The social worker's view of this time is that the decision had not changed prior to the conference and she does not remember talking to the Child Protection Chair. There is no record of this conversation. As far as she was aware the decision not to remove the baby from A's care was taken after the Child Protection Conference because the information shared at the Conference had changed her manager's view of the risks and strengths of the family. She does not know if this decision was made in discussion and agreement with anyone else. It has not been possible to shed any further light on this as despite considerable effort to locate them, the team manager at the time of these events could not be contacted to assist in the Serious Case Review.

The Chair believed that 'there was no significant historical knowledge and a person's behaviours in a new environment are different' It was her view that the format of the conference did not affect the way that she thought about risk but largely impacted on the conference content and process. The Chair liked the new approach believing it to be a way in which parents could be engaged to develop solutions. She remembered agencies participating well in the discussion and that it was a positive meeting. The Chair remembers her intention that whatever the outcome of the conference, the case should continue to be managed under the Public Law Outline.

The Conference was badged as an Initial Conference rather than a pre- birth conference and the practitioners commented that this was in line with local procedures. It is noted that ethnicity was recorded as "Not available at present" so it is unknown if their backgrounds informed thinking at Conference.

14.4 The decision sheet for the conference records the risks to the child as being from parental drug use that would cause the parents to be less capable of providing the baby with safe and consistent care, plus the previous history of A's other children who were assessed to be at risk of significant neglect and domestic violence between parents**.**

These risks were mitigated by the information shared at the conference that A had not been using street drugs throughout her pregnancy and had maintained a substitute programme well. B was also noted to be doing well on his substitute programme and was not using street drugs at the point of the conference.

Positive views of A’s progress were presented by the Community Drug & Alcohol Team, the social workers written report to Conference, the health visitor’s report (who had had no contact with A, as the change of direction earlier in her care had left no time for pre-birth work) and other comments made at the conference. The midwife also advocated the positives for A. The chair commented in the SCR Forum that there was no sense that one or more agencies were trying to convince the conference that the significant risks were not real. Members of the Practitioners’ Forum were aware that A had not been known to Essex services for very long and that the improvements in her engagement and co-operation with services had been recent. The recommendation of the Legal Planning Meeting to progress to Public Law Outline had been communicated to A and B by the time of the conference. The fact that A was aware of this fact was noted in the conference. Nevertheless A’s level of co-operation with drug services had improved shortly after the Legal Planning Meeting and can be viewed as indicating her positive response to the prospect of losing this child to care also.

A presented well at the conference. She had begun to keep appointments and seemed to understand the serious nature of professionals concerns. She told the conference that she had left B but still turned to him for support.

14.5 At the SCR Practitioners’ Forum there was a collective view that the conference did not receive or form a coherent picture of the history of both parents. There was no one who was able to present the history who seemed to have a grasp of the historical concerns in detail although in summary they were part of the awareness of the conference that the risks were serious.

The SCR Managers’ Forum was able to hear from the team manager who had a copy of the social worker’s Core Assessment which formed her report to the conference. This contained extensive detail of the history and included information that A’s previous children had suffered physical abuse including bruising and cigarette burns from their father, her ex-partner and that she had not been able to protect them due to the domestic abuse from her ex-partner.

A comment was made at the conference and not challenged that there was no history of parents hitting or shaking A’s previous children suggesting that they had not been subject to physical abuse. It was assumed that A had not been the perpetrator of the abuse as it has been stated in the information from adjacent borough council X that A agreed it was her former partner who had physically abused the children. This was not established as a fact but A was never charged with any offence in relation to physical abuse of her older children. .

No consideration was given to A or B's violent behaviour in the recent past and the propensity for further violent offences nor was there any analysis of potential triggers. No discussion took place concerning the potential risk of physical abuse to the baby.

14.6 Again the summary of concerns was to do with the potential impact of parental drug use and noncompliance with appointments. The reality of A's attendance at appointments was in fact, not as positive as was indicated by discussion at conference. Between the Legal Planning Meeting on 5th March and the Initial Child Protection Conference on 10th April a period of 5 weeks, A was selective about which appointments she attended, knowing that her non arrival would generate a subsequent appointment being offered. On looking back it appears that A had attended only 1 of 5 Antenatal appointments, 3 of 5 appointments to collect her Subutex, and none with Open Road. The high likelihood of her non-compliance or disguised compliance with a Child Protection plan did not form part of the Plan either in terms of assessment or monitoring.

The fact that there had been no (known or disclosed) domestic abuse between the couple was noted as a positive as was the fact that B's children from a previous relationship were no longer subject to Child Protection plans (believed to have been made because of the risks posed by domestic abuse by B to their mother) and were now doing well. However B's role as a parent was not explored.

In hindsight the Chair commented at the SCR Managers Forum that one thing she would have done differently was to explore the risk from the parents' propensity to violence in the recent past including serious offences against the person.

The local authority solicitor was of the view that the Initial Child Protection Conference should have been held within the context of the Public Law Outline and in parallel to the issuing of care proceedings – giving the parents the opportunity to demonstrate whether they were able to sustain progress and provide safe care for the baby. Otherwise tracking progress in an evidential way would prove more difficult.

Common practice in Essex is that the Initial Child Protection Conference often occurs before a Legal Planning Meeting so that the conference content can inform discussion about legal options. However in this case, social care services did not share the conference content with legal services. No review Legal Planning Meeting ever took place to decide how to proceed in the light of what had been shared.

The decision whether to institute care proceedings rests with the local authority but it is unclear from the discussion and information available exactly what the partner agencies understood as the status of care proceedings and what had changed and why.

Both the midwife and health visitor at the SCR Practitioners' Forum stated that they knew the main risks to John did not arise from poor physical care as long as A stayed off street drugs which she had managed to do very well. Yet the category of the plan was neglect and the detail of the Child Protection Plan was all about monitoring the baby's growth and development. This resulted in a plan which primarily involved scrutiny of parents for drug use and neglectful physical care.

The conference seemed to focus primarily on A in terms of the identification and management of risk and there was a failure to present the concerns about the parents' relationship and its actual or potential impact on parenting together with the lack of any formal assessment of parenting capacity. The responsibility for the plan was distributed to the midwife and later the health visitor to monitor "health, growth and development", while social care would visit fortnightly to "evaluate, and assess the situation"

14.7 Analysis and Findings from Key Episode 3

There was no process that was followed to change the decision to seek removal of the child at birth. It is not clear to the multi-agency system in Essex, where and by whom such a decision would be made. There is no current failsafe system in place to ensure that such momentous decisions cannot be taken without the engagement of senior managers in social care, legal services and partner agencies.

A major concern was that this conference went ahead without the social worker present and their intended absence was known when the Conference was planned. The fact that the birth was imminent may have been a factor but a greater consideration is whether the worker who knew the most about the case and understood the twin track process that was going on was not present. The only person round the table who had worked directly with the family (on just 2 occasions) was the midwife. She was working to an assumed plan for removal of the baby but did not challenge the decisions of the conference and the plan for the baby to go home after birth under the assumption that "legal steps have been taken to protect the baby". This may have been because there was a close and good working relationship between the social worker and the midwife and a degree of trust had developed in their judgements and practice. The SCR Practitioners' Forum discussed this and there was consensus that more strengths became apparent during the course of the discussion. However these were presented by those without direct evidence of working with A or B directly and with no assessment of parenting capacity.

Had the social worker attended she could have given a much more in depth presentation and been open to questions and challenge about her recommendation for removal. The tabling of the social worker's report on the day of the conference did not help agencies to assimilate, consider and comment on the implications of the information for the case.

The significant delay in arranging a pre-birth Child Protection Conference in this case resulted in pressure on workers to formulate a Child Protection Plan while trying also to address the discharge arrangements for the baby. Practical arrangements for care and monitoring took precedence over a multi-agency assessment of risk. Formulating and implementing a Child Protection Plan very close to the birth of a baby is exceptionally challenging. Parents who are practically and emotionally making preparations for the birth and immediate aftermath are less likely to assimilate the need for actions with regard to their own relationship and behaviour. Professionals get caught up in routine and necessary work to ensure a healthy delivery and focus on post-natal care of the child. This case highlights the need for prompt action in response to concerns about an unborn child and particularly where there have been concerns about a previous child or children. If this conference had been held sooner it may be that the assessment of parenting capacity would have been completed and that this could have informed the need for a further Legal Planning Meeting.

14.7.1 There was no prioritising of any assessment of parental capacity or psychological profile. A had lost 4 children to care and had been in prison . The impact of this was not assessed or planned to be assessed during the course of this case

14.7.2 The focus of the Child Protection Plan on daily monitoring in the first few weeks of the baby's life was all that was offered within the context of an assumption by most of the partner agencies that this period was being used to gather further evidence for the removal of the child. There was a sense that the local authority could not be confident that the family court would make a decision to remove the child at birth on the basis of the history.

14.7.3 If the information about the parents' history had been properly considered in a multi-agency forum such as a Child Protection Conference at this stage it should have highlighted for practitioners the degree of A's potential for non-compliance with agencies and also her inability to protect her older children from assault by her partner. The information shed new light on the person of A that they had come to know as a sympathetic character, with significant personal strengths and capacity who had been articulate, personable and seemingly competent as a mother.

14.7.4 The impact of the Strengths Based approach may have made it more difficult for practitioners to be appropriately sceptical although the practitioners who attended all agreed that the conference was rigorous and robust in the analysis it undertook. The fact that the conference was the first of the newly introduced model of Strengths Based approach may or may not have had an influence. The desire to work the conference according to its best principles and the presence of an assessor to review how the conference progressed may have added weight to the need to emphasise and tease out the strengths in this family without the real and recent history of decision making about removal at birth being played out and discussed. There was no such challenge at this conference for reasons that have been outlined.

The lack of engagement of and information exchange with the General Practitioner should have been picked up at this conference but was not. There are systems in place in Essex now to identify the GP for a family but it seems these were not used and resulted in a valuable professional who could have helped to identify potential risks to the baby postnatally, being out of the loop. Health professionals did not pick this up and nor did the Child Protection conference administration process. It is a social care duty to create the invite list.

14.7.5 The impact of the parents' Gypsy Roma Traveller culture was not addressed by the conference despite the expressed view of legal services at the Legal Planning Meeting that a specialist worker might be helpful. There was no consideration as to whether the Child Protection Plan was reflective of the culture.

14.8Summary and recommendations

These findings are not intended to be a critique of the Strengths Based approach to conferences. The model has been tested in many local authorities and delivers good outcomes generally. It is the particular circumstances of this case that raise the concerns. The impact of the delay in holding the conference, the absence of the social worker, the lack of awareness by agencies of the content of the Core Assessment and the confusion about the direction of planning for the case should have been evident at the time of the conference and should have resulted in action to put the case back on track.

14.8.1 **Recommendations**

Essex Children's Social Care

Essex children's social care should provide guidance to Child Protection Conference chairs about the need to consider risk of physical harm to new-born babies or and very young children in all cases where there is a parental history of care proceedings on older children as a result of any form of abuse or neglect. This may mean including the risk of physical abuse in the category for the Child Protection Plan.

Essex children's social care should ensure that General Practitioners are always be invited to attend Child Protection conferences, requested to provide reports if they are unable to attend, copied into all relevant minutes and informed of any major decisions and newly identified risks by the social worker.

Essex children's social care should introduce a process whereby approval must be given at a senior level to any decision to not proceed with a previous decision to initiate care proceedings.

15 Key Episode 4: The Child Protection Plan

15.1 Relevant areas of enquiry from Terms Of Reference (see section 4.6)

iv) To what extent, decisions made in this case were influenced by children's social care's view of;

- the evidence of positives in the physical and emotional care of John by his mother after his birth
- her commitment to stay drug free
- the fact that home conditions were good the apparent co-operation of parents with professionals and their seeming ability to put John's needs before their own.

v) The first discharge planning meeting held a day after birth.

vi) GP involvement – in particular;

- The discharge summary that went to the GP after John's post-natal admission to an Essex district general hospital with a possible apnoea attack did not refer to any child protection concerns
- The two GP Practices concerned had no record of the unborn child being subject to a Child Protection Plan despite both having clear arrangements for the discussion of key cases with the midwife and health visitor.

vii) Care of John and particularly the involvement of B

viii) The apparent lack of clarity about B's visits to John (parents were said to be living separately) and a reliance on A to oversee this.

ix) Why there weren't firmer arrangements in place about supervised contact after B alleged the child had suffered from an apnoea attack and was subsequently admitted to hospital whilst in B's sole care.

x) Parenting Assessment and in particular;

- Part of the child protection plan was to be an assessment of the parents' relationship including their capabilities in respect of their parenting, but by the time of the incident in July this had not started.
- Some work was to be done with A about domestic violence suggesting that there were sufficient concerns about the current relationship to warrant this but this had not started by the time of the incident.

xi) There was an apparent lack of rigour in the implementation of the Child Protection Plan despite the fact that significant risks had been identified and there had been a decision to remove the child at birth only a few months previously.

15.1 Addressing Risk

The Child Protection Plan identifies the risk that 'being around violence and drug users is frightening and dangerous to children' and 'B is not to visit the baby at A's home without supervision as the social worker states they were unable to assess the risks'

However the social care managers participating in the Serious Case Review were clear that there was no way that B's contact with the baby could be monitored 24/7 although the Child Protection Plan was modified in the second week after the birth, to include one session per day for the family support worker to supervise B's contact with John.

It is curious why such a plan was put in place if professionals believed it could not be properly supervised, and why such a recommendation was not considered within supervision by the managers. There must have been a considerable degree of confidence placed in A's decision to no longer have B in her life and to protect the baby from him. However, this was an untested area of risk as A had not been able to protect her older children from abuse by her former partner. It is concerning that practitioners believed and trusted her without any real evidence apart from her verbal assertion, that she was prepared to keep B away from the home except when the family support worker was there.

15.2 Monitoring

The Plan required the health visitor and the midwife to concentrate on monitoring and supporting baby's health growth and development. There was no challenge to this at the time despite the health visitor and midwife reflecting their understanding at the SCR Practitioners' Forum that there were no real concerns about how A would parent the baby on a day to day basis while clear of the influence of drugs.

15.3 Resourcing monitoring and support

The case was presented to the Resource Panel prior to the conference as there were significant resourcing issues to support the plan for an 'intensive support package' for 2 weeks with a commissioned family support service providing twice daily visits. The multi-agency network involved in the case were not aware of the function and purpose of the Access to Resources panel. Clearly all agencies have their own internal processes for determining the allocations of resources according to priorities but the network was unaware of the influence that such a panel could have on the care plan for the child. There was no consideration of the potential additional risks posed by introducing a commissioned service which was not an integral part of the multi-agency team supporting the family postnatally but which reported solely through the social worker. The SCR Practitioners were not themselves entirely clear that this was a commissioned service anyway.

The social care managers identified that this package was a high level of resource to support a Child Protection Plan in addition to the monitoring that was provided by the usual agencies. It was said to reflect the high levels of concern noted at the Conference as well as the confidence in the strengths identified in A.

The purpose of the intensive support was understood and expressed in 2 ways at the SCR practitioners meeting; firstly to monitor A's care of the baby and secondly to monitor her contact with B.

15.4 Analysis and Findings from Key Episode 4

15.4.1 **Assessment of risk**

The plan did not identify and address any risk of physical violence towards the child from either parent although risk to John was identified as mainly coming from B and to do with accidental events as a result of the effects of his drug use, hence the supervision of his contact. The plan did not detail any robust arrangements to ensure that B did not see John unsupervised. This was given to the Core Group to arrange. The implication of this was that all the responsibility for keeping B away from John rested on A and there was an expectation (unwritten) that she would report any instances where he tried to breach the arrangements made. This was a misplaced confidence as A's history suggested she also posed risks to her older children and even at this late stage; this had not been assessed by Essex in relation to John.

The category of the plan was neglect which had been the concern about A's older children. However A was about to be a parent with a new partner in a new environment and this needed a broader assessment of risk so as not to restrict or limit professional thinking to narrowly defined concerns.

From this point onwards the Child Protection Plan should have been explicit about the need for a comprehensive and time limited assessment of parenting by the Family Centre. Part of this assessment should have addressed the question of whether A posed any risk to John.

15.4.2 **Role of the Child Protection Conference in determining an appropriate plan**

The practice of the social worker briefing the Child Protection Conference chair before the conference as to the relevant issues, the potential perceived risks as seen through the eyes of the social worker, and the social care plan for a child is reasonable given the social workers absence at the conference. The role of the Chair is then to assess the level of risk for the child, whether the social care plan makes sense and to challenge the plan if need be. This does not seem to have happened in this Conference. However the social worker, with much of the information in her head and file, the Probation service with information about B, the drug services with their history of A and B and Housing who had extensive knowledge of B and his family (coupled with the Police service's knowledge of B's criminality and the domestic violence) were not at the meeting. Instead the conference relied on professionals who had limited and superficial working knowledge of A and some or no knowledge of B, to assess risk, while under the mistaken confidence that they were fully appraised of and understood the limitations and remit of the actions required to mitigate the risk identified.

15.4.3 **Role of Resource Panels**

The Resource Panel is an additional although single agency forum that has significant impact on the direction of a case. Its role is probably not clear to external agencies. The social worker would have had to make a case to the panel for the resource but the SCR social care managers described how the panel would have considered the alternatives to the care plan i.e. – removal at birth. Neither the panel nor the Child Protection Conference was in a position to make this decision. The way in which such a decision is made may exclude options that the Initial Child Protection Conference might want to consider and in this way, could influence the social worker's decision before the conference has had time to evaluate information from all sources. Resource Panels may not take place immediately prior to Child Protection Conferences and so may work with out of date or incomplete information.

15.4.4 **The role of the GP was not addressed**

The GP was not invited to the Conference nor was their absence discussed. The social worker when contacted after the Practitioner's Forum gave a worrying response when asked about this fact. It suggested that it was not considered worth pursuing the engagement of the GP in the Child Protection process as generally speaking, there was no helpful response from GPs. The GPs involved with the family were part of the Practitioners' Forum and were also approached again at a later date to clarify some points. They expressed their significant concern that had they had more information and been part of the multi-agency team for this child, they may have been able to offer more effective support to the family.

15.4.5 Lack of progress regarding the Public Law Outline (PLO)

The Child Protection Plan also required that the Legal Planning Meeting paperwork was shared with A and that the PLO was to be considered by the social work team. It is very concerning that at this crucial stage in planning for safeguarding John, there was no legal framework for a case with so many known, unknown and unassessed risks. It is a significant concern that the SCR has not been able to establish the reason why the PLO was not progressed such that even after the Initial Child Protection Conference underlined the need for this action and the Core Group meeting reinforced this, no action was taken. No management action or review seems to have considered this a serious failure by the service constituting a need for specific investigation and review. There was no suggestion by anyone that a Child Protection Conference should be reconvened early to consider this matter and there was no challenge by the Conference or any agency to the local authority about the lack of adherence to the Child Protection Plan.

15.5 Summary and recommendations

The acknowledgement by the Child Protection Conference of a risk of potential physical harm to the baby by the parents would probably have ensured that the supervision and monitoring arrangements in the Child Protection Plan would have had greater emphasis on the need to examine the baby, to take any unexplained health issues very seriously and to ensure that the parents were completely compliant with requirements for supervised contact – invoking sanctions where this was not the case. There was a complete lack of consideration of risk of physical harm to John from either or both of his parents. While there was close scrutiny of John's physical well-being and development because of the category of neglect, there was a sense that professionals were not considering any other possibility other than evidence of physical neglect, poor hygiene and nutrition. A had ceased to disguise her compliance with plans and was openly not complying with them. The supervising agencies were complicit with that, even joining with A in her criticism of B for his non-compliance when she had instigated and fully supported his actions i.e. in having sole care of the baby.

The more effective and purposeful engagement of GPs in the child protection process must be championed by the Clinical Commissioning Groups in Essex, by other health professionals and by children's social care.

15.5.1 **Recommendations**

Essex Children's Social Care and the Clinical Commissioning Groups (CCGs)

Essex children's social care and the CCGs should ensure that there are effective arrangements in place for identifying, contacting and engaging the GP for every child and parent who are subject to a Child Protection Conference.

Essex Children's Social Care

Essex children's social care should ensure that the role of Access to Resources Panels in decision making about cases which are the subject of Child Protection plans is made explicit to all agencies and that any deliberations by Access to Resources Panels which have a bearing on the direction of a case should be shared with the Conference or other multi-agency forum.

16 Key Episode 5: Birth of baby John, pre-discharge planning meeting 18th April 2013

Relevant areas of enquiry from Terms Of Reference (see section 4.6)

iii) Whether and to what extent A's history with her other children and the impact of the relationship she had with their father on her parenting was sufficiently understood, assessed, highlighted and borne in mind by agencies undertaking the monitoring and assessment of John's care.

vi) discharge summary that went to the GP after John's post-natal admission to an Essex district general hospital with a possible apnoea attack did not refer to any child protection concerns

16.1 Hospital stay and discharge planning

John was delivered by emergency Caesarean Section in spring 2013 only 7 days after the Initial Child Protection Conference.

There was a pre-discharge meeting held on the day after John's birth between the social worker, midwife and named nurse for safeguarding (who has not been available to the Review to clarify any points within the narrative). It was noted to be "a very quick meeting" of which there are only brief notes but no evidence of any contribution from ward staff either in person or in written information.

Hospital records detail that after the pre-discharge meeting had taken place, A was absent from the ward for long periods (presumed to be having a cigarette) and did not make arrangements for the supervision of the baby while she was away. A doctor noted that he could smell alcohol on her breath at one stage – this was not followed up and neither piece of information was shared with social care. This meant that the commissioned family support service monitoring the situation at home after the birth would not have known this information and could not take it into account in their work with A.

The circulating understanding by the midwife, health visitor, Police and Probation who were caring for this family in the community was the assumption that the Public Law Outline was in place and proceeding. These agencies also assumed that B was having contact supervised by the family support worker.

16.2 Analysis and Findings from Key Episode 5

16.2.1 Lack of updated information prior to discharge

The Pre discharge meeting took place in the afternoon after John was born. Babies born to drug using mothers would routinely be kept in the hospital between 24 – 48 hours, and as this would have meant discharge at a weekend, it was decided to discharge John on Monday (3 days later). According to procedures a discharge planning meeting should be held within 24 hours of discharge to ensure that information is up to date, hence there should have been a meeting to update the information and decisions.

The discharge plan was not updated with the information about observations of A's behaviour on the ward and this only came to light through the process of creating a chronology for the Serious Case Review. As the safeguarding nurse from the Essex district general hospital has not been available, there has been no accessible person who could throw light on why this scenario happened as it did. Anecdotally the community midwife remembers there being a great "pressure for beds" indicating the ward was very busy.

No consideration was given at this point to what good care of a new baby might look like in the context of a mother who had had 4 children already removed to care and with whom she no longer had contact. Nor was attention given to what she might feel or think about her situation.

16.2.2 Consideration of the impact of A's culture on the presentation of neglect

There was no consideration of the impact of A's Gypsy Roma Traveller culture on her child care practices.

16.2.3 Lack of engagement of Primary Health

Despite the decision for the child to be cared for by A with intensive support, the health visitor was not invited (the reason for which has not been established) to the pre discharge meeting nor did she receive any significant alert. It is noted that Student Health Visitors attended as they were shadowing the Named Nurse though no minutes have been forthcoming, the midwife recorded the decisions as midwife to visit 'every other day until 28 days; Review Child Protection Conference in 2 weeks'; 'B to have supervised access only'. There seemed to be unquestioned acceptance by the midwifery service to the lack of involvement of the health visitor and the fact that the Review Child Protection Conference was delayed.

16.2.4 The discharge summary form issued by the hospital was sent to the GP with the 'significant events' box ticked but without an explanation as to what in this case it meant. A copy of the summary is given to parents and this may explain the lack of detail however the GP (unaware as they were of John's child protection status), would not necessarily have assumed it indicated safeguarding concerns given that A's care had been Consultant led. It is more routine that notable information is sent directly to GPs either in a letter from the Consultant or from direct liaison from the midwife.

16.2.5 The GP should have received the information that the baby was subject to a Child Protection Plan directly from the social worker. This failure was compounded by there being no regular functioning primary health care meetings or active liaison from the midwife which would have conveyed and made sense of this limited information

The health visitor and midwife were still of the opinion that the arrangements made by the pre-birth Child Protection Plan for intensive monitoring were temporary in order to gather evidence for care proceedings and this may have been the reason that there was no challenge to the plan being executed.

16.3 Summary and recommendations

Recommendations

Essex Safeguarding Children Board (ESCB)

ESCB should review current guidance on the interface between pre-birth/ante natal Child Protection processes and discharge planning to ensure practitioners know about the need to make clear distinctions between practical arrangements for the safe, physical care of new-borns and the need to implement the Child Protection Plan.

The Essex district general hospital and Essex Children's Social Care

Where professionals have concerns about a possible child protection issue, Hospitals and Essex social care working to SET procedures must agree a multi-agency plan to safeguard the child and ensure it is recorded before the child leaves hospital. Partner agencies will be responsible for supplying all up-to-date observations, assessments and decisions concerning parents and children to the discharge planning meeting, and at time of discharge to all other agencies and staff who then become responsible for the child's immediate future care.

17 Key Episode 6: the implementation of the Child Protection Plan including Core Group meetings 25th April

17.1 Relevant areas of enquiry from Terms Of Reference (see section 4.6)

vii) Care of John and particularly the involvement of B

viii) There appears to be a lack of clarity about B's visits to John (parents were living separately) and a reliance on A to oversee this.

ix) Why there weren't there firmer arrangements in place about supervised contact after B alleged the child had suffered from an apnoea attack and was subsequently admitted to hospital?

17.2 Child Protection Plan

The Child Protection Plan was for John to go home with A with a period of intensive family support to monitor his well-being and to ensure that contact between John and B was supervised. The Access to Resources Panel had agreed funding for a commissioned family support service. There was agreement to fund a family support worker for 2 hours per day for 2 weeks (including weekends) and then to review, where a further week could be agreed.

This was intended to monitor and report on anything of concern in the early stages of the child's life with A. It was assumed that A's relationship with B was over. What actually happened was that the family support worker visited for 1 hour in the morning and then for one hour in the afternoon and this hour (from the second week) was used for supervised contact with B. There was no legal framework for this arrangement. Social care managers advised that it was quite a high level of resource for such a package to be put in place for a child subject to a Child Protection Plan but not a Public Law Outline however the resource was seen to reflect the concerns.

17.3 Contact with John by B

Different professionals understood different things by the arrangement for contact by B. Some thought that he was not allowed to have contact outside of the hour arranged with the family support worker present and some that he was not allowed unsupervised contact but that the contact could be supervised by

A. At the time B had ongoing contact with his 2 older children that was unsupervised and he had problems understanding why A could not supervise his contact with baby John.

It is not clear who had the discussion with B about contact and whether he was absolutely clear about expectations. It was also unclear as to whether A understood what was required.

The provision of an expensive resource to supervise contact suggests significant concerns about B's contact with John but this arrangement was not within any legal framework and there were no clear sanctions although the recommendation of the Child Protection Conference was that Public Law Outline was to be used suggesting that parental noncompliance with the plan would result in issuing the Public Law Outline. What the parents understood at this point is not clear.

There was no ability of any agency at this point to ensure that contact by B with the baby was restricted to this session with the family support worker. He could have visited at any time – no one was asking this question of A.

17.4 Role of family support worker in the Child Protection Plan

There was a presumption that the commissioned family support resource was there to identify signs of neglect and would have been briefed by the social worker. Whether they were looking for the right things is in question. The assumption is that with a young baby and Child Protection plan to address neglect, they would probably be looking for A who was neglecting herself and the physical care of the baby, a dirty house, dirty bottles and failure to respond to the baby appropriately. These were not the main concerns in this case. There was nothing to suggest neglectful care of a child while A was not using drugs.

The family support worker was not personally linked into the professional network but communicated observations to the social worker. This made the management of the intensive support period post birth more complicated than it needed to be in making sure all working directly with the family day to day, were completely up to date with each other's observations and assessments.

Other practitioners were not aware that the intensive service would necessarily be withdrawn – it is unlikely that this was ever communicated. Practitioners at the SCR Forum were clear that they did not know it was a commissioned service or that it would decrease sharply after 2 weeks. They assumed that B was being formally supervised at each contact with the baby. All agencies also believed that the Public Law Outline was in place. The social worker had been instructed once again to arrange the Public Law Outline at this point.

17.5 Increasing focus on B as the source of risk to John

This whole period illustrates a shift in the concerns of professionals and the identification of risk away from A and towards B. The need for supervised contact obviously contributed to this as did the competent handling and clean environment of the A's home and care. Professionals were seeing A's relationship with B as a source of stress and potential risk to John because of his drug taking. Practitioners seemed to form a view that A and John would be much better without B. However A's criminal background and history of street drug use were very similar to B's and in terms of child care – more concerning. A's pregnancy had been an excellent motivating factor in staying off street drugs and she was able to continue her substitute programme. With hindsight it is apparent that she made no attempts to work with Open Road to reduce her dependency on Subutex and her regular attendance at drugs services was to collect her script. This does not necessarily indicate a motivation to co-operate with a Child Protection Plan and address the historical issues identified at the Legal Planning Meeting as being essential to her keeping the baby.

B was increasingly distanced from the discussion and planning for the baby and A was given responsibility by practitioners for communicating with him even though there were expressed concerns by professionals about possible domestic abuse between them being a risk to John. There was a handover meeting to the new social worker which B attended but it appears that he did not really understand what the expectations were of himself. One example given at the SCR Practitioners' Forum was that B had reported to probation that the Initial Child Protection Conference had no concerns about him.

There was no progression of an assessment at the family centre of their parenting. The referral was to look at the relationship between the parents in the light of domestic abuse. This was not progressed as A reported she was no longer in a relationship with B.

17.6 Core Groups

17.6.1 The Core Group of late April (took place just 3 days after John's discharge from hospital) and the Core Group reiterated the plan for B to have supervised contact and that the social worker would start the Public Law Outline Process in case B and A did not comply with the Child Protection Plan. The local authority solicitor at the SCR Practitioners' Forum commented that there may not have been sufficient structure at this point to effectively monitor progress certainly for evidential purposes.

A was advised to get a solicitor as she stated that she wanted her fourth child (in care proceedings in another Local Authority) back and she was advised that the Public Law Outline was now being pursued in respect of John.

17.6.2 **Concern about B's contact**

The midwife reported to the social worker that she had heard a man's voice inside A's room while visiting on the day John was discharged, but didn't see anyone on entering the room. As the shared house had other male residents at the time, this was not seen as evidence of breach of the plan. The social worker reports this as 'no evidence or proof' that B was visiting unsupervised. While it may not have been possible to verify, it raised a concern that in the context of the plan should have contributed to a hypothesis that could be tested. It's not clear whether A was challenged about this. It seems that the unsupervised visiting was not really a concern and that A was trusted with the responsibility of supervising contact without it ever being made explicit. All other aspects of her care of John were reported very positively.

The social worker's understanding of the matter was that there were no issues with B visiting but that he should not have sole care of the baby.

17.6.3 **Changes to the Child Protection Plan**

There was e mail correspondence between social care managers and legal services on 24th April to agree that Public Law Outline letters would be completed by the social worker. On 29th April the service manager informed legal services of the change in decision following the Initial Child Protection Conference and that care proceedings would not be progressed.

The attendees at the Core Group were aware that the Child Protection Plan had not been implemented as intended but did not feel able to challenge this as they felt that decisions had been made by the lead agency who were the specialists in risk assessment.

There are no written or verbal accounts available to the SCR to explain why this fundamental change happened and what evidence supported the decision. This decision was not communicated to any other agency at this time.

Agencies may have assumed that the short period of intensive monitoring without harm to the baby had somehow removed or ameliorated the risks identified through the legal planning and Child Protection processes.

17.7 Analysis and Findings from Key Episode 6

17.7.1 **Supervision of contact**

The main protective element in the Child Protection Plan lay in the perceived need to supervise all contact between the baby and B. This period illustrates just how confidence in A had increased to the point where she was used to communicate what was required to B and more than that to supervise the contact herself. When John was 10 days old, A told the midwife that B could only attend in the afternoon 'hour' when the family support worker was there. It was acknowledged by the team manager for social care that the implementation of the Child Protection Plan as it was, could never have ensured that contact with B was supervised. - It just could not be enforced even with the supervision arrangements without relying on A to comply with the spirit as the letter of the plan as well. At this point the Professionals had ceased to see A as posing risk to John.

17.7.2 **Summary and recommendations**

It is essential that all agencies that are to be involved in the implementation of the Child Protection Plan are part of the multi-agency network overseeing implementation.

The shift in the focus of concerns about risk to John from B may reflect a pattern that exists in Child Protection work where the parent who is apparently co-operative and compliant is considered to be the 'good' parent and the more chaotic disorganised parent becomes the focus for concerns. The truth is very often that the 'good' parent is the one who has learnt how the system works. The need for vigilance and objectivity is even more important once work within a short space of time appears to be going well.

17.7.3 **Recommendation**

Commissioners of services for children involved in this case

Commissioners of Services within all partner agencies should ensure that any commissioned service which is a key part of the Child Protection Plan should be included in their own right as part of the multi-agency arrangements i.e. the Core Group, responsible for implementing the plan.

18 <u>Key Episode 7: Review Child Protection Conference May and Core Group 10 days later</u>

John was not quite 4 weeks old.

18.1 Relevant areas of enquiry from Terms Of Reference (see section 4.6)

vii) Care of John and particularly the involvement of B

viii) The apparent lack of clarity about B's visits to John (parents were said to be living separately) and a reliance on A to oversee this.

ix) Why there weren't firmer arrangements in place about supervised contact after B alleged the child had suffered from an apnoea attack and was subsequently admitted to hospital whilst in B's sole care.

x) Parenting Assessment

- Part of the plan was to be an assessment of the parents' relationship in respect of their parenting but by the time of the incident in July this had not started.
- Some work was to be done with A about domestic violence suggesting that there were sufficient concerns about the current relationship to warrant this but this had not started by the time of the incident.

xi) There was a lack of rigour in the implementation of the Child Protection Plan despite the fact that significant risks had been identified and there had been a decision to remove the child at birth only a few months previously.

18.2 Review Child Protection Conference

18.2.1 **A's engagement with services**

The Review Child Protection Conference took place when John was 4 weeks old. It was attended by 2 social care members, Housing, Probation, health visitor, midwife and the Community Drug & Alcohol Team worker. Still the GP was not on the invitation list, nor had any one accessed any information from them. Ethnicity is still recorded as "Not available at present"

This Conference also used the strengths based model but by the time of the review conference there was a fall off of engagement with agencies by both A and B. A was seen to be working well with drug and alcohol services. A had kept both appointments with the health visitor, but only 6 out of 11 appointments with the midwife who had seen B at A's home twice. The health visitor had also been told by A that B was having unsupervised contact with the baby.

18.2.2 **Unsupervised contact**

Aspects of the Child Protection Plan seem to have fallen off the radar or been changed outside of the Child Protection process. A and B said that they were not in an intimate relationship but were seeing each other daily and supporting each other. B was heavily involved with John's life. A was leaving the baby with other people and with B. There was an incident reported by the midwife when B was looking after the baby alone and had left the child unattended on the couch. The baby was gaining weight and developing well. A decision had been taken before the Review Child Protection Conference that A could supervise contact with B but this had not been communicated to all professionals involved.

Housing were still unaware of any other concerns about A other than drug use. At the SCR Practitioners' Forum, they described how housing officers had seen B at the flat and knew that he stayed there overnight sometimes.

18.2.3 **Consideration of risks**

Risks outlined at the Conference were couched in unspecific language and an undefined area of risk was seen to relate to B’s drug abuse and A’s housing situation, but these are then balanced by a positive report from the Community Drug & Alcohol Team (CDAT) for A.

The Review Conference reflects the difficulties of agencies grappling with the issues. The minutes do not reflect what Probation practitioners at the SCR meeting said their concerns were that contact should still be supervised. No one knew whether B was having regular contact with the baby but with daily contact between the parents this is likely. The revised Child Protection Plan appears to have been cut and pasted from the Initial Child Protection Conference and was not tailored to any changes that had occurred since the midwife had ended her care at 28 days. The health visitor records that the Review Child Protection Conference was “all very positive” and B would now be allowed unsupervised access – this was despite CDAT reporting B had tested positive to cocaine at the beginning of May.

Practitioners seemed to see natural development and growth of the baby as indicative of good protective care in the context of the stated concerns and category of the Child Protection Plan of neglect. This despite the fact that A was an experienced parent of young babies.

However, no one highlighted the fact that A’s casual attitude to leaving the baby with B and B’s leaving the baby unattended on a couch indicated a neglectful attitude.

18.2.4 **Referral to Family Centre**

The social worker had referred A to the family centre but there was no clarity about the purpose of the referral.

18.2.5 **Legal Services concerns**

Legal services wrote to the social care service manager 3 days after the review conference and in response to the e mail advising that the case would not proceed to care proceedings expressing concerns regarding the course of the case.

18.3 Core Group

18.3.1 **Reinstatement of supervised contact**

The meeting was held 10 days after the Review Child Protection Conference and decided to reinstate supervised contact because of B’s reported use of street drugs (he had tested positive for cocaine on 2 separate days in May). This was not to be supervision by a professional but by A.

A attended this Core Group meeting and she reported that she had left John alone in the care of B. She was told in the meeting that this was not appropriate but even so the meeting continued knowing that B had sole care of a very young baby with the possibility that he had been using drugs, this was the very issue that had been identified as a key risk to John. A was still not engaging with Open Road about her own addictive behaviour. The meeting asked A to advise B that he should not have unsupervised access disregarding the fact that A was the very person who had allowed this to happen despite the requirements of the Child Protection Plan following the initial conference.

18.3.2 **Disguised compliance**

The discussion at the SCR Practitioners' and Managers' Forums illustrated how much A had ceased to be a the focus of concerns by this stage and was now perceived as someone who was taking responsibility for the safe care of her baby and managing the person who was causing concern i.e. B. By now it was very evident that there was an overly optimistic approach taken towards the A's capacity to keep John safe and to make necessary changes to her lifestyle. Practitioners working directly with A agreed that she had a charismatic and plausible character, seemed to show genuine insight and desire to change. They also made positive observations of her care of John. However there was real evidence of A's lack of compliance with the child protection plan in respect of supervised contact with B that was disregarded. The more detailed history held within the adjacent borough council X files illustrates that disguised compliance was a consistent feature of the way that A engaged with agencies in the past and there was no reason to assume that this had fundamentally changed.

18.3.3 **Transfer of the case within social care**

Despite the visible lack of progress on any aspect of the Child Protection Plan, the case was transferred to the (long term) Family Support and Protection Team, 6 weeks after John was born in line with local procedures. At the SCR Managers' Forum the social care representative said that in Assessment and Intervention services 'it was hard to keep a focus on cases which appear to be doing ok as your eye is always on the front door of the service and you worry what is there waiting to come in' This suggested that the lack of momentum and challenge in this case while held by the Assessment and Intervention Service may have been due in part to the pressure on social workers in this service to take on new cases. This would inevitably impact on the capacity of a worker to reflect on a case which while it was not progressing, was not causing significant concerns as the baby seemed well and happy.

18.3.4 At this point in the case Housing were actively involved in seeking accommodation for A and the baby and had attended the Review Child Protection Conference yet were not involved in the protection plan despite the reduced use of other support services.

The Review Child Protection Conference identified an undercurrent of seemingly minor criminal and drug activity by parents but there was no proactive engagement by social care with the Police about this.

18.3.5 The reduction in concern for the child seems to be exclusively linked to the fact that the baby's health and development was not a problem as reported by the health visitor. There had still been no contact with the GP (who A had changed in May), though the GP was still not aware of any concerns about this child. The New Patient registration form completed when A joined the new GP practice did not contain any information which would indicate significant events in her past. John was seen by the GP in June for his 6 week check and all was well developmentally.

18.4 Hospital attendances and admissions

18.4.1 There were 2 visits by John to A&E before the significant injuries to him. On the first occasion at the beginning of June, the parents took him to A&E because he was off his feeds and was crying. He was diagnosed with oral thrush and discharged home

18.4.2 The second occasion in June (8 days later) was much more concerning. John had apparently been left by A in the sole care of B while A went to the shops in breach of the recent decision that contact should once again be supervised by A. B reported that the baby had stopped breathing and that he had shaken the baby and given mouth to mouth resuscitation. Both parents took him to A&E where he was admitted. The focus of the medical assessment seemed to be the medical explanation and no illness that would cause breath holding could be found.

The doctor examining the child did not have any information regarding the history of the case to hand because the information was not 'flagged' on the system so the Doctor was not aware that the child was subject to a Child Protection Plan. The Doctor did not then query why the baby had been left with B and what exactly B meant by having to shake the baby. There was no working hypothesis that such an incident could have been caused deliberately by a parent. The outcome of investigations was inconclusive although there was a suggestion that the baby had been breath holding. This suggestion was adopted as the reason for the incident by the parents. On examination John was found to have a small hole in his heart which was unrelated to his symptoms but the parents then began to give this as an explanation for the incident. Following this incident the social worker was concerned enough to attend the hospital to speak to staff on the ward. She was reassured that there was no overt evidence of abuse but neither was there a satisfactory medical explanation for what had been described by the parents i.e. breath holding.

A Research summary by the National Collaborating Centre for Women's and Children's Health commissioned by the National Institute for Health and Clinical Excellence (NICE) in 2009 and titled 'When to Expect Child Maltreatment' reviewed many studies of 'Apparent Life Threatening Events' (ALTEs) in young children – primarily looking at apnoea and its causes and concluded;

'There are many causes of ALTEs and the literature suggests that an ALTE due to maltreatment is rare. However, the high number of children with unknown diagnosis represents a potentially hidden population of maltreated children.'

An unusual and worrying incident such as this combined with the parents' histories did not lead to a reassessment of risk to the baby or to any consequences for the parents in relation to their non-compliance with the Child Protection Plan. There were no other witnesses to the event other than the parents and in the context of their continued non-compliance with the plan to keep John safe plus B's continued use of street drugs and the sense of stalemate in the case, such a reassessment and further investigation into what actually happened. There were no attempts to progress any psychological evaluations of the parents at this stage either. This incident should have prompted a review of what was known and understood so far about risks posed by the parents to John.

When discussing this review with the GP's both felt that it was the lack of information (which was known to other agencies) was detrimental the care they offered John, especially at the contact with A at the routine 6 week check and later after the A&E admission.

18.5 Core Group June 2013

John was 10 weeks old.

18.5.1 There had been little contact with A and the baby by professionals in the home as A had not kept appointments with the health visitor and while attendance at CDAT appointments was not highlighted as a problem, both A and B had only attended 1 appointment each. Discussion at the Core Group focussed on drug use by the parents, recent diagnosis of a hole in John's heart and the physical development of the baby. The health visitor was not in attendance as she was on annual leave. Non-compliance with the Child Protection Plan was not a feature of the discussion and there was no focus on what was required of A in order to retain the care of the baby. In fact A was noted as being a protective factor primarily because her drug tests continued to be clear for street drugs. B reported to CDAT that he had used cocaine due to the stress of John's recent health scare.

18.5.2 A and the baby were seen by the social worker on 3rd July at a meeting. Later that afternoon the parents attended the GP with John who was sleepy and sneezing. He was diagnosed with a viral illness but continued, according to his parents, to be unwell. Later in the evening they took him to A&E because he had started fitting later to be found to be a result of the injuries he had sustained.

John was diagnosed with a bilateral subdural haematoma and a retinal haematoma, bleeding on the brain and behind the eyes eventually assessed as being due to someone shaking him quite violently.

18.6 Analysis and Findings from Key Episode 6.

18.6.1 Following the high degree of concern at the Initial Child Protection Conference and the two weeks of intensive support and monitoring after John's birth, the case lost momentum. The focus of risk turned away from A towards B without any indication of compliance by A or B with the Child Protection Plan.

18.6.2 **Supervised contact**

The supervision of contact with B was completely confused. Preventing B's contact with the baby could only have been achieved by A but professionals understood and had heard social care stipulate at various meetings that there would be more formal arrangements to ensure his contact was supervised by someone other than A.

Despite reports that B was having unsupervised contact and that he had sole care of the child on at least 2 occasions, no action was taken to ensure compliance. Even when A said she had left John in the care of B while she attended a Core Group which was responsible for the Child Protection Plan, no action was taken other than to ask her to let B know this was unacceptable. On another occasion when B had sole care, John had to be admitted to A&E as B had said the baby had stopped breathing and had to be shaken and resuscitated. As no medical cause was found, B's account appears to have been accepted at face value with no professional seeing it as indicating concerns about his care. No professional made any challenge to the fact that A was completely and blatantly ignoring the protection plan she had agreed to.

No professionals considered at any point that the child may be at risk of physical abuse by either parent.

18.6.3 **A's ability to protect**

The judgment in the care proceedings for John reported the following;

"It is important to consider who caused John's injuries and unfortunately at this stage I do not have that information. I therefore feel it is an unknown risk and has an impact on the parents' ability to keep John safe. If B caused the injuries A failed to protect John by leaving their son in his care against professional advice. Therefore placing John with either parent could leave him exposed to further harm in the future."

"It is evident from this assessment that A has the capacity and the ability to meet John's basic care and health needs fully alongside support from her family. However, A's choices in relationships and poor decision making in the past suggest that John's safety could not be guaranteed if cared for solely by A."

The judgement quotes the social worker for John who says in her report;

'A's fundamental parenting difficulties and underlying personality traits have not significantly changed from reading the files from previous proceedings with John's older siblings there was a clear pattern of neglect, drug use, domestic violence and criminal activity and sadly she is now without significant support from friends or extended family members."

This suggests that during the care proceedings following the incident there was a clearer grasp of the risks to John both from B but also from A arising from the impact of their history and the patterns of behaviour they had developed.

18.7 Summary and recommendations.

18.7.1 This episode illustrates the further faltering of momentum in the case by practitioners and of engagement with practitioners by A and B. John was still a very young and vulnerable baby who had suffered a significant health scare in the incident where he was alleged to have stopped breathing.

The lack of progress with the Child Protection Plan, of any assessment of parenting capacity, of any assessment of the risk posed by both parents to his ongoing well-being and the lack of sanctions and sometimes even mention of the parents non-compliance with the Child Protection Plan left John exposed to at the very least, an increasing likelihood of neglect and as proved, an increased risk of physical harm.

There is no recommendation to be made here as the events and their consequences are cumulative and other recommendations have been made with the intention of changing the way that agencies responded to what they heard and saw and what they did not hear and see.

19 Summary and Conclusions

19.1 Process

The process used for this review was invaluable in providing an understanding of the working hypothesis that practitioners had of this case, sometimes regardless of what was recorded in their own notes or in the minutes of multi-agency meetings.

It demonstrated just how powerful assumptions can be when they are not challenged or explored together.

The process was limited in its ability to identify and track the decision making process through a forensic examination of written material but in this particular case it became clear that the aspects of the decision making process were not well defined and understood.

The process was proportionate to the issues raised by the case in that significant learning has been identified without the considerable investment of resources required by a traditional or SCIE model

One significant challenge was the fact that both the original social worker had left Essex Children's Services and the Team Manager had retired and were not available for the Practitioners' and Managers' Forums. This resulted in additional work having to be commissioned by the Serious Case Review Panel. While the social worker was traced and made a helpful contribution to the review, the Team Manager was not and this left a significant gap in information regarding the change in the decision to remove the child at birth which could not be satisfactorily resolved

19.2 Predictable or preventable

As stated in the introduction, the injuries sustained by John were not predictable in that there was no evidence from the family history that A or B had ever been violent to a child. Nor was there an escalation of events or concerns about the safety and wellbeing of John in the weeks after his birth. The only potential indicator of concern was the hospital admission when B reported John had stopped breathing but there was no evidence of any maltreatment by B or A at this time. It was not a serious enough event to warrant a fundamental change in the plan.

There were many opportunities during the course of this case to make a plan for John that would have kept him safe while making the necessary assessments regarding parental capacity within a legal framework that would allow for significant testing of the parents ability to care for him. The change of plan for John to go home with his parents after birth was made without due consideration of risk. It has not been possible for this review to understand who made such a decision and why or to really understand how such a decision was not challenged either within social care management and supervision structures or by the multi-agency network. The review must conclude that this was a serious and significant error and that the injuries were only completely preventable if a different decision had been made and John had been removed from his parents care at birth and placed elsewhere.

19.3 Considerations from research – implications for practice

Whether or not that should have happened in this case is a matter of professional judgement based on a risk assessment informed by research. There is a paucity of research in the area of identifying children who need to be removed at birth because their parents have had previous children removed from care. The ‘Home or Care?’[6], and the ‘Neglected Children Reunification’[7] studies found that many children who go on to be maltreated or neglected are identified at a very early age. 56% of children in the latter study had been referred to social care before they were two years old and a third, before they were born. 65% of sample in the ‘Significant Harm of Infants’[8] study had also been identified before birth. The key indicators of risk include links between child maltreatment and parental problems such as mental ill health, substance and alcohol problems and domestic violence particularly in combination and these studies have also found links with parental criminal conviction for violent offences particularly those committed under the influence of alcohol. It is therefore likely that John would have experienced neglect or physical abuse warranting intervention by social care services at some stage in his early years. The fact that neglect by A was not apparent in the first two weeks of his life while under constant scrutiny is of little consequence. A began to demonstrate her pattern of disguised and then non-compliance with arrangements to keep John safe as soon as the pressure on her was lifted and the focus was turned towards B.

[6] Wade J.Biehal N, Farelly N and Sinclair I (2011)Caring for Abused and Neglected Children: Making the Right Decisions for Reunification or Long-Term Care London JK publishers
[7] Farmer E and Lutman E (2012) Working Effectively with neglected Children and Their Families
[8] Ward H, Brown R and Westlake D (2012) Safeguarding Babies and Very Young Children from Abuse and Neglect London JK Publishers

However, the judge's comments about the case are pertinent. The parental history, even the history that was known before John's birth made it essential in the view of the reviewers that a legal framework was in place at the time of his birth. Had he remained at home there would have been a greater degree of clarity about the process of assessment over time of A and B's parenting capacity, ability to protect John, ability to make and sustain lifestyle changes, and the consequences of their failure to do so would have been explicit and would have allowed decisive action to be taken at an early stage.

Similarly greater attention to the childhood experiences of the parents, to their psychological profile particularly for A in the light of her loss to care of four children, the youngest of who she was still in the process of fighting for, seems essential and was available in part at least through the psychology assessment found on the adjacent borough council X legal file.

For John, his vulnerability as a new-born made it essential to understand define and articulate for practitioners, what constitutes an assessment of risk and what constitutes monitoring. This is not to minimise but rather to appreciate the complexity of the assessment required and the need for the processes which support them to allow for a multi-agency formulation of the case.

Appendix 1 Recommendations

Recommendation 1: Sharing historical information about families

1.1 Essex Safeguarding Children Board (ESCB)

The ESCB should raise with the Department for Education the need to improve practice in sharing historical information about parents of new children whose older children have been at risk of significant harm, between local authorities and consider how this can be reinforced and monitored.

1.2 Essex Children's Social Care

Essex children's social care should consider creating clear guidance for the sharing of historical information about children and their families where there are safeguarding concerns with other local authorities in discussion with regional and national bodies

Essex children's social care should consider the way in which it shares such historical information with the multi-agency network especially where there has been significant history of previous criminal activity, and/or care proceedings/child protection concerns about older children. The criteria for and place of a Multi-Agency Planning Meeting within existing processes should be considered

1.3 Essex Health Commissioners

All Health service commissioners and providers in Essex should re-evaluate current methods and expectations of sharing information (both internally and externally), regarding children for which there are Child Protection or Child in Need concerns. Following this NHS England Area Team, Clinical Commissioning Group and NHS England Public Health (Essex) together as commissioners should act on these findings to advise, alert or commission (as appropriate) revisions to these methods to ensure that the deficiencies in existing IT systems supporting information sharing do not hinder the sharing of information between professionals which is essential to keeping children safe. The outcome of this work to be reported to the ESCB within 6 months.

Recommendation 2: Assessments of parenting capacity

2.1 Essex Children's Social Care

Essex children's social care should ensure that assessments of parenting capacity are a feature of all core assessments and pre-birth assessments so that potential impact of parents' history particularly that of parents who have had older children who have been removed to care is understood, shared and addressed within any work with their children

Essex children's social care should clarify the criteria for and requirements of the assessment of parental history for all core and pre-birth assessments to ensure that they specifically address concerns about the risk of physical harm to young babies/children and how the resultant care plans might ameliorate those risks.

Recommendation 3: The legal framework and Child Protection Conferences

3.1 Essex Safeguarding Children Board

The ESCB should ensure that all agencies involved in assessment of risk of harm are aware of and familiar with the Public Law Outline and how it interfaces with the Child Protection system so that they are equipped to ask appropriate questions, to deliver consistent messages to families and to staff and to make the fullest possible contribution to decision making. Consideration should be given to underpinning this with procedural guidance.

3.2 Essex Children's Social Care

Essex children's social care should ensure that a formal escalation process is in place to review the implementation of decisions/agreements made at Legal Planning Meetings.

Essex children's social care should consider whether there is a need to make Legal Planning Meetings/processes open to the multi-agency child protection network.

Essex children's social care should clarify the role of the Child Protection Conference in recommending or challenging the need for a legal framework such as the Public Law Outline for cases that carry high levels of risk.

3.3 Essex Legal Services and Essex Children's Social Care

Essex Legal Services and Essex children's social care should together review the way in which they communicate to ensure that the best possible advice based on current circumstances of a case is available and that the decision to proceed or not to care proceedings is based on the merits of the case rather than the likelihood of a successful application.

In cases where the Public Law Outline is recommended and there is a history of older children of either parent being removed to care, Essex children's social care and Essex Legal Services should work together to seek all available information and assessments if carried out by another local authority, at the earliest possible stage. The need for and commissioning of parenting and/or psychological assessments of the parents should also be considered at an early stage. A requirement for this should be included in the Pre-Birth practice guidance.

Essex children's social care should introduce a process whereby approval must be given at a senior level to any decision to not proceed with a previous decision to initiate care proceedings.

Recommendation 4: Pre-birth assessment and planning

4.1 Essex Safeguarding Children Board

ESCB should review current guidance on the interface between pre-birth/ante natal Child Protection processes and discharge planning to ensure practitioners know about the need to make clear distinctions between practical arrangements for the safe, physical care of new-borns and the need to implement the Child Protection Plan.

Recommendation 5: Resource Panels

5.1 Essex Children's Social Care

Essex children's social care should ensure that the role of Access to Resources Panels in decision making about cases which are the subject of Child Protection plans is made explicit to all agencies and that any deliberations by Access to Resources Panels which have a bearing on the direction of a case should be shared with the Conference or other multi-agency forum.

Recommendation 6: The role of GPs in relation to Child Protection Conferences

6.1 Essex Children's Social Care and the Clinical Commissioning Groups

Essex children's social care and the CCGS should ensure that there are effective arrangements in place for identifying, contacting and engaging the GP for every child and parent who are subject to a Child Proteciton Conference.

6.2 Essex Children's Social Care

GPs should always be invited to attend Child Protection conferences, requested to provide reports if they are unable to attend, copied into all relevant minutes and informed of any major decisions and newly identified risks by the social worker

Recommendation 7: Child Protection Conferences

7.1 Essex Chidlren's Social Care

Essex children's social care should provide guidance to Child Protection Conference chairs about the need to consider risk of physical harm to new-born babies or and very young children in all cases where there is a parental history of care proceedings on older children as a result of any form of abuse or neglect. This may mean including the risk of physical abuse in the category for the Child Protection Plan.

7.2 Commissioners of services for children involved in this case

Commissioners of Services within all partner agencies should ensure that any commissioned service which is a key part of the Child Protection Plan should be included in their own right as part of the multi-agency arrangements i.e. the Core Group, responsible for implementing the plan

Recommendation 8: Discharge planning

8.1 The Essex district general hospital and Essex Children's Social Care

Where professionals have concerns about a possible child protection issue, Hospitals and Essex Social Care working to SET procedures must agree a multi-agency plan to safeguard the child and ensure it is recorded before the child leaves hospital. Partner agencies will be responsible for supplying all up-to-date observations, assessments and decisions concerning parents and children to the discharge planning meeting, and at time of discharge to all other agencies and staff who then become responsible for the child’s immediate future care.

ADDITIONAL RECOMMENDATIONS

Following consideration of the Baby John Serious Case Review Report the Essex Safeguarding Children Board have agreed three additional recommendations to draw out further specific areas of consideration highlighted in the report.

These recommendations are as follows:-

Additional Recommendation A: Consideration of cultural background of the family

It is an essential requirement in understanding the functioning of all families that the cultural background of the family is fully explored and taken into account. This is particularly relevant in respect of families who may be very mobile.

This requires:

- An understanding of the features of the family’s cultural background, their cultural norms and behaviours, and the impact this may have upon the family.
- That this is explored further with the family themselves, as well as being analysed within assessment and decision-making processes.

All agencies are to develop further their awareness, knowledge and understanding of the different communities across Essex that agencies are working with.

The Essex Strategic Domestic Abuse Board should include coverage of Gypsy, Roma, Traveller (GRT) culture within the further development of domestic abuse strategy in Essex.

Additional Recommendation B: Agencies’ response to DNA (Did Not Attend) Appointments

Agencies should strengthen their existing guidelines to ensure more robust lines of enquiry are undertaken when appointments are missed and confirm that this information is recorded and shared with partner agencies.

Agencies should ensure that patterns of DNA appointments are explored and analysed, with recognition given to the impact upon assessment processes.

In addition there should be increased rigour to ensure that parents and families are truly engaging with professionals and are clear about the expectations placed upon them.

Additional Recommendation C: Managerial Oversight and Supervisory Practice

Agencies should review levels of managerial oversight and supervisory practice, especially in relation to:

- Professional curiosity about parental histories
- Decisions being taken but not followed through
- Recommendations from Child Protection Conferences being carried out.