Essex Safeguarding Children Board

Serious Case Review

Child G

Report Author

Jane Wonnacott

BA MSc MPhil CQSW AASW

Director In-Trac Training and Consultancy

CONTENTS

1. THE REASON FOR THIS SERIOUS CASE REVIEW

1.1 At the age of three months, Child G was taken to hospital and found to have serious inflicted injuries which occurred whilst in the care of her mother (known in this report as "Mother") and her mother's partner (known in this report as Mr A). These injuries were considered to have enduring life changing consequences for Child G. A serious case review referral was made to Essex Safeguarding Children Board.

1.2 Initial information gathering revealed that at the time of the injury Mother lived alone but was in a relationship with Mr A. This relationship had started after the birth of Child G. Mother had another child, age three (known in this report as Half Sibling) who had been subject of a child protection plan in Essex in 2010.

1.3 Mr A was known to Essex Probation as a result of a number of offences and had been known to other Local Authorities due to concerns about domestic violence and risk to children.

1.4 As Child G had sustained serious injuries and there was evidence to suggest that there were weaknesses in the way that information regarding Mother and Mr A was shared and acted upon between agencies, the Essex Safeguarding Children Board serious case review referral panel agreed that the criteria for a serious case review had been met. On 3rd September 2013 the panel recommended to the chair of Essex Safeguarding Children Board that a serious case review should be carried out. The Board Chair agreed with the recommendation and commissioned this review.

1.5 Mother was subsequently charged with offences and received a custodial sentence. Mr A was convicted of two offences and received a significant custodial sentence in respect of one offence, and a concurrent custodial sentence for the other.

2. THE REVIEW PROCESS

2.1 The review has been undertaken in line with the principles set out in statutory guidance[1] at the time and has been overseen by a panel of senior professionals from the local partnership. Independence has been assured through the involvement of two independent lead reviewers, Kevin Harrington (panel chair) and Jane Wonnacott (report author). Full details of the review process including the terms of reference and the credentials of the lead reviewers are set out in Appendix One.

2.2 The original intention had been to use a review methodology which took a multi-agency perspective from the start, collaborated with professionals who had worked with the family and did not rely heavily on individual management review reports. However, this was not possible due to complications associated with the criminal process (see para 2.3 below) and as a result agencies provided individual management review reports with associated recommendations for their own organisations. This has resulted in a lengthy set of recommendations in addition to those resulting from this overview report which will need to be monitored by the Essex Safeguarding Children Board.

[1] HM Government (2013) *Working Together to Safeguard Children*

2.3 The main reason for the delay in the process and completion of this review has been the concurrent criminal proceedings which were completed in July 2014. The position of Essex Police, following discussion with the Crown Prosecution Service (CPS), was that they were unable to participate in any aspects of the review (including panel meetings) whilst the criminal process was taking place. At the second panel meeting they recommended that the review should be suspended. This is an unusual stance as, although it is not uncommon to delay speaking to key witnesses and family members prior to a trial, in many areas in line with current guidance[2] the review still proceeds with police involvement in the process. The decision of Essex Police meant that although individual organisations did complete individual management review reports and therefore reviewed their own practice, a full multi-agency review of practice was not possible until the completion of the criminal proceedings. This has been a problem in another serious case review in Essex and there is a recommendation at the end of this report addressing this issue.

2.4 A further issue hampering the smooth running of this review has been the ability to locate and access health records in respect of Mr A. The panel were originally informed that his records could not be located as they are within the prison system, although subsequent information from NHS England is that "*when someone goes into prison their community health records do not follow them. Prison GPs will contact GPs, hospitals or mental health providers for relevant information if appropriate".* In the light of this information a further attempt was made to locate the full GP records but this was unsuccessful, although some information has been obtained from the GP responsible for Mr A at the time of the injuries to Child G.

2.5 In addition, despite several attempts by the GP individual management review author to gain further insight from GPs involved in the care of Mother, the practice has not responded to requests for further information in relation to why domestic violence incidents were not recorded in Mother's notes and previous child protection concerns were not noted on the ante natal booking. It cannot therefore be said with confidence that this review has fully explored the role of GPs in the information sharing process, particularly in respect of historical information.

2.6 In spite of the challenges presented by the review process, the author is satisfied that sufficient information has been obtained in order to understand what happened and the various factors that affected the way in which professionals responded to the family. Consequently it has been possible to identify lessons learned areas for service improvement.

Family Involvement

2.7 Following conclusion of the criminal process Mother and Maternal Grandmother were offered an opportunity to contribute to the review. Maternal grandmother, accompanied by an aunt of Child G, met with the report author and the manager of Essex Safeguarding Children Board and we are very grateful for their contribution to this review. The information they gave has given a better understanding of the family circumstances during the period under review.

[2] ACPO/CPS (May 2014) *Liaison and information exchange when criminal proceedings coincide with chapter four serious case reviews or welsh child practice reviews.* (first published 2011) http://www.cps.gov.uk/publications/docs/liaison_and_information_exchange.pdf

2.8 Mother expressed a willingness to contribute but at the time of writing felt that she was too upset to do so. Since the report had already been significantly delayed it was agreed by Essex Safeguarding Children Board that her views should be sought by the Board at a later date, reported to the Safeguarding Children Board, any necessary amendments made to the report and an amended version placed on the board website.

2.9 In addition Mother gave permission for the release of two reports ordered by the Court prior to sentencing. The pre-sentence report and psychological assessment contain information gained directly from Mother and have been used to inform this review.

3. AGENCIES INVOLVED WITH THE FAMILY

3.1 The following agencies had been involved with either Mother and her children, or Mr A, and provided information to this review either via an individual management review report with associated recommendations for their agency, or via a written report for information.

In respect of Mother

3.2 *The Local Provider Health Service* provided health visiting services to Mother and was responsible for the management of the local minor injuries unit. The service completed an individual management review report for this review.

3.3 *The local Clinical Commissioning Group* commission extended GP services and completed an individual management review report for this review. Two GP practices were involved as Mother had moved areas within Essex in January 2012.

3.4 *The local hospital Foundation Trust* provided maternity care, accident and emergency services and specialist paediatric services. The hospital completed an individual management review report for this review.

3.5 *Essex Children's Social Care* had been involved with Mother during the period that Child G's Half Sibling had been subject of child protection and child in need plans.

3.6 *Essex Police had* some historical involvement with Mother and the father of Half Sibling and provided a report for information.

In respect of Partner - Mr A

3.7 *A London Borough Council area* provided an information report for this review. They had involvement with Mr A in 2001-2002 when his child was on the child protection register under the category of physical abuse. There were concerns about domestic violence perpetrated by Mr A. His child's name was removed from the child protection register when he moved away from the area. We understand that Mr A had no further contact with his first child apart from making contact via letter when in prison in 2013.

3.8 *Another local authority area Police* Force had considerable contact with Mr A as he lived sporadically in the other Local Authority area since 2005. They have provided an individual management review report.

3.9 *The other Local Authority children's social care* had contact with Mr A in relation to a child abuse incident with another family. They have provided a report for information.

3.10 *Essex Police* had knowledge of Mr A from approximately 2009 onwards in relation to a wide range of offences. They have provided an information report for this review.

3.11 *Essex Probation* was involved with Mr A in 2010 when he was released from prison on license following a conviction for assault. He was subject to a further period of probation in 2012 when he received a community order and Essex Probation were responsible for providing supervised unpaid work. In 2014 the responsibilities of Essex Probation were divided between the National Probation Service and Essex Community Rehabilitation Company and a combined individual management review report has been provided to this review.

3.12 *NHS England* commissioned the core GP services to Mr A via the national contract and the Clinical Commissioning Group provided the named GP[3].

4. EVENTS PRIOR TO TIMEFRAME FOR THIS REVIEW

4.1 The timeframe for detailed consideration during this review was agreed as 1st August 2012 – 10th August 2013; the rationale for this being that early August was at the beginning of Mother's pregnancy with Child G. However, any relevant background information within case records prior to this date was to be included in the chronology and agency reports. Since this background information has proved to be useful in understanding the context for later events, a summary is included in this section of the report.

4.2 Both Mother and Mr A had significant involvement with statutory agencies and the extent to which this information was taken into account in work with Child G pre and post birth is a focus for further discussion later in this report.

Events relating to Mother

4.3 The first contact between children's social care and the family was during Mother's adolescence when she made an allegation of sexual abuse by a family member. Child protection enquiries were carried out, Mother withdrew the complaint and after putting her in touch with other adolescent support services the case was closed to children's social care. Maternal Grandmother told the review that after this Mother began running away, self-harming and eventually became pregnant whilst living away from home in another part of Essex. Maternal Grandmother feels strongly that more help should have been offered to Mother at an earlier stage and that the lack of help for Mother with her mental health problems and support at a critical stage affected her for the rest of her life.

4.4 When Mother was pregnant, Maternal Grandmother referred her to children's social care expressing a number of concerns relating to Mother's unsettled lifestyle, difficult family relationships, domestic abuse from the baby's father, mental health issues (including self-harm and mention by the GP of a possible personality disorder) and her emotional vulnerabilities.

4.5 This referral led to a pre-birth child protection conference. The social work report to this conference stated that Mother had learning needs and attended a special school at primary phase, although she then attended a mainstream secondary school. The report

[3] A named GP is a GP with specific responsibility for supporting good practice in safeguarding children

recommended that further information should be gathered to understand if this impacted on her and her child. Mother's own account confirms that she had diagnosed learning difficulties as a young child and psychological testing for the criminal proceedings confirms a full scale IQ within the "extremely low" descriptive classification of overall intellectual functioning.

4.6 The initial child protection conference agreed that the baby (known throughout this report as Half Sibling) should be subject of a multi-agency child protection plan under the category of neglect. It should be noted that Mother's own account of this period of her life is that the issues in relation to the father of Half Sibling related to drug use, he was never violent and that she left him and returned to live with her mother when children's social care became involved. Maternal Grandmother also recalls Mother returning to live with her for three to four months after Half Sibling's birth, before Mother and Half Sibling moving into a mother and baby home nearby.

4.7 A child protection plan remained in place at the first review conference but at the second review conference in January 2011 it was agreed that the child protection plan should be discontinued and replaced by a robust child in need plan. The reason for this was that although Mother had not completed recommended work in relation to managing risks with violent partners, her care of the baby was good.

4.8 The problem at this point was that the child in need plan was not developed into an effective multi-agency tool which provided a framework for evaluating whether Mother was able to sustain the changes needed to provide safe care for her baby. It had also not addressed all the issues highlighted in the social work report, with no further investigation taking place in respect of Mother's learning difficulties. This is significant in relation to whether the plan was tailored to her needs, and expectations set out in the most appropriate format. The case was closed to children's social care two and half months later; there is little evidence of effective supervision and management oversight resulting in a clear rationale for case closure. Health visiting input continued with Mother attending the baby clinic eleven times during 2011. No concerns were noted.

4.9 The review panel discussed the significance of the failure to progress the child in need plan. Although it cannot be said with any certainty that this would have made a difference to later events, it would have ensured that Mother's capacity to maintain the changes needed was properly assessed and that the most appropriate family support services were in place.

4.10 Mother moved area in January 2012 and registered with a new GP practice. Notes were reviewed according to expected procedure and the previous child protection concerns were recorded as being primarily due to domestic violence and that Mother had now taken steps to distance herself from her abusive partner. Around this time, Maternal Grandmother recalls Mother moving to another area of Essex (initially staying with her aunt) in order to distance herself from further harassment from Half Sibling's father. Maternal Grandmother felt that following case closure by children's social care the family was relied upon to support Mother, but this was not always easy due to her reluctance to listen to advice from her relations.

4.11 Just prior to confirmation of Mother's pregnancy with Child G, Half Sibling was taken by Mother to Accident and Emergency after a possible ingestion of washing up liquid. The health visitor received a report a week later and made a note that Mother had not mentioned this at a contact the previous day. This did not prompt any follow up visit and the panel were informed that this would not have met specific commissioned criteria to

do so.

Events relating to Mr A

4.12 Records indicate that Mr A had a troubled childhood and spent most of his teenage years in the care of the local authority. He has a significant criminal history dating back to 1999 involving theft, fraud, violence, public order and firearms offences.

4.13 He is known to have had a child whilst living in the London Borough Council area and this child was placed on the child protection register as a result of concerns about physical abuse. Before this child's name was removed from the register Mr A had moved away from the area.

4.14 Whilst living in the other Local Authority area there were two allegations of abuse of his new partner's child. The first allegation was investigated by police and children's social care but not substantiated and at this point neither agency were aware of the previous concerns in the London Borough. Following evidence of a second serious incident he was charged with assaulting his ex-partner and her daughter. He was convicted of these assaults and received a prison sentence. He was also convicted of driving whilst disqualified and sentenced to a further period in prison. In total he completed a nine month prison sentence.

4.15 This short period of custody did not attract a period of post release supervision. However whilst in prison he received a further prison sentence for an assault on an adult male that had taken place in the community prior to his imprisonment. During his time in custody, prison staff intercepted letters to an underage girl. This information was passed to Essex Probation as following this second offence he was released on licence in 2010 with various conditions. These conditions restricted his employment or residence with children under 18, and included a requirement to disclose any developing relationships with women, as well as attend a domestic violence course. He was allocated to an offender manager, was referred to MAPPA[4] and remained subject to these arrangements for four months when he was considered to no longer need multi-agency risk management. He successfully completed his period of license in February 2011 and no further concerns were raised about his relationships with women or children.

4.16 During this period there is no evidence of any information sharing or communication between the other Local Authority area and Essex police forces. However, the MAPPA referral from Essex probation to Essex police contained information that raised clear concerns about Mr A's risk to children as well as women.

4.17 The information regarding Mr A's previous abuse of a child was therefore clearly known within the Essex multi-agency arena through MAPPA arrangements which included police, probation and children's social care.

4.18 The other Local Authority area Police report refers to allegations in 2011 that a 15 year old was being influenced, controlled and directed by older men to commit crime. Two of these older men were Mr A and his uncle, a known burglar in the other Local Authority area. There was a professionals' meeting and an action plan set up to share intelligence with local CID regarding the grooming of children to commit crime. At this stage it is not

[4] MAPPA is the name given to the multi-agency public protection arrangements are in place to ensure the successful management of violent and sexual offenders https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2
.

clear whether Mr A was known to be living in Essex but intelligence reports in relation to other crimes suggested that Mr A was using addresses in both the other Local Authority area and Essex.

4.19 There is nothing in the Essex or other Local Authority area police reports to indicate that information regarding grooming young girls to commit crime was shared across police forces. Had this been known to Essex police this *may* have been a reason to consider reconvening the MAPPA in respect of Mr A, although the intelligence did not relate to any crime relating to sexual abuse or violence.

4.20 In 2012, Mr A received a community order for an offence not related to violence to women or children. This sentence included a supervision requirement which meant that he was allocated an offender manager and also carried out unpaid work which was managed by the unpaid work team. One month into his licence period the offender manager had concerns about him living in the grounds of a family home and made a referral to Essex children's social care initial response team. When the offender manager followed up this referral they were told by children's social care that a social worker had spoken to the family concerned and safeguarding measures were in place. As far as the review is aware, this family had no connection with Mother and Half Sibling. The offender manager also made a referral to MAPPA but there is no record within the MAPPA system of this referral being received and there was no follow up by the offender manager.

Summary of learning: events prior to timeframe for this review

Although these events were outside the initial scope of this review it has become clear that actions during this period had a significant impact on the case during the review period. Most crucially Mr A had a significant history of violence towards women and children, resulting in one child being placed on the child protection register and Mr A serving a prison sentence for violence against a woman and child. There was a lack of systems in place for ensuring that all relevant information was tracked across local authority borders as well as limitations to the MAPPA arrangements which are in place to manage current risk of violence. However, despite some limitations in the process, evidence shows that the most significant information regarding the assault in the other Local Authority area was known to Essex Probation and was available to inform any future contacts.

In addition, Mother had been known to have a level of vulnerability and the potential to be targeted by perpetrators of domestic violence. Although there was evidence to suggest that she had made progress, the assessment had not fully addressed the possible implications of any learning difficulty for service provision, and the work carried out had not addressed all the requirements of the child protection plan. The capacity of Mother to sustain change was therefore insufficiently assessed and did not provide an adequate foundation for decision making by any professional in the future. The child in need plan was not specific enough, nor focused on outcomes for the child and the case was closed to children's social care without sufficient scrutiny by managers.

Key lessons from this period are therefore:

- the need to develop effective systems for tracking men who are known to be violent. This needs to include proactive information sharing of any intelligence about related activities where they are known to have moved across local

authority boundaries
- the importance of robust, fully documented, outcome focused child in need plans
- the need to work with parents to understand the implications of any learning difficulty and mental health problems for service provision. This should, where appropriate, include liaison with colleagues in Education.

5. EVALUATION OF PRACTICE FROM 1ST AUGUST 2012

5.1 It was in September 2012 that Mother's pregnancy with Child G was confirmed. The father of Child G is not Half Sibling's father or Mr A, who started the relationship with Mother when Child G was approximately six weeks old. This narrative is therefore split into two parts, the first part focusing on Mother's pregnancy and the second, events following Child G's birth and the relationship between Mother and Mr A.

Mother's pregnancy with Child G

5.2 One key feature of this period is the challenge of taking a whole family approach within health services where a woman is pregnant. The focus of midwifery services is on the mother and her developing child; serious case reviews in other areas[5] have found that indicators of vulnerability or previous concerns in relation to siblings may not be easily accessible to midwifery services. Similarly without effective systems for information sharing, health visitors may not be aware of any concerns known to GPs or midwives. The following section of this report should be read with this in mind.

5.3 In August 2012, two months prior to the confirmation of Mother's pregnancy, Half Sibling was taken to the minor injuries unit by Mother. He had burns to his foot sustained some days before due to treading on hair straighteners. Due to the delayed presentation the liaison health visitor sent notification to health visitor team. This was reviewed by a student health visitor but since the wording suggested that follow up would be at the minor injuries unit and the document did not concentrate on issues related to delayed presentation, there was no follow up by a health visitor. At this point Mother was living with Child G's father.

5.4 The The Local Provider Health Service[6] and GP individual management reviews note that, in September 2012 police were called following an alleged assault by Mother on her sister. According to the police report, Mother was initially arrested and taken to a police station but there was no further action due to insufficient evidence. Both the health visitor and children's social care received a police notification of this event and it was reviewed by the senior practitioner in the initial response team who considered the family history and noted:

This incident was not witnessed by [Half Sibling] and the adults involved in this incident do not reside within the same home. NFA recommended at this time. This referral does however raise concern regarding coping mechanisms and should further DV incidents be received consideration will need to be given to further assessment.

This was a reasonable professional judgement at that time.

[5] For example the deeper analysis in relation to Daniel Pelka (Coventry LSCB 2013) found that concerns relating to Daniel were not taken into account during a subsequent pregnancy. The importance of effective information sharing across health agencies was a key feature of that case.
[6] The health organisation responsible for health visiting services.

5.5 Eight days after the domestic abuse incident, Half Sibling (age 25 months) was again seen in the minor injuries unit on a Sunday with swelling in the underarm area. According to Mother he had fallen from his bed. Again the health visitor was notified and reviewed the case three weeks later; at this point Half Sibling had been taken to hospital three times in four months.[7] Eight days after the case was reviewed, the health visitor attempted to contact Mother and found her telephone was disconnected. This health visitor would not have been aware that a nursery nurse had seen Half Sibling in clinic earlier that day. As it was not possible to contact Mother on the telephone, a letter was sent out to offer a two year check at home; this took place in November several weeks after Mother had been seen by a midwife in respect of her pregnancy. At this check no concerns were noted, her sister was present throughout and family relationships had settled. Mother would have known she was pregnant at this point but did not tell the health visitor and she was returned to a universal health visiting service.

5.6 It had been in mid-October 2012 that Mother had been "booked" by a midwife in respect of her pregnancy with Child G. Despite the previous child protection plan for Half Sibling, there were no risk indicators for child protection noted at this stage and Mother was booked for midwifery-led care. The midwifery individual management review clarifies that when women book with a midwife the booking form is usually completed over the telephone, although in the area where Mother lives the individual management review does note that "women also drop into maternity". A week later there is evidence of a face to face consultation with a midwife in clinic during which a full ante natal history was taken. Although medical factors changed the assessment to high risk, the form noted "*No social circumstances affecting the family. Previous/current support involvement from a social worker in 2010 - as previous partner a drug user.* The summary noted no social care issues. Information given by Mother during her psychological assessment explained that Child G's father moved out during her pregnancy as he did not want any more children. Mother described him as "gentle not controlling" and she was extremely upset when their relationship ended.

5.7 There was no further exploration by the midwife of the previous involvement by social care and midwifery care continued in apparent isolation from more detailed information about the previous child protection concerns. The midwifery individual management review explores a number of possible reasons for this including:

- The midwife concerned was new to community midwifery
- Staff shortages within the midwifery service
- No single named midwife responsible for each mother and therefore no single midwife overseeing actions including safeguarding. All history taking was in a paper format and information/alerts were easily overlooked
- Community midwives did not have access to the Mother's main health records until later in the pregnancy and therefore they were not routinely reviewed.

5.8 There was an opportunity at this point to consider all the information available across health agencies. This did not happen and information about Mother's potential vulnerability and indicators (from accidents and delayed presentations) that she may be struggling to care for Half Sibling whilst pregnant with Child G were not bought together in one place and used to explore mother's situation with her in more detail.

[7] One occasion was prior to the start of this review period: (presenting problem diarrhoea and vomiting)

5.9 Knowledge about previous safeguarding concerns would have been available within the GP records but the lack of routine information sharing between GPs and midwives contributed to the fragmented approach across health organisations. At the point that previous concerns became known the midwife should have completed information sharing form and sent it to the GP and cannot explain why this was not done. There were therefore no discussions between GPs and midwives regarding potential vulnerabilities. Up until the birth of Child G, midwifery involvement consisted of seeing Mother at regular ante natal appointments, two brief hospital admissions, and one attendance at clinic due to abdominal pain.

5.10 The fragmented approach within health precluded any reasoned assessment of whether a referral to children's social care for a pre-birth assessment was needed. The review was told that an additional factor that may have influenced practice was that although pre-birth procedures did not prevent a referral early in pregnancy, custom and practice within children's social care was to ask referrers to call back when the pregnancy was more advanced. A myth had therefore built up that no referral could be made until after 15 weeks and therefore even if a professional had a concern it is unlikely that a referral would have been made at the point.

5.11 There is some evidence that Mother was in contact with her own Mother (Maternal Grandmother). In December 2012 Maternal Grandmother contacted the health out of hour's service as Half Sibling was unwell and complaining of pain on the forehead, cold symptoms, and not eating for two days. He was asked to attend the out of hours centre and he was sent home with advice on fluid intake and paracetamol. It is not recorded who took him to be seen and there is no reference to this event in the GP report.

5.12 Apart from routine ante natal care and three attendances at hospital with abdominal pain, there are no further records of contact with Mother and Half Sibling until the birth of Child G and Mr A was not in a relationship with Mother during her pregnancy. Mr A was in contact with Essex Probation. His Community Order had started in April 2012, the supervision requirement finished in April 2013 although the unpaid work requirement continued beyond this as, due to Mr A's sickness, the required hours had not been completed. From this time onwards, although he remained allocated to an offender manager, he was not seen by them and was supervised on a day to day basis by the unpaid work supervisor.

Summary of learning: Mother's pregnancy with Child G

During Mother's pregnancy with Child G the main issue is the challenge of effective information sharing across a fragmented health system. During this period there was an accumulation of events that, put together, could have been seen as indicative of increased vulnerabilities for children within the family. These events were:

- two attendances by Half Sibling at the minor injuries unit.
- evidence of family tensions resulting in Mother being arrested for an alleged assault on her sister,
- Mother's second pregnancy
- little evidence of Mother accessing support outside the family.

If these events had been considered in the light of previous knowledge of the family, health professionals could have considered referring to children's social care with a request for an assessment of Mother's needs and any potential concerns relating to her

capacity to care for both her children. However, information was known to different health professionals at different times and communication pathways between GPs, health visitors and midwives at time of booking were not used. There were no practice meetings within GP surgeries where vulnerable patients could be discussed and although the review has been informed that this is now happening in some areas, the surgery concerned still reports lack of effective communication with health visitors and midwives.

In addition, midwives recorded Mother's self-disclosed history regarding previous child protection concerns but did not explore this further or ask searching questions about the father of Mother's child. Although the father was not Mr A, lack of a practice culture which does not focus on fathers/partners is significant when Mr A later joins the household.

Key lessons from this period are:

- the need to consider whether it is possible to track the whereabouts and activities of individuals with a history of violence involving children
- the importance of developing and using effective information sharing regarding vulnerable families across GP's midwives and health visitors
- the importance of systems which enable midwives to access a full history from medical records at the point of booking
- the need to mitigate the risks associated with no overall lead midwife for each mother
- the need to ensure a focus on the role of fathers/partners throughout pregnancy and during the early years of a child's life.

Most importantly practitioners need to develop respectful curiosity about the circumstances of people they are working with and ask questions which will help them to develop a picture of the whole person and follow up any queries which may indicate a cause for concern.

The birth of Child G until the serious injury

5.13 Child G was born in hospital in late May 2013 and maternal grandmother and maternal aunt are noted in the records as Mother's birthing partners. Following the birth there were no concerns about the care of Child G and Mother and baby were discharged. The community midwife was informed of transfer of care by telephone and the GP informed by letter. The information on the midwifery records was contained in a series of tick boxes (as described in the individual management review) "*complex social factors/safeguarding 'yes'"* and *"social services involvement with previous partner*" does not seem to have reached the GP as the GP individual management review notes that there was nothing on the GP records to indicate that Child G was part of a vulnerable family, and there did not seem to be any discharge planning in place despite the previous history.

5.14 The health visitor received discharge information that did note previous social care involvement in 2010 but stated that there were no indicators of any additional needs at that time. Due to pressure of work, the health visitor did not access Half Sibling's records and explore the previous concerns any further and Mother and Child G were therefore seen as requiring universal health visiting services only. The local Provider Health Service individual management review gives a helpful explanation as to why accessing

Half Sibling's records would have been a challenge at that time in a health visitor team under pressure. Trigger factors would have been necessary to alert the staff member to review records and one disadvantage of electronic records is that there is not the trigger of bulky paper files that automatically indicate a high level of previous contact with the family. The individual management review goes on to explain:

In this case the health visitor seeing the baby at the new birth visit did not have these clear information/triggers to indicate past concerns either by the physical presence of the paper record, or ante natal triggers from the midwife ... Although the siblings are linked in groups and relationships making for rapid retrieval, it is reliant on practitioner expertise to think to access and review prior to visits. The electronic system at this time did not have a process where significant information can be recorded and then accessed to provide a succinct overview of events. In addition if the electronic record for the sibling had been reviewed it then required the HVC to access and read the paper record for the detailed information. This would have been time consuming when under pressure and under resourced. This is a three step process to gain vital information.

5.15 The importance of accessing sibling records and face to face handovers between practitioners is understood by the Trust but it is recognised at the time of the events in this review, the Standard Operating Policies (SOP) did not cover this aspect of the work. This is now being rectified.

5.16 A new birth visit by the health visitor took place two days after Mother was discharged from midwifery care but this was rescheduled as mother was going out.

5.17 The next day Mother called the out of hour's service at 20.15 saying Half Sibling had fallen from high chair the previous day and hit his head. He was described as quiet and cold, with his tummy and head hurting. When seen at 21.27 Mother's focus was on urinary symptoms and there was no recording of any investigations relating to the head injury. A recommendation was made to see the GP but there is no record of this taking place. This was the third delayed presentation of Half Sibling to an out of hour's service but nowhere within the health system was this pattern identified. The attendance was summarised in the GP record but not reviewed or linked with previous attendances and there was no formal notification to the health visitor team with the result that when the health visitor carried out the new birth visit, they were unaware of all the details of the consultation with out of hours as Mother only informed her of the urine symptoms. Mother explicitly stated that the father of Child G was unknown. There was no expectation at that time of a full family needs assessment and the notes recorded that mother was coping well and there was good handling between mother and children. The next health visitor appointment at the family home was set for one month later. In addition, Mother attended the baby clinic, each time being seen by a different member of staff. She was not at home as agreed for the next home visit, but had attended clinic earlier that afternoon.

5.18 According to Mother, she met Mr A when Child G was about six weeks old. She had known of him previously as he had attended the same school as her sister and after briefly communicating via BBM[8] they began a relationship and he quickly began to live with her on a part time basis. Maternal Grandmother felt uneasy about him from the start and local people made various comments about him not being a nice man. They were reluctant to say more, seemed to be afraid of his family and Maternal Grandmother was similarly reluctant to contact children's social care.

[8] Blackberry messaging

5.19 If Maternal Grandmother had contacted children's social care at this point with worries about Mr A it is possible that this would not have led to any action as social work practitioners told this review that the practice then (and now) is they could not undertake any checks on Mr A without his permission. This concern about data protection does not take account of the very clear information sharing guidance both at that time and currently which states that where there are concerns that a child is suffering or likely to suffer significant harm practitioners do not need to seek consent[9]. Today, under the Domestic Violence Disclosure Scheme (Clare's Law) maternal grandmother would have had the "right to ask" Essex Police to check whether Mr A had a history of domestic violence but this did not come into force until March 2014.

5.20 None of the health records indicate that any health practitioner was aware of Mother's relationship with Mr A. Mr A's allocated offender manager had left the organisation in June 2013 and the case transferred to offender manager 2. The transfer papers did contain alert flags for domestic violence, schedule 1 offences[10] and the fact that he had been subject to MAPPA arrangements, although the verbal handover did not specifically explore third party information that may have indicated specific additional risks to children. Mr A talked about his new partner (Mother) to his unpaid work supervisor but there did not seem to be a need to tell anyone about them. The unpaid work supervisor would not have been aware of the details of Mr A's offending history as such information is held by their manager, (the community payback coordinator), and the offender manager.

5.21 In late July 2013 Child G was referred by the GP to the paediatric department at the hospital with a fever and poor feeding. She was admitted and discharged two days later after a course of IV antibiotics. Maternal Grandmother recalls going to the hospital but Mr A would not let her near Child G. She also remembers Half Sibling having a bruise around that time and saying that Mr A had "done it".

5.22 On the same day, Mr A had left his unpaid work site early telling his unpaid work supervisor that he needed to go to hospital with his partner and her baby. The supervisor told the unpaid work requirement organiser and due to the known history of safeguarding concerns, offender manager 2 was alerted. There is no record that this was discussed with the offender manager's supervisor although they were aware that they needed to gather further information and then make a referral to children's social care. However, since they were not aware at this stage of all the confidential information on the files, they did not assess that an urgent referral was required.

5.23 An alternative course of action at this point would have been for the offender manager to visit Mr A, ascertain the name of his partner and refer to children's social care, specifying the risks posed by Mr A to women and children.

5.24 Eight days later, the health visitor carried out a home visit. Due to concerns about significant weight loss Child G was seen the same day by a locum GP and since the loss was felt to be as a result of her recent illness a review was planned for two weeks' time. Although by now Mr A was living part time in the home the health visitor was unaware of

[9] HM Government (2015) *Information Sharing: advice for practitioners providing safeguarding services to children and young people, parents and carers.* Page 13.

[10] Offences against a young person under the age of 18 as set out in in the Children and Young Persons Act 1993

Mother's relationship with him.

5.25 Four days later, Child G was taken to the minor injuries unit at 18.18 hrs. Mother informed staff that she had laid Child G on the sofa the previous evening, and her three year old brother had picked her up and dropped her onto her head. She had been grizzling since and vomited once. Subsequent reports given by Mother as part of the criminal proceedings vary in detail and it is beyond the scope of this report to comment on the accuracy or otherwise of the varying accounts. However, it is now known that the original account given by Mother was false and Mr A has now been convicted of causing the injuries to Child G, and Mother pleaded guilty to child neglect. Information to the court identified a gap of one and half days between the injury and Mother's presentation at the minor injuries unit, a delay explained by Mother as linked to her fear of Mr A.

5.26 On arrival at the minor injuries unit Child G was examined by a nurse, was alert and looking around but in view of history of a fall Mother was advised to take Child G to the accident and emergency department at the hospital to be reviewed by a doctor.

5.27 The local Provider Health Service individual management review makes the point that there was an insufficiently robust assessment of Child G's injuries by the nurse practitioner within the minor injuries unit. Child G was not undressed and Mother's explanation was taken at face value. The symptoms in a non-mobile baby should have been taken as signs of a more serious injury and the possibility that they were non accidental could not be ruled out. The most appropriate course of action would have been to arrange for an ambulance transfer to hospital rather than relying on Mother providing the transport. There should also have been a formal referral to the hospital by the minor injuries unit.

5.28 The individual management review report discusses in detail the factors that contributed to the practice decisions within the minor injuries unit and highlights the challenges of responding to young children presenting with a head injury when this is an unusual presentation within that setting.

5.29 On arrival at hospital Child G was examined and found to have sustained a fracture to one of the bones in her skull with an associated brain injury and suspicious bruising elsewhere. Due to concerns about the nature of the injuries, a safeguarding referral was raised.

Summary of learning: the birth of Child G until the serious injury

A number of issues emerge from this period, particularly in relation to the importance of taking a whole family approach to understanding the needs of parents and children. Health services continued to be fragmented, with the health visitor being unaware of the details of the out of hours medical consultation and not having a full picture of previous concerns regarding Half Sibling. Neither the GP nor the health visitor had a sufficient grasp of the whole picture to reflect on the number of times that Half Sibling presented to health services and there is no indication that any practitioner identified the level of Mother's vulnerability.

Within the probation service there was a similar pattern of insufficient consideration of the meaning of historical information combined with current events. One reason for this was the transfer of the case between offender manager 1 and offender manager 2 and an overreliance on verbal information at handover that did not include all the information

contained within the records.

Key lessons from this period are:

- the importance of a holistic approach to families including family needs assessment within health visiting practice
- the need for effective information sharing and review of vulnerable families between GPs and health visitors
- the need for thorough review of all records when a case transfers between offender managers
- the need to consider whether the system for alerting unpaid work supervisors to potential risks offenders may pose to children is sufficiently clear and understood
- the need for offender managers to consult *immediately* with their supervisors where information comes to light that a person with a history of safeguarding concerns has formed a new relationship with a partner who has children. This discussion should consider what further information they should obtain immediately from the offender and whether a referral should be made to children's social care. The rationale for the decision made should be recorded.
- the need for clarity that consent to share information may be dispensed with where a child is suffering or is likely to suffer significant harm
- the importance of developing skills and confidence of staff working in settings, such as the minor injuries unit, where they may not be regularly exposed to severe injuries indicative of child abuse.

6. THEMATIC ANALYSIS OF PRACTICE

Managing mobile individuals who may pose a risk to children

6.1 This is a significant concern which highlights the challenges in managing situations where individuals known to be a risk to children move between partners. Police reports indicate that Mother met Mr A via Blackberry messaging and professionals were totally unaware of his presence in the family. Essex children's social care were made aware of risks posed by Mr A in relation to another family but when a visit reassured social workers that the family had appropriate safeguards in place the case was closed.

6.2 One issue that has emerged is the sharing of information across police force and local authority areas. Mr A was operating across both the other Local Authority area and Essex and was known to pose a risk to children and young people either through direct violence or grooming to commit crime and exploitation. Much of the information was known by Essex probation and shared within the MAPPA process but other activities, not linked directly to physical violence, including the grooming of young people to commit crime, were not. The professional meeting in the other Local Authority Police area which considered intelligence related to this grooming activity was not shared with Essex police or children's social care; although in the current context it is not clear how this might have affected the final outcome. The other Local Authority Police investigation did not lead to any criminal charges and since the crimes were nonviolent, may not have reached the criteria for a reinstatement of the MAPPA arrangements and hence informed other agencies such as probation of the additional concerns.

6.3 The individual management review from the probation service helpfully highlights the

difference between monitoring arrangements for men with violent or sexual offences, noting that had Mr A been convicted of a sexual offence ... *he would have been subject to Sex Offender registration and police monitoring. The police would have been an ongoing presence in his life. The current conviction for violence against a child will not trigger police monitoring in the community. Potentially an additional licence condition could be imposed that requires [him] to cooperate with police monitoring officers, however ongoing statutory obligations will not apply.*

6.4 A serious case review in Southampton (Child G, April 2012) had a number of features similar to this case and makes the point that where violent offences have been committed against children, risk assessments do not address risk of future harm, and no system exists for the same level of monitoring that is in place for sexual offences. It made two national recommendations. The first recommendation identified the need for a system whereby *offenders who have committed certain offences against children are required to register their details of their address with the Police and to be subject to monitoring arrangements for specified period of time.* A second recommendation to the Home Office emphasised the need to have in place systems *for monitoring and working with individuals who have offences against children,* and ensuring that these *not only address current risk but … ensure that their assessed high risk to children in the future can also be adequately addressed.* Southampton Local Safeguarding Children Board have informed this review that no progress has been made with these recommendations.

6.5 Had the systems outlined in the above recommendations been in place, the assessment of potential future risk may have resulted in multi-agency risk management arrangements being more effective. However, since Mr A apparently did not move in with Mother the requirement regarding registration of address would not have made a difference in this case.

Safeguarding practice within the probation service

6.6 Issues relating to safeguarding practice within the probation service will in part be influenced by the issues discussed in the section above. In this case the significance of an offender with a previous conviction for violence against a child, describing a relationship with a new partner was not given sufficient weight and urgency. Confidential information within the file should have increased concerns but this was not adequately reviewed or communicated verbally between offender managers. However, even without this information there was sufficient knowledge about Mr A's criminal history to indicate that he could pose a risk to a family with a child. Consequently immediate action should have been taken by the offender manager once it was clear that Mr A was in a relationship with a woman with a child. This action by the offender manager should have included seeing Mr A and making an immediate referral to children's social care. This is the subject of a recommendation in the probation individual management review.

6.7 The panel has considered why there was a lack of recognition by the offender manager of the serious implications of Mr A forming a relationship with a woman and her child. One hypothesis is that the offence for which he was carrying out unpaid work did not relate to violence against women and children and did not involve this current partner. The focus of probation activity is on preventing reoffending (in relation to the offence) and as far as this was concerned Mr A was compliant with his order.

6.8 There is the additional issue of the role of unpaid work supervisors needing good safeguarding knowledge and ability to recognise when they should raise a concern. Although they do not receive details of offences, they do have access to codes which in this case would have indicated that Mr A was a risk to others (including children). The individual supervisor in this case had not familiarised themselves with the codes and the lack of an individual code relating to children also contributed to the likelihood that risks would not be recognised. Training for unpaid work supervisor and the provision of a separate code are subjects of recommendations in the individual management review.

Information sharing across health organisations

6.9 With the various aspects of health provision to families being provided by different health organisations, information sharing across health disciplines is a common theme from serious case reviews. In this case, integrating the previous information regarding child protection involvement with Half Sibling did not always work well and when Child G was born, the possibility that Mother may have additional needs was therefore not adequately assessed. This was for a variety of reasons but the overriding message from reports to this review is that although there were known and used processes for liaison, at the time the pressure of work overwhelmed practice.

Between midwives/health visitors and GPs

6.10 GP records could be the hub of all information sharing since they bring together all aspects of health care, received by an individual, in one place. However, within current contracting arrangements, relying on this is not possible as the central GP contract does not include specific requirements in relation to safeguarding. In this case there appears to have been both a lack of formal and informal processes where information could be shared, particularly between the midwives and GPs. In addition, the health visitor did not have time to access all the historical records regarding the sibling. As a result of the health individual management review a formal “link post” within the health visiting teams has now been established which aims to ensure communication flow to and from the GPs and that health visitors are invited to and attend practice meetings.

6.11 As it has not been possible to access Mr A’s GP records, it is not possible to assess how far his own GP was aware of his relationship with a woman with a child and whether or not proper consideration was given to finding out more about this relationship and sharing information regarding possible risks.

Between midwives and health visitors

6.12 The impression from the reports is that communication was via written reports of variable quality. There was (and is) no expectation of face to face meetings although the Standard Operating Policies currently being developed do prompt a review of information at handover and require verbal communication (at least) if there are any indicators that are out of the ordinary.

Generally

6.13 The panel has been informed that Essex, as part of the eastern region, will be early adopters of the *Child Protection Information Sharing Project*[11] and that this may address some of the issues within this review. However, this will not be the case since the project focuses only on:

- children with a child protection plan
- children with looked after status
- pregnant women whose unborn Child Gas a pre-birth child protection plan.

6.14 Children who do not fall within these categories will continue to need practitioners to think carefully about how they record information, who they need to share information with, and the most appropriate method for doing so.

Understanding parental learning difficulties

6.15 Impaired intellectual ability does not in itself mean that a parent cannot successfully care for their child. However, when low intellectual ability combines with other stressors relevant to all parents, such as adverse childhood experiences and other social problems, extra support is likely to be needed. The vulnerability of mothers to abusive males in these circumstances also needs to be addressed.[12]

6.16 It is only with the benefit of hindsight that it has been possible to understand precise nature of Mother's vulnerabilities, although she was known to have had a statement of special educational needs and the social worker who wrote the report for the initial child protection conference made the very appropriate recommendation that there should be further exploration of the nature and impact of any learning difficulty. This would have been important to make sure that services were appropriately tailored for both Mother's needs and those of her unborn child. However, this recommendation became lost and did not find its way into the child protection plan. It is hard to know why this key aspect of Mother's life did not receive further attention. Reports prepared as part of the criminal proceedings have confirmed that Mother's intellectual ability falls within the "extremely low" range and her verbal ability exceeds her cognitive ability. The psychological report notes that "she may experience few, if any, difficulties in keeping up with her peers in situations that require verbal skills". This may well have lulled professionals into a false sense of security.

6.17 How far there were unique features in this case that should have informed the support offered to Mother as a parent, or whether there is the need to improve knowledge, skill and access to specialist assessment services, will need further scrutiny by both children's social care and Essex Safeguarding Children Board.

The importance of child in need plans

[11] This is an NHS England sponsored work programme which is developing an information sharing solution that will connect local authorities' child protection social care IT systems with the healthcare systems of the NHS.
[12] Cleaver, H., Unell, I. and Aldgate, J (2011) *Childrens Needs Parenting Capacity 2nd Edition* London: TSO Page 35

6.18 This review has confirmed the importance of effective child in need planning[13] arrangements when children are stepped down from child protection plans.

6.19 It is clear from the reports received for this review that at the time that Half Sibling was removed from a child protection plan, significant parts of the child protection plan had not been progressed. Mother had not completed group work in relation to managing risks from violent men and the parenting assessment had not been completed. These issues could have been picked up during the child in need planning phase but this plan was never actively implemented. From reports received for this review it seems that although there are a number of family support services in the area where Mother lives, she was not using these and relied heavily on the support of her own mother. The case was closed to children's social care without a proper review within supervision of outcomes achieved.

6.20 The significance of this in relation to later events with Child G can only be speculated upon and it is important to remember that there were no concerns about mother's parenting identified by any professional until after her pregnancy with Child G. It is not unreasonable to assume that had there been active multi-agency involvement at that stage, and a clearer assessment of Mother's parenting capacity on file within health records, this would have provided a more effective foundation for understanding any vulnerabilities in the future. Responsibility does not only lie with children's social care, as there was no evidence of any challenge from other agencies when the child in need plan did not progress. It is possible that at that time expectations were low and consequently there was a lack of challenge from other professionals.

6.21 The children's social care report identifies that in 2010 social care services were on a trajectory of improvement but still recovering from a history of staffing shortages, high levels of agency staff, high caseloads and a backlog of assessment work. The CQC inspection report[14] published in April 2014 noted problems with child in need meetings including lack of minutes, clarity about the support being offered and roles and responsibilities of the services involved. In contrast, the Ofsted inspection (January/February 2014)[15] confirmed that children with additional needs are benefiting from "good coordinated multi-agency help and support".

6.22 Given the disparity between the two inspection findings it is likely that the quality of child in need planning was patchy in 2010-11 and the significant improvements described to this review had yet to bed in. The panel heard that, from February 2014, Essex children's social care have made significant improvements in their child in need services which are set out in more detail in the response to this review. This includes a dedicated child in need reviewing service staffed by child in need reviewing officers who chair complex child in need review meetings. Although this currently only constitutes 18-20% of the child in need reviews there is a positive move towards a greater degree of consistency, challenge and oversight within the system.

[13] S17 of Children Act 1989 defines a child in need as a child whose health or development is likely to be impaired without the provision of services by the local authority. Child in Need Plans set out how those services are to be coordinated and delivered.
[14] CQC (April 2014) *Review of Health Services for Children Looked After and Safeguarding in Essex (Communities served by Mid Essex, North East and West Essex Clinical Commissioning Groups)* Para 2.8
[15] Ofsted (February 2014) *Inspection of services for children in need of help and protection, children looked after and care leavers.* Para i

Pre birth assessments

6.23 In this case there was the opportunity to consider whether a pre-birth assessment should have been undertaken at the point mother was pregnant with Child G. Given the previous child protection plan it would have been reasonable for health professionals to have looked carefully at all current and past information and explored with mother the extent to which she was coping with Half Sibling whilst pregnant with Child G. However, due to the lack of a holistic approach, and fragmentation in information sharing identified above, this did not happen.

6.24 It is important to consider whether additional reasons relate to more general problems with the pre-birth processes within Essex, and paragraph 5.10 identifies the myths that had built up regarding at what stage in pregnancy a referral could be made to children's social care. There is no evidence that this was a problem with procedures or general practice in relation to pre-birth assessments. The most recent CQC report[16] identified that generally the process for pre-birth assessments works well with children's social care responding promptly to concerns. It does, however, note that there is no formally agreed pre-birth protocol in place to ensure a clearly identifiable pathway and a recently published serious case review[17] has recommended that current guidance on the interface between pre-birth/ante natal child protection processes and discharge planning should be reviewed. The guidance is currently in the process of development and it will be helpful if the pathway gives clear guidance relating to factors to consider when there has been a previous child protection plan in place.

Supervision within Health organisations

6.25 There is evidence of supervision structures being in place and it is positive that safeguarding supervision is provided within acute settings as many areas struggle with this. The area where regular safeguarding supervision was not in place is within the minor injuries unit (MIU); this is significant as the nurse practitioner has identified that within that setting there may be a lack of confidence in dealing with babies with injuries. There is relevant recommendation within the Local Provider Health Service individual management review which is in the process of being implemented.

6.26 Another gap is safeguarding supervision arrangements for GPs and this is an area for development. However, in the area of Essex where this family lived it has not proved possible to recruit to the post of named GP and move this aspect of practice forward.

6.27 Even though supervision structures were in place for midwives and health visitors, there is little evidence that this was promoting a critically reflective approach to the work which identified potential gaps in information and reduced the likelihood of taking parental explanations at face value. Where there are significant workload pressures it would not be unusual for supervision to concentrate on those children subject of a child protection plan, resulting in little reflection time for children such as Child G. The panel have been told that supervision has been improved and discussions about the child are recorded in the notes. This is basic good practice and the new “lead nurse” role that is tasked with leading peer review and reflection will be key in ensuring the development of an approach to supervision which enables sufficient attention being paid to both recording,

[16] CQC (April 2014) *Review of Health Services for Children Looked After and Safeguarding in Essex (Communities served by Mid Essex, North East and West Essex Clinical Commissioning Groups)* Para 3.8
[17] Child J

and the critical reflection, that informs an effective analysis of the meaning of the information being presented.

Organisational risk and the role of the LSCB

6.28 The Local Provider Health Service individual management review sets out in some detail the extreme pressures on the health visitor during the period under review. The health visiting team is described as being understaffed and there were no suitable candidates for any vacant positions. In an establishment of 4.5 whole time equivalent (WTE) posts, 1.14 were vacant, and within the team 1.36 health visitors were new to the area and two were both newly qualified and new to the area. The health visiting team were therefore in "survival mode" but did escalate their concerns, and there is evidence that managers attempted to support their staff within available resources. However, commissioned resources at the time are described as insufficient to provide any sustainable support in the long term.

6.29 It is clear from the Local Provider Health Service individual management review that managers were attempting to find ways to manage the service and prioritise safeguarding, and they did alert the Clinical Commissioning Group via three different quarterly meetings (contracts, quality and monitoring). The 2013 section 11 audit did not include any standards in relation to workforce capacity of non-safeguarding specialist roles and the Safeguarding Children Board would not have been alerted to any concerns via this route. There is no evidence that the risks associated with the stresses on the service were escalated to the Essex Safeguarding Children Board in any other forum. One function of Safeguarding Children Boards is to monitor and evaluate the effectiveness of what is done by partner organisations to safeguard and promote the welfare of children[18] and *while LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed*.[19]

6.30 In this case it seems that the questions were not asked via audits, or other mechanisms, about capacity to deliver effective safeguarding, nor was information volunteered. This inhibited the effectiveness of the LSCB in holding organisations to account for the effectiveness of their safeguarding practice.

7. CONCLUSIONS

7.1 The injuries to Child G were caused by a man who had a history of violence towards women and children and to this extent it was predictable that women and children with whom he formed an intimate relationship were at risk of harm. Prevention of harm must include knowledge about the perpetrator's whereabouts, activities and relationships. This case highlights gaps in the systems that are in place to track perpetrators and identify risk of future harm where the identified concern is physical rather than sexual violence.

7.2 One of the challenges in this case was that the relationship with Mother was relatively new and Mr A was not living with her on a full time basis. Mother's only contact with professionals at this time was with health practitioners, and within health organisations there was a general lack of curiosity about fathers/men in the family. This was

[18] Regulation 5, Local Safeguarding Children Boards Regulations 2006
[19] HM Government (2015) *Working Together to Safeguard Children* Page 67

exacerbated by a workforce which was under extreme pressure, lack of a joined up approach across GP services, midwifery and health visiting and supervision which did not provide sufficient opportunities for critical reflection. Members of the family did have concerns about Mr A's relationship with Mother but were unclear who to talk to about this. In fact, a great deal of information was held within the extended family, who provided Mother with a significant level of support but this was not known to those professionals who may have been able to intervene to protect Child G from harm.

7.3 The safeguarding risks associated with workload pressures within health visiting were not brought the attention of the Essex Safeguarding Children Board and quality assurance systems within the Board did not bring these to light.

7.4 At the time of the injuries, Mr A was still in contact with the probation service and there was insufficient recognition of risk when Mr A spoke during unpaid work activity about his relationship with Mother and her children. Information systems did not give sufficiently precise information to unpaid work supervisors regarding potential risks to children, and not all supervisors were familiar enough with the meaning of the coding system used. In addition, lack of attention to the detail in the file at the point of transfer from offender manager 1 to offender manager 2 meant that when his relationship with Mother came to the attention of the offender manager, they did not see the risks as immediate. Although they planned to contact children's social care this did not happen before the injuries to Child G took place.

7.5 The other side of the prevention coin is recognising when mothers may be vulnerable to being targeted by violent men. In this case Mother's learning difficulties, combined with her problematic social history and lack of social support outside the family, made her particularly vulnerable. These factors had not been sufficiently assessed and the child in need plan in relation to Mother's first child was therefore insufficiently tailored to Mother's needs. The lack of focus within the plan on outcomes for the children and insufficient management oversight contributed to case closure within children's social care without sufficient scrutiny or challenge. This in turn may have contributed to health professionals subsequently paying insufficient attention to Mother's vulnerability, over-relying on family support and not recognising a pattern of events that indicated that she may be struggling to cope. Improvements have been made to child in need planning processes in Essex but there is varying evidence as to the impact of these changes. This will be explored further in the Safeguarding Children Board response to this review.

7.6 Throughout the various stages of work with Mother and her children there was a need for practitioners to stop and think about the information that they held, what additional information they needed and who might hold that information.

8. FINDINGS AND RECOMMENDATIONS

8.1 The following findings and recommendations focus on areas for attention by the Safeguarding Children Board and are in addition to a large number of specific recommendations made by the individual management reviews.

8.2 *Although Mr A had a history of violence against women and children there were no systems in place enabling effective tracking of his movements and relationships. This finding was also made by a serious case review in Southampton in 2012.*

Recommendation One

Essex Safeguarding Children Board should ask the Home Office and Ministry of Justice to develop:

- arrangements at a national level to ensure that offenders who have been convicted of violent offences against children are required to register their details of their address with the Police and to be subject to monitoring arrangements for specified period of time
- systems for monitoring and working with individuals who have offences against children, to ensure that their assessed high risk to children in the future can also be adequately addressed.

8.3 *Information sharing systems between health agencies did not facilitate the development of a full understanding of Mother's vulnerability by any one practitioner.*

Recommendation Two

Essex Safeguarding Children Board should ask Commissioners of health services to report via the Health Executive Forum how compliance is measured and monitored in relation to the information sharing issues identified within the review. Namely

- Between health visitors, midwives and GP's
- Between midwives and health visitors

8.4 *Practitioners did not consistently stop and think about the information that they held, what additional information they needed and who might hold that information.*

Recommendation Three

Essex Safeguarding Children Board should ask partner agencies to report to the Board on

- the criteria they use to determine how reflection and critical thinking is embedded within their organisation in order to enable practitioners to consider the information they hold, what additional information they need and who would hold this information
- why they are content that this is working well
- any steps that need to be taken to improve this aspect of safeguarding practice.

8.5 *There is a lack of clarity within children's social care regarding when enquiries can be made of other agencies about a person who may cause harm to a child without their consent. If a referral had been made by family members expressing concerns about Mr A this may not have led to any further action due to a belief that his consent was needed to seek further information.*

Recommendation Four

Essex Safeguarding Children Board should ask children's social care to use the information sharing guidance (HM Government 2015) to clarify with all staff good practice in seeking and sharing information where a child is suffering or likely to suffer significant harm.

8.6 *The child in need plan for Half Sibling was not sufficiently outcome focused, was*

discontinued and the case closed without effective management discussion, oversight or challenge from any other agency. Children's social care has reported that there has been significant improvement in practice since events in this review took place.

Recommendation Five

Essex Safeguarding Children Board should ask children's social care to coordinate a multi-agency audit of child in need planning arrangements and report to the LSCB on the effectiveness of management oversight and plans for provision of services at the point of case closure.

8.7 *The nature, extent and impact of Mother's learning difficulties were not fully understood and taken account of in service provision within any agency and did not inform an assessment of parenting capacity.*

Recommendation Six

Essex Safeguarding Children Board should:

- ask children's social care and health commissioners to consider whether there are adequate accessible arrangements in place for providing any necessary psychological assessments to help the development of effective plans and service provision
- review learning and development needs in relation to the impact of learning difficulties/learning disability on parenting capacity
- ask for evidence that the implementation of PAM assessments in family centres is having a positive influence on child in need and child protection plans.

8.8 *The quality of health visiting service to vulnerable families was compromised by capacity within the service. This was not brought to the attention of Essex Safeguarding Children Board and Board mechanisms did not provide active scrutiny of this aspect of safeguarding practice.*

Recommendation Seven

Essex Safeguarding Children Board should:

- require agencies to inform them of any untoward "risk" their organisation acknowledges which has implications for safeguarding children in any of the services they commission or provide
- reflect on the effectiveness of s.11 audits

8.9 *The quality of GP information available to this review was compromised by problems in accessing records once someone has entered the prison system.*

Recommendation Eight

Essex Safeguarding Children Board should ask NHS England to review the mechanism for making the GP records of prisoners and ex prisoners available to serious case reviews and inform all Safeguarding Children Board chairs of the correct process.

8.10 *The review process was delayed by the inability of Essex police to fully participate due to the criminal proceedings.*

Recommendation Nine

Essex Safeguarding Children Board should work with Essex police to implement ACPO/CPS (May 2014) *Liaison and information exchange when criminal proceedings coincide with chapter four serious case reviews or welsh child practice reviews* (first published 2011).

Appendix One

The Review Process

Introduction

Statutory guidance at the start of this review was set out in *Working Together to Safeguard Children* (2013). The approach of all serious case reviews should be governed by the principles set out in the guidance although the specific methods used may vary. These principles are:

1. There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works to promote good practice.

2. The approach taken to reviews should be proportionate according to the scale and complexity of the issues being examined.

3. Reviews should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.

4. Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

5. Families including surviving children should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring the child is at the centre of the process.

6. The final report must be published, including the LSCB's response to the review findings.

7. Improvement must be sustained through regular monitoring and follow up.

Following the decision to undertake this serious case review, a panel of local senior professionals was appointed to oversee the review process. Independence was assured

by the appointment of two lead reviewers, one acting as an independent panel chair and the second as an independent report author.

The Panel Chair

Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has worked on more than 40 Serious Case Reviews in respect of children and vulnerable adults. He has recently been engaged by the Department for Education to re-draft high profile Serious Case Review reports so that they can be more effectively published. Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council, and has undertaken investigations commissioned by the Local Government Ombudsman. He has served as a magistrate in the criminal courts in East London for 15 years.

The Report Author

Jane also trained in social work and social administration at the London School of Economics and qualified as a social worker in 1979. She has an MSc in social work practice, the Advanced Award in Social Work and an MPhil as a result of researching the impact of supervision on child protection practice. She has published two books on supervision and co-wrote, with Tony Morrison, the national training programme for social work supervisors. Since 1994 she has been the author or chair of many serious case reviews and in 2010 completed the accredited Tavistock Clinic and Government Office London nine day training programme for panel chairs and authors. She has also attended the 2012 Department for Education serious case review training programme.

The Panel

The panel comprised:

- Executive Director for People Operations, Essex County Council
- Director for Safeguarding, Children's Social Care
- Deputy Chief Executive, Essex Community Rehabilitation Company
- Professional Lead Designated Nurse SCCN
- Designated Doctor for Child Death Review, NHS Mid Essex
- Chief Inspector & District Commander, Essex Police
- Head of Commissioning Education of Children Looked After, Essex County Council
- Lay member, Essex Safeguarding Children Board.

Also in attendance at each meeting were:

- Lead for Safeguarding, Family Operations, Essex County Council
- Business Manager, Essex Safeguarding Children Board

- Serious Case Reviews and Child Death Review Manager, Essex Safeguarding Children Board
- Project Officer, Essex Safeguarding Children Board

Review Method

The initial aim had been to use an approach to this review which moved away from individual agency reports and collaborated directly with practitioner from the start. It was agreed at the first panel meeting that the process should start with the compilation of a detailed chronology which would be reviewed by the panel. The next stage would be to meet with key practitioners to explore the detail of events and why actions and decision were taken at key points in time.

The timeframe for the detailed chronology was agreed as starting from August 2012 through to the date that Child G was taken to accident and emergency in August 2013. Since this was a relatively short time frame, it was agreed that all organisations should review previous records in order to ensure that all information relevant to the terms of reference was available to the review.

The specific questions to be answered by this review were:

- Were practitioners knowledgeable about potential indicators of abuse or neglect and what to do if they had concerns about a child's welfare? Did they identify any causes for concern? If not, why was this?
- Were assessments, including pre-birth assessments, carried out and followed up appropriately? How did the adults present to the agencies they were in contact with? Was domestic abuse adequately taken into account? What factors affected the quality of assessments?
- Where relevant, were formal planning arrangements in place and implemented appropriately? Were MAPPA[20] arrangements used appropriately? How effective are the multi-agency systems/ processes for flagging adults who are considered to be a Risk To Children (RTC), and how do we link adults who are RTC when they become involved with other families?
- Did agencies have reliable and efficient arrangements for storing, accessing and sharing information? Were they used to best effect in this case? What factors affected this?
- Were communications, within and between agencies, effective and what factors affected the quality of communication?
- Was practice sensitive to racial, cultural, linguistic and religious identity and any issues of disability?
- Were managers appropriately involved in this case? What role did supervision play in managing the emotional impact of the work and professional relationships in order to aid decision making and practice interventions?

[20] MAPPA is the name given to the multi-agency public protection arrangements are in place to ensure the successful management of violent and sexual offenders https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2

- The area where this family lived is relatively well resourced with services that could have supported them. If referrals to these services were not made, or were not effective, why not? Did any resourcing issues affect the way this case was dealt with?
- Is there evidence of good practice in the way this case was handled?

At the second panel meeting in December 2013 Essex Police asked for the review to be deferred due to unspecified complexities within the criminal proceedings. Their position was that they would be unable to continue to contribute to the review at this point. A compromise position was reached whereby agencies would complete a paper based review without talking to any practitioners. The usual position of only a small number of practitioners who may be witnesses being “out of bounds” was not possible since Essex police were unable at this stage to specify which information might compromise the proceedings. Once the criminal proceedings were over, practitioners would be spoken to, agency reports would be finalised and Essex police would resume their involvement in the process.

Following the conviction and sentencing of both Mother and Mr A in October 2014 agency reports were finalised and presented to a full day meeting of the panel, following which a draft overview report was produced and discussed at panel meetings in January and April 2015.

Family Involvement

Following production of a first draft overview report in April 2015 arrangements were made to see Mother and Maternal Grandmother, but due problems in finalising these meetings they did not take place at this stage, causing some further delay in the process.

The Mother of Child G decided that she did not feel able to contribute to the review and the offer has been left open for her to make her views known to a member of the Safeguarding Children Board should she wish to do so at a later date.

Maternal Grandmother and an aunt of Child G did meet with the lead reviewer and the Essex Safeguarding Children Board Business Manager and their comments have informed the final report.

Involvement of practitioners

The original intention to work closely with practitioners from the start of the review was not possible in this case. A meeting was held with practitioner to share a final draft of the report and this was attended by 17 people representing all the agencies involved in this case. This provided an opportunity to check accuracy and develop further the findings and recommendations.

Quality Assurance

This report was presented to the Essex serious case review subcommittee on 19th August and minor amendments were made to the wording of the recommendations.

The report was then presented to the Essex Safeguarding Children Board in October 2015.