ESSEX SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CHILD L

Author of report: Fergus Smith, Independent Consultant

July 2016

Contents

1 INTRODUCTION

BACKGROUND & DECISION TO INITIATE A SERIOUS CASE REVIEW

On 20.01.14 it is understood that child L (a White British male aged 14 weeks) was at home in the care of his parents when they report that they noticed him becoming floppy, unresponsive and vomiting. They took him to GP Practice 1 from where an ambulance was called and child L was conveyed to the A&E department of hospital 1 and admitted.

After two days of investigation, extensive sub-dural haemorrhages were detected. Child L was subsequently transferred to an alternative hospital. Following further observations which revealed bilateral retinal haemorrhages, it was concluded that the injuries were 'non-accidental'.

A strategy meeting between Police and Children's Social Care was held on 24.01.14 and a criminal investigation initiated and later completed without charges against any individual. The parents of child L (who had been subject of a 'child in need' plan at the time of his injuries) agreed to his accommodation by the local authority under s.20 Children Act 1989. Following completion of Care Proceedings, arrangements for safe and permanent alternative care of all the children were made.

In accordance with Essex Safeguarding Children Board procedures, a meeting was convened to consider whether the criteria for conducting a serious case review were satisfied. This 'consideration for serious case review' meeting concluded (having first sought and later received additional detail) that a serious case review *was* required and the 'serious case review sub-committee' on 30.04.14 agreed to formally recommend that course of action to the independent chair of the Essex Safeguarding Children Board.

On 02.06.14 the chair of the Safeguarding Children Board accepted the recommendation and determined a serious case review would be held. The Department for Education and regulatory bodies Ofsted and Care Quality Commission were subsequently notified.

PURPOSE & CONDUCT OF THE SERIOUS CASE REVIEW

PURPOSE

Regulation 5 Local Safeguarding Children Boards Regulations 2006 requires Local Safeguarding Children Boards (LSCBs) to undertake reviews of 'serious cases' in accordance with procedures in *Working Together to Safeguard Children* HM Government.

A 'serious case' is one in which abuse or neglect is known or suspected and either a child has died or has been seriously harmed, and there is concern about the way in which the local authority, its LSCB partners or other relevant persons have worked together to safeguard the child.

Its purpose is to:

- ‘Establish what lessons can be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result and
- As a consequence, improve intra and inter-agency working and better safeguard and promote the welfare of children’

A serious case review is not concerned with attribution of culpability for a non-accidental injury, which is a matter for the criminal courts.

CONDUCT

Independent authorship & chairing

An independent lead reviewer was commissioned from CAE Ltd (**www.caeuk.org**) (which has experience of over sixty serious case reviews). It was agreed that upon submission of all relevant material, author Fergus Smith would, in accordance with terms of reference appended to this report, collate and appraise individual management reviews (IMRs) and other sources of written and oral evidence and develop for consideration by the serious case review panel an analysis, conclusions and recommendations for action by Essex Safeguarding Children Board, its member agencies and (if relevant) other local or national agencies.

The review panel was chaired by an independent consultant Ms Jane Wonnacott who has extensive experience in that role and as an overview author, and no connections with any of the agencies providing services to child L or his family.

Panel members & scope of review

- Professional Lead Designated Nurse
- Designated Doctor for Safeguarding Children
- Head of Social Care & Safeguarding, other Local Authority University Foundation Trust
- Executive Director for Family Operations Children’s Social Care
- Director for Safeguarding Children’s Social Care
- Head of Commissioning & Lifelong Learning
- Deputy Chief Executive Essex Community Rehabilitation Company
- Detective Inspector (Head of Child Abuse Investigation Team) Essex Police
- Director for Integrated Commissioning & Vulnerable People Essex County Council
- A lay member of the Safeguarding Children Board

A decision was made that a proportionate approach would be to focus on the period from when it was estimated the father of child L joined the family i.e. April 2011 to the date that the injuries to child L were recognised in January 2014.

SOURCES OF INFORMATION & EFFECTIVENESS OF REVIEW

The following agencies were identified as sources of relevant information:

- Local Provider Health Visiting Service (health visiting service)
- Local Hospital Trust (midwifery and Accident and Emergency (A & E) services)
- East of England Ambulance Service (responding to calls)
- Essex Children's Social Care (family support)
- Essex Education (provision of schooling to siblings)
- Essex Police (investigation of crime)
- GP Practices
- Local Children's Centre (family support)
- Home-start (befriending)
- Probation Services (In June 2014 what had been Essex Probation split and staff involved with child L's father transferred either to National Probation Service NPS or to Essex Community Rehabilitation Company ECRC - enforcement of Suspended Sentence Order including Drug Rehabilitation Requirement)
- Former local provider of 'immediate access to psychological therapies' (IAPT) services
- Specified Drug Agencies (voluntary monitoring of child L's father)
- Sure Start (drop-in services)

Guidance on the development of IMRs was circulated and a briefing session convened for authors led by the independent chair and overview author. With one exception, IMRs initially submitted were drafted by suitably experienced professionals with no direct involvement in service delivery or case supervision. Home-start was unable to identify an un-involved individual to provide a critique of its service delivery. Subsequent research at the national level of Home-start confirmed that the review would need to depend upon the account provided by the local senior organiser. This account was supplemented at a face-to-face meeting with the author.

Though reported to have been completed prior to Christmas 2014 the Local Provider health service IMR was provided only days before a draft of the overview was due to be completed. On the grounds of 'patient confidentiality'[1], the agency declined to share health visiting records of contacts with the family, offered no analysis of professional practice and failed to address any of the terms of reference. The report had been an interesting and well–written account of the wider Political context and local health service environment

[1] This view was initially sustained in spite of S.14B Children Act 2004 introduced by s.8 Children, Schools & Families Act 2010 - generally interpreted to mean that it is sufficiently in the public interest in the context of a serious case review, to override a lack of parental consent to access health-related records relating to them or their child/ren

rather than an IMR**.** It was re-written in time for consideration by the SCR panel in March 2015 and in its final version, aside from its premature anonymisation of staff, helpfully informed this overview.

The material initially provided by the Children's Centre (a service commissioned by Essex County Council) was judged insufficient (though the Centre had not reportedly been provided with the terms of reference for the review). It was replaced by a very thorough report from a senior manager and the critique of practice within it was further explored at meetings the overview author completed with that IMR author and the Centre's manager.

Involvement of family & professionals

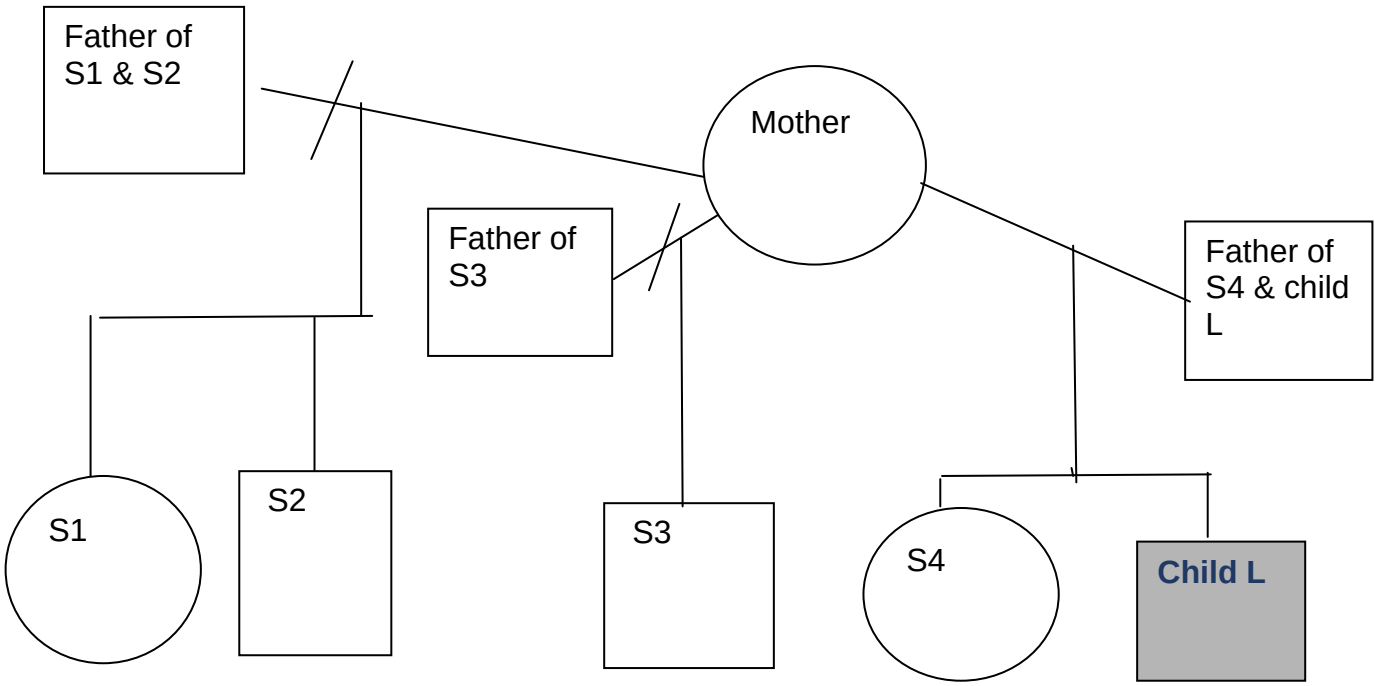
Both (now separated) parents were provided with an explanation of the serious case review process and encouraged to contribute. Neither elected to do so. Invitations were also issued to members of the extended family and child L's paternal grandmother and partner met with the author and the Safeguarding Children Board manager. Their helpful observations are reflected at relevant places within the following report.

At the point when events and judgments about them were sufficiently clear a consultation event was held for professionals. Provisional views about the evidence emerging were discussed with respect to the following four issues:

- The roles and expectations of local agencies
- The particular responsibilities of GPs and IAPT services
- Striking a balance between supporting a family and overlooking risk to children
- Scope for improved co-ordination of planning, assessment and service delivery to children in need

The event was well received and enabled correction of misunderstandings, contextualisation of professional practice and some re-calibration of comments and conclusions. Positive feedback from those who attended suggests that the event also served to generate a greater level of commitment to the changes that were identified as being required.

GENOGRAM OF FAMILY



TERMS USED IN REPORT

Abbreviations	Meaning
ADHD	Attention Deficit Hyperactivity Disorder
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
DASO	Domestic Abuse Support Officer
DRR	Drugs Rehabilitation Requirement
ECRC	Essex Community Rehabilitation Company
EDT	Children's Social Care Emergency Duty Team
EMIS	GP Patient Management System in use locally and across much of the country
IAPT	Improving access to psychological therapies
JDATT	Joint Domestic Abuse Triage Team
IMR	Individual Management Review (a report drafted by a suitably experienced author from each agency with no supervisory or management responsibility for the case)
MARAC	Multi-agency Risk Assessment Conference
NPS	National Probation Service
OCD	Obsessive compulsive disorder
PSR	Pre-sentence Report
SCR	Serious Case Review

2 BACKGROUND & EVENTS DURING PERIOD OF REVIEW

INTRODUCTION

The serious case review analysed the period between child L's father joining the household in early 2011 and the date of the trigger event in January 2014. A report and/or information was collated from over a dozen agencies providing ongoing or intermittent services to child L's family.

FAMILY CONTEXT

Background

Mother had a long-standing history of anxiety-related mental ill-health. She had three children by two previous partners and then, with the man hereafter referred to as 'father', gave birth to a fourth child (S4) in 2012 and to child L in late 2013. The four siblings of child L were within the age range of 1 to 8 years.

Mother has no criminal record. Father has an extensive criminal record and was subject to a Community Order with a drug rehabilitation requirement (DRR) for a proportion of the period under review. Extensive testing whilst subject of the DRR indicated that father was not using illicit drugs during this period though misuse of alcohol remained a concern.

In the period prior to the birth of child L a high level of practical support was provided both by Home-start (a voluntary befriending service) and by the local Children's Centre (a service commissioned by Essex County Council). Aside from safety audits of the home, efforts were directed toward helping mother to be a more confident parent. Although there were some everyday childhood accidents, there was never any suspicion of deliberate abuse and mother's anxiety made her quick to seek medical advice about her children's health. Mother's chronic anxiety about her own health may be discerned, though this information was unknown to any other agency, by a very high rate of 999 calls seeking an ambulance for minor or perceived illness.

Mother's report of auditory hallucinations

In late 2011 a pregnant mother reported to her Home-start worker that she was hearing voices that were telling her to kill herself and her children. Home-start and the Children's Centre staff liaised and initiated a referral to Children's Social Care, which undertook an initial and subsequently a more comprehensive assessment. In response to mother's account of how she felt, her GP had also responded. In the view of former local IAPT service mother was suffering severe depression. Her reference to harming others was deemed to be linked to obsessive-compulsive thinking and no liaison was initiated by that Service with other mental health professional agencies.

In November 2011 a multi-agency partnership meeting prompted by the above circumstances focused on school attendance. The need for all involved agencies to remain so was agreed. Children's Social Care concluded its assessment and determined that a

'child in need' plan was required. In early 2012 the plan was reviewed at a multi-agency meeting. Mother's ongoing engagement with Home-start and Children's Centre was noted but concerns remained about the lack of routines for the children. Mother's compliance with the treatment being offered by her therapist was reducing and Children's Centre visits ceased in March.

After a further multi-agency child in need review in April 2012, Home-start visits continued and Children's Social Care decided to close the case. Its closing summary recognised uncertainty about mother's ability to sustain improvements but concluded that her care of the children was adequate. This case closure was considered premature by the Children's Centre but was not challenged.

First domestic abuse allegation

In late August 2012 Police attended when child L's maternal grandmother alleged father had pushed mother during an argument. Mother denied this and no offences were established. The children present were reported not to have heard any argument.

Cessation of IAPT treatment

In late October 2012 the former local IAPT service therapist notified the GP that involvement has ceased. In spite of only 50% attendance the therapist reported significant improvements with respect to anxiety and depression. This was at odds with mother's still frequent anxiety-related presentations at the Practice, though the health visitor *had* observed tangible improvements in the appearance of the household and some lifting of mood state. An absence of communication amongst these professionals meant that the contrasting indicators were not shared, thus preventing the development of a professional consensus.

Further references to domestic abuse

In late 2012 Home-start had been advising mother on how she might separate from father. His behaviours as reported by mother, suggested financial and emotional, though not physical abuse. Mother continued to present her healthy new baby to the GP Practice at a significantly higher rate than was normal. Those doctors and nurses whom mother consulted initiated no contact with sources of community help such as health visitors or school nurses.

Ante-natal period of child L / further evidence of mother's anxieties

Mother acknowledged at her initial antenatal appointment the fact that she and father had learning / literacy difficulties as well as her history of mental health treatment. This source of background information was not pursued. It seems that mother self-referred to former local adult mental health service in summer 2013 and was placed on a waiting list. She continued to present frequently to her GP about her own health or that of one or other of her children.

Events following birth of child L

Records indicate that at child L's birth in late October 2013 mother's anxiety levels were extreme. Her belief that she was dying could not be modified by any health professional. Soon after child L's birth, the GP, without reference to midwife or health visitor, referred mother for a psychiatric opinion citing severe anxiety and post-natal depression.

Referrals to Children's Social Care

An anonymous referral in October 2013 about home conditions caused Children's Social Care to complete checks with local agencies. Responses were sufficiently reassuring to prompt its conclusion that no further action was required. Home-start's contact with the family continued and that agency was clear that in exchange for father's active involvement and support with the children, mother was enduring a level of financial and emotional domestic abuse.

A further referral was made to Children's Social Care by the then therapist in the former IAPT service. His level of concern was high especially with respect to the parents' ability to care for the two youngest children. At this time the involved health visitor took the case to 'safeguarding supervision' and agreed to maintain a level of additional contact. Mother's GP was notified by the therapist of the referral to Children's Social Care though this information was not logged in a manner that would facilitate easy future access. The GP Practice was also notified of father's discharge from the former local adult mental health service after only a couple of sessions.

By mid-November 2013 the level of distress shown by one of the older children and mother's presentation prompted the school to initiate a referral to Children's Social Care. The school subsequently shared a number of low-level concerns not previously collated. Home-start responded to the enquiries then initiated by Children's Social Care and shared its experience of mother's struggles to cope with her children and father's coercive behaviour.

Allegation of abuse by father

In late November 2013 whilst the latest Children's Social Care assessment was being undertaken mother reported to Police an abusive incident involving father. A sensitive and thorough criminal investigation was conducted. Mother later withdrew her allegation.

The psychiatrist to whom mother had been referred by her GP notified the Practice that he had in turn referred her on to the now former local IAPT service post-natal service for more cognitive behavioural therapy (the same approach that had been tried with limited success previously). A level of confusion about the respective roles of that IAPT Service and more formal psychiatric support is apparent in the reports provided.

Though exchanges between the GP and psychiatrist at this period spoke of the possibility of sectioning (compulsory detention under the Mental Health Act 1983) no contact was made with the health visitor or Children's Social Care. Mother was seen by a second psychiatrist (a consultant) in early December and diagnosed as depressed and non-compliant with prescribed medication. A plan for re-engagement of the former provider of the IAPT Service was made. A 'psychiatric care plan' received later that month at the GP

Practice included the psychiatrist's view that mother, whose dose of anti-depressant was increased, was able to provide basic care to all her children. The GP Practice has reported a sense of reassurance that Children's Social care was 'keeping a close eye on mother'.

Upon completion of the assessment of need by Children's Social Care, a child in need meeting was convened just before Christmas 2013 and both parents participated. No formal record was kept of the meeting. Regular visits were to be made by the newly allocated social worker and a further referral to Home-start initiated.

A home visit by the Home-start worker in early January observed that the home was in a mess and that the children lacked clean dry clothes. This worker alerted the allocated social worker to a report that mother had tried to drown herself though the accuracy of that suggestion remains unknown. Contact by the health visitor at this time also indicated that mother was not coping well with the organisational demands of the family.

The intention of the Community Mental Health Team remained to close the case and re-refer to the former IAPT service. The scheduled child in need review meeting was postponed at short notice. The health visitor (having raised the case at safeguarding supervision) sought to engage the interest of a GP at this time but the life-threatening injuries occurred to child L before a response was received and in advance of the postponed child in need meeting being held.

3 ANALYSIS & CONCLUSIONS

ANALYSIS

A number of themes emerge from the evidence submitted and the performance of each relevant agency with respect to the relevant theme is evaluated below.

THEME 1: MULTI-AGENCY WORKING

Family Support Agencies & School

The substantial *material* assistance provided by the Children's Centre, Home-start and Sure Start seems to have been valued by mother and certainly those initiatives related to safety e.g. stair gates or home safety kits probably helped avoid accidents, in what was at least sometimes, a chaotic household.

A high level of *non-material* support e.g. parenting programmes was also offered and to a more limited extent, accepted by mother. Its value is more open to question. A strong wish amongst very committed staff to make things better and the considerable efforts expended on trying to do so, can easily be mistaken for change when a more objective view would be that there was little progress with respect to mother's own capacity and motivation to develop greater resilience and be an adequate parent.

A 'hands-on' approach to support illustrated best by the Home-start Service e.g. completing large quantities of laundry for the family was clearly helpful at the time. Such initiatives may also serve to distract attention from a parent's capacity and motivation to be more self-sufficient or indeed to understand *why* mother apparently struggled with personal care of herself and her children. For example, to what extent was it related to her chronic anxiety and specified obsessive fears (as shared with the GP Practice and elaborated upon at length with the former local IAPT service therapists) or to her acknowledged cognitive limitations.

The school had the advantage of knowing mother and father from the time they had themselves been pupils. This may have meant that staff better appreciated than some other professionals, the learning difficulties that both parents had, in particular their limited level of literacy. Though not privy to all relevant information, school staff did demonstrate a welcome sensitivity to the needs of child L's school-aged siblings.

Father joining the family in 2011 was associated with improved school attendance and punctuality, which had until then, been the school's primary concern. The school maintained adequate records of the few incidents of accidents and injuries to S1 and S2 and liaised well with Home-start and the allocated health visitor. With hindsight, the class teacher had been aware of a number of indicators of low-level neglect though, until placed alongside a larger evidence base, these had not triggered sufficient concern for her to alert the school's 'safeguarding lead'.

The school also contributed effectively to the period in late 2011 – early 2012 when the children were first deemed 'in need', enabling SW1 to meet them and complete an assessment. This period was not well managed by Children's Social Care.

The school's sensitivity to the distress of S3 in November 2013, possibly associated with mother's allegation against father and its referral to Children' Social Care was commendable. In common with other agencies, there may have been something of a presumption that the known ongoing involvement of support agencies, in particular Home-start, would diminish the need to initiate any protective action.

Probation & Drug addiction treatment centre

Conscious of father being in the early stages of drug treatment and joining a family with pre-existing children, offender manager (OM1) in the drug addiction treatment centre had made an appropriate referral to Children's Social Care in August 2011. OM1 also contributed well to the assessment later completed by Children's Social Care. Although more is known about the referral to Children's Social Care initiated by Home-start in October 2011, records indicate that the drug addiction treatment centre also alerted the latter agency to mother's report of auditory hallucinations.

The liaison between Probation, the drug addiction treatment centre and the local drug addiction support charity (where group–work sessions were provided) was very close. A good level of professional supervision of the drugs worker in drug addiction treatment centre is also apparent. With respect to father's avoidance of offending and drugs and increased 'employability', the court order was very effective. With some minor exceptions (non-attendance excused by fictional reasons), he complied well with conditions imposed and showed a more responsible attitude than in previous years.

Father's attitude and reported involvement with stepchildren S1, S2 and S3, later supplemented by his own S4 indicated a young man taking at least an equal share of responsibility for childcare. The level of liaison with family support workers is said to have been greater than records indicate (poor recording was an issue in many agencies). Although the formal 'sentence plan' did not, as it is supposed to, include objectives with respect to the children, it is clear that they were often the topic of conversation when father spoke with OM1 and OM2.

As reported by father anyway, it was appreciated that mother had some mental health difficulties and the challenge of that as well as, eventually, five children was considerable.

At a 'partnership meeting' in November 2011 when a view was formed that the children required 'child in need plans' neither Probation nor the drug addiction treatment centre were present. The latter agency had provided a positive written report of father's progress. A later review of risk appropriately concluded that father was 'medium risk'. Probation contributed to the review meetings set up, though not minuted by Children's Social Care. Perhaps in part because of the absence of minutes, OM2 who had assumed responsibility in early 2012 was uncertain about the status of the children following the third 'partnership meeting held in late February that year.

The Children's Centre has indicated though not evidenced, its opposition at the time to case closure by Children's Social Care. It is thought that there was a consensus amongst other

agencies including Probation that case closure *would* be justified albeit the drug addiction treatment centre and the agencies regularly conducting home visits noted a reduction in compliance and a parental struggle to keep on top of housework.

A more objective and child-centred view of the evidence in the work of OM1 and OM2 is that it *would* have been justifiable to argue for continuing child in need status. OM2 was also still hearing from father about his difficulties coping with the family and mother. There was some loss of continuity of service in summer 2012 when OM2 was absent and colleagues who knew the family less well were insufficiently engaged to complete a home visit and assess father's self-reported alcohol misuse following the birth of S4.

Although of more direct relevance to Probation, a less than minimum standard frequency of visiting by OM2 after the drug rehabilitation requirement ended in August 2012 inevitably reduced the chances of discerning any child safeguarding issues were they to arise. It is not possible to describe any specific consequences of the above examples of discontinuity across agencies though self-evidently it was unhelpful in terms of the recognition of need and risk.

GP Practice

The GP IMR points out that the numerous presentations at Practice 1 most though not all by mother, were responded to competently. It highlights that an 'individual list system' (when a patient usually sees the same doctor) benefits the majority of occasional or planned appointments, but was unhelpful here because nearly all were 'on the day' with one of several nurses or an on-call doctor. A 'summary screen' populated by a colleague cannot offer the same quality of information as a clinician who has previously seen the patient and is able to compare and contrast progress or lack of it in a much more nuanced manner.

A recurring weakness was a failure to note which adult presented a child. Of greater significance was the dilution and sometimes loss of significant medical information in consequence of the way in which summary screens were used:

- Pertinent parental issues were not linked to children's records, in mother's case because the Practice team were not in the habit of doing so and in father's case as a result of their failure to identify him as being within the household
- Mother's anxiety was not seen by clinicians as relevant to her parenting in the same way depression might be and the fact she herself had been subject of a child protection plan did not figure in any assessment of her ability to parent or the reassurance taken from presence of her extended family
- Multiple attendances by the children at the Minor Injuries Unit and hospital 1 were not recorded in any easily retrievable manner so it was left to individual clinicians to identify repeat episodes within individual records and across the family as a whole

Maternal anxiety appeared to underlie most presentations and the author hypothesises that mother's chronic behaviour pattern became 'normalised' in the eyes of the clinicians thus

further diminishing the prospect of considering its impact on her children. The potential value of the 'health information form' completed by the midwife and sent to the GP Practice 1 (and health visitor and school nurse) remained un-realised. Responses to it were purely administrative or narrowly medical and did not consider the implications of what was reported for current or unborn children.

Immediate access to psychological therapies (IAPT) Services

The first of mother's three episodes of treatment via 'Improving Access to Therapies' (IAPT)[2] the former local adult mental health service was during 2009/10 and pre-dated the period under review. The second episode followed the self-referral of 2011 and the third a further self-referral in May 2013. Only the latter two have been evaluated.

In the view of the current service provider of IAPT Services, mother's known history and reported symptoms in October 2011 (supernatural powers, intrusive thoughts about knives and harming her children) required an immediate referral to the Community Mental Health Team (CMHT) for a psychiatric assessment. With the change of IAPT service provider in April 2014, it has not been possible to locate the policies that pertained at the time. What is clear is that there was in 2011:

- A prompt assessment i.e. within one month
- Then, a delay in offering treatment of some three months and that
- At no stage was a risk assessment completed about the welfare of children

The former local IAPT service therapist 1 used supervision to share and explore the complexities of the case though the follow-on lacked rigour and precision. An example of a missed opportunity to draw on the expertise of another professional arose in February 2012 when mother's level of engagement was reducing and recommended liaison with a health visitor to address mother's poor self-care and its implications for care of her children, was not progressed by therapist 1.

There appears to have been an unjustified concern about client confidentiality when the local drug addiction support charity (which *had* obtained mother's consent) sought to exchange information with the then provider of IAPT services and was refused. Therapist 1 completed a well-intentioned but arguably risky unaccompanied home visit in July 2012. The therapist appears to have recognised and indeed recorded that mother was 'more complex than our remit…' The result of that justifiable judgment was limited though to an agreement with mother to end the sessions, as opposed to referring to psychiatric services.

By November 2013 and usefully clarified through a supervisory discussion, there was recognition of the children's vulnerability and a consequent referral to Children's Social Care. What followed suggests that there certainly was, notwithstanding close liaison with Children's Social Care, and *probably* remains, insufficient clarity about the respective roles of the IAPT services and the Mental Health Partnership Trust (the CMHT).

[2] National guidance indicates that IAPT services work with those who have 'mild to moderate anxiety and depression'.

Psychiatrist 2 met mother in early December 2013, diagnosed post-natal depression and referred her for cognitive behavioural therapy to what was labelled 'MIND post-natal services'. With the knowledge and support of SW3 and the care co-ordinator, the following joint interventions followed:

- A home visit and attendance at a scheduled out-patients' appointment
- A child in need meeting just before Christmas

The view formed and shared with the GP Practice, in addition to a prescribed increase of anti-depressant medication, surmised that mother 'was able to look after her children and provide basic care for all her children'. This view was insufficiently evidenced. The North Essex Mental Health Partnership NHS Trust became aware on 06.01.14 of accounts of mother's then recent self-harming and psychiatrist 2 consequently increased prescribed medication. GP Practice 1 was informed of this response. Thus, the CMHT was aware of the existence and nature of other sources of support for child L's family (Home-start, health visiting etc.), *in theory* co-ordinated by Children's Social Care via means of child in need meetings.

Hospital Medical & Midwifery

An apparent failure of hospital 1 to notify the GP when S2 broke his arm in June 2011 remains unexplained though the later communication from the fracture clinic meant that the information (of potential relevance to the issue of safe and adequate parenting) was not lost to future professional involvement.

The decision by the examining practitioner at the Minor Injuries Unit in November 2011 to refer to a health visitor was a proportionate response to observed concerns. If hospital 1 staff had accessed available records they might have noticed that S2 had been reported less than a month before to have a similar accident. This could have raised concerns about parental supervision. They *did* ensure the GP Practice was notified, though the fact the incidents were not included on the summary screen rendered them less visible to future clinicians.

Actions by community midwife CM1 in October 2011 during mother's pregnancy with S4 evidenced her knowledge of and confidence in using, internal and inter-agency safeguarding procedures. Regrettably her prescient thought that mother might require a psychiatric assessment was subsequently overlooked. The Midwifery Service records captured clearly mother's high level of anxiety when child L was born. Though CM1 initiated contact with GP11 about the observed anxiety, its implications for providing safe parental care (and indeed her history of significant levels of depression) were not discussed.

Health Visiting

There is no recorded confirmation that the then health visitor followed up her commitment mid-June 2011 to seek additional support for mother from the Children's Centre. In between the unrecorded child in need meetings, there is little evidence of liaison by health visitors with agencies except Home-start. After S2's injury in June 2012 (a report of falling down the stairs) the promised involvement of Children's Social Care was not achieved. There was also additional scope for involvement by health visitors of the former local IAPT Service,

and for informing the GP that mother was non-compliant with her prescribed anti-depressant medication.

Children's Social Care

With respect to the period being reviewed, Children's Social Care first became aware of the family in summer 2011 when contacted by Probation. Insofar as no concerns about the children had been expressed by the author of the pre-sentence report, the decision to take no further action was a justifiable one.

Responses made by Home-start, specifically its referral to Children's Social Care in October 2011 offer evidence of *its* timely contribution to the local safeguarding network. The responses i.e. to complete an initial and subsequently a core assessment were appropriate.

A 'partnership meeting' of November 2011 provided a valuable opportunity to share information and plan a supportive strategy. The potential value of the approach agreed was reduced in part because the presumption that all support agencies would remain involved was a mistaken one and also because the meeting and the child in need plan emerging from it focused insufficiently on mother's mental health. This served to reinforce agencies' preoccupation on the more tangible aspects of the family's struggle.

The children's school attendance had been one of the more tangible concerns identified by the local network. Because, during the life of the child in need plan, their attendance improved and father's reports from the local drug addiction support charity continued to be very positive, the partnership may have assumed that progress was being made on all fronts relevant to the care of children.

In fact, little progress was made with respect to mother's ability to offer her children consistent parenting in spite of very significant efforts across the years and father's willingness and ability to be the primary carer may have masked mother's inability to provide good enough emotional care and control. Because no records were kept of at least three child in need review meetings, it is not possible to be certain of the rationale for all decisions made. Given the failure to keep and share minutes, one may safely conclude that there were probably differences in understandings of need or risk and of any allocated tasks.

Any uncertainty arising from the absence of an agreed record of child in need reviews was compounded when the social worker failed to attend a scheduled meeting in February 2012. There was a month or so later, a growing consensus that Children's Social Care could justify case closure. This view was in spite of reports from Home-start of a growing number of cancellations by mother of its visits as well as those scheduled by Sure Start. The drug addiction treatment centre records also refer to reduced levels of engagement.

Although the report from the Children's Centre refers to its opposition to case closure by Children's Social Care, it does *not* indicate to whom or how this view was expressed. The local 'escalation procedure' was not engaged. The case was closed to Children's Social Care without it convening what had been a scheduled review. This action denied the network an opportunity to collectively update one another and form an objective view of the fundamentally unchanged family circumstance viz: father's direct care was good enough and that mother's inadequacy as a parent in her own right was un-improved.

The next opportunity for Children's Social Care involvement was the anonymous referral of October 2013 referring to the physical state of the home. The response was a very limited one and unduly influenced by a response offered by parents via phone. A check made with health visitor HV1 was a sensible one but no home visit was completed nor any check made with the school. A reference within the referral to what might have been financial domestic abuse remained unexplored.

Within weeks a further referral was received, this time from a very concerned therapist 2. His views were supported by his supervisor. Though his follow-up confirmation was belated, he had made clear by phone his acute concern about the impact of mother's mental health on the youngest children.

Whilst social worker SW2 was undertaking his 'combined assessment'[3], a further school referral about observed distress of S3 and his need to know that elder siblings were safe, added weight to the growing evidence the family was in or near a crisis. Evidence was appropriately sought from key agencies such as school and GP Practice 1. The school usefully aggregated a number of concerns that had not hitherto been seen as of sufficient import to trigger even an internal alert of the school's safeguarding lead.

GP11 reported concern about mother's parenting capacity and referred to her anxiety and depression. GP11 has indicated that her concerns were at that time relatively recent and that she was reassured by her understanding that Children's Social Care and Home-start were involved. SW2 was sent an email from Home-start, which outlined that agency's lengthy involvement and mother's particular struggle with child L. It also cited father's financially controlling behaviour and mother's stated consideration of a women's refuge.

The specific abusive incident in November 2013 arose in the course of SW2's assessment and relevant details were shared with the social worker by school and Police. It is not possible, with the material submitted to be certain, but it does appear that the involved Children's Social Care staff were reluctant to award the crisis represented by the incident and its implications for the children, as great a priority as did the Police.

The Child and Family Assessment was completed on the 4th of December and the Children-in-Need meeting was held on the 19th of December. It seems that the Children-in-Need meeting agreed with the Social Care recommendation that they would undertake a "combined assessment" and that the children would become subject to a Children-in-Need plan. As with earlier such meetings, no formal records were maintained rendering it difficult to be certain about precisely which agencies contributed and what was agreed.

Though the formal output of SW2's assessment has not been provided, it is clear the plan included home visits at least every 10 days by newly allocated SW3. The remaining actions appear to have been little more than an attempt to re-create the arrangements that previously prevailed and proved insufficient.

Inconsistent observations were made by SW3 and Home-Start worker on the standards of cleanliness/order when both professionals visited the family home on the same day in

[3] Local authorities now have the freedom to complete more case-specific assessments instead of the previously government-defined '10 day 'initial' and 35 day 'core' assessments.

January 2014. The child in need review meeting was postponed at very short notice and events then overtaken by the injuries to child L.

Police

Though father had previously had a considerable level of contact with Essex Police, since joining the family in 2011 he had seldom come to notice. The first contact was of no direct relevance to child L's family. The second example of involvement (maternal grandmother's allegation of domestic abuse toward her daughter by father in August 2012) was more pertinent but appeared to be little more than a verbal altercation. No evidence of drugs or alcohol impacting on parental behaviour was noted. It was concluded, though this is questionable, that S4 who was present, would have been unaffected by the argument.

The reported circumstances would have fallen below the threshold requiring notification to Children's Social Care but such notification *was* sent, albeit some weeks later, when it was understandably, 'no further actioned'.

The most significant episode for the Police was its response to the abusive incident in November 2013. Aside from its sensitive and thorough response to mother, officers liaised well with Children's Social Care.

In spite of the then recently formed Joint Domestic Abuse Triage Team (JDATT) there appears to have been a less than 'collegiate' response to the sensible request from Police that a social worker complete a home visit urgently.

THEME 2: EFFECTIVENESS OF AGENCIES' COLLABORATION

Family Support Agencies & School

HV1 in early 2011 had recognised the family's needs and prompted involvement of the Children's Centre. Staff there subsequently completed a number of safety-related tasks in the home and organised funding for day care of S2, though had less success in attempts to help mother to become a more effective parent. On the basis of what has been shared with the panel, it seems likely that this reflected mother's insufficiency of understating, confidence and/or skill.

In response to the difficulties described by father to Probation, a referral was made in October 2011 to Open Road. Family support worker FSW3 subsequently joined the large number of other involved staff from Home-start, Sure Start and the Children's Centre. In response to mother's reports of auditory hallucinations, there was useful internal debate and liaison between Home-start and the Children's Centre, followed by an appropriate referral to Children's Social Care. Though staff lacked the confidence to escalate it, they retained the belief that the severity and significance of mother's mental ill-health for parenting was under-estimated by Children's Social Care and by Mental Health Services.

The school (including its linked nurse) contributed fully to the 'partnership meeting' and core assessment that was completed in late November 2011. That assessment noted mother's mental health difficulties but did not explore how they might impact on parenting, nor what

risk the nature of her reported hallucinations might pose to the children. The focus seems to have been on the more practical issues such as budgeting and school attendance.

Mother's psychological / psychiatric needs were meanwhile insufficiently apparent to the wider network and were contained (and under-estimated) by the former IAPT provider. The school again showed sensitivity and an ability to engage partner agencies when it made its November 2013 referral.

Probation & the drug addiction treatment centre

There was an effective level of liaison between Probation and the drug addiction treatment centre and by them with other relevant agencies. The author of initial pre-sentence report had been sensitive to the significance of the father (with his history of substance misuse) joining the family, and there was a *high* level of co-operation between those organisations as well as the local drug addiction support charity which provided support to father and mother in terms of individual needs and later potentially as a couple. The addiction treatment centre usefully contributed a report to the partnership meeting of November 2011. With effect from summer 2012 father's involvement with the treatment centre had ended and the frequency of contact with OM2 reduced to below the minimum national standard until the Order was terminated in 2013.

GP Practice

Insofar as the issue was not cited in medical records, mother's auditory hallucinations of autumn 2011 were shared only with FSW2 from Home-start and had not been reported to GP1.

There was no response within GP Practice 1 to the arrival in late October 2011 of mother's assessment by the former local IAPT Service (including references to 'severe depression' and 'thoughts of harming others'). The presumption amongst clinicians consulted i.e. that they would *assume* that any required protective action would be initiated by the agency initially recognising that risk was complacent and potentially dangerous. *All* professionals have a duty of care and must not seek to avoid accountability for taking all reasonable steps to safeguard a vulnerable patient of any age.

The passivity of the GPs in Practice 1 is also apparent by virtue of the fact that in spite of dozens of presentations by mother with real and perceived symptoms of her own or her children's ill-health, not a single contact was initiated with a health visitor. The fact that up to twelve different GPs as well as several Practice nurses were involved suggest that this inward-looking practice reflected an organisational culture not just the attitude of some individuals.

The primary, at times almost exclusive focus at GP Practice 1 appears to have been on narrowly medical i.e. physical matters. The personal or family context from which physical or psychiatric problems were emerging was not addressed to any useful extent. Because the GP Practice is not routinely notified of a patient's use of 999 calls, mother's high level of (mostly anxiety-led) calls remained unknown until April 2012 when she referred to her sixth such call during a consultation with GP6.

By July 2012 the GP Practice had been notified of two episodes within a month in which S2 had reportedly fallen down stairs. These events, if placed in the context of what was already known about the family could usefully have triggered involvement of a health visitor, or at a minimum adding an entry to the EMIS summary screen so that clinicians at future presentations could more easily discern these indicators of inadequate parenting.

There was no evidence of any joint working between GPs and the former local IAPT Service and it seems likely that there was insufficient shared understanding of the role of the latter as opposed to the Community Mental Health Team. The reassuring letter from therapist 1 received in October 2012 about mother's progress was at odds with the collective previous and future experience of her at the GP Practice. No attempt was made to reconcile the differing professional views or how (whichever one was more accurate) mother's difficulties could impact on her children. The letter was simply read and filed.

In addition to what seem to be variations in understanding of how serious a mental health issue had to be to justify use of the CMHT, the underuse of summary screens served to obscure the chronic nature of mother's anxiety-related symptoms. The reluctance to liaise with health visitor colleagues was again apparent when in June 2013 mother reported to GP8 that her health visitor was concerned about some symptoms in S4. Rather than confirm the report directly and/or place the concerns into the context of mother's known chronic anxiety a referral for an orthopaedic consultation was made.

The decision by GP11 in October 2013 to refer mother for a psychiatric opinion was long overdue. It remains wholly unclear on what basis that referral included the assurance that….'midwives have no concerns about the children…' Neither midwives nor health visitors had been involved in formulating the referral.

A letter from the former local IAPT service therapist 2 in November 2013 prompted no action at GP Practice 1, nor was the acute concern of this professional flagged on the summary screen of any family member. Further letters from the then IAPT provider to father were seen by different clinicians and triggered no link to the family or to the recently received request for the Practice to contribute to the s.17 Children's Social Care assessment.

GP11 helpfully negotiated an expedited psychiatric consultation in December 2013 and indeed spoke with the psychiatrist in what for the Practice, seem to have been (in this case anyway) an unusual example of links to professionals outside the surgery). GP11 also composed the response to Children's Social Care's request for information and cited issues of concern about which neither he nor others had previously made records.

Perhaps because of the *extensive* experience of mother's anxious pre-occupations about her own or her other children's health, clinicians at GP Practice 1 may have 'normalised' them and given insufficient thought to the likely impact over time on her children. The presumption that no further mitigation of risk was required received a boost in late December when psychiatrist 2 offered an opinion that mother …'is able to look after and provide basic care…'.

An opportunity for a further re-assessment of need was missed in early January 2014 when GP3 read an incoming notification from the Ambulance Service, noted involvement of the

Community Mental Health Team and Children's Social Care and asked for an appointment to be made. Why this request was overlooked remains unknown.

Mental Health Services

It seems likely that the severity of mother's depression coupled with her declared thoughts to harm others (and disclosure to Home-start in October 2011 that her voices were telling her to kill herself and her children) should have triggered a referral at that stage for a formal psychiatric assessment. There are some indications that IAPT therapist 1 felt constrained, perhaps by a mistaken notion of client confidentiality e.g. she did not follow up her supervisor's suggestion in January 2012 of involving the health visitor; was reluctant, in spite of mother's reported consent, to discuss the case with the local drug addiction support charity in April 2012.

The former local IAPT Service during 2012, under-estimated the need for formal psychiatric assessment and the implications of the reduction in the level of engagement to about 50% of appointments. Therapist 1's letter of October 2012 confirming case closure reported 'significant improvements with respect to anxiety and depression scores'. Mother had only just begun to take her prescribed anti-depressant / anxiolytic medication. It is unlikely that any improvement was attributable to that. Mother's undiminished and ongoing expressions of mental health difficulties pose questions about the accuracy or validity of the scores provided by the former local IAPT services.

Following mother's re-engagement with the former local IAPT Service in summer 2013 therapist 2 met the couple in November. The therapist recognised at once that their ability to safely parent 5 children (in particular the youngest 2) was questionable and made a prompt referral to Children's Social Care.

Hospital Medical & Midwifery

With the exception of its failure to notify S2's GP of his broken arm in 2012, medical services provided by the involved hospital 1 and Minor Injuries Unit with respect to accidents to S2 or S3, were unremarkable. The response of the midwife CM1 prior to the birth of S4 was of a high standard, though her well-informed view that a psychiatric assessment might be required was subsequently overlooked by GPs and obstetrician.

Health Visiting

There was no communication between the health visiting and mental health services in the period April 2011 to January 2014 and health visiting records contain no reference to mother's reported auditory hallucinations. There were conversations during 2013/14 between health visitors, Home-start, GPs and Children's Social Care staff though the implications of her mental health difficulties for parenting were under-estimated.

Children's Social Care

Aside from routine responses to Probation in 2011 and later processing of Police notification of the domestic incident of August 2012 the most substantive opportunities for joint work and a shared understanding of the risks represented by mother's mental health were:

- The referral from the voluntary sector and subsequent core assessment and child in need plan formulated in Autumn 2011
- An anonymous referral of October 2013 followed in mid-November by referrals from therapist 2, the children's school and in late November contributing to the Police and partner agencies responses to the abusive incident

Though the attempt to develop a multi-agency response in 2011 was well intentioned, its potential value was lost in part because insufficient attention was paid to mother's mental health and learning difficulties and in part because the 'plan' emerging involved little more than was already being provided by involved agencies. In hindsight mother's mental health and cognition were of central relevance to her overall under-functioning as an adult and as a parent.

The impact of what *was* provided was reduced by an absence of agreed minutes and further reduced by confusion when no social worker attended the review meeting in February 2012 and by subsequent uncertainty about whether the children remained 'children in need'. The decision in April 2012 to close the case was taken without the benefit of a multi-agency review of progress and was therefore insufficiently informed. The response to what seems to be a deterioration of family functioning toward the end of 2013 remains uncertain and possibly ineffectual, in that:

- No records of the crucial pre-Christmas 'child in need' meeting were kept (a systemic weakness)
- No confirmation of the health visitor completing her agreed visit on 23.12.13 has been located
- No action appears to have been taken in response to the report provided on 06.01.14 that mother had tried to drown herself
- The first and perhaps only recorded visit by SW3 (due to visit 'every 10 days') was on 09.01.14
- The child in need review meeting was postponed at very short notice and had not been re-instated prior to child L's injuries

Police

When police officers attended the August 2012 domestic incident, records confirmed no evidence of parental use of drugs or alcohol. Mental health or learning difficulty issues were not considered. The next involvement was in response to the abusive incident in November 2013. The response was sensitive and thorough, and mother's vulnerability by virtue of cognitive functioning or depressed affect was not apparent.

THEME 3: APPRECIATION OF MATERNAL MENTAL HEALTH BY SUPPORT SERVICES

Family Support Agencies & School

Though the voluntary agencies (Home-start in particular) had had more experience than any others of how mother coped with intimate relationships and parenting, they had not

characterised her long-standing difficulties as being a function of mental ill-health or a cognitive deficit sufficient to cast doubt on her parenting capacity. However, when mother reported her auditory hallucinations, Home-start was quick to alert Children's Social Care. Home-start and the school where staff also had a long-standing familiarity with the difficulties both parents faced and presented, were fully involved in the partnership planning of late 2011.

The above planning did not though have the benefit of the recently completed local adult mental health service assessment or even the summary of its work provided to and filed away without a further response at the GP Practice. Neither was the substantive support thereafter provided to mother (and the family) informed by the views of her treating therapists. This left the support agencies and school largely dependent upon their own direct contact and what was shared by Children's Social Care during its episodic involvement.

Probation & the drug addiction treatment centre

The Probation Service had no responsibility for mother. Father did though share with OM1 and OM2 his difficulties in coping with mother's behaviours. The account provided by father prompted the referral in October 2011 for 'family support' to the local drug addiction support charity, which was already involved by virtue of providing a site for the work of the drug addiction treatment centre.

It is unclear whether Probation was present at the partnership meeting in November 2011 nor how much information about mother's mental health was known to or shared amongst those present. The focus of the subsequent review meetings attended by local agencies was *not* on mother's mental health though the paucity of minutes render it difficult to be certain about the topics addressed.

The involvement of the drug addiction treatment centre ceased in summer 2012 and OM2 had relatively little involvement and none relating to mother's mental health in the final year of the father's Community Sentence.

GP Practice

Insofar as mother's symptoms first reported in October 2011, appeared moderate and did not (according to records) include auditory hallucinations, the suggestion of a self-referral to the former local IAPT Service with which mother had had an historical involvement was a reasonable one. The results of the initial assessment, which was provided to GP Practice 1 and simply filed, included mother's 'thoughts of harming others'. The inherent risk of the GP making no response to that revelation was compounded by an ensuing 3 month delay before therapist 1 was able to offer mother any treatment.

The view of the current equivalent service is that the symptoms apparent at this time required an immediate referral by the GP to the CMHT and that the former local IAPT Service should *not* have retained the case.

The majority of mother's numerous self-presentations at GP Practice 1 (and the out of hours service) reflected non-physical or primarily non-physical illness. Although each clinician appeared to be clear that this was the case, there was little thought given to the

probable impact on her parenting of a growing number of children. The apparently positive closing summary from the former local adult mental health service of October 2012 was in sharp contrast to the ongoing experience at the Practice and cannot have provided much genuine reassurance. At no time, did any clinician initiate contact with health visiting or other colleagues.

The urgent referral made to the Community Mental Health Team in October 2013 by a GP was appropriate though under-informed by accurate or timely contributions by a midwife or health visitor.

Mental Health Services

As indicated previously, there appears to have been confusion within the former local IAPT Service as well as between it, the Community Mental Health Team and GP Practice 1 with respect to its unique role. On advice received from the current provider of the equivalent service, therapist 1 and her supervisor (who appeared to have had some appreciation that mother's needs extended beyond the remit of the former local IAPT Service) should have liaised with the referring GP and/or sought consultation with the Community Mental Health Team.

The confusion about the respective roles of the former local IAPT service, the Perinatal Service and Community Mental Health Team remained apparent in late 2013 (and presumably underpinned the development of what was labelled an 'intermediary service meeting'). The confusion needs resolution and a recommendation has been made to the Essex Safeguarding Children Board.

Insofar as mother had already received in three preceding periods unsuccessful cognitive behavioural therapy the plan formulated by psychiatrist 2 in December to re-engage the former local IAPT Service with a view to further such treatment remains unexplained. So too, does the ill-evidenced comment in the 'psychiatry care plan' sent to GP Practice 1 that mother 'was able to look after her children'.

Hospital Medical & Midwifery

At mother's initial ante-natal appointment for S4 in October 2011 CM1's commendable internal alerts and external referrals offered the safeguarding network an opportunity to evaluate mother's mental health. The obstetric care that followed in mother's pregnancy with S4 took no account of mother's mental health or wider social circumstances. CM1 indicated in the post-natal discharge sent to GP Practice 1 in July 2012 that there were mental health issues but this reference was not picked up.

When mother booked at hospital 2 in late March 2013 the fact of her history of depression was noted and passed on to the GP Practice where it triggered no specific response. The unusually high level of mother's anxiety at the time of child L's birth was passed on to the GP Practice 1 at the time and CM2 made further direct contact when mother became preoccupied by her further fears.

Health Visiting

As far as the Health Visiting Service was concerned, the primary source of information about mother's mental health condition was mother herself. In the view of the IMR author, there was scope for sharing more of this than actually occurred.

Children's Social Care

The first awareness within Children's Social Care of mother's mental ill-health was in October 2011 when its 'Assessment & Intervention Team' was informed of her auditory hallucinations. Whilst the progression to a core assessment and later decision to develop a multi-agency child in need plans were sensible responses, the focus on the tangible, coupled with the exclusive containment of mother's mental health needs by the former local adult mental health service meant that no pre-birth assessment of the family's ability to provide safe and good enough care to the child-to-be was completed.

Because it closed the case in April 2012 the agency would have had no awareness of mother's reducing commitment to her former local adult mental health service sessions during the remainder of that year, nor therefore to what extent this reflected any change in her ability to adequately parent her children.

Following the anonymous referral in October 2013 the agency was told by HV1 of mother's low mood state / possible post-natal depression. HV1 agreed to make a home visit and *may* have done so. Children's Social Care took no further action with respect to the reference to depression; nor is it clear that there was further liaison with the health visitor.

Finally, when Children's Social Care received the referral from therapist 2 in November 2013, he had expressed the view that the individual needs of each parent were so substantial as to prevent them adequately caring for the children. The need for the assessment that was triggered by the therapist's referral was reinforced when the school also made contact. The assessing social worker was told clearly by therapist and school of mother's significant chronic anxiety (and of signs of physical neglect of S1, S2 and S3). The newly allocated SW3 helpfully accompanied mother to her first out-patient / care planning review so was aware of the plan for medication and further cognitive behavioural therapy.

The conclusion of the Children's Social Care assessment that a further child in need plan was required, was informed by the proposed psychiatric care plan. Indeed the child in need meeting in December was attended by the care planning co-ordinator from the Community Mental Health Team. Evaluation of any progress made *would* have been undertaken at the review meeting of 19.01.14 had that not been postponed.

Police

Police would have had no knowledge of mother's mental ill-health until the abusive incident in November 2013. Officers involved showed commendable sensitivity to the vulnerability they discerned.

THEME 4: SENSITIVITY TO DOMESTIC ABUSE

Family Support Agencies & School

Though Home-start records in 2011 confirm arguments between the parents, there were no allegations or evidence of domestic abuse at that time. Its records of autumn 2012 reflect a period of high tension between mother and father with the former contemplating separation. Mother's reported reasons for sticking with father seems to have been recognition, thought by Home-start staff to be realistic, that without him she would struggle to manage the then three children.

The first reference to possible financial abuse was in January 2013 when father reportedly took out a 'Wonga' loan in mother's name. A further example arose in June when mother referred to father drawing money out of the bank before she could get there. Mother also spoke at this time of her fear that father would return to robbery. A third reference to what may have been an example of the price mother was paying to have support with the children arose in September 2013 when father had reportedly opened up a further account in her name. The facts behind these assertions remain unknown.

Though mother alluded during October 2013 to 'nasty things' that father had done to her in the past, she did not elaborate. There was a further incident in November, which suggests that father had lied to mother about money.

Home-start staff were fully appraised and supported mother through the abusive incident in November 2013. It would appear that the school had never had any reason to suppose from observed behaviours or comments of the children that there might have been domestic abuse in their household.

Probation & the drug addiction treatment centre

An inability to trace the referral made to the drug addiction treatment centre by Probation in summer 2011 means that the issue of whether it contained a reference to any history of domestic abuse is unknown. The difficulties between father and mother *were* discussed regularly in individual sessions with the drug addiction treatment centre practitioner and in 3 way meetings involving OM1 and OM2. Records refer to father's appreciation of mother having previously suffered domestic abuse and how he was able to find other ways of managing feelings of anger and frustration. There was though no explicit exploration of the possibility of domestic abuse. In the light of all known information, there should have been.

GP Practice

The *possibility* of domestic abuse might usefully have been considered in late January 2012 when mother presented herself at GP Practice 1 and reported 'tripping over her daughter and injuring herself'. At the vast majority of mother's numerous self-presentations at the GP Practice 1 only narrow medical issues or her anxiety state was considered; familial issues such as domestic abuse or the welfare of the dependent children were not considered and no liaison with relevant others initiated. None of father's relatively few presentations offered any suggestion of domestic abuse.

GP Practice 1 became aware of the abusive incident in November 2013 only when mother had a consultation with GP11. This GP was sufficiently concerned about the state of mother's mental health at this time to discuss the need for sectioning with psychiatrist 1 but not to liaise with a health visitor or Children's Social Care.

A later opportunity to raise the issue of domestic abuse arose when (supported by a Sure Start worker) mother consulted the now retired GP8 in October 2012. Though her own childhood and her relationship with father were discussed, the question of domestic abuse was not raised.

Mental Health Services

The content of mother's extensive contacts with therapist 1 remain largely unknown, though seemed to have been preoccupied with anxiety relating to her children rather than relating to any form of domestic abuse.

Hospital Medical & Midwifery

Opportunities by medical or midwifery staff to detect or explore any form of domestic abuse were very limited and no overt indicators emerged. Though not apparent from records, midwives during the course of mother's pregnancy with child L did converse with mother and discussed the quality of her relationship with father. Mother disclosed no concerns about any form of domestic abuse.

Health Visiting

The involved health visitors were aware of the domestic abuse within the household and arguments, alongside father's controlling behaviour were all known. Mother's own perception was that because father was not violent, other forms of abuse, including financial, were of less importance. The health visitor and others *had* in late 2013 shared details of a suitable refuge if mother was to decide that this was necessary.

Records do not indicate that health visitors discussed with mother and/or father the damaging impact on the children of witnessing or being aware of any form of domestic abuse. It would appear no use was made of any relevant tools for the evaluation of the impact of the ongoing, possibly mutually abusive relationship.

Children's Social Care

A proportion of possible financial or emotional abuse became apparent to those undertaking social work assessments. It may be argued that a proportion of father's controlling conduct reflected mother's struggle to cope and that she was, in addition to intrinsic cognitive limitations, constantly distracted by chronic anxieties, thus rendering an assumption of control by father helpful. For example, the paternal grandparents spoke of mother's inclination to destroy mobile handsets if she was angry with a caller. They reported that this led to the couple having only one phone, retained by father. The actual balance of power and its impact on the children remains unknown since the issue was never tackled by any agency. What *was* recognised by mother and professionals in other agencies was father's active involvement as an apparently conscientious parent.

Police & Ambulance Service

Though a notification to Children's Social Care *was* in fact later dispatched, the first domestic incident attended in summer 2012 was minor. The abusive incident in autumn was very effectively investigated. The Ambulance crew demonstrated a responsible attitude in January 2014 when, in response to a concern about mother, rather than the children, they recognised vulnerability and initiated a 'safeguarding referral' to Adults Social Care.

THEME 5: RELEVANCE OF FATHER'S DRUG USE TO FAMILY FUNCTIONING?

Family Support Agencies & School

School staff had no knowledge of father's history of drug misuse until (*presumably* – absence of minutes render confirmation impossible) it was shared at the meeting in November 2011. Father's presence had anyway acted as a stabilising force. It had for example improved the children's school attendance.

Records provided by Home-start confirm that staff became aware at some point in 2011 of father's DRR. The justifiable understanding in that agency was that all tests for illicit use of drugs had provided negative rendering that source of concern about parenting irrelevant. The contact initiated by the local drug addiction support charity to the former local adult mental health service during early 2012 showed a sensitivity toward the needs of the children.

Probation & the drug addiction treatment centre

The formal 'sentence plan' should have included objectives specific to the needs of the children, whose existence and significance was acknowledged by both offender managers - mainly in relation to the impact on father's likelihood of re-offending or resuming misuse of drugs. Father was quite open about familial issues and a DRR review in September 2011 had noted a brief separation and reconciliation. In response to father's acknowledgment of mother's pregnancy, the drug addiction treatment centre worker recognised the implications for the existing children and unborn baby and informed him Children's Social Care would be informed (in fact the Midwifery provided a comprehensive referral just a few days later).

The drug addiction treatment centre also provided a report to the partnership meeting of November 2011 and its later review, which assisted those present to develop and update their collective response. During an exchange between Probation and the drug addiction treatment centre in February 2012 it was agreed that father was no longer misusing drugs but that there remained concerns about him controlling his temper. Records do not clarify whether the implication for the children (or mother) were explicitly in the minds of those professionals.

OM2's contact with father during the final twelve months of his sentence was limited and the Order ended before mother's pregnancy with child L became apparent, hence there was no opportunity for a discussion about how a fifth child might impact upon father's abstinence and ability to cope as a parent.

GP Practice

GP Practice 1 was placed at a disadvantage with respect to awareness of drug misuse by the failure of father's previous Practice to enter into its records his compulsory and later voluntary attendance at the drug addiction treatment centre. This significant information may have remained unknown unless father alluded to it during one his relatively infrequent consultations.

It is probable that when father was seen by a nurse at Practice 1 in June 2012 and he complained of a low mood state, stress at home and unemployment, she would have had little or no knowledge of his history of drug misuse nor wider social circumstances.

Mental Health Services

Because the agency's records were not made available, it is uncertain to what extent mother may have alluded to father's historic misuse of drugs while being seen by therapist 1 or therapist 2.

'Couples work' in late 2013 had scarcely begun before it ended so it seems improbable that father's previous drug misuse, and risks of unsafe parenting in the event of a relapse could have been addressed. Therapist 2 was sufficiently concerned by how the parents presented to take the urgent action he initiated.

Hospital Medical & Midwifery

The post-natal discharge completed in July 2012 by the Midwifery Unit and provided to GP Practice 1 indicated that there were no 'complex social factors / safeguarding issues'. It may be assumed that father's personal history remained unknown to the staff completing the report.

Health Visiting

Though health visitors were aware of father's history of drug misuse, its potential relevance to his care of the children and/or to the relationship with mother was apparently not clear from records.

Children's Social Care

Children's Social Care first became aware of father's misuse of drugs when the author of his pre-sentence report made contact in August 2011. It was anticipated father would not receive a custodial sentence and would therefore be co-habiting with the mother of S1, S2 and S3. In the absence of any other evidence of concern, the written reassurance that…'there are no specific concerns about the children'…was enough to justify closing the referral down.

No further information was received that suggested *any* current mis-use of drugs by father. The absence of any minutes of the child in need meetings, where potentially information from other relevant agencies would be collated, means that any quantification or evaluation of what at times was considered by the drug addiction treatment centre to be excessive *alcohol* consumption may not have been undertaken.

Police

Officers who dealt with the first domestic incident in August 2012 observed and recorded that there was no evidence of drugs or alcohol having precipitated or exacerbated the argument. Though father, by virtue of his extensive criminal record would have shown up in several databases, it seems unlikely that such checks would have been undertaken. Nothing noted prompted any concern for the welfare of the only child present (S4).

THEME 6: CHILDREN'S VOICES

Whilst the material supplied may not do justice to the extent to which the varying wishes, feelings and fears of the children were actually sought or considered, reference to them in the material supplied to the panel was limited . For that reason agencies have not been considered individually as they have been in addressing the other themes above.

The school's observations of the appearance, affect and behaviours of S1, S2 and S3 in late 2013 were almost the *only* times that they emerge, though to what extent those indicators were then factored into the multi-agency planning is hard to discern. Because there were no minutes of most multi-agency meetings, it is not possible to know whether each or any child's views were sought about the planned ways of supporting the family.

In advance of the formal assessment initiated in November 2013 the school had already been sufficiently concerned about the distress of S3 to have contacted Children's Social Care. It also contributed its previously un-aggregated observations of the children when asked to do so by SW2.

The assessment in November 2013 *did* appropriately involve meeting the children and the Children's Social Care IMR reports that it includes a detailed account of all the children. What was discovered about their individual ways of coping with their family and how that influenced further planning of family support have not been shared with the serious case review panel.

A chance remark by S1 (then 7 years old) when her mother was being seen by GP12 in September 2013 because of reported difficulty in breathing was noted. The child commented that her mother 'often had that feeling'. Though not an area explored in material provided to this serious case review, it seems likely that this eldest child was becoming or was anyway likely to become something of a 'young carer' to her chronically anxious mother.

THEME 7: FORMAL ASSESSMENTS OF NEED & RISK

Family Support Agencies & School

Information provided by Home-start in response to the request from Children's Social Care usefully highlighted a particular difficulty that mother seemed to be experiencing in respect

of child L. It also drew attention to some of father's behaviours that suggested emotional, financial and possibly physical abuse of mother.

The significance of Home-start's extensive involvement with the family may have been underestimated in the assessment. The opportunity its involvement represented was a closer sense of the family's strengths and weaknesses than was available elsewhere. There was also a need to address the issue of the extent to which the family was coping *only* because of the high level of ongoing support and what would happen if it were reduced or withdrawn?

Probation & the drug addiction treatment centre

It appears that these two sources of potentially useful information remained unexplored in Autumn 2013 possibly because father's active involvement with the drug addiction treatment centre had ceased in 2012 and that with Probation in the Summer of 2013.

GP Practice

As has been reported elsewhere, a written request was made by Children's Social Care, albeit on the wrong form and without the confirmation of parental consent claimed to accompany it, to the GP Practice for information that could help complete a picture of the family and its level of need. The content of the Practice's response has not been shared with the serious case review panel.

Mental Health Services

The level of discussion by SW2 with either the former local adult mental health service or CMHT is unclear from material provided. If neither source of information and advice was explored, it represents a missed opportunity.

Hospital Medical & Midwifery

These sources of information and expertise were not involved in the assessment of need in autumn 2013 or in any formal pre-birth assessment of risk.

Health Visiting

An unidentified health visitor had taken the case to safeguarding supervision in mid-November 2013 and her views were appropriately sought for the purposes of the Children's Social Care assessment. Setting aside the worrying muddle that ensued about the receipt of what she had sent, its content and how it informed the assessment remain unknown.

The result of the assessment completed in late 2013 was *not* shared with the Health Visiting Service. This fact has been reported by some managers in Children's Social Care to reflect its local policy viz: the agency draws on the information available from relevant agencies but regard the emerging assessment as confidential to the individuals concerned. The need to explore and clarify this policy has prompted a recommendation.

Children's Social Care

The anonymous referral in October having triggered a very limited response, the more substantive one from therapist 2 in November 2013 did appropriately prompt a formal assessment.

The serious case review panel was not provided with a copy of the assessment but the Children's Social Care IMR offers a reassurance that its analysis was informed by contributions from most, though not all relevant agencies. The assessment did capture and consider mother's history as a child in care and more recent periods of involvement with the agency as well as her chronic anxiety. The assessment is said to have needed more analysis about why previous attempts to promote greater self-sufficiency had failed.

Police

Though there was a significant level of contact whilst Police investigated the abusive incident in November 2013, it would appear that the Police were not directly invited by Children's Social Care to contribute to the assessment being completed. The exchange between DC2 and TM2 in late November suggests perhaps a level of resistance to a joint approach.

THEME 8: INTERPRETATION OF THE OVERUSE OF AMBULANCE SERVICE & EPISODIC INJURIES TO CHILDREN

The IMR provided by the East of England Ambulance Service Trust (EEAST) explains that what appeared to have been a remarkably high use of ambulance usage is not as unusual as it first appears.

The frequency of calls was anyway insufficient to have triggered the Trust's 'frequent caller' threshold and was contextualised by local professionals who pointed out that the alternative to an ambulance for some families if they felt an urgent need to access A&E services would be a taxi ride costing £45 each way.

The frequency of ambulance use is not routinely notified to any other agency and in the view of the author, any such system would be disproportionate to the need or risk implied. The meaning of a high frequency of such calls is best initially evaluated by the Service and action/s triggered by that evaluation.

Aside from the injury in January 2014 that prompted this review, and even with the advantage of hindsight, there is limited evidence of injuries or a need for emergency medical treatment that *should* have been responded to as suspected 'non-accidental' or which were mistakenly tolerated because of misplaced sympathy for the family. Advice from staff in Home-start is that mother was overly cautious with respect to her children and preoccupied about the risks of illness or accident. Insofar as records are complete and accurate, responses to all but one (S2's broken arm) of the episodes were within the range of reasonable.

It *would* have been helpful, though was unlikely to have been decisive if the episodes and other concerns that were spread across the local network had been more efficiently shared and evaluated via child in need planning processes.

SUMMARY OF IMPACT OF MULTI-AGENCY SERVICE DELIVERY

There is no evidence to conclude that any involved professionals could have predicted the injury that child L suffered, but the preceding analysis of the way in which agencies worked together has highlighted a number of systemic weaknesses.

In some respects, it appears that professionals have reflected the apparent chaos and dysfunction within this family. It does not appear that they were overly optimistic, as has emerged often in other serious case reviews. They may have been somewhat overwhelmed by the intractability of the issues they faced.

Professionals did not seem to sufficiently appreciate the respective remit and responsibilities of other agencies. Home-start in particular appeared to have been seen by other agencies inappropriately as providing a 'safety-net' for this family. There was insufficient coherence of involvement of health professionals in relation to primary health services and with respect to mother's mental health.

Because of the scope determined by the terms of reference, little sense of the parents' own childhood and its probable impact on ability to parent has emerged. It has latterly been reported that both parents were in care at times as children and mother was subject to a child protection plan three times. These facts may have been unknown and anyway did not inform professionals' analyses of need.

The interventions and focus of professionals were generally adult-orientated, not child-focused, with little sense of 'what it was like being a child in this family'. There were clearly insufficient co-ordinated assessments of the parental relationship, respective learning difficulties and parenting capacity or the significant impact of mother's mental health.

The family was recognised as especially vulnerable with mother loving her children but at times overwhelmed by anxiety-related mental ill- health issues. The professional focus was largely on day to day support rather than a co-ordinated plan to effect change. There did not seem to be either clarity or a plan about what needed to change, why, and how this might be achieved.

There are contrasting views as to the extent of domestic abuse within the parental relationship , but 'controlling behaviours' certainly seems to have been an issue and was insufficiently explored by agencies in their working with the family. The substantial practical and emotional support offered to the family , whilst undoubtedly helpful in respect of keeping the family functioning on a day-to-day level , also obscured the extent of the difficulties and the struggles the parents were experiencing.

The family situation deteriorated from autumn 2013 and there is a sense that child L (the fifth) may have tipped the family functioning 'over the edge'. No sense emerged from material provided of what child L meant to his parents, particularly to his mother. It seems likely that the parental relationship at the time of conception was probably in difficulties.

Mother at times seemed to be ambivalent in relation child L e.g. she had contemplated a termination and some reports suggest a less secure attachment to child L than to his older siblings.

Whilst the material supplied to the serious case review panel enabled a detailed picture of agencies' involvement with this family to be considered, it could not fully explain (other than the fact that this family was not significantly more dysfunctional than many others in receipt of services) why professionals did what they did, and why the plans for supporting and working with this vulnerable family were as uncoordinated as they were.

CONCLUSIONS

GENERAL

Efforts to support child L's family were unhelpfully spread across several agencies, the respective roles of some were (and to some extent remain) insufficiently clear. The net result was a *fragmentation* (of particular significance amongst the primary health care and mental health-related services) of the considerable volume of individual efforts and resources provided to the family.

Well-intentioned attempts by Children's Social Care to co-ordinate the substantial efforts of many professionals in 2011 and 2013 were poorly managed with a consequent underestimate of risks and premature case closure after the first episode of involvement.

Mother's mental health needs which were of *central* importance to the safety and emotional welfare of the children were insufficiently apparent to those actively involved in family support.

This was in part a consequence of the inappropriate retention of the case by the former local adult mental health service coupled with its unjustified reluctance to share information even when mother's consent had reportedly been given.

SPECIFIC

More specific conclusions emerging from the evidence considered are that:

Positives

- the drug addiction treatment centre liaised well with Probation, the local drug addiction support charity and Children's Social Care & provided regular supervision of its allocated workers
- The school was very supportive of the children though *may* have under-estimated the aggregated significance of individual incidents
- Home-start provided a great deal of material and unconditional psychological support, for a long time before and throughout the period of review

- Health visitors were very attentive but worked in relative isolation from GPs
- Police responses to the abusive incident were sensitive and thorough
- The Ambulance Service was very responsive to the family's heightened needs and potential improvements are limited to the quality of some record keeping and capacity to retrieve records
- Community midwives were *extremely* attentive during mother's pregnancy with and after delivery of child L

Systemic weaknesses

- GP responses were unduly medically focused and illustrated insufficient awareness of or interest in social circumstances and potential safeguarding issues – a number of internal systemic weaknesses have also been identified
- Former local adult mental health service staff worked outside of their remit and in isolation thus adding confusion to the already insufficiently understood array of local services
- The extent of involvement of Children's Social Care was insufficient and the case 'stepped down' in spite of contra-indicators
- There is a *widespread* need for a clearer understanding of the essential roles, approaches and terminology of other local services & a vital need to develop and use a common language for multi-agency work e.g. distinct roles of Sure Start, Home-start, Children's Centre, the former local adult mental health service and Community Mental Health Teams, and 'core groups', 'partnership meetings', 'child in need' meetings, 'safeguarding conferences' etc.
- Services were insufficiently co-ordinated e.g. Practice 1 GPs did (and do) not liaise sufficiently with health visitors, Children's Social Care management of partnership / child in need meetings was inadequate
- Examples of some poor recording or information systems were seen in most agencies e.g. Probation (no record of some home visits), the drug addiction treatment centre (absence of its referral from Essex Probation), GP Practice 1 (inadequate 'summary screens'), CMHT (loss of historical data about post-natal depression); Hospital 1 (absence of written handover to health visitors)
- The possibility of domestic abuse was insufficiently explored during mother's fourth pregnancy but by the time of mother expecting child L had become routinised in the Midwifery Service hence no recommendation for service improvement has been made.

SERVICE IMPROVEMENTS ALREADY IN PLACE

In response to what has been emerging from this review, a number of initiatives have already been taken and for that reason, the need to provide a recommendation been avoided:

- The Joint Domestic Abuse Assessment Team (JDATT) is reported to be well established
- The child in need (CIN) function within Children's Social Care (which at any one time is coping with over 2,000 cases) has adopted a welcome level of formality comparable to that longer established for children subject of a protection plan i.e. minimum frequency of visiting and independent chairing of priority reviews

4 RECOMMENDATIONS

PARTNER AGENCIES NEED TO ASSURE THE ESSEX SAFEGUARDING CHILDREN BOARD THAT:

1. The lessons from this SCR are disseminated to their staff and lessons learned locally are implemented and included in their internal training programmes.

ESSEX SAFEGUARDING CHILDREN BOARD IS RECOMMENDED TO:

2. Promote better understanding of the changing roles, mutual expectations and operational pathways, by co-ordinating workshops jointly delivered between:

   - Local providers of mental and physical health services
   - Criminal Justice agencies (National Probation Service, Community Rehabilitation Company and other local providers)
   - Clinical Commissioning

3. Ensure that the learning from multi-agency case audits on Child In Need, specifically in relation to information sharing, is disseminated across partner agencies.

3.1 Ask partner agencies to report how this learning has been communicated to their practitioners to enable them to have a better understanding of the importance of appropriate information sharing.

4. Re-circulate the Serious Case Review Toolkit which sets out the expectations around parental consent to access their health-related records, and the extent that this can be overridden when a Serious Case Review is being conducted.

5. In collaboration with the Adult Safeguarding Board, ensure that policy and procedures relating to parental mental health and the impact on adequate parenting are fit for purpose, backed up by cross service training programmes and monitored via multi-agency audits.

THE ESSEX SAFEGUARDING CHILDREN BOARD INDEPENDENT CHAIR IS RECOMMENDED TO:

6. Write to the Director of NHS Commissioning to ask them to consider the need for GP standard contracts to include:
   - Communication with health visitor and others
   - Information sharing
   - Recording who presents a child
   - 'Household composition' so as to capture new adult patients joining a household with existing children

5 BIBLIOGRAPHY

General

- *Working Together to Safeguard Children,* HM Government 2010 & 2013
- *Improving safeguarding practice, Study of Serious Case Reviews, 2001-2003* Wendy Rose & Julia Barnes DCSF 2008
- *Analysing child deaths and serious injury through abuse and neglect: what can we learn*? A biennial study of serious case reviews 2003-2005 Marian Brandon, Pippa Belderson, Catherine Warren. David Howe, Ruth Gardner, Jane Dodsworth, Jane Black, DCSF 2008
- *A Study of Recommendations Arising from Serious Case Reviews* 2009-2010 M Brandon, P Sidebotham, S Bailey, P Belderson University of East Anglia & University of Warwick
- Understanding Serious Case Reviews and their Impact a Biennial Analysis of Serious Case Reviews 2005-07 Brandon, Bailey, Belderson, Gardner, Sidebotham, Dodsworth, Warren & Black DCSF 2009
- *Building on the learning from serious case reviews*: A two-year analysis of child protection database notifications DFE – RR040 ISBN 978-1-84775-802-6 2007-2009
- *Learning Lessons, Taking Action*: Ofsted's evaluations of serious case reviews 1April 2007 to 31 March 2008 Published December 2008
- *Ages of Concern*: learning lessons from serious case reviews: a thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011
- *Learning Together to Safeguard Children*: A 'Systems' Model for Case Reviews March 2009 SCIE
- *New learning from serious case reviews*: Marian Brandon et al RR226 DfE 2012
- *Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers HM Government March 2015 Ref DFE-00128-2015*
- *Personal Guide to the Children Act 1989 / Child Protection* CAE Ltd www.caeuk.org

Case-specific

- 2015-16 National Health Visiting Core Service Specification NHS England October 2014 ref: 02230
- Essex County Council Children in Need Practice Guidance January 2014
- [2015] EWFC 11 Before Sir James Munby President of the Family Division In the matter of A (A Child) between Darlington Borough Council and (1) M, (2) F (3)GM and GF, (4) A (by his children's guardian Case number MB14C01592 at Royal Courts of Justice
- Review of Health Services for Children Looked After and Safeguarding in Essex (Communities served by Mid Essex, North East & West Essex Clinical Commissioning Groups Care Quality Commission 2014