Overview report on the SERIOUS CASE REVIEW relating to Child AA

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1. INTRODUCTION

1.0 Background to the review

1.1 This serious case review has been carried out as a result of serious injuries to a 10 week-old baby, Child AA, whilst in the care of young parents, who were living in a hostel for the homeless. Child AA was the younger of 2 small children, being born prematurely at 31 weeks gestation. The older sibling aged 13 months, had been subject to a Child in Need Plan with Children's Social Care, and this continued following Child AA's birth. In the 6 weeks leading up to the injuries, there had been many concerns raised about Child AA by the health professionals, but the level of these concerns was not fully understood by social workers. A professionals meeting was held on the 6th of June 2014 to seek to resolve differences of opinion between the two agencies and a full parenting assessment was agreed. Unfortunately this was overtaken by an incident on the 15th of June 2014, when Child AA was taken to A&E by ambulance. Child AA was described as being floppy and unresponsive, and a CT scan revealed "…*bilateral subdural blood from different ages, meaning there has been more than one incident*"[1]. This was considered to be non-accidental injury and both parents were subsequently arrested by the police and bailed pending further investigation.

1.2 At the time of writing, Child AA and the older sibling are in foster care, and Child AA's health is improving, though the child has suffered significant brain damage, the long term effects of which are still being assessed.

1.3 Criminal proceedings concluded in September 2016. Care proceedings in relation to both of the children concluded in December 2014.

1.4 In line with government requirements, the incident was referred to the Independent Chair of the Surrey Safeguarding Children Board (SSCB), who, following peer review, determined that it met the criteria for a serious case review, as set out in Working Together 2013.

1.5 One of the key questions for the review has been to consider whether the poor inter-professional communication and relationship between Children's Social Care and health visiting services in this case had an identifiable impact on the safety of the children. In addressing this it is important to note that the time scale from the discharge of Child AA home from hospital, four weeks after birth, to the serious injuries that resulted in this review was a matter of only 6 weeks. Events moved very quickly, and there was a huge level of visiting and support offered to the family in that period. However, there was no full assessment carried out following the birth of Child AA and professionals continued to work to an earlier social work assessment that did not draw fully on the history of the family. This meant that they did not have a full picture about the potential risks and stresses faced by the parents. It is possible that, had there been such an assessment at this time, there would have been a better shared understanding and a clearer focus on the emerging risks. However, it is impossible to conclude whether this would have resulted in a different

[1] SSCB Notification of Serious Incident Form 17/6/14

outcome, in preventing the injuries to Child AA, given the very short timescale in which action could have been taken.

1.6 It is also important to acknowledge that whilst hindsight enables us to learn from these events, staff involved at the time could work only with what they knew. The emotional impact of working with the family and of the events that resulted in this review, have been significant, and it is important to acknowledge that there was evidence of good practice, as well as areas from which LSCB partners can learn.

2.0 PURPOSE OF THE REVIEW

2.1 Working Together to Safeguard Children 2013 was the statutory guidance in force at the time of the review[2], provided by governments to Local Safeguarding Children Boards and their constituent agencies, and setting out how agencies should work together. It states that Serious Case Reviews must be held for:

"…every case where abuse or neglect is known or suspected and either:

- *a child dies; or*
- *a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child."* [3]

2.2 The purpose of a serious case review is:

- To establish lessons to be learned from the case
- To look at what actions and procedures may need to be changed
- To improve inter-agency working and better safeguard children

2.3 The guidance is clear that:

"Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children." [4]

3.0 THE REVIEW PROCESS

3.1 The review process reflected the principles set out in *Working Together 2013* and aimed to contribute to learning and improvement through consolidating good practice and identifying where practice could be improved.

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[2] This has subsequently been updated in 2015

[3] *"Working Together to Safeguard Children: A Guide To Inter-Agency Working To Safeguard And Promote The Welfare Of Children."* Page 68 HM Government March 2013

[4] *"Working Together to Safeguard Children: A Guide To Inter-Agency Working To Safeguard And Promote The Welfare Of Children."* Page 68 HM Government March 2013

3.2 These principles are as follows:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process.
- Final reports of SCRs must be published, including the LSCB's response to the review findings, in order to achieve transparency**.** The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections;

3.3 The review will recognise the complexity of safeguarding children and seek to understand not only what happened but why individuals and organisations acted as they did.

4.0 SCOPE OF THE REVIEW

4.1 The principal focus of the Review was the period from 01.09.2012 to 22.06.2014

4.2 However, the SSCB asked agencies to provide a summary of all significant events and relevant family history outside the specific scope and timescale, where this would help to inform the overall analysis.

5.0 THE FOCUS OF THE REVIEW

5.1 The SSCB agreed that the review should focus on the following questions:

1). Did agencies communicate effectively and work together to safeguard and promote the children's welfare?

2). Was the level and extent of agency engagement and intervention with the family appropriate? Were assessments undertaken in a timely manner, was the quality adequate and did they include fathers, extended family and all historical information?

3). Was any information known by any agency about parental mental health issues, domestic abuse, substance misuse or parental antisocial behaviours or concerns

re neglect? If so was appropriate consideration given to how these impacted on parenting capacity and were appropriate referrals made?

4). Was there sufficient consideration of the vulnerability of this family in relation to their housing situation and the impact on their parenting capacity and what support was provided?

5). Were the decisions and actions that followed assessments appropriate and were detailed plans recorded and reviewed?

6). Were the children's views and wishes sought and taken account of in assessments and planning? Did this include the presentation of these young non-verbal children being fully considered?

7). Were any safeguarding issues in respect of the children identified and acted on appropriately and in a timely way by all agencies?

8). Were missed appointments and failure to engage considered as indicators of neglect?

9). Was race, religion, language, culture, ethnicity or disability a factor in this case and was it considered fully and acted on if required? How was the uniqueness of this particular family recognised?

10). Were there any organisational or resource factors which may have impacted on practice in this case?

11). Were appropriate management/clinical oversight (supervision) arrangements in place for professionals making judgments in this case?

6.0 THE METHODOLOGY

6.1 The SSCB has a well-established methodology which this reviewer agreed to adopt. This reflects good practice in that it seeks to ensure that those most involved in the incident which resulted in the review are fully engaged and supported to reflect on their practice and to contribute to the recommendations from the review.

6.2 Governance of the review was provided by the Surrey Safeguarding Children Board Strategic Case Review Group, chaired by the Independent Chair of the LSCB, Alex Walters. The other group members were:

- Director of Rehabilitation and Deputy Chief Executive - Kent, Surrey and Sussex Community Rehabilitation Company
- Consultant Designated Nurse Safeguarding Children - NHS Guildford and Waverley Clinical Commissioning Group
- Designated Doctor Safeguarding Children - NHS Guildford and Waverley Clinical Commissioning Group
- Deputy Director, Children's Schools and Families - Surrey County Council (Children, Schools and Families Directorate)
- Head of Youth Support Services - Surrey County Council (Children, Schools and Families Directorate)

- Assistant Director - National Probation Service, South East and East Division
- Detective Superintendent, Public Protection - Surrey Police
- Director of Quality and Executive Nurse - NHS Guildford and Waverley Clinical Commissioning Group
- Assistant Director for Schools and Learning - Surrey County Council (Children, Schools and Families Directorate)
- Acting Principal Solicitor - Surrey County Council

6.3. The author met with the group on three occasions: 25th November, 2014; 23rd January 2015, and 26th March 2015, and had a telephone conference with them on 21st May 2015.

6.4. The methodology required that the relevant agencies provide details of their involvement, which was drawn together in to an integrated chronology. This was then supported by individual agency Internal Management Review reports - IMRs

6.5. The following agencies were asked to contribute IMRs;

- Surrey Hospital
- Community Health provider
- Surrey and Borders Partnership Foundation Trust
- Surrey Children's and Safeguarding Service
- Surrey GP
- The District Council (housing)

6.6. The following agencies had less direct involvement and were therefore asked to provide a briefing report rather than a full IMR:

- South East Coast Ambulance Service
- Surrey Police
- Surrey Early Years Service
- Surrey Schools and Learning
- St George's Hospital NHS Foundation Trust
- The Housing Support Agency

6.7 A neighbouring Children's Social Care service were also asked to provide information, which they did in the form of an email about their brief involvement with the family, before the birth of Child AA.

6.7 The reviewer attended a meeting of the strategic case review group on 25th November 2014, at which all of these reports were tabled and discussed. The IMR authors

were also present at this meeting and had the opportunity to present their reports and to discuss their findings with each other, with the group and with the reviewer.

6.9 Practitioners were then invited to meet with the reviewer in order to discuss their contribution and to reflect on learning and recommendations for change. Given that the chronology evidenced some clear differences of opinion between social care and primary health care professionals it was agreed that each of these groups of staff would be invited to meet with the reviewer separately prior to any larger multi-agency practitioners event.

6.10 The reviewer met with the four health practitioners from Community Health on 10th December 2014, and with the social care professionals on 9th January 2015. The delay between these meetings was due to the Christmas and New Year break and professionals leave arrangements over this period. Unfortunately, only 3 staff from social care, out of the 8 who were invited, were able to attend. These were the student social worker who had held the case from April 2014 (now a qualified social worker), the family support worker, and the social worker who managed the initial court proceedings following the injury and removal of the children from their parents. Unfortunately no managers were able to attend this session. The supervising manager for SW2 was on maternity leave, and the others were unable to attend due to operational pressures, although they did give apologies. There appears to have been a breakdown of communication in that some of the social work participants who did not attend had misunderstood the nature of the meeting, and therefore did not appreciate its importance to the review.

6.11 A discussion subsequently took place between the reviewer and the Area Manager for the Children's Social Care teams involved in the review on March 4th 2015. This has been enormously helpful in clarifying the context of the structural changes within the service and the overall system, and the learning for the social care service.

6.12 There was clearly a great deal of distress for staff about these events and both the reviewer and the serious cases group were keen to manage the review and the involvement of those staff with as much sensitivity as possible. This meant accepting that there would be a delay in completing the review to allow for staff to be properly debriefed and to comment on the draft report in a timely way. The draft report was circulated for comment and the responses incorporated into this final version.

6.13 The serious cases group have agreed to hold a further learning event engaging with the staff involved to give them time to debrief and to reflect, before any wider scale rollout of the learning.

7.0. HOW FAMILY MEMBERS WILL BE INVOLVED

7.1. Whilst it is the commitment of the Board and the reviewer to fully engage with the family, the parents have not responded to letters sent to them in October 2014 inviting them to be involved.

7.2 They will be contacted again prior to publication of the report to discuss their experiences of working with agencies.

8.0 THE REPORT AUTHOR

8.1 The report author is Ruby Parry, who is a senior associate consultant for Reconstruct, a children's services company which provides training and development and consultancy to children's services professionals, and advocacy and participation services to children and young people as well as serious case review expertise. Ruby is a registered social worker and former Assistant Director of Children's Social Care, an experienced author and reviewer, and meets the criteria for independent authors of serious case reviews.

9.0 PUBLICATION OF THE REVIEW

9.1 As previously stated, Working Together requires that Local Safeguarding Children Board's maintain a learning and improvement framework of which serious case reviews are part. The guidance states that there should be:

"….transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of Serious Case Reviews (SCRs) with the public." [5]

9.2 This report is therefore written with full publication in mind. That means that the names of the adults and the children, as well as some of the facts in this review have been changed to protect identities and to respect individual rights to confidentiality in relation to personal information. The report therefore contains only that information which will ensure that the facts can be understood in order for lessons to be learned.

10.0 DISSEMINATED LEARNING AND HOW CHANGE WILL HAPPEN AND BE MONITORED

The Board has a well-developed learning and improvement framework and the learning from this review will be incorporated into existing training, as well as being the subject of specific workshops with the practitioners and managers concerned. The action plan will be monitored by the Board.

11.0 CONTEXT OF THE REPORT

11.1 At the time that Child AA was expected and then delivered into the world, Children's Social Care (CSC) was undergoing a significant restructuring which had been phased in across the authority and was being implemented in the area responsible for the care of Child AA's family from April 2014. This was outlined in a paper to Surrey Children Safeguarding Board in January 2014, and involved a restructuring of the Area social care teams Assessment and Child in Need Teams to support the developing Surrey wide Early Help Strategy and the local authority's responses to the revised Working Together 2013 statutory guidance including the introduction of the single assessment process.

11.2 Staff state that they had been well prepared for this through a series of inclusive consultation and information events. The key changes in relation to Child AA and the way in which the case was managed, were in relation to the former Children In Need (CIN) Team within which SW1 and SW2 worked, being disbanded, and moving into a different model of

[5] Working Together, Op cit Page 65

working as an Assessment and Intervention Team sitting within the area Referral, Assessment and Intervention Service. The focus of the work within that team was, from 1st April, to provide an assessment and short term intervention to families, and then on the basis of this to make a decision about whether the case would be closed, stepped down in to the multi-agency Early Help system (with or without a social worker as lead professional, depending on need) or move into the specialist child protection (social work) team. Children in need who have been assessed and provided with a social care intervention through the single assessment process that remain vulnerable with unmet need or the family being in need of continued support would be supported by the Early Help System or a lead professional from the Referral, Assessment and Intervention Service. The management of Child AA's case however, did not reflect these new arrangements, and was managed as an existing Child In Need case.

11.3 Whilst there was no wholescale movement of staff, with only 5 social workers posts across the County moving in to the new Multi-Agency Safeguarding Hub, the health practitioners stated that this meant that some of the positive relationships previously built up with social workers were broken down as there was initial confusion about who they should contact about what. They were also aware of some morale issues as some social workers shared their concerns and anxieties with them.

11.4 The Community Health service staff described a positive and 'can do' culture in their own organisation where health professionals feel well supported and able to discuss concerns and to take creative action to support families. Their working context was therefore stable, and very different from the day to day experience of the social workers involved at the time of these events.

12.0 FAMILY CULTURE AND IDENTITY

12.1 The Oxford English Dictionary defines culture as being "*the ideas, customs, and social behaviour of a particular people or society*"[6]. The experience of family 'culture' can shape the way in which we as adults then view the world and seek to parent our own children[7].

12.2 The mother's family is White British and she was born and grew up in Surrey. She was known to CSC from an early age due to her mother's alcoholism and dementia, and she was a young carer. Her family life can be said to have been lacking in emotional nurture and care for her as a child in her own right, whilst her parents struggled with their own considerable health needs. She was bullied at school because of her mother's condition, and her school work and attendance suffered as a result. She became pregnant at 16 years old, and a mother at 17.

12.3 The children's father described himself to the health visitor as 'half Romany/Gypsy'. Culturally, this may have resulted in fixed ideas about the roles of men and women, most notably, that the men provide for their families, and the women take care of the

[6] Oxford English Dictionary

[7] See, for example, The Child's World, Jan Howarth, 2010

children – certainly the professionals records of father's behaviour suggest that this was the case.

12.4 There is little evidence of any extended family network or support to the couple and their children, and they appear to have been very isolated in this respect.

13.0 SUMMARY OF EVENTS

13.1 The integrated chronology which tells the detailed story of agency involvement with the family runs to 341 pages, and this is not reproduced here. Instead the following is a brief summary of events which provides the background to the analysis to enable connections to be made between these events and the learning arising from the review, without compromising the anonymity of the family concerned.

13.2 As above, Health and Children's Social Care records indicate that the mother had been known to Children's services from 2003, when she was 8 years old, until 2011 when the case was closed. Her own mother was admitted to hospital with alcohol induced dementia in 2008, and subsequently diagnosed with Korsakoff's' Syndrome – a form of early dementia associated with alcohol abuse. CSC subsequently started a Children In Need[8] (CIN) plan, and a referral was made to Child and Adolescent Mental Health Services (CAMHS) for the mother due to the emotional impact of her home life which manifested itself in physical palpitations. She then suffered a miscarriage at age 16.

13.3 The mother then moved areas to live with her partner and again became pregnant, presenting to her GP seven times through the pregnancy with abdominal pain, including once at 23 weeks when she complained of hip pain due to a fall.

13.4 Her first baby was born in June 2013, and she attended A&E with the baby 2 weeks later, worried that the baby was unsettled. During this period mother also indicated to hospital staff that children's social services had been called by neighbours due to shouting in the home, and the local Children's Social Care service has subsequently confirmed that they carried out both an Initial and Core assessment in July 2013, following allegations that the mother had been shouting at the baby and had tried to smother it with a pillow. However, they quickly closed the case following the assessment.

13.5 By September, 2013, the mother had presented to A & E eleven times, with anxieties about the baby but with no medical issues being identified. She was also at one point prescribed anti-depressants. On 6th October 2013 the GP received an NHS 111 notification that the mother had called because her 3 month baby had rolled off of the sofa and had a bump on the back of the head. She was advised to call her GP, but went to A & E instead, leaving before being seen. A&E therefore sent a safeguarding form both to the health visitor and to the local Multi-agency Safeguarding Hub, as well as asking the police to complete a welfare visit, which they did. This did not result in any further action, although the police report noted that the house was "*incredibly messy and with obstacles all over the*

[8] The Local authority has a duty to provide services to Children who are in Need as defined within Section 17 of the Children Act 1989. At this time, this was provided in Surrey as part of a CIN plan, which children's social care managed to coordinate help to families who met the Section 17 criteria

floor"[9] and that mother seemed to be struggling to get into a routine with the baby. In October the mother's GP prescribed anti-depressants and noted that she had thoughts of self- harm, but the family then moved out of the area.

13.6 In December 2013 the mental health social worker visiting the mother's parents noted that the couple had moved in with their baby, and made a referral to Children's Social Care due to concerns about "*cramped, chaotic and unhygienic conditions in the flat and the possible risk posed by the grandparents*[10]". The worker also expressed concerns that neither parent was in receipt of the appropriate benefits. The mother was also again pregnant.

13.7 By January 2014, the local health visiting service had been informed about the couple's circumstances, and made a series of visits in which they provided food parcels and advice, and also referred the family to Children's Social Care (CSC) due to concerns about the conditions the couple were living in, and their capacity to manage the baby safely due to overcrowding and the mess in the flat.

13.8 CSC subsequently allocated a social worker who carried out an assessment, and recommended a Children in Need plan to support the family in finding accommodation and caring for the baby. A team around the child (TAC) meeting was agreed, but did not happen before the mother was admitted to hospital in early April 2014, and Child AA was born prematurely at 31 weeks gestation. The baby was transferred to the Neo-Natal Infants Unit (NNIU). The mother was discharged home as she said that she found it difficult with all the other babies crying and she wanted to be with her older child who was being cared for by the father and grandfather.

13.9 CSC had at that point decided to close the case, but calls from the mother and the named health visitor (NHV1) changed this decision, and CSC agreed to support mother with money for transport to the hospital to see Child AA. As the case holding social worker was a locum who had now left the service, the case was transferred to a student social worker, SW2, on 28th April, and she made plans for the family to move into a hostel for the homeless when the baby was discharged. A family support worker (FSW) was also allocated to help the mother manage the needs of her 2 small children, and the local Children's Centre also provided a support worker and invitations to 'drop in' and parenting groups to reduce the mother's isolation.

13.10 Between 6th May, 2014, when Child AA was discharged home to her parents at the hostel, and June 15th, 2014, when she was re-admitted to hospital by ambulance, there were almost daily visits by professionals who were trying to support the family to manage the babies and to sort out their finances and housing situation.

13.11 There were very early concerns highlighted by the health visiting service to SW2 about what they saw as being very poor conditions in the rooms the family was living in, which they described as dirty and messy, with many hazards left unattended and which they considered to present a danger to the children. Both the named health visitor (NHV) and the health visitor for the homeless (HVH) recorded and expressed a high level of anxiety about

[9] Police IMR

[10] ICS recording, integrated chronology

the mothers ability to cope, about her young age and immaturity and her dependence on professionals for money, food and equipment for the children. They continued to provide food parcels, equipment and toys to the family.

13.12 SW2 and the Family Support Worker (FSW) did not understand this level of concern and sought to support the mother and the father to take responsibility for their children and their circumstances. They quickly formed the view that the family were being overwhelmed by the level of professional visiting and requested that health reduce this. SW2 therefore convened a team around the child (TAC) meeting on 19th May to discuss the concerns, but the HVH who attended the meeting, did not consider that this meeting had addressed her concerns, and she continued to raise these with her colleagues and with her manager.

13.13 Between May to June 2014 there were 2 minor injuries to the older baby – small bruises which the mother brought to professionals attention, and one of which resulted in the child being admitted overnight to hospital for observation. Doctors were satisfied that these were not safeguarding concerns, as were CSC, although the health visiting service saw these as significant and indicative of neglect, and so now sought to escalate their concerns to the manager of SW2.

13.14 Child AA was at that time also admitted to hospital overnight with suspected sepsis (infection) but released home with a cannula inserted for antibiotics to be administered the next day. This was then removed as the infection had resolved.

13.15 A professionals meeting was held on 6th June at which the differing opinions of the health and social work professionals were aired, and a plan was agreed for a full parenting assessment to be undertaken by SW2, along with unannounced visits by SW2. However, before this plan could be put into action, Child AA was admitted to hospital with severe brain trauma, associated with Non Accidental Injury.

14.0 **ANALYSIS**

14.1 The following considers these events in relation to the questions raised in the terms of reference. This includes reference to research evidence and the procedures that were in place at the time. However, the Terms of Reference lists 11 questions to be addressed, which are interlinked and inevitably overlap with each other. To avoid unnecessary repetition the analysis is very brief in response to some, where this has already been covered elsewhere.

14.2 As stated in the introduction, it should also be noted that the period between the birth of Child AA and the injuries that resulted in this review is very brief – a matter of 10 weeks, 4 of which were spent in hospital in the NNIU, with only 6 weeks at home in the parents care. This provides important context in relation to the level of professional involvement and visiting and the timeliness of professional understanding of, and response to, concerns – it is not much time in which to fully understand and respond to complex and dynamic family circumstances.

14.3 There is also a lack of detailed information in relation to the social work involvement with the family prior to the allocation of SW2, compared to the very full health visiting records. This is reflected in the IMRs from both agencies, so that the level of concern

being recorded by the health visitors is very clear, and can easily skew analysis as there is less detail available in the IMR about the social services response. This in turn reflects the different cultural, professional, procedural and practical contexts within which these professionals were working, and which are further explored in the lessons learned section of this report.

1. Did agencies communicate effectively and work together to safeguard and promote the children's welfare?

14.1.1 There is evidence of appropriate referrals being made in relation to the older sibling of Child AA, during 2013, when health professionals noted the vulnerability of the mother due to her youth, and previous history with social care. However, she moved twice during this period – once to be with the baby's father, and then back into her home area – and these referrals and the information about her many visits to A&E in the neighbouring authority do not then seem to have been picked up and understood as possible indicators of safeguarding concerns when she returned to her home area. This includes an incident on 6th October 2013 when the older sibling was 3 months old and according to mother hit its head rolling off the sofa. Mother attended A&E but did not wait to be seen. This information was appropriately passed to the local MASH on a Safeguarding Form, and there was a police welfare check carried out at the hospital's request – an example of good safeguarding practice. Information about the core assessment undertaken by the local Children's Social Care in July 2013 however, was not accessed as part of the 2014 assessment, and this is further commented upon later in this report.

14.1.2 On the 15th of October 2103, whilst still in the neighbouring authority, the mother is recorded to have visited her GP who prescribed anti-depressants due to her low mood, and wrote in the notes that mother was: "*Panicky, thoughts of self-harm but not enacted due to baby.*"(Integrated chronology GP Records)

14.1.3 The family are noted to have moved shortly afterwards, but this head injury in a 3 month old baby in the care of a very young mother who is noted to be considering self-harm, is of concern. Unfortunately this information does not appear to have informed any later assessment, or to have been known to the health visiting service that became responsible for the care of the children when the family moved back into the area. The 0-19 team from the Community health service did follow the 'transfer in' procedure but were informed by the previous team that there were no concerns, which is surprising given the history. The information appears in the GP notes, but these do not appear to have been transferred over at this point. The current process for GP records passing from one practice to another is triggered by the patient registering at the new practice. This then starts the process of the records being requested from the original practice, and subsequently being forwarded to the new practice. However, the family did not register with a new GP until after the birth of Child AA, by which time the receiving health team already had significant concerns based on their observation and interaction with the family, but without this historical information which may have increased their evidence base in discussing risk with CSC.

14.1.4 There are many examples of immediate communication from Surrey health professionals with each other and with children's social care following visits to, and contact with the family. For example, NHV1 appropriately communicated with other agencies when she was made aware of the family, and arranged for a food parcel and essential equipment

for them. She contacted the health visitor for the homeless (HVH) and did a joint visit with her, and then appropriately referred into Children's Social Care on 4th February 2014 by telephone, and followed this up with a detailed FAX. The HVH also telephoned to give her support to the referral, and the social care records are clear that this listed a number of safeguarding concerns, including the history of the mother, whom HVH had known previously, having been her school nurse.

14.1.5 Following this there was then a great deal of communication between health professionals and children's social care, and between social care and the other helping agencies, particularly following the allocation of SW2 to the case at the end of April 2014. There was also good communication in most instances between health professionals across the health community and information was shared with CSC about ambulance call out and hospital admissions in relation to Child AA and the older sibling – although not on every occasion. This is discussed in the next section in relation to safeguarding.

14.1.6 SW2 communicated effectively with housing to advocate for the family, and with the Children's Centre to engage additional support.

14.1.7 However, it is clear that there was a very difficult relationship between the health visiting service and children's social care in relation to this case, and unfortunately this meant that they did not work together, but in parallel. There is evidence of a wide difference of opinion about the level of concerns about the parents' capacity to provide safe care to their children from the outset, and it appears that as events unfolded professionals become further entrenched in their relative positions, with growing frustration on both sides.

14.1.8 Communication appears to have been problematic from the start. In February 2014 NHV1 arranged a joint visit to the family with SW1. The Assistant Team Manager recorded a recommendation that such a visit should take place. However, the social worker did not turn up to the visit and gave no explanation for this. When the health visitor phoned she was told that the social worker was 'out', and there was no further discussion with her about this failed visit. This would inevitably have had a negative impact on the ongoing relationship between these two core agencies and unfortunately served as a baseline for the poor communication which is a feature of the case going forward.

14.1.9 The ICS records then show one visit from SW1 to the family on 11th February, and a phone call with the mother, and with NVH. On the 19th February the social workers assessment was signed off by the ATM, with a recommendation for short term support.

14.1.10 NHV1 and HVH continued to visit and record their concerns, and were under the impression that SW1 was undertaking a core assessment. RIO health records outline many concerns from both health visitors about the crowded and unsuitable living conditions, and note on 4th March a telephone call to NHV1 from SW1 in which it was agreed that a Team around the Family would be arranged and NHV1 would complete the Family Health Needs Assessment.

14.1.11 Neither the Team around the Family meeting, nor the Family Health Needs Assessment occurred however, and SW1 left the service in April 2014. This was not communicated to the health visitors, who learned about the change of social worker when NHV1 contacted the department to talk about the discharge planning meeting for Child AA on 1st May. NHV1 also then moved to a new post and handed over to NHV2. This meant that

there was no effective cross agency handover of the case and a real potential for misunderstanding and miscommunication between the two agencies was created, which became evident very quickly thereafter.

14.1.12 Following the discharge of Child AA from hospital into the care of the parents at the hostel, there were a series of difficult telephone calls between SW2 and NHV2 and between SW2 and HNH about the provision of equipment to the family and about who was responsible for what. The tone of the communication deteriorated quickly, and began to reflect professional differences about whether the level of concerns actually reflected *safeguarding* concerns. SW2 was clear that she had been allocated the case on the basis that this was a short term piece of work with children in need, and although she recognised that "*the arrival of baby AA increased the level of support that would be needed*" she still viewed this as a 'Child in Need' case and was supported by her manager in this view.

14.1.13 This view does not appear to have changed at any point, and on the contrary, escalated to the point where CSC workers were of the view that health visiting professionals were undermining mother and the progress that she was making with their help. Health visiting professionals records evidence a number of internal discussions where the risks as they saw them are outlined and the advice of the lead nurse for safeguarding is sought.

14.1.14 This difference in opinion was unfortunately communicated to the parents and there are examples in the records of parents complaining about professionals to each other. On 12th May, the mother told the HVH that the social worker had told her to '*just get on with it'*, and on 14th May the father told the EDT worker that he was going to make a complaint about the health visitor.

14.1.15 On 16th May, SW2 then recorded a telephone call to mother "*She (mother) believes the pressure from professionals visiting is causing her and (the father) to argue*." The social workers response to this was to try to get health visiting reduced. She also the same day recorded a conversation with father: *"I informed I had spoken with the HV and acknowledged their concerns and reiterated that to father. Also that I felt we were not helping but hindering the situation with so many people telling them what to do, without practical help and informed him of Homestart."* (ICS record - integrated chronology) This made it very clear to the parents that the social worker did not share the health visitors concerns and that these professionals were not working effectively together.

14.1.16 There were 2 professionals meetings held to try to resolve these issues.

14.1.17 The first was on 19th of May, which is recorded in the social care record as "*Professionals meeting to co-ordinate services*" and this is what HVH stated that she thought she was coming to. However, what transpired was described by the health visitor as a TAC[11] meeting with mother present, which was chaired by SW2. HVH stated that it was difficult to articulate her concerns with mother present throughout this meeting. There was also another person present who was not introduced to her. This later turned out to be SW2s tutor, who was there to observe her practice.

[11] Team Around the Child in which family members discuss and agree their needs and the plan to meet these with professionals

14.1.18 The Housing Support service did not attend the meeting, but noted that: *"The meeting closed without appearing to make any recommendations about future inter agency contact arrangements, or if they were, then they were not documented on the minutes of the meeting circulated on 20/5/14."*

14.1.19 This meeting did not therefore resolve the professional differences, and the next day, the sibling of Child AA was admitted to A&E via the GP with bruising to the ear which was queried by the hospital as possible Non Accidental Injury. On the 21st May SW2 recorded a telephone call from HVH in which she expressed her concerns and suggested that the mother required a fostering placement with her babies. SW2 requested that these concerns be put in writing to her, and the named nurse for safeguarding followed up this with a telephone call and an email outlining health's concerns the following day, the 22nd May.

14.1.20 SW2 subsequently made a joint visit with her manager on the 28th May. However this visit, which is briefly recorded on ICS, does not contain any assessment or report on the outcome of that visit, and it does not appear to have been communicated to the health visitor, so that the relationship and communication between health visiting staff and children's social care remained difficult, with health professionals continuing to believe that their concerns were not being taken seriously.

14.1.21 This can clearly be seen in the recording in RIO on 4th June, of a disagreement between SW2 and HVH, concerning the mouldy Moses basket: "*The HVH then contacted the SW2 and ……asked that the FSW visited to support mother to get a new Moses basket. SW2 advised that mother had cancelled the FSW visit and that she would have to get her own Moses basket. HVH asked how this was possible with no transport, no buggy and 2 babies. SW2 is recorded as telling HVH that she should source one as she has no capacity or FSW available to help. HVH informed SW2 she was equally busy but that she would source and supply a carrycot as a temporary option on the basis that the present Moses basket presented a significant safety issue for a premature baby"*

14.1.22 As a consequence, the next day, the Lead Nurse for Safeguarding appropriately sought to use the escalation procedure and to discuss the case with the Service Manager, who was not available. She spoke instead with the Assistant Team Manager, who agreed to convene a professionals meeting to discuss her concerns.

14.1.23 This was held on 6th June, chaired by the Assistant Team Manager. By this point SW2 had received information from Housing about the couples impending eviction, the strong suspicion that father was using cannabis, and concerns that the couple were not following up their benefits application. The meeting resulted in a plan to include unannounced visits from CSC and a parenting assessment. It also agreed that health visiting would reduce. This was of course, very quickly overtaken by events.

14.1.24 SW2 regularly discussed her perceptions with the FSW, who had started work in the new team in April 2014. FSW agreed with SW2 and was clear that she saw mother as gaining in confidence and that in her view mother was feeding the baby properly and sterilising her equipment well. Interestingly, the police IMR contains the following statement: *"The crime report records that hospital staff noticed that the baby's feeding bottles looked unhygienic"* (para.7.5) which appears to support the health visiting staff's assessment, and which adds confirmation that the thresholds and expectations of health and social care were

very different. What the health professional saw as being unhygienic, the social care professionals thought was 'good enough'.

14.1.25 What is key here is that health professionals in interpreting risk will include infection risks, whereas social care training focusses more on a social model of parenting capacity. The important factor is the ability of different professionals to understand and engage with the professional expertise of others – a basic requirement of Working Together to Safeguard Children. What would have been helpful therefore in these circumstances would have been a joint visit between SW2 and HVH at an early stage in order to identify and discuss their differing professional perspectives and further joint visits or regular TAC meetings thereafter to explore any continuing points of disagreement.

14.1.26 The chronology confirms that the meeting of the 19th May was originally intended to seek to explore and resolve this difference in threshold and understanding. However, this unfortunately did not turn out to be the forum that the health visitor expected, and it is also clear that SW2 did not understand the depth of health concerns at this point, hence her use of the meeting to provide an opportunity for her tutor to observe her practice.

14.1.27 SW2 did then request that these concerns be set out in writing to her, but is not clear what she then did with the e-mail she subsequently received from HVH. HVH and the Named Nurse then appropriately escalated their concerns to the team manager of SW2 when HVH realised that the notes of that meeting did not reflect the level of anxiety that she felt she had expressed to SW2.

2. *Was the level and extent of agency engagement and intervention with the family appropriate? Were assessments undertaken in a timely manner, was the quality adequate and did they include fathers, extended family and all historical information*?

14.2.1 Following Child AA's discharge from hospital into the care of her parents, until the incident just under 6 weeks later, according to the chronology there were 11 recorded visits by health visitors, and 9 by the social worker, plus 5 by the family support worker and children's centre worker. The Housing Support service also visited 7 times between the 1st of May and the 12th of June. On some days, mother was visited twice – by health visitors and by the family support worker, and she also attended the Children's Centre with both babies.

14.2.2 It is easy therefore to understand that the mother may have found this level of intervention somewhat overwhelming at times, and it clearly also resulted in her being given conflicting information. For example, the health visitors were unhappy about the buggy which they considered to be unsafe and told the SW2 this on 7th May, but SW2 visited on 12th May and recorded that the buggy was "*a little scruffy, however, suitable and safe*" (ICS recording – integrated chronology) As above, this conflicting approach was apparent to the parents and they complained to the professionals about each other.

14.2.3 What was lacking in this level of activity was a full assessment leading to a clear plan of purposeful action, including joint visiting so that professional opinions could be discussed, differences highlighted, agreement reached, and resources coordinated. As outlined below, neither CSC nor health undertook this task and the plans from the hospital discharge meeting and then from the TAC meeting on 19th May, were not informed by any updated assessment that took account of all the known risks and stresses.

14.2.4 The CSC IMR acknowledges that the initial assessment "*was not undertaken in a timely way and was delayed due to the absences of the worker who was a locum and who was challenged by …the managers…in relation to performance."* It also goes on to say that: "*However the "quality of the assessment was acceptable*". (p7)

14.2.5 The CSC IMR author however also states that '*there were gaps in the assessment….. The father did not feature greatly in the assessment and throughout the lifetime of the case prior to the critical incident very little was known about his history. (The manager) had requested that enquiries should be made of the London Borough of The local as to the reasons for the family's departure and whether they were known to Children's Services. This was not followed up and that gap in the knowledge remained.*"

14.2.6 The chronology only records one visit to the family by this social worker to undertake the assessment, in February 2014, and none thereafter, so that the expectation of the health professionals and the couple, that a full 45 day assessment was being undertaken, was inaccurate. The manager of SW1 had also asked that a joint visit with the referring health visitor be undertaken, and, as above, this was arranged but the social worker did not turn up, without any explanation.

14.2.7 On the 7th April the manager of SW1 recorded: "*I am unable to approve this assessment due to inconsistencies between the analysis and the recommendations. The analysis identifies that (the baby) could get 'physically hurt' due to clutter whilst it also mentions that parents provide close supervision and act appropriately to keep safe.*". On 9th April the manager then records: " *As per previous oversight, please amend analysis of 'risk that the baby (sic) can get physically hurt' as this has not been evidenced and remove the recommendation for CAF as no specific issues identified for CAF to address, then close."*

14.2.8 Therefore, despite the paucity of assessment the decision was made to close the case in early April, and the identified risk was to be removed, rather than further explored, to enable this to happen.

14.2.9 The neighbouring authority has subsequently provided the following information to the Board as part of this SCR:

"Our involvement was in respect of (the sibling of Child AA)…..who was subject to both an Initial and Core assessment in July 2013 following concerns being raised by a neighbour and the midwife about mothers treatment of (the baby), shouting at (the baby) and alleged to have smothered (the baby) with a pillow".

14.2.10 This information and the details of the assessments would have been helpful information, although without having sight of these it is impossible to determine what impact they would have had on the planning around Child AA. However, it is also clear that this information was known to the previous midwife, who had made the referral, but it was not passed on to the case- holding health visiting service when the couple moved back into the area. As stated previously neither CSC nor the Community Health service in fact followed up on the historical records, so that neither had the full information about the family background. Whilst the health visitors nevertheless acted quickly to refer on their concerns to CSC, the additional history may had some impact on the response from CSC in terms of the level of risk they understood to be present.

14.2.11 Although the mother's own history of being parented was known to both CSC and health services, the impact of poor early childhood experience on the mother's ability to parent her own children was not explored in the social work assessment. Indeed, many assumptions were made by CSC about her ability to parent despite her young age and the lack of familial support networks available to her. The medical history of repeated A&E visits, and the injury to the older baby at 3 months old would also have been important in highlighting vulnerability and the risk factors already present in the situation.

14.2.12 There was also little known about the father and there was no attempt to access any information about his history. The CSC IMR notes that this lack of information was strangely also translated by SW2 into seeing father as a positive influence. This had no bearing in fact, and indeed the mother had told the health visitors that father did not help her. SW2 was made aware of this but considered that she had addressed this by "*making my expectations clear*" and that he had subsequently "*made more of an effort"*. (ICS recording, integrated chronology) Unfortunately, this was not borne out by fact. It was not until the meeting with mother on the 5th of June that they discussed the possibility of domestic violence and mother shared that the father was controlling of her. However, events then moved very quickly and overtook the decision at the professionals meeting to start a full parenting assessment, before this could begin.

14.2.13 As above, the IMR author goes on to explain that the case was allocated to SW2, who was a student social worker, on the basis of the initial assessment that this was a Child in Need case, and that the role of the worker was to "*focus on housing, finances, and self-esteem for the mother*"(IMR p8) and this is what she did. The premature birth of Child AA was viewed by her as being an indicator that the family would be in need of more support, but was not interpreted as an additional stressor which might heighten risk to either of the children.

14.2.14 In this context – that is, that this was a short term CIN case - the provision of support to the family to enable them to move out of the maternal grandparents home and into a hostel for the homeless was appropriate, and SW2 engaged the help of a family support worker to "*engage with the mother in a six week programme of regular visiting to offer support with the family's practical needs and emotional support for the mother"*. (ICS recording integrated chronology)

4.2.15 However, at the point that Child AA was born, there were already a number of risk factors in place:

1). Both parents were very young – mum was 18 and dad was 19

2). Mother already had a young baby about whom she had sought reassurance from health professionals on many occasions, including repeated presentations at A&E

3). Mother had a difficult childhood where she was a young carer and had lived with an aggressive alcoholic parent

4). The family were living in cramped and unsuitable conditions with the maternal grandparents – one of whom suffered from alcohol related dementia

5). This also meant that the mother did not have access to familial support and the couple were quite isolated

6). The reasons for the move from their previous tenancy were unclear

7). The couple had financial problems which they did not appear to be managing despite repeated advice from professionals and had required several food parcels as well as basic equipment for their older child

8). Experienced health professionals were very concerned about mother's ability to manage her baby and also about her awareness of dangers in the physical environment she provided the baby

9). Mother talked about having a low mood, had a history of depression and was very thin, presenting to the duty social worker as '*unkempt*'.

10). Fathers background was unknown

11). Child AA was premature and as such was likely to require a high level of parental care in the first few months

14.2.16 Working Together to Safeguard Children, 2013 sets out the aim of an assessment as being to "*use all the information to identify difficulties and risk factors as well as developing a picture of strengths and protective factors*."[12] This statutory guidance also states that: *"Assessment should be a dynamic process, which analyses and responds to the changing nature and level of need and/or risk faced by the child"*[13]

14.2.17 The change of worker should have resulted in a requirement to revisit and review the existing assessment, and the birth of the new baby clearly indicated that the family circumstances had changed and that there were new and increased stresses on the parents. This should have triggered an assessment, as should the increasing concerns being raised by the health professionals, particularly following the professionals meeting on 19th May, when these concerns were put in writing.

14.2.18 However, as above there was no further formal assessment at any point pulling together the above factors as the situation deteriorated, with the family being threatened with eviction, the allegations about father's cannabis use, and his unemployment. Many of these are known risk factors, and new born babies, particularly those who are premature, are known to be highly vulnerable to injury.[14]

14.2.19 Prior to the professionals meeting on 6th June all of the social work visits to the family were by appointment, whereas the majority of the health visits were opportunistic. This may account for some of the differences noted on these visits, as the parents may well have tidied up in preparation for the social worker. SW2 and SW3 advised the reviewer that there was a culture in the department at that time that one "*did not do unannounced visits on*

[12] Op Cit. paragraph 42, p.21.

[13] Ditto p.28

[14] Biennial Review of Serious Case Reviews, 2008-10, Brandon et al

Children in Need cases", as this was seen as not working in partnership with those parents, and only possible as part of a child protection plan. This is ill advised as social workers, drawing together and reviewing their evidence about the needs of children must do so on the basis of the child's whole context, including their home environment at different times of day and not always by appointment.

14.2.20 Within this lack of updated or in depth assessment, SW2 and FSW appear to have remained focussed on their initial task and perceptions, and expressed a great deal of frustration about the health professionals, whom they saw as not understanding children's social care thresholds and responsibilities. This was compounded by the suggestion from HVH at the May 19th meeting that a mother and baby fostering placement should be sought, an option which was very much out of the scope of the existing plan and would have required a very high level of assessed risk to have been identified.

14.2.21 There are conflicting views about the provision of the health chronology and the photos of the Moses basket as evidence and this remains unresolved, as SW2 believes that these had been requested at the meeting on 6th June, but that HVH "*was not prepared to hand them over.*" (SW2 in interview) The HVH is of the view that she had agreed to provide the chronology when it had been completed and that she was not asked for the photos. This difference of opinion about events suggests that the professional differences which are an unfortunate feature of this case still need to be resolved in order to move professional practice and working relationships forward.

14.2.22 Unfortunately, the failure to carry out an up to date assessment was mirrored within the health visiting services, and the Community Health IMR acknowledges that "*a Family Health Needs Assessment was never done even though this is a standard assessment and is in the appropriate guidelines. The FHNA is also a means of gathering evidence and supporting referrals made to Children's Services. However it does appear that though attempts were made to book appointments to complete this, events overtook each time*." (p13. 8.2)

14.2.23 This would have been incredibly helpful in setting down the concerns and risks in a structured way that may have assisted social care to fully understand the level of concern being experienced by the health visiting staff and the evidence base against which they were forming their judgments about risk.

3. Was any information known by any agency about parental mental health issues, domestic abuse, substance misuse or parental antisocial behaviours or concerns re neglect? If so was appropriate consideration given to how these impacted on parenting capacity and were appropriate referrals made?

14.3.1. In terms of parental history, the reasons why the couple had left their previous tenancy were unclear, and the Housing IMR contains the following information:

"*With the support of The Housing Support Agency, (the couple) submit a letter ..which…lists an unattended fire in garden that led to some external damage to their property, neighbours asking for money/complaining when the baby was crying, a recent gas inspection which highlighted a need for a mechanical part and that they felt unsafe. These were unsubstantiated reasons and, as such, would be considered fairly weak cause for leaving a tenancy…..the file showed that (the father) had written to say that he had to leave the*

property because he was being threatened. There was no record on file of anti-social behaviour, either towards or from (the father). There were rent arrears and Council tax arrears at this property, and the tenancy was terminated by …(the father) The local."

14.3.2 The source of these threats and whether they were linked to father being in debt, or to drug use, was never explored. The ATM in CSC had asked SW1 to follow up the history of the family with The local, and it is unfortunate that this did not happen, as it may have provided important context to the family circumstances. Certainly there is reference in the health records from 4th July 2013 to the mother talking about some disturbance at the property which she said had resulted in a visit from a social worker.(EMS record – integrated chronology)

14.3.3 There was information about the father's use of cannabis. The first time this appears in the chronology is on 7th April 2014, when Child AA was born. When the family arrived on the ward to see Child AA, the delivery suite midwife noted *"a strong smell of cigarettes and cannabis on partner".* (ESH notes, integrated chronology) This was not shared with the community health service.

14.3.4 The chronology also records a police stop in relation to father smoking cannabis on 12th April, but this was not referred on as there was no information to the police that this was the father of vulnerable children.

14.3.5 This issue was referred to again on 16th May when HVH and NHV1 did a joint visit to the mother and the 2 children at the hostel. They had a discussion with her about finances and she shared that she had to give money to her partner *".. to pay 'someone'. Mother did not think this was for drugs referring to past payments*" (RIO – integrated chronology)

14.3.6 The CSC IMR records that "*On 5th of June the housing manager contacted SW2 and informed her that he had met with dad and noted that he smelt strongly of cannabis. On the same day the SW2 had met with mother who told her that a neighbour had made a similar allegation. The SW2 visited and challenged the father who denied it. SW2 recorded that she had never smelt cannabis or seen any other evidence of drug use during any of her visits and there were no complaints from neighbours or the staff at the hostel. The FSW further confirmed this and noted that she had seen that the ashtrays did not have any evidence of cannabis use in them*"

14.3.7 This appears to have satisfied both workers that the allegation was unfounded, and the fact that all of their visits were announced, and could therefore be prepared for, was not considered.

14.3.8 The Housing Support Agency worker visited a few days later and was "*told that the applicant's partner was smoking cannabis. It was understood that other agencies had also been made aware of this…*" (The Housing Support Agency report to SCR) The worker did not therefore follow this up.

14.3.9 Cannabis use can contribute to parental neglect[15] and for this family may also have had a bearing on their financial circumstances. Certainly money management was a

[15] Insert reference

real problem, and as above, when the HVH visited one evening with bedding and a cot, the father was playing with a new x-box, so appears to have given his own needs priority over those of the children, another potential indicator of neglect.

14.3.10 Mother's alleged low mood and depression and apparent need to be told how to do things several times before she grasped this was also a source of considerable concern to the health visiting professionals, who as above, made many attempts to raise the level of concern in CSC to that of child protection. In this they were unsuccessful. Mother's mental health and the dynamics of the parental relationship would have been crucial factors to understand in relation to their parenting capacity, but the agreement that CSC would undertake a parenting assessment after the meeting of 6th June was, sadly, too late.

4. Was there sufficient consideration of the vulnerability of this family in relation to their housing situation and the impact on their parenting capacity and what support was provided?

14.4.1 Resolving the family housing situation was the primary focus of the work by CSC and by the Housing Support Agency, and there is clear evidence that professionals from all agencies worked to support the couple in attempting to sort this out. There were visits from many professionals giving advice and practical support in relation to housing and managing the necessary day to day tasks involved in looking after 2 young babies in cramped and temporary living conditions.

14.4.2 The initial referral into CSC from NHV1 concerned the cramped and unsuitable conditions in which the family were living. The couple had moved into the mother's parents 2 bedroomed flat in November 2013, and according to the District Council IMR, the grandfather "*appears to be surprised at the length of their stay as he says that GS had rung to say that she would be leaving their home in The local for a few days due to a gas leak, but they had moved in and had never left."*(Section 6)

14.4.3 The NHV and the HVH both expressed safeguarding concerns to CSC about the conditions in the flat which they saw as unsuitable for a young baby, and also about the vulnerability of the mother, who did not seem to be able to understand basic safety issues. The grandmother's dementia and father's alcohol use meant that they were not able to give practical support, and on the contrary, medication and overflowing ashtrays were left in the reach of the baby, who was starting to pull up on the furniture.

14.4.4 SW2 agreed with this perspective that the flat was overcrowded and unsuitable, and she supported the couple to make a homelessness application, supported by a letter from the grandfather evicting them from the flat, in order to provide a case for the District Council to regard them as urgent for rehousing.

14.4.5 The hospital was also made aware of the plan to try to rehouse the family prior to the discharge of the baby into the parents care, and held on for longer than they normally would in order to support this. The hospital had noted no concerns about the parent craft of the mother, and had received no information to suggest that there were any issues other than the practicalities of finance and accommodation. The fact that Child AA had been on the NNIU for 30 days at the point of discharge also meant that there was no outreach offered to support the parents in the hostel with any aspect of the care of a premature baby. This was to be provided by the health visiting service instead.

14.4.6 The couple were interviewed by housing officers on 6th May, where they explained that they had to leave the mother's parent's flat due to overcrowding, and that *"Social Services felt that household would not be conducive to a new-born and premature baby".* (District Council IMR)

14.4.7 SW2 also then telephoned that day to support the application. Although the officer considered that it would have been helpful to have had more information, he was able to offer them temporary hostel accommodation the following day, which was incredibly fortunate as it was rare for there to be empty accommodation without any waiting.

14.4.8 In addition, the couple were fortunate enough that the hostel was not full, so they were able to have an area to themselves for most of the time, and did not have to share bathroom or toilet facilities. They were allocated a *"double-room unit which is of sufficient size considering both children were very young."* (DC IMR)

14.4.9 SW2 and the FSW from CSC then helped the couple to move their things into the hostel and to unpack, and the next day took the mother to the hospital to collect Child AA. The FSW then visited regularly with a view to helping the mother to keep the rooms clean and tidy and to support her in the parenting task. The Children's Centre had also made a referral to the Housing Support Agency who visited quickly to risk assess and then provided regular visits to focus on the housing situation and future options.

14.4.10 However, as discussed above, there were professional differences of opinion about the level of vulnerability of the couple, and therefore of their children. SW2 was also aware of the level of rent arrears that the couple had already incurred in their previous property, which by early June meant that the family were facing eviction. This related in part to the couple's failure to apply for housing benefit and to provide the necessary paperwork to support their application and this was a source of considerable frustration to the housing officer as he expected this to be resolved quickly. This failure to follow through on advice about finance had continued from the time when the couple had been living with the maternal grandparents, and was indicative of a degree of immaturity which does not appear to have been fully understood and taken into account in relation to the couple's parenting capacity.

14.4.11 As already discussed, there was also an ongoing difference of opinion about how well the couple managed the tenancy, with the health visitors concerned about how dirty and untidy it was, and about mould and damp affecting the babies bedding. CSC considered that the mother was doing her best in the cramped conditions. The District Council IMR however states the following:

"*However their rooms were poorly kept. The hostel warden had cleaned up the condensation mould but said the room was in a mess. He recalled how one of the other residents helped (the mother) clean up a couple of times, but then commented that she had stopped because she wasn't going to keep going in to clean up after them."*

14.4.12 This appears to support the health visitors' view, but was not understood by SW2 until 5th June when she emailed housing about the 'mould' and received an immediate response that this was due to poor cleaning and the couple's poor management of the property.

14.4.13 The District Council IMR also refers to the change in the family circumstances when the father lost his job. *"…..he was around at the hostel a lot more and was seen smoking more frequently. There were then more arguments between the couple."*

14.4.14 Again, this evidence that the father's unemployment was increasing stress on the mother did not appear to factor into any CSC understanding about the increasing vulnerability of the children in these circumstances. There is no recording about this in the chronology so it is likely that the social worker did not know about it, as the ICS recording is very full on all other matters.

14.4.15 The IMR concludes that the homelessness staff did not see the family as any different from the others they work with. However, the author goes on to say that "*They were perceived as chaotic and exceptionally difficult to engage with….. (the couple) received more than the average input and support from the homelessness team as they were failing to pay towards the cost and rent of accommodation. There were frequent calls and shared frustrations between professionals regarding the difficulty in getting (them) to engage or carry through any actions that only they could complete. Council officers were concerned that the family were realistically looking at the prospect of being evicted from the hostel due to rent arrears and consequently their housing options would be severely restricted*."

14.4.16 It therefore appears that professionals were doing everything possible to support the family with their housing need, but that this was likely to fail in the light of the couple's immaturity and inability to follow through with the important life skills of budgeting and the practicalities of day to day living.

14.4.17 Housing confirmed to SW2 on 6th June that the couple had lost their previous tenancy in their previous authority due to rent arrears, and SW2 met with mother that day and worked out the money the family had coming in. Mother agreed to pay £1000 off the arrears (this seems to be a misprint in the records as this would have been nearly all the money they had) at the end of the month and SW2 appears to have managed to get an extension on the eviction. However, there does not seem to have been a contingency plan for the likelihood of eviction, which may well have resulted in the children coming into care.

14.4.18 The professionals meeting on 6th June did not include a member of the housing team, so that their information about how the couple functioned within the hostel was relayed to the meeting by the HVH, and the importance of these observations appears to have been somewhat undermined by the focus on the professional disagreements between CSC and community health services. Part of the plan from this meeting was therefore that the Housing Support Agency worker was to be asked for her observations of how the family were coping in the hostel.

14.4.19. Again, what would have been helpful at the outset was a clear and focussed assessment, leading to a realistic plan and recognition of the risks to the children given the mounting pressures on the young adults who were caring for them.

5. *Were the decisions and actions that followed assessments appropriate and were detailed plans recorded and reviewed?*

14.5.1 The CSC IMR author concludes that the plan resulting from the initial assessment was followed through in relation to the housing and social needs of the family.

The CIN plan was reviewed at a Team around the Child meeting on 19th May, which was chaired by SW2.

14.5.2 However, as outlined above, there was no further assessment, and a lack of agreement between the key professionals working with the family about the level of risk and the amount of support required. This resulted in a significant amount of visiting which lacked coordination and purpose.

14.5.3 Given the guidance in Working Together 2013, it would be reasonable to expect that SW2 would have been required to complete a new assessment on allocation of the case, given that the family circumstances had changed significantly with the birth of the premature baby. This would also have been a good learning vehicle for a student social worker.

14.5.4. However, as previously stated, this did not happen, and whilst there was a plan arising from the discharge planning meeting held at the hospital on 1st May, this focussed on the practicalities of obtaining alternative accommodation for the family so that the baby could be discharged home. This did not include any further assessment, and there was no detailed plan co-ordinating the work with the family, resulting in numerous professionals visiting, sometimes on the same day, and no resolution to the very different views being expressed between health and CSC.

14.5.5 The first real plan, to which all of the professionals appear to have given their agreement, was the one that resulted from the professionals meeting on 6th June. Unfortunately this was too late for Child AA.

6. Were the children's views and wishes sought and taken account of in assessments and planning? Did this include the presentation of these young non-verbal children being fully considered?

14.6.1 The recording of both health and social care staff contains many references to the presentation of the children. As above, they paint different pictures. What they do have in common is the positive relationship between the mother and her older baby, prior to the birth of Child AA, albeit within a context of basic safety concerns expressed by health.

14.6.2 The fragility of Child AA is commented on frequently by health visitors, but the IMR acknowledges that "*There is evidence that on many occasions the health visitors were overwhelmed by the maternal concerns that were apparent*" (Community Health IMR p15, 8.6)

14.6.3 The Social Care IMR records that "*Both children were too young to be able to formulate and express a considered wish. Observations of them were recorded in ICS. (The sibling) always presented as well cared for, appropriately dressed and as a happy little (baby)The interactions between (the baby) and both parents were reported and observed by SW12 and FSW to be warm and affectionate…..Child AA was also seen to be clean and appropriately dressed"*(p11 para 8.6)

14.6.4 These observations, as previously discussed, did not always correspond with those of other professionals.

7. *Were any safeguarding issues in respect of child AA and sibling identified and acted on appropriately and in a timely way by all agencies?*

14.7.1. There is evidence from the records that potential safeguarding concerns were identified by the midwife in 2013 when mother was booked for maternity care for her first child. A referral was made to Children's Social Care due to the fact that this was a teenage pregnancy and there was previous involvement with children's services as a child herself. However, she moved out of the area a few days later before this could be activated.

14.7.2 There were then a high number of hospital attendances during pregnancy with unspecific stomach pains, and these attendances continued after the baby was born. In July the mother is noted as saying that a social worker had visited her in response to arguing reported by neighbour. Taken together, this is suggestive of possible domestic abuse, as there is some research evidence that unspecific stomach problems in pregnancy are a possible indicator[16]. A safeguarding form was completed, but as the case was not open to The local social care, there was no further action taken.

14.7.3 As discussed previously, there was a timely and appropriate response when the mother attended A&E with her 3 month old baby who had rolled off the sofa, and left without being seen. This resulted both in a police welfare check and a second information form to the The local MASH.

14.7.4 The first visit from any professional to the family on their return to the area was by NHV1 In January 2014 who appropriately identified potential safeguarding concerns and made a referral to Children's Social Care. She also provided a travel cot, bedding, sheets and clothing for the baby, and followed up with a joint visit with the health visitor for the homeless. This health visitor shared her colleagues concerns and both described in the practitioners meeting their horror at the living conditions. They describe the mother as being very thin and frail, child-like, and not taking in what they were saying about the presence of full ashtrays, medication, and rubbish at a level that was accessible to the baby, who was crawling around in the mess. NHV1 faxed her referral to CSC after this visit.

14.7.5 SW1 visited the family the following week and did not share the safeguarding concerns. As above, this difference of opinion became a serious issue between the two departments over the next few months, with the health professionals becoming increasingly concerned about the couple's failure to sort out their finances and to take control of their circumstances. Health professionals describe the mother as being very much like a child herself, who was not able to take on advice, and who repeatedly ran out of money and asked for help to sort out food and basic equipment. They felt that this deteriorated hugely after the birth of Child AA and they became increasingly frustrated in their attempts to raise the level of concern in CSC.

14.7.6 The safeguarding issues arising during this time are well documented above. However, further exploration of the injuries to the sibling and the first hospital admission of Child AA is warranted.

[16] NHS England website – Domestic abuse in pregnancy

14.7.7. There were two (further) reported injuries to the sibling whilst in the care of the parents - on 5th May and 20th May.

14.7.9. Child AA's father called NHS 111 on 4th May (recorded as 5th in the chronology, and 4th in the Ambulance Service IMR) and was advised to contact 999 and an emergency ambulance was dispatched. The IMR from the Ambulance Service records that "*AA's sibling was described as having become more drowsy than usual and seemed to have an unexplained bump on the head. (The baby) was treated at scene and not transported to hospital. A vulnerable person (VP) form was completed in line with (local ambulance service) procedures as staff felt that the family may need extra support with the child having an unexplained bump on (the) head and the Father also disclosing that he believed the child may have a worm infestation. The VP form was shared with children's social care."*(p2 – 3)

14.7.10 This was good practice by the paramedics, and this referral was considered by a CSC manager on 8th May, who determined that this was not a safeguarding concern.

14.7.11 The second (third) injury to this child was self-referred by the mother on 20th May – the day after the TAC meeting she had attended with CSC and HVH. The mother visited her GP to show him a small bruise at the top of the child's ear, which she was unable to explain, but said she was worried was indicative of leukaemia or meningitis. The chronology notes that the GP made an immediate referral to the Children's Assessment Unit at the hospital, and "*In view of unexplained bruise, GP asked for non-accidental injury to be excluded."* (integrated chronology Hospital Notes 20th May 2014) The baby was admitted overnight to hospital and was noted to be "*a happy smiling (child) who was well kept and interacting well with (the) mother. There were no other bruises seen".*(Surrey Hospital IMR p8) The mother was very open about her involvement with social services. The IMR goes on to say "*The decision was made to contact social services and not to request a CT scan or skeletal survey at that time until more information was available".*

14.7.12 This seems an appropriate decision given that it was now late evening, and contact was made with EDT who confirmed that the child was not subject to any child protection plan. A Safeguarding Information Sharing form was completed for the liaison health visitor and also for CSC. The form stated that *"(Mother) was tearful and thought she had post- natal depression. She stated that her partner is supportive but works a lot and she feels lonely, is scared to be alone, and is worried that she is a bad mother."*(p9)

14.7.13 SW2 telephoned the ward the next morning for an update and confirmed that *"Social Services would be happy for (the child) to be discharged if doctors were happy*"(Surrey Hospital IMR p9.)

14.7.14 The child was seen by a consultant paediatrician on the ward that morning who noted that "*this is not a safeguarding issue*" and discharged the child home. The IMR notes that there is no explanation given on the record for this conclusion, though no other bruises or concerns were noted in relation to the child, and the parent child interaction was noted to be positive. Given that the social worker had not raised any concerns with the doctor, it was then reasonable for the child to be discharged.

14.7.15 The next safeguarding concern was when Child AA was admitted to hospital, via the GP, with a suspected sepsis. This manifested itself as *"a spreading, non-blanching*

petechial rash, apparent on forehead, arm and left leg".(Surrey Hospital IMR p10) However, Child AA had no sign of a temperature.

14.7.16 The mother's story was that she had "*left AA with (the) dad in the morning who said AA had been vomiting and scratching at (the) head. Mother said on her return AA's ears appeared a darker colour.."* (p10)

14.7.17. Child AA was admitted overnight and started on IV antibiotics.

14.7.18 The hospital then appropriately contacted CSC to share this information and on request faxed a copy of the safeguarding information form to SW2, who telephoned the next morning. The IMR notes that this conversation was not recorded in the notes, but that "*SW2 shared nothing of concern".*

14.7.19 Child AA was not at any point examined by a consultant paediatrician during this admission. The SSHT IMR points out that the consultant on the ward was off sick that day, and that the ward was being covered by another doctor who was also covering the SCBU*..."(This doctor) was to see all children who had not been seen by a consultant (in line with children being reviewed by a Paediatrician in 12 hours). The doctor believed that Child AA had been seen by a consultant the previous evening on CAU, whereas the CAU consultant had been contacted by phone to discuss AA but had not seen her in person."*(p15)

14.7.21 The IMR author notes that whilst AA was not seen physically by a consultant, there is no suggestion that there would have been any changes to the management plan had this happened as there were no safeguarding concerns.

14.7.22 However the IMR then goes on to say that "*the mother shared that she suffered from anxiety and depression, she also shared about their living circumstances and LBs job loss and financial difficulties.."*

14.7.23 These statements are somewhat contradictory given that this was a 2 month old premature baby. The hospital appears to have been very reassured by the fact that SW2 was not raising safeguarding concerns. Historically, the 'child protection register' was discontinued partly because of the risk of 'false positives' – that is, the belief that if a child was not on the register, professionals could assume that there were no risks to the child. Whilst Child AA was of course not subject to a child protection plan, the same '*false positive'* must also be guarded against when social workers give an opinion that they have no concerns. Other professionals must consider whether this reassurance is sufficient for them to also have no concerns in their own right – that is, they must make their own considered and professional judgement based on the facts before them. The IMR author acknowledges that this episode may well have been a 'cry for help' as mother was so forthcoming about her anxieties. However, she was discharged home with a cannula in the baby's arm that would have increased those anxieties.

8. Were missed appointments and failure to engage considered as indicators of neglect?

14.8.1 There is no evidence that this was the case, and indeed the mother is noted to have been in regular contact with professionals and to have missed appointments only when there were valid reasons.

9. Was race, religion, language, culture, ethnicity or disability a factor in this case and was it considered fully and acted on if required? How was the uniqueness of this particular family recognised?

14.9.1 As discussed previously, very little was known about the father, though he did tell the NHV1 that he was half 'Romany/gypsy and also had ADHD. These would have been significant factors in relation to his cultural identity and expectations of family life.

14.9.2 The lack of any full assessment meant that this was not considered or addressed, and indeed the CSC IMR author remained unaware of this cultural heritage, assuming from the records that the family were 'White British'. The IMR notes that the professionals were aware of the mothers' background and her own parents' mental health issues, but that "*Her own experience of being parented and of how this may impact on her ability to parent was noted, although not explored in great depth. However all the professionals working with her commented on her apparent frailty and vulnerability and her low mood at times*." (p14, 8.9)

14.9.3 There was therefore an unrealistic expectation from CSC about the mothers' ability to parent, given her vulnerability as a young person who was responsible for 2 very young children and who clearly lacked the life skills to manage budgets, housing, and independence without considerable support from professionals. She was in fact herself still a child as defined in the Children Act 1989. The social care professionals did note that the mother seemed to struggle to take in instruction and advice, and in interview pondered whether she had a mild learning disability, but this did not trigger any assessment of her parenting capacity at the time.

10. Were there any organisational or resource factors which may have impacted on practice in this case?

14.10.1 In terms of community health services, there was good information sharing and support and the staff reported feeling that they work within a supportive organisational culture in which creativity is encouraged and staff feel valued. The IMR for the Community Health service notes that there may have been a lack of clarity around the role of the HVH and the NHV which is being addressed through the action plan arising from this review.

14.10.2. The social workers referred to the major restructuring that had been taking place across Surrey and which was being implemented in the area where the family lived in April 2014. As previously discussed this involved the disbanding of the Children in Need Team and the creation of an Assessment and Intervention Team into which SW2 transferred.

14.10.3. The FSW shared that she had been interviewed for a post in February 2014 in the CIN Team, but that by the time she started in April 2014 the post had moved to the Assessment Team. Similarly, the student social worker, SW2, had moved from the CIN team to the Assessment Team and taken her CIN cases with her.

14.10.4. SW3 described the new arrangements that the Assessment Team would undertake all assessments and that CIN work would now be stepped down into the Early Intervention Service after a maximum of 45 days when other agencies would in many cases be required to take the role of lead professional. She acknowledged that other agencies were expressing concerns about this and that this has been creating a backlog in the Assessment Team.

14.10.5. The Area Manager for the service has acknowledged that the scale of the changes has been enormous, and that not all staff appear to have fully grasped the model. This may have resulted in some misinterpretation of the way in which cases are to be managed, and certainly the social workers in the practitioners event gave an impression that there was a clearer 'cut off point' for social work support to children in need than the strategy suggests – although this may in fact be an issue of interpretation. There is no evidence that this change in approach had any direct significant impact on the management of the case, but it does provide a context within which SW2 and her manager would have been operating. However, it is all the more surprising that, given the move to an Assessment and Intervention team, no assessment was actually undertaken when the case transferred to SW2.

11. *Were appropriate management/clinical oversight (supervision) arrangements in place for professionals making judgments in this case?*

14.11.1 The Community Health IMR notes that NHV1 had only been qualified for 3 months when this family arrived on her caseload and so did have limited experience. She did not appear to have sought advice from a safeguarding supervisor or her clinical team leader though she did liaise regularly with her peers and the HVH. It is also noted that there was a delay of 3 weeks by the CNN1 to record her visits on the electronic records. This will be disseminated to the practitioners involved and their line managers.

14.11.2 It is clear from the notes in the chronology that both NHV2 and HVH regularly consulted with the safeguarding team and advisors as required within their procedures and policy guidance, and they documented these conversations on RIO.

14.11.3 In relation to Children's Social Care, the management of SW1 is not fully explored in the IMR but there is reference to performance concerns and a lack of recording and visiting. The poor quality of this social workers assessment is noted in the chronology and commented on previously, but this does not appear to have informed the plan for SW2's intervention, and surprisingly she was expected to work with the family using this assessment as her basis for planning. As outlined above, SW2 explained that she had very little handover and that she had no reason to doubt the assessment of the previous social worker, and neither should she. However, her manager did have this information and it would be reasonable to expect that the re-allocation of the case would have been accompanied by an instruction to SW2 to revisit the assessment so that the plan for Child AA was not undermined by previous poor quality of work. Given the significant change in family circumstances as a result of the birth of Child AA, this was even more important.

14.11.4 The ATM provided a minimum of 2 weekly supervision to her student, and the CSC IMR records that "…..*there was in addition a considerable amount of ad hoc supervision. There is evidence of management oversight on the case notes although only*

one record of formal supervision. SW2 felt that she was listened to by (ATM), that her views were respected and that she was supported in relation to her assessments (p15. Para 8.11).

14.11.5 This lack of recorded supervision is not good practice and makes it difficult to evidence the degree of challenge being offered to the student. It also means that there is no record of the rationale for decision making in the light of concerns being expressed by community health professionals. The chronology for example, indicates that there were points at which the student social worker clearly felt very threatened and challenged by HVH. Whilst the nature of this challenge was a professional one, the CSC IMR makes reference to "….*one particularly difficult telephone conversation between SW2 and HVH in which SW2 had felt somewhat intimidated and(the manager) had offered her peer support following this"* (p6 8.1) Given the confident presentation of SW2 described by the health visitors, they may have underestimated the emotional impact of professional challenge on a student who was still in a position of learning and being assessed on her competence.

14.11.6 SW2 was subsequently offered a great deal of support by her supervisor to deal with what was seen as 'over-anxiety' by health colleagues. The approach seems to have been one of nurturing and supporting the student, and this meant that she was supported in her views about the cases she was working with. What might have been more helpful at this point was a direct conversation between the manager and HVH to address this apparently 'threatening' approach, both in terms of better understanding the dynamic between the student and HVH, but more importantly, to follow up the difference in professional opinion and its impact on the management of the case. There appears have been an over emphasis on the part of social care on the personal impact of the disagreement between SW2 and HVH, rather than on the professional viewpoint which underpinned it, and which should have been the main focus. This was not a <u>personal</u> challenge, but a <u>professional</u> one.

14.11.6 Eileen Munro, states that: "*The single most important factor in minimizing errors (in child protection practice) is to admit that you may be wrong"*[17]. For this to happen requires that "*all processes that support and inform practice foster a questioning approach or a spirit of inquiry as the core professional stance of the child protection practitioner*"[18]. This enables the practitioner to separate the personal from the professional and to consider the facts in a different light.

14.11.7 Similarly, Working Together 2013 states that: "*It is a characteristic of skilled practice that social workers revisit their assumptions in the light of new evidence and take action to revise their decisions in the best interests of the individual child"* and that: "*The social work manager should challenge the social worker's assumptions as part of this process*"[19]

14.11.8 These are key lessons for a student practitioner and the absence of written supervision notes makes it difficult to fully understand the quality of supervision being given to her and whether this degree of challenge was present.

[17] Munro, E. (2008). Effective child protection (2nd Edition). London: Sage

[18] Turnell, A Signs of Safety, A comprehensive briefing 2010

[19] Op cit. paras 41 and 43.

14.11.9 As above, the context of organisational change may also have undermined the capacity of the supervisor to present this necessary degree of challenge. Unfortunately the manager was absent on maternity leave for the duration of the review so it was not possible to further pursue this line of enquiry.

14.11.10 Finally, as also noted previously, there was no further assessment, and SW2 was not asked to explore the family history, which would have been good practice in student learning, as well as providing important information about the family with whom she was working.

15. **LESSONS LEARNED**

15.1 The key issue arising from the review is that of inter professional trust and collaboration, without which children will not be well protected or their needs fully understood. There is a clear theme running through the chronology and the IMRs about the differences of opinion between children's social care and the community health service in relation to this case, which were further compounded by the lack of clear and current assessment and co-ordinated planning.

15.2 The Community Health IMR concludes that: "*Working with families where there is chronic neglect highlights the need for practitioners to work together in a supportive way, each understanding the difficulties faced in approaching the family. Joint supervision sessions may have helped all concerned to focus entirely on the safeguarding concerns for the children*". This is an important consideration, as there were several points where a joint approach in terms of visiting and/or supervision would have been helpful and may have resolved some of the professional differences so that there was a united and well informed approach to the growing risks in this situation.

15.3 Within Community Health it is noted that "*professionals showed considerable tenacity and combined together to cover key visits, meetings and make full reports. They were each managing the emotional demands of this family and making individual assessments at contact. Group supervision sessions when teams are managing such complex cases would be useful and this will be suggested as an action.* This is a helpful analysis and highlights also the heightened emotions that appear to have been a feature of this case. Good reflective supervision is a foundation stone of safe practice, and shared supervision, as suggested, may have helped to identify and to resolve the underlying differences of opinion.

15.4 It should also be noted that the HVH had prior knowledge of the mother, having been her school nurse, and that she therefore felt a huge degree of compassion for a young woman whom she described as "*still a child herself*". This undoubtedly shaped her view and ongoing relationship with the family, and it is important that where such a prior relationship exists, there is an acknowledgment in supervision of the potential impact, both on the professional and on the management of the case.

15.5 Robert Dingwall[20] states that: " *Professionals (sic).. have to make difficult decisions with imperfect, limited and fragmented information. An inter-agency system*

[20] The Rule of Optimism – Thirty Years On: Robert Dingwall | Published: September 18, 2013

creaking under resource pressures and lacking public support for a more interventionist approach necessarily has to find ways of bounding its work. Sometimes the result is that children die (or suffer serious harm). There are no quick fixes to a complex – and, in a technical sense, wicked – problem."

15.6 This is a reference both to the complex and imperfect systems within which professionals work, but also to the notion of children's social care thresholds. There is repeated evidence in this review that social care did not believe that health professionals understood social care roles and responsibilities, and that the needs of the children did not meet the 'threshold' for child protection. This inter professional difference of opinion is a national issue which is highlighted time and again in serious case reviews, as a failure in multi-agency working[21]. National statistics show a steady increase in numbers of referrals in recent years, which social workers are finding problematic to manage.[22] In addition, some practitioners argue that the reluctance of other agencies to share safeguarding responsibility clogs the system up with inappropriate referrals. 'Thresholds' therefore become higher to manage demand, and social workers can develop a 'siege mentality' in which they become less open to the concerns of others, and protective of their own resources and skills in order to cope with the stress of the work[23].

15.7 This is compounded by the way in which children's social care services are traditionally organized: the Munro report offers examples of good practice in multi-disciplinary arrangements for dealing with enquiries and referrals.[24]This includes reference to the creation of a Multi-Agency Safeguarding Hub as a means of managing the 'front door' in a multi-agency way and Surrey has implemented this approach.

15.8 However, whilst there is clear evidence that the quality of local partner relationships is key to effective joint working, it is also clear that structures and systems alone are unlikely to make a significant difference[25]. The Surrey Early Help Strategy acknowledges that the existence of a MASH will not in itself resolve all of the issues, and the strategy seeks to take a bold step in changing the whole system in Surrey from a traditional early intervention and child protection system to one of "Early Help, Safeguarding and Well-being"[26].

15.9 This requires significant culture change and the success of such a system will be strongly dependent on the development of effective collaborative shared ways of working, precisely the opposite of what has been demonstrated here. What is needed to support this is a move away from the narrow professional perspectives in which social workers and others have been trained, and which are compounded by traditional structures and systems

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[21] Brandon et al, 2008

[22] See Department for Children, Schools and Families (2009) *Referrals, Assessments and Children and Young People who are the Subject of a Child Protection Plan, England – Year Ending March 31 2009* (www.data.gov.uk/dataset/ referrals) and Department for Education (2010d) *Children in Need in England, including their Characteristics and Further Information on Children who were the Subject of a Child Protection Plan (2009–2010 Children in Need Census, Final)*. London: Department for Education.

[23] Tunstall, op cit. and Munro,E

[24] Munro, E. (2010) *The Munro Review of Child Protection. Part One: A Systems Analysis*. London: Department for Education

[25] Audit Commission, *Are we there yet? Improving governance and resource management in children's trusts*.(2008) London. The Stationery Office.

[26] Surrey Early Help Strategy, op cit.

for dealing with child concerns, to one which is based on an open and facilitative approach rooted perhaps in a model of appreciative inquiry[27] in which professionals are able to engage in positive dialogue with each other and with families. In its purest form appreciative inquiry "*advocates collective inquiry into the best of what is, in order to imagine what could be, followed by collective design of a desired future state that is compelling and thus, does not require the use of incentives, coercion or persuasion for planned change to occur."* [28]

15.10 Examples of this model in action in protecting children can be seen in the application of the system wide 'Signs of Safety'[29] model for example, which is gaining prominence in many local authorities in England, although there are other evidence based models, such as strengthening families, and solution focussed intervention, which also have promising results.

15.11 Regardless of what model is adopted, successive studies support the need for professionals to train together, and if possible to be co-located and working to a common understanding and agenda, in order for a shared culture to develop which will deliver the intended changes in the Surrey Early Help Strategy, that is, "*Shared values and principles, common methodology and approach towards working with children, young people and/or within their families".* This will not develop on its own.

15.12 Some of the learning from this review therefore is about the management of this transition, and the need to ensure that cultural change is supported at every level within the services, cutting across supervision, assessment, and work allocation, particularly in the case of trainee and newly qualified or inducted staff.

15.13 Within this current context however, there are elements of good practice, which need to be highlighted and celebrated. For example, the health visiting staff demonstrated a huge commitment to ensuring that the situation was as safe as they could make it, including one health visitor shopping for the family out of hours with her own money, to ensure that they had food and equipment, and visiting in the evening to check that the children were ok. The ambulance service followed up some concerns about the children as the result of their call outs, referring into social care, and the GP practice registered the family locally without question or historical paperwork. The GPs also responded quickly, and in a protective manner to potential safeguarding concerns about both babies. SW2 made huge efforts to get alongside the mother and to understand her perspective. The District Council offered immediate homeless hostel accommodation and sought to avoid eviction, despite the couples' failure to complete necessary paperwork. All of these are examples of putting the needs of the children first, and understanding safeguarding responsibilities.

15.14 Surrey has also now adopted the Family Nurse Partnership model which specifically targets vulnerable parents, including young parents, for intensive assessment and support. Child AA's family would clearly have met the criteria for this had it been in place at time of the birth of her older sibling. However, the FNP criteria do not extend to a second child, which is unhelpful, as this approach may well, through its focus on risk assessment,

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[27] Bushe, Gervase (2012). "Foundations of Appreciative Inquiry". *Bushe's website*. Appreciative Practitioner.

[28] ditto

[29] A. Tunstall, et al, op cit.

have provided an additional safety net for this family. Consideration of the extension of the criteria for FNP to include a second or subsequent pregnancy to vulnerable young parents is therefore a recommendation arising from this Review.

15.15 All professionals have recognised the need to work more openly and jointly. The introduction of joint assessment visits and joint supervision, as well as co-location and integration were mentioned by all of the staff interviewed.

16. RECOMMENDATIONS

16.1 No professional wants to work in a way or in a system that fails to protect children, and there is no doubt that there was both good practice and practice which fell short of the level that Surrey SCB would want to promote. The Surrey Early Help strategy presents a brave attempt to change the current prevailing approach in which children are not well served nationally, to a local solution in which there is shared understanding about risks and needs. Clearly, whilst there is still some way to go in terms of joint training, risk focussed assessment and interagency communication, if the vision set out in the strategy is to be realised this review has identified some helpful learning to inform progress.

16.2 I support the single agency recommendations from the IMRs to the Surrey Safeguarding Children Board, and also recommend the following:

16.2.1 That Children's Social Care reports back to the Board that the guidance for social workers on assessment includes the following requirements:

- Joint visiting with other professionals to share perceptions and views
- clear 'triggers' for reassessment when circumstances change in families,
- a focus on history and chronology
- understanding the role of fathers,
- challenging assumptions and producing clear evidence for professional opinion
- identifies risks as well as needs and strengths, regardless of whether the case is CIN or CP
- that, where children are subject to Children in Need Plans, social work visits are both announced and unannounced in order that the child's whole context can be understood

16.2.2 Surrey Safeguarding Children Board should also satisfy itself through its learning and improvement framework and a system of audit that:

- the risks to new born babies and premature babies are fully understood and the expertise of community health professionals are acknowledged in this area, and
- the Family Nurse Partnership arrangements are improving the focus on the needs of very young parents, and in particular the focus on the parents as Children in Need themselves, and therefore improving outcomes for them and their children

16.2.3 Surrey Community Health services should consider revision of the criteria for inclusion in the Family Nurse Partnership programme to include young parents who have a second or subsequent child.

16.2.4 Surrey Safeguarding Children Board should also ensure that the Escalation policy is brought to professionals attention and in particular the urgency in the case of very young children

16.2.5 Surrey Safeguarding Children Board should consider how best to support joint training and consideration of the appreciative inquiry or a similar model as a means of promoting common dialogue and developing positive shared practice.

16.2.6 The Safeguarding Children Board of the neighbouring authority should also assure itself through audit that policies and procedures reflect the requirement to vigorously pursue and share information and concerns, where there are families with additional vulnerabilities who move between health practices. This would include the health practitioner following up by telephone with the receiving practice any issues that indicate vulnerability direct with the new practice in order that safest and best practice is assured.

16.2.7 The Safeguarding Board should also ensure that a full de-brief is held between the health and social care staff involved in this Review.

Ruby Parry

Ruby Parry

Independent Consultant, On behalf of Reconstruct, July 2015

SINGLE AGENCY RECOMMENDATIONS

Community Health

1. Definition and Clarity of roles between different health visitors. Though it is felt that all the health visitors concerned identified the risks and were clearly working together to improve the situation for these children it is apparent that too many were involved. There needs to be a clearer definition of the role of the Health Visitor for the Homeless and for the 0-19 teams to understand where their responsibilities lie in conjunction with this post.
2. Improved links with Children's Services. There were clear differences of opinion between Children's Services and health and a degree of not understanding what the different roles were. Measures are already in place to improve this working relationship and managers from the 0-19 team, the safeguarding team and children's services are now meeting regularly to liaise about complex cases. Shadowing between the agencies is actively being encouraged.
3. Improved Assessment and Record Keeping. The annual record keeping audit will include a deeper audit of safeguarding records and supervision records including risk assessment and action plans evidenced by the effective use of chronologies and the use of the Family Health Needs Assessment.
4. Clinical managers are to update all 0-19 team members on record keeping issues via service meetings and team leaders.
5. The Family Health Needs Assessment should be used as a continuing document assessing risks, strengths and resilience and it will be recommended that practitioners should be given more training on its use in universal practice assessments and how it can be used to provide objective evidence to support referrals and concerns.
6. Group Supervision. As has already been documented there were a large number of health professionals and professionals from other agencies involved with this family. Group supervision and joint supervision would have been a useful way for all individuals concerned to meet together and discuss the concerns that they had and decide in a more organised way exactly what support each practitioner or agency could provide.

District Council

1. Ensure that the regular liaison and visits (as described in the good practice example) between the SHO, health visitor and Children's Services outreach worker are sufficiently resourced and prioritised so that they continue.
2. Ensure that staff continue to receive and update their training on safeguarding and child protection as this clearly engenders confidence for staff in dealing with difficult situations.

Children's Social Care

1. A chronology to be started at an early point in the life of the case and to be a piece of ongoing work and a tool for analysis and supervision

2. Where a parent of a child referred to children's Services has themselves been known to the Local Authority as a consequence of Child Protection concerns, has been on a Child Protection Plan, Looked After or a child in need, their own early history should be examined with a view to an assessment of their own patterns of childhood attachment.
3. For supervision notes to address each aspect of the plans and record the risks and to outline a clear plan of work
4. For assessments to include fathers and the wider family.
5. Where there are difficulties between agencies in their understanding of the case for consideration to be given to early joint meetings and supervision.

APPENDIX

TERMS OF REFERENCE

1. Did agencies communicate effectively and work together to safeguard and promote the children's welfare?
2. Was the level and extent of agency engagement and intervention with the family appropriate? Were assessments undertaken in a timely manner, was the quality adequate and did they include fathers, extended family and all historical information?
3. Was any information known by any agency about parental mental health issues, domestic abuse, substance misuse or parental antisocial behaviours or concerns re neglect? If so was appropriate consideration given to how these impacted on parenting capacity and were appropriate referrals made?
4. Was there sufficient consideration of the vulnerability of this family in relation to their housing situation and the impact on their parenting capacity and what support was provided?
5. Were the decisions and actions that followed assessments appropriate and were detailed plans recorded and reviewed?
6. Were the children's views and wishes sought and taken account of in assessments and planning? Did this include the presentation of these young non verbal children being fully considered?
7. Were any safeguarding issues in respect of the children identified and acted on appropriately and in a timely way by all agencies?
8. Were missed appointments and failure to engage considered as indicators of neglect?
9. Was race, religion, language, culture, ethnicity or disability a factor in this case and was it considered fully and acted on if required? How was the uniqueness of this particular family recognised?
10. Were there any organisational or resource factors which may have impacted on practice in this case?
11. Were appropriate management/clinical oversight (supervision) arrangements in place for professionals making judgments in this case?