

**HARINGEY LOCAL SAFEGUARDING
CHILDREN BOARD**

**SERIOUS CASE REVIEW
'CHILD A'**

November 2008

**Published by the Department for Education on
26 October 2010**

First Serious Case Review Overview Report relating to Peter Connelly

This document contains the redacted first Serious Case Review overview report relating to Peter Connelly. This overview report was written by an independent author commissioned by Haringey Local Safeguarding Children Board. It was published on 26 October by the Department for Education. The only editing undertaken by the Department prior to publication by the Department is the redaction of information that it is not appropriate to put into the public domain.

The process of redacting the overview report has involved:

- considering the welfare of children involved in the case;
- comparing the executive summary already in the public domain, with the corresponding overview report; no information that is included in either of the executive summaries has been redacted;
- considering the extent to which information in the overview reports is capable of being used to identify living individuals whose identity is not already common knowledge;
- considering whether information that is by its nature sensitive personal data under the Data Protection Act 1998 (for example, because it is information about a person's physical or mental health or condition, his / her sexual life, or the commission or alleged commission by him / her of an offence) is likely to have already been made public (for example, as part of the criminal trials) and whether its inclusion in the reports is necessary to give a complete picture of events;
- redacting personal data or information which would breach reporting restrictions imposed by the Court; and
- redacting any personal or sensitive personal data, including clinically confidential information, that has not already been published and which cannot be justified as necessary or relevant, bearing in mind the overall purpose of publishing the overview reports.

HARINGEY LOCAL SAFEGUARDING CHILDREN BOARD

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November 2008

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PREFACE

The following main report of this serious case review was drafted in mid July 2008 and its conclusions and recommendations reflect the evidence available to partner agencies at that point in time.

Final amendments were made during October only to improve the specificity of recommendations and to correct the by then erroneous references to a 'forthcoming trial' of the defendants referred to in paragraph 1.2.5

On legal advice, finalising of this report and publication of its executive summary was deferred until the conclusion of that criminal trial.

1 INTRODUCTION

1.1 RATIONALE FOR SERIOUS CASE REVIEW (SCR)

- 1.1.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires Local Safeguarding Children Boards (LSCBs) to undertake reviews of serious cases in accordance with procedures set out in chapter 8 of *Working Together to Safeguard Children* HM Government 2006.
- 1.1.2 When a child dies, and abuse or neglect is known or suspected to be a factor in the death, the LSCB should conduct a serious case review (SCR) into the involvement with child and family of organisations and professionals.
- 1.1.3 The purpose of a SCR is to:
 - 'Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
 - Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result and
 - As a consequence, improved inter-agency working and better safeguard and promote the welfare of children'

1.2 CIRCUMSTANCES OF CHILD A'S DEATH

- 1.2.1 On 03.08.07 at approximately 11.30am Ms A (mother of child A - a White male child with Irish ethnic origins) called the London Ambulance Service (LAS) to her home address. The attending paramedics took the apparently lifeless body of child A (aged seventeen months) to the North Middlesex University Hospital (NNUH).
- 1.2.2 In spite of efforts by Ambulance and hospital staff to revive him, child A was pronounced dead at 12.10pm. On initial examination, he was seen to have bruising to his body, a tooth missing, a torn frenum and marks to his head.
- 1.2.3 The Police individual management review (IMR) referred to a post mortem completed on 06.08.07 which revealed further injuries (a tooth was found in child A's colon and eight fractured ribs on the left side and a fractured spine were detected). The provisional cause of death was described as a fracture / dislocation of the thoraco-lumbar spine.
- 1.2.4 Police enquiries established that at the time of child A's death, Ms A's boyfriend Mr H lived at her address; Mr H's brother, his fifteen year old girlfriend and his [REDACTED] children had been staying there since 17.07.07.
- 1.2.5 Ms. A, Mr H and Mr H's brother have been charged with murder and causing or allowing the death of a child.

1.3 STATUS OF THIS REPORT

- 1.3.1 So as to ensure that lessons to be learned are disseminated without delay, this report has been produced prior to the completion of the above criminal proceedings and does not incorporate any relevant evidence that might arise in the course of the above trial. If those criminal proceedings present new evidence for the partners represented by Haringey's Safeguarding Children Board it is understood that the serious case review sub-committee will consider the need for an addendum to this main report.
- 1.3.2 An executive summary will be produced and, in accordance with statutory guidance, published at the conclusion of current legal proceedings.
- 1.3.3 It is understood that each agency, which provided an IMR for the review, is acting upon its own recommendations in advance of the completion of the SCR. An overall 'action plan' is to be produced and it will be the responsibility of the LSCB to monitor its implementation.
- 1.3.4 Following acceptance of this report by Haringey's LSCB, a confidential 'briefing note' encapsulating key messages and agreed recommendations will be circulated to relevant managers in each of the agencies that contributed to this serious case review.

1.4 INVOLVEMENT OF LOCAL AGENCIES

- 1.4.1 At the time of his death, child A (then aged seventeen months), child [REDACTED] (aged [REDACTED]) and child [REDACTED] (aged [REDACTED]) were subjects of child protection plans:
- Child A's name had been on Haringey's 'child protection register' ¹ under the category of physical abuse and neglect since 22.12.06
 - Child [REDACTED]'s name had also been on the register since 22.12.06, under the category of neglect
 - Child [REDACTED]'s name had been on the register since [REDACTED], under the category of physical abuse

¹ Though the current term preferred by the Department for Children, Schools and Families (DCSF) is ‘a child subject of a child protection plan’, records maintained by agencies and IMRs provided for this SCR have used the previously preferred terminology of ‘a child whose name is on the child protection register’. For the purposes of this report, the terms are interchangeable.

1.4.2 During the period covered by this SCR, the following agencies were involved with child A and/or his family:

- Haringey's Children & Young People's Service (CYPS) (conducting enquiries and subsequently implementing agreed child protection plans)
- Haringey's Teaching Primary Care Trust (HtPCT) (providing health visiting, GP, primary care mental health and school nursing services and supporting the child protection plans) [from 01.04.08, GOSH has undertaken management and employment of Haringey's provision of health visiting, school nursing and designated and named nurses for child protection]
- Whittington Hospital NHS Trust (providing out patient, day patient and in patient care and diagnostics including pathology and radiology)
- North Middlesex University Hospital (NMUH) (offering ante and post-natal care)
- Great Ormond Street Hospital (GOSH) providing on behalf of HtPCT paediatric medical services in Haringey including the designated and named doctors for child protection and the paediatric A& E service at NMUH
- Metropolitan Police Service (MPS) (working with and alongside the CYPS to jointly investigate reported injuries to child A)
- Family Welfare Association (FWA) (offering specific tenancy and family support in an 'individual support plan')
- Two of Haringey's schools (providing educational services for [REDACTED] child A's [REDACTED])
- Haringey's Legal Services (providing legal advice to CYPS)
- Haringey's Strategic & Community Housing Prevention & Options Team (organising provision of long term temporary Housing Association accommodation for the family)

1.5 SUMMARY

1.5.1 Section 1.5 provides a high-level summary of the considerable detail contained in the remainder of this report.

BACKGROUND & SIGNIFICANT EVENTS

1.5.2 Ms A separated from her husband in the [REDACTED] of 2006, from which time she undertook the care of their [REDACTED] children ([REDACTED] a boy - child A who was about four months old).

1.5.3 There were no concerns about the welfare of any of the children prior to December 2006, when child A (by then nine months old) was presented at a hospital with a head injury and bruising, considered by medical staff to be suggestive of non accidental injury.

- 1.5.4 Child A remained in hospital for four days until discharged to the temporary care of a family friend pending completion of multi agency enquiries some six weeks later. At that point the Police investigation was continuing, but had not identified any perpetrator of child A's injuries and CYPS appear to have concluded that child A's injuries were most likely to be the result of inadequate supervision.
- 1.5.5 Following the incident in [REDACTED] 2006 a child protection conference was convened and child A and his [REDACTED] were made subjects of child protection plans. From that point Ms. A and her children had extensive involvement with professionals from local agencies particularly Police, CYPS and primary, community and acute health service providers.
- 1.5.6 From the time of child A's first presentation at hospital, observations and assessments of the relationship between Ms A and her children remained largely positive and she was considered to be co-operating with the child protection plans.
- 1.5.7 Various professionals noted that child A was an active child who was observed to throw his body around and head-butt family members and objects. This appeared to support Ms A's concerns that her son suffered frequent accidents due to being an active, clumsy child with a high pain threshold. From March, a main element of the child protection plan was obtaining a developmental paediatric assessment, to ascertain if there was any organic reason for such behaviour.
- 1.5.8 With one exception, the [REDACTED] elder [REDACTED] did not give cause for significant concern. [REDACTED]
- 1.5.9 The exception to the above apparently reassuring perception was an incident in [REDACTED] 2007, when Ms A was seen to slap [REDACTED]. This child was consequently made subject of a child protection plan at a child protection conference in March 2007.
- 1.5.10 In early April 2007 child A was presented at a hospital for a second time, this time with a swelling to the left side of his head, understood to have been the result of hitting his head on a fireplace after being pushed by another child. He also had bruises and scratches to face, head and body, a rash to his face and neck and it was noted he had head lice. He was admitted for two days for observation and treatment with antibiotics and then, with the agreement of CYPS, discharged home.
- 1.5.11 There was a further significant event in early June 2007 when a social worker observed marks on child A, informed the Police and, with Ms A's co-operation, arranged and attended a medical examination, at which it was concluded that there was a reasonable probability that some of the bruising was due to abuse.

- 1.5.12 On 04.06.07 CYPS and Police agreed temporary safeguarding measures involving a childminder and the same friend who had previously provided temporary care of him, so as to ensure no unsupervised contact between child A and his mother.
- 1.5.13 Also agreed at that point, and confirmed at the review child protection conference a week later, was the need to complete the still outstanding developmental assessment, to obtain legal advice on the justification for initiating protective legal proceedings and to learn the result of then ongoing Police investigations.
- 1.5.14 Police enquiries with respect to potential perpetrators of child A's injuries both in December 2006 and June 2007 proved inconclusive and were ultimately completed in July 2007, with no criminal charges being preferred against any individuals.
- 1.5.15 CYPS obtained legal advice on 25.07.07, which indicated on the basis of the information provided, that the threshold for Care Proceedings was not met.
- 1.5.16 Child A was seen by a paediatrician on 01.08.07, for the purpose of the developmental assessment. The paediatrician judged that he was unwell and miserable with a possible viral infection and partly healing scalp infection. The doctor completed a history, prescribed medication and arranged that various tests be completed and a follow up appointment made so as to complete the assessment.
- 1.5.17 On 03.08.07, child A was brought by ambulance to hospital and pronounced dead soon after midday.

OBSERVATIONS

- 1.5.18 The absence of previous concerns about Ms A's [REDACTED] children and the positive observations of her parenting led to a high level of trust of Ms A. This was further reinforced by her predominant behaviours and presentation (the current criminal proceedings may reveal whether the positive picture was more apparent than real) i.e:
- Co-operation with most professional visits and appointments
 - Positive response to offers of help
 - Frequent initiation of communications with professionals, often relaying information between them
 - An openness of manner
- 1.5.19 As a consequence of professional perceptions of Ms A coupled with the lack of an identified perpetrator, child A's injuries were perceived to be largely a consequence of insufficient supervision and of his own observed behaviours. The latter led to concerns about a potential organic causation of child A's bruising and injuries and prompted the involvement of the Specialist Child Health Service (SCHS).

- 1.5.20 Within the above context, new incidents were interpreted in terms of the existing understandings of the family dynamics, with insufficient attempts to use the incidents to prompt re-assessments.
- 1.5.21 All the professionals working with the family understood the household composition to be Ms A and her [REDACTED] children. Although it was known that a Mr H was a friend, neither his intimate relationship with Ms A nor his presence within the household, had been discerned by any professionals.
- 1.5.22 With the benefit of hindsight, the indication that Mr H may have been present in the household since February 2007 (current finding of the Police investigation following child A's death) offers a new perspective.
- 1.5.23 It should be noted that during the last month of his life, Ms A presented her son to health professionals eight times, and in his last week, he was seen by a social worker and a paediatrician. None of those professionals identified major concerns about child A's health and well being.
- 1.5.24 It is of concern that during this critical period the persistence of the sores on child A's scalp did not raise questions about the effective application or appropriateness of the various medications prescribed.
- 1.5.25 Most critically child A was seen on 01.08.07 by a community paediatrician for the purpose of the long awaited developmental assessment. The GOSH addendum to the HtPCT IMR (dated [REDACTED] 08) concludes that a diagnosis of abuse should have been made at that point.
- 1.5.26 This SCR has revealed clear evidence of appropriate communication between and within agencies, though also weaknesses in specific areas of information flow e.g. transmission of information to Police CAIT, between other core group members and FWA, between the social worker and the Mellow Parenting group leaders and in the ambiguity of a referral to CYPS.
- 1.5.27 With the benefit of hindsight, a number of key issues can be seen to have compounded the risk to child A including:
- Limited efforts made by professionals to involve child A's father in the early period of intervention
 - Trust and responsibility placed by CYPS in a family friend, with insufficient assessment, monitoring and review of her ability, role and performance
 - The pervasive belief that child A's injuries were caused by lack of supervision and his own behaviour and the lack of adequate re-assessment of the household following further injuries and bruising
 - The inability to identify and prosecute a perpetrator of child A's injuries
 - Delay in an adequate referral to and provision of the SCHS appointment
 - Delay in holding a legal planning meeting and advice subsequently provided that the threshold criteria for obtaining a Care Order under s.31 Children Act 1989 were not satisfied

EVALUATION

- 1.5.28 The quality of the work of the different agencies in this complex case, varied between and within them. Numerous examples of good practice within all agencies have been acknowledged in the analysis provided in section 6. Of particular note were the multi-agency responses by all professionals and agencies to the December 2006 injury.
- 1.5.29 The report's detailed analysis and conclusions inevitably focus on the lessons to be learned.
- 1.5.30 The main finding emerging from this SCR is that, despite a great deal of professional input, the conclusions of the various assessment processes had not reached an adequate understanding of the:
- Cause of child A's injuries and bruising
 - Nature of Ms A's relationship with Mr. H and the extent of his involvement in the family
 - Value of Ms J's input
- 1.5.31 There were many factors that contributed to the inability of the agencies to understand what was happening to child A. With the possible exception of the paediatric assessment of 01.08.07, none on their own were likely to have enabled further responses that might have prevented the tragic outcome. The factors in combination contributed to the lack of understanding of the family's functioning and consequently compounded the risk to child A.
- 1.5.32 The *reality* was that local professionals were wholly unaware that Mr H had been living with Ms A for some months; that [REDACTED] other individuals had been staying at the home for approximately a fortnight before child A was killed and that (according to expert medical opinion commissioned by GOSH in the course of this SCR) child A had visible symptoms of physical abuse and chronic neglect in the week before his death.
- 1.5.33 Thus, although the SCR found that safeguarding structures exist across Haringey agencies and offer a sound framework for the implementation of child protection procedures, it has also identified scope for improving the detailed application of some processes.
- 1.5.34 The recommendations in section 8 specify the opportunities identified by this SCR for strategic multi-agency action by Haringey's Local Safeguarding Children Board and for enhancing operational effectiveness in each of the local agencies that provided services to child A's family.

1.6 REPORT CONSTRUCTION

1.6.1 In an attempt to render more accessible a significant amount of detail, the remainder of this report is laid out as follows:

- A genogram illustrating the most relevant members of the household and personal network
- Key dates of the most significant events and professional decisions
- Agencies' involvement presented chronologically
- An analysis of the extent to which records demonstrate best practice
- Conclusions with respect to general and agency-specific practice and therefore lessons to be learned
- Practical recommendations for action by Haringey's Local Safeguarding Children Board and member agencies
- A glossary of abbreviations used within this report
- Appendix 1: terms of reference for the SCR

1.6.2 An anonymised integrated chronology has been provided separately.

2 REVIEW PROCESS

2.1 INITIATION & SCOPE

- 2.1.1 Haringey's LSCB immediately recognised that child A's death satisfied one of the criteria for convening a serious case review (SCR) contained in chapter 8 of the government's statutory guidance *Working Together to Safeguard Children* 2006 i.e. that 'a child dies and abuse or neglect is known or suspected to be a factor in the death'.
- 2.1.2 OfSTED was formally notified of the decision to initiate the review on 06.08.07, a serious case review sub-committee was convened and on 08.08.07, in accordance with statutory guidance:
- Agreed the initial scope of the review
 - Initiated the formulation by all relevant agencies of individual management reviews (IMRs)
- 2.1.3 Informed by the IMRs received and following a second meeting of the above sub-committee on 24.09.07, final case-specific terms of reference were determined. Following advice received from the Government of London Office (GOL) and further discussion on 12.12.07, those terms of reference were enhanced and are now reproduced in appendix 1.

2.2 MEMBERSHIP

- 2.2.1 Membership of the sub-committee was determined as follows:
- Sharon Shoesmith: Director of the Children and Young People's Service (CYPS) (chairperson of the LSCB and of this serious case review)
 - Cecilia Hitchen: Deputy Director Children & Families (CYPS)
 - Teresa Walsh-Jones: Service Manager Child Protection (CYPS)
 - Jan Doust: Head of Children's Networks and Lead for Safeguarding (CYPS)
 - Dick Henson: Detective Chief Inspector Metropolitan Police Service
 - Alastair Horne: Critical Incident Review Officer Metropolitan Police Service (lead for this serious case review)
 - Dr. Sukanta Banerjee: Consultant Paediatrician / Designated Doctor for Child Protection Haringey PCT & Great Ormond Street Hospital
 - Jane Hatt: Designated Nurse Haringey PCT
 - Jane Elias: Partnership Director of Operations GOSH
 - Sarah Peel: LSCB Training & Development Officer (CYPS)
 - Gill Earl: Nurse Consultant Child Protection (GOSH) [now retired and replaced by Caroline Joyce Assistant Director of Nursing for Workforce at GOSH]
 - Chloe Eaton: Principal Lawyer (Haringey Legal Services)

2.3 APPOINTMENT OF INDEPENDENT AUTHORS OF THE OVERVIEW REPORT

- 2.3.1 CAE Ltd (Edi Carmi and Fergus Smith) was selected to produce for approval by the serious case review sub-committee, a draft overview report. This work commenced in mid November (CAE's earliest availability).

2.4 INITIAL PRODUCTION OF IMRS AND CHRONOLOGIES

- 2.4.1 With respect to this case, finalised IMRs were provided as agreed to CAE by 10.10.07 and an integrated chronology on 11.10.07. Information provided by agencies for their individual chronologies was based on written records and interviews with staff.
- 2.4.2 There were significant variations in the value of the material provided, in particular with reference to the level of detail provided and the extent of analysis of the respective agency's practice in IMRs. The integrated chronology provided by the LSCB was clear and well presented.

2.5 FURTHER INFORMATION PROVIDED TO OVERVIEW AUTHORS

- 2.5.1 Following provision of IMRs as described above, further proposals for changes and additional material were received via amended chronologies and IMRs, amended IMR recommendations, written comments within emails, comments within sub-committee meetings and via provision of additional original documentation.

Government Office for London advice

- 2.5.2 Consequent upon additions made to the terms of reference by the Government Office for London, CAE suggested all agencies be offered an opportunity to re-visit IMRs or provide additional comments. The result was:
- An amended version of the FWA's IMR (received on 07.01.08)
 - Haringey's PCT / GOSH written response on 10.01.08
 - CYPS and Schools submitting revised recommendations on 14.01.08 and 17.01.08 respectively
 - GOSH submitting an action plan, including revised recommendations on 23.01.08 and a further action plan on 31.01.08
 - CYPS submitted a revised chronology and a revised IMR on 24.01.08

Further agency and specialist opinions

- 2.5.3 Children & Young People's Service (CYPS) submitted an amended chronology on 05.12.07, reflecting a report recently received by it of an incomplete paediatric assessment of child A two days prior to his death.

- 2.5.4 Mindful of the potential significance of this (final) contact with medical services, CAE made a request that GOSH address the issues raised by CYPS within its amended chronology.
- 2.5.5 A written response was received on 10.01.08, from the medical expert nominated by GOSH and is reflected in the analysis and conclusions of this report.
- 2.5.6 On 04.02.08 CAE requested (in the light of the findings of the initial post mortem) a need for an expert paediatric opinion to consider the implications of this report for the professionals who saw child A during the last week of his life, in particular any medically trained staff.
- 2.5.7 On 24.05.08 CAE received a summary of a highly significant document entitled 'addendum to the HtPCT IMR', dated 28.05.08 [sic] together with an 'action plan' dated 25.05.08 [sic]. The former reported upon an independent and critical expert medical opinion commissioned by GOSH about the quality of the paediatric service provided on 01.08.07 and the latter the response of GOSH to that report.
- 2.5.8 Finally, CAE requested a comment from GOSH about possible neglect in relation to child A's apparent long standing 'lice infestation'. This was provided on 18.02.08 and subsequently an amended version was received on 18.03.08. This is reflected in the analysis and conclusions of this report.

Original documents requested

- 2.5.9 Examination of the material provided highlighted inconsistencies and the need for further detail about the assessment and multi-agency planning processes. Consequently CAE requested and was provided with the following documents in addition to the chronologies and IMRs:
- Child protection conference records
 - Child protection plans
 - Core group meeting records
 - Core assessment

Responses to drafts of the overview report & discussions in meetings

- 2.5.10 Presentation of drafts of the SCR overview report and subsequent discussion highlighted the need for the provision of further information or prompted agencies to supply additional material or make changes in their recommendations.

2.5.11 This has been provided in amended IMRs, chronologies, various emailed comments and discussion at sub-committee meetings, and has included:

- Amended recommendations from agencies on 03.03.08, with subsequent changes to specified recommendations in several email communications
- Child protection summary sheets from NMUH dated 09.04.07 (referral following paediatric examination within A & E) and 01.06.07 (child protection paediatric assessment), with new information from GOSH on 14.04.08 regarding the status of such forms
- A report of a meeting between child A's father and CYPS managers on [REDACTED].08
- Amended IMRs and chronologies from CYPS and from schools (received on 03.02.08) with further amendments on 10.03.07
- Amended IMR from Legal Services (received on 03.02.08)
- Further amended IMR and chronology from schools on 11.02.08
- Part of the SCHS Operational Policy and extract from the SCHS appointment diary on 07.03.08
- CYPS emailed statement in relation to the role of Ms J (a family friend) on 15.05.08
- A 'care pathway planning' document emailed from CYPS on 02.06.08

2.6 INVOLVEMENT OF FAMILY

2.6.1 Mindful of the need to offer the family an opportunity to contribute to the SCR *and* of the importance of not interfering with the current criminal investigation, letters to child A's mother and father were drafted which:

- Explained the process being followed
- Provided an opportunity for contribution to it, and
- Offered access to the executive summary of this SCR that would in due course be placed in the public domain

2.6.2 The authors received no direct response from the family. However, child A's father (Mr A) met with CYPS managers on [REDACTED].08 and was briefed about the SCR process. CAE has been told that he indicated he did not wish to take the opportunity to contribute to the serious case review.

2.6.3 A further attempt was made in [REDACTED] to involve Mr A but to date no response has been received.

2.7 REFLECTION ON SCR PROCESS

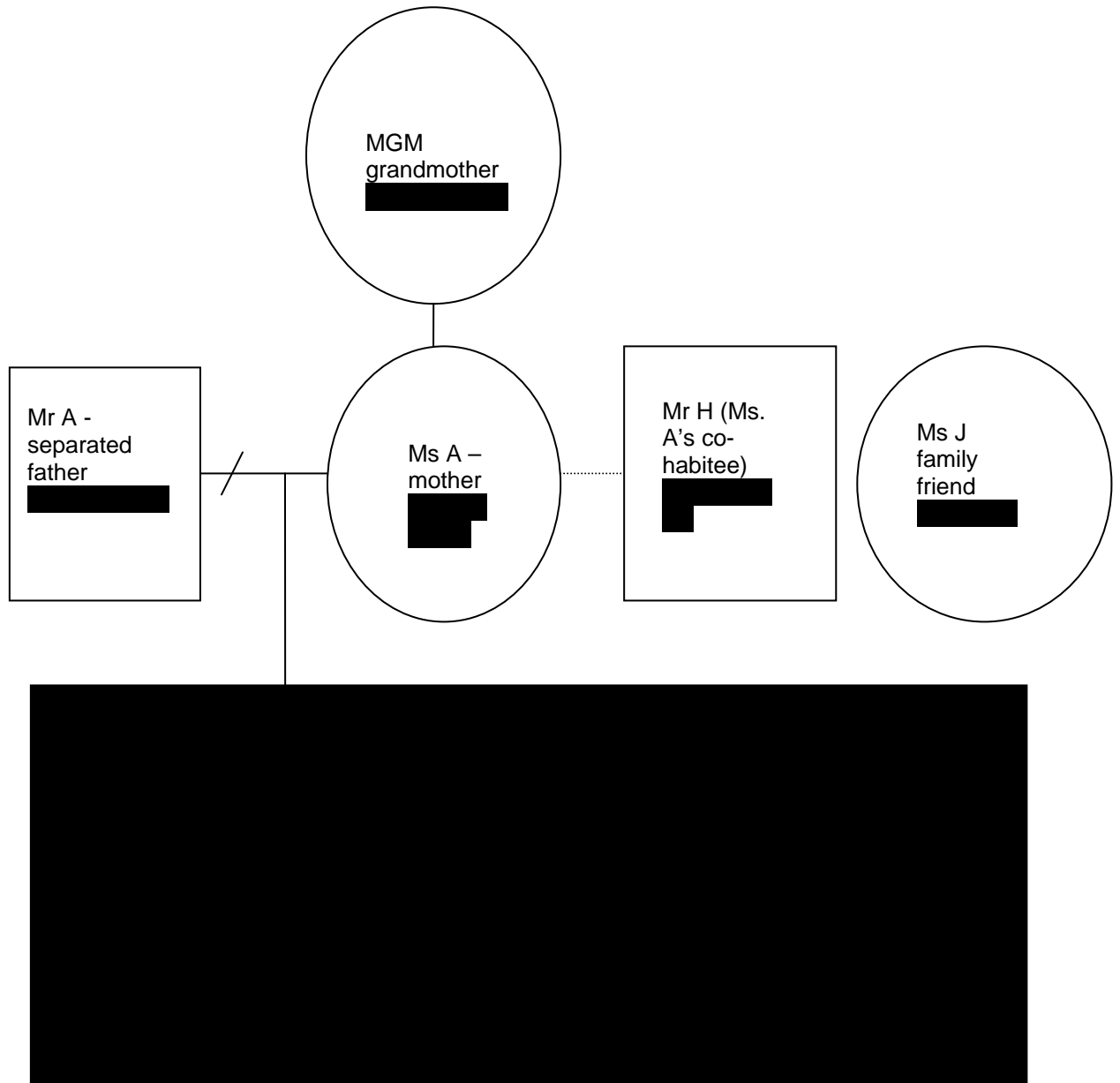
- 2.7.1 Reflecting upon the SCR process, it is possible to identify strengths, complicating factors and areas for improvement in the event that Haringey's LSCB was to undertake another SCR.
- 2.7.2 This process benefited from:
- An immediate recognition by the LSCB that a SCR was required and the speedy co-ordination of relevant agencies
 - The timely production of initial versions of agencies' IMRs
 - A clear and well presented integrated chronology
 - Efficient organisation / administration of meetings / minutes
 - Robust and thorough debate
- 2.7.3 A significant weakness was the variable quality of the IMR's and it may be instructive to reflect upon a finding in the recently published *Improving Safeguarding practice, Study of Serious Case Reviews, 2001-2003 (DCSF 2008)* 'the quality of the overview report is dependent on the agency management reviews and their chronologies. Acknowledgement is not always given to the time this may take, the training needs of those preparing reports and to the management issues required' (Wendy Rose and Julie Barnes 2008)'.
- 2.7.4 In this case the subsequent information provided by agencies and the extensive debate has addressed the weaknesses in some of the IMRs.
- 2.7.5 Further complicating factors for this review process were:
- The additional issues identified by GOL as requiring consideration within the terms of reference after the completion of IMRs
 - The need to distinguish carefully between information that was known or could reasonably have been discerned during the period of multi agency involvement with child A's family and what may emerge as 'fact' from evidence presented in forthcoming criminal proceedings
- 2.7.6 Any future SCR could be more efficient and effective if there were training provided for those writing the IMRs and explicit terms of reference agreed for IMRs, thus ensuring clarity of required scope, comparability of detail and overall quality.

Quality assurance

- 2.7.7 So as to add further objectivity and credibility the Local Safeguarding Children Board commissioned a suitably qualified and experienced independent consultant to act as a 'critical friend' during the sub-committee's final discussions.

3 GENOGRAM

SIGNIFICANT INDIVIDUALS



4 KEY TIMES & DATES

4.1 INTRODUCTION

- 4.1.1 Events and decisions considered to be of the most significance are tabulated below. Authors' comments are italicised. An integrated chronology (provided separately) provides full details of agency involvement with the family from [REDACTED] 2005 to the death of child A in August 2007.

Date	Event
[REDACTED].05	Ms A seen by Primary Mental Health Worker (PMHW); history of post natal depression; Ms A reports she has [REDACTED] children [REDACTED] and is pregnant; she described conflicts in the marital relationship and an unsupportive husband
[REDACTED].05	Ms A attended NMUH ante-natal clinic for booking by midwife; she was 12 weeks pregnant; subsequently attended ante-natal appointments regularly
[REDACTED].05	Ms A referred to Sure Start by PMHW. <i>No further info provided on outcome</i>
[REDACTED].05	Ms A saw PMHW. Mood reported to be low and relationship difficulties said to continue
[REDACTED].05	Ms A saw PMHW. Records state 'domestic violence' - only detail provided is [REDACTED]; Ms A provided with contact details of Samaritans
[REDACTED].05	Ms A told PMHW she was angry, upset and felt used because a male friend was seeing another woman and had not told her
[REDACTED].05	Ms A saw PMHW. She has asked Mr A to leave and he wants to attend family therapy. Ms A described as abusing alcohol, as stressed, poor appetite and little sleep. Records refer to referrals / sign posting to relate, SPACE, family therapy
[REDACTED].05, .05 & .05	PMHW recorded that Ms A was brighter
[REDACTED].06	PMHW recorded Ms A was tired, oversensitive and not sleeping well
01.03.06	Child A born at NMUH: normal delivery of male infant in good condition; mother and baby well; baby cuddled at birth; breast feeding on demand
[REDACTED].06	Grandfather recorded as taking Child [REDACTED] for [REDACTED] appointment ([REDACTED])
[REDACTED].06	Child A discharged home. Discharge summary includes Ms. A's history of postnatal depression. Midwives visited [REDACTED], when Ms A said she was going away for a few days
[REDACTED].06	Ms A did not keep a PMHW appointment
[REDACTED].06	Midwife saw Ms A and child A on return from [REDACTED]. Mother and baby had [REDACTED]; advised to see GP; also advice given on smoke filled room; 'partner' said to be providing support with cuddling baby and trying to space out feeds; discharged from midwifery

██████.06	1 st health visitor home visit for new birth assessment; Ms A self reported post natal depression with first child, but felt well and in touch with GP 'counsellor' (<i>presumably the PMHW</i>). Father said to help with children. ██████ discussed and advice given re: smoking; home described as very untidy; HV1 followed this with a telephone call on ██████.06 inviting Ms A and child A to attend child health clinic (CHC) and a letter to GP1 on ██████.06 seeking update of information from PMHW
██████.06	Child A seen by GP re ██████ and medication prescribed
██████.06	Ms A saw PMHW. Said Mr A providing a lot of help. Felt guilty about starting to bottle feed child A. Felt tired, anxious when in crowded places and has urge to make herself sick, said she had been ██████ Ms A and child A seen at CHC: child A on 2 nd – 9 th centile
██████.06	Ms A attended 6 week post natal check with GP; exhausted and suffering with migraine
██████.06	Ms A failed appointment with PMHW. PMHW re-arranged for ██████.06, when Ms A was reported to be brighter in mood and controlled ██████, although she complained of poor sleep and mood swings
██████.06	Ms A and child A attended CHC. Weight 2 nd – 9 th centile. Now bottle fed, but 'vomiting'
██████.06	PMHW recorded Ms A as having ██████ ██████ felt let down by a friend and about to go on holiday. Ms A advised to see GP re starting anti-depressants
██████.06	GP1 diagnosed Ms. A's chronic depression and prescribed ██████
██████.06	Child A seen by triage GP: vomiting after feeds 'impression gastroenteritis'
██████.06	HV1 sent letter to PMHW seeking information on Ms A's well being. PMHW left message for HV1 on ██████.06, to call her on return from leave
██████.06	PMHW recorded that Ms A brighter and not feeling suicidal. Compliant with medication for a week but forgot when on holiday Ms A spoke of new male friend who was very supportive; still angry about other male; she said she had asked the school to look for changes in children as wanted to avoid it affecting them as happened previously. <i>The meaning of this is unclear and no record of this from school</i>
██████.06	PMHW telephoned HV1: reported low mood and anti-depressants. Ms A said to have improved and on holiday 'now'
██████.06	HV1 telephoned Ms. A. Discussed child A's incomplete immunisation. Advised to attend CHC for weighing
██████.06	PMHW saw Ms. A. Reported to be brighter in mood, sleeping better and off medication since holiday. Plans to speak to school about ██████ concerns re child █. Reported her new supportive male friend
██████.06	PMHW recorded that Ms A was low, tearful, poor sleep. Coping with children and has support from her mother. Plan to monitor deterioration in depression and refer to Harts for family support
03.08.06	Referral to Harts, Family Welfare Association by GP/ PMHW due to depression over housing issues and difficult relationship with partner; no concerns raised about the welfare of the children; no response by Ms A to attempts made to arrange a home visit

██████.06	PMHW recorded Ms A still low mood, feels needs antidepressants, coping with children, support of her mother and husband wishes to return to family home; locum GP advised Ms A to take ██████████
██████.06	PMHW informed HV1 of change in mood on 14.08.06 and that Ms A wanted contact with HV to have the children weighed
██████.06	HV1 called Ms A on mobile: she reported feeling better and out shopping
██████.06	Ms A told PMHW she was on medication and feeling better; ██████████ ██
██████.06	Ms A told PMHW that she was angry with husband and considering divorce; she was taking medication and mood described as stable
██████.06	HV1 telephoned Ms A and agreed a follow up [date unknown] appointment at the clinic. Ms A failed appointment
██████.06	Home visit by HV1. Child A appeared well, had commenced weaning and had thrush on buttocks. 2 nd and 3 rd immunisations outstanding
19.09.06	Ms A attended GP with child A (6 months); nappy rash and cough noted, stating A 'bruises easily and she may be accused of hurting him'
██████.06	Ms A at school observing children in playground due to her concern that child ██████ was being bullied. Ms A had disagreement with teacher about her presence and the school's lack of facilities for parents to observe their child. School had no records of a bullying problem
██████.06	Ms A attended the school wishing to complain to the head teacher about T2's behaviour the previous day and also historical concerns towards her and her mother; the head teacher was not available
██████.06	PMHW saw Ms. A. Low mood, poor sleep and ongoing bulimic urge. Support from own mother with children. Taking medication, but ongoing relationship problems
13.10.06	Child A seen by GP. Reported to have accidentally fallen downstairs the previous day. No broken bones, but 'bruise left breast, left cranium' Advice given about stair gate. <i>Child A only 7 months old, not yet a 'toddler'</i>
██████.06	Child A seen by GP for upper respiratory infection and query thrush of groin
██████.06	Home visit to undertake HARTS assessment: assessed as low risk and put on waiting list for allocation; support requested by Ms A was resolve housing issues and access a solicitor for divorce proceedings; she mentioned domestic abuse and her depression
11.12.06	Child A, aged 9 months old, admitted to paediatric ward, Whittington Hospital with unexplained haematoma on forehead. Referred by GP who recorded additional bruising on right shoulder, breast and sternum. Ms A resident with child and contacted his father and maternal grandmother (MGM)
12.12.06	Strategy discussion at hospital: bruising said to be on forehead, right cheek (described as classic NAI), right buttock; agreed joint investigation and possible EPO; minutes mention Mr H as a friend who helps Ms. A Ms A met with police on the ward; she provided a variety of possible explanations for the injury
██████.06	CYPS record refers to consultant paediatrician 1 obtaining a second opinion; small abnormality on skeletal survey noted; bone and CT scan to be considered if further concerns; CP medicals arranged for other children

13.12.06	Detective constable and a social worker saw children [REDACTED] at school; they said that Ms A never hit them and no concerns were raised about levels of chastisement; child [REDACTED] knew of child A's injuries, but unaware of how they happened
14.12.06	Medical report faxed to CYPS: bruising on body would suggest rough handling, children do not easily bruise on the cheek, bruising on buttocks said to be 'quite unusual'; 'combination of bruising is very suggestive of NAI' Parents informed that child A to be accommodated unless alternative carer identified by them. Ms A upset and indicated she would not allow MGM to baby-sit again. Mr A agreed to take time off work to care for child A and Ms A provided details of a friend (Ms J) as a possible carer
[REDACTED].06	Nothing abnormal detected on bone scan
[REDACTED].06	Ms A confirmed to SW1 that prior to attending a practical parenting course Mr A used to hit the children
[REDACTED].06	SW1 contacted Ms J who confirmed she was willing to care for child A. Both Ms A and Ms J signed written agreement: Ms J to care for child A; contact with Ms A and with MGM to be supervised; CYPS to be informed of any concerns – child A discharged from hospital to care of Ms J
[REDACTED].06	Paediatric assessments [REDACTED], who remained at home with Ms A. [REDACTED] [REDACTED] [REDACTED]
[REDACTED].06	Ms A informed PMHW of child protection concerns and concerned that child A 'will be taken away'. (<i>The PMHW contacted the social worker on [REDACTED].07 to ask if she could attend the child protection conference</i>) Ms A informed HARTS of child protection enquiry. HARTS referred to FWA and case immediately allocated within FWA (<i>no direct contact by CYPS, but HARTS were invited to subsequent child protection conference</i>)
[REDACTED].06	Invitations to child protection conference faxed by social worker. Social worker telephoned HV1, learnt of Ms. A's post natal depression, that she was [REDACTED] and according to Ms. A, [REDACTED]. HV has no concerns re: care of children. HV1 telephoned Ms A who was upset, said she was unable to understand why this occurred – she offered no explanation for the injuries
19.12.06	Ms A and MGM arrested. Both denied any assaults and made suggestions of possible incidents when child A may have been injured
[REDACTED].06	Child A brought to Whittington Hospital by Ms J (described as foster carer) for x-ray (as an out patient). CYPS informed on [REDACTED].06 that images were not very good and the consultant paediatrician planned to repeat them in the New Year Ms J contacted CYPS requesting money for caring for child A. Ms J stated child A was head butting cot, people and fridge; bruise on bottom had gone

	<p>and bruise on testicles caused by hospital staff doing scan. <i>Only mention of bruise on testicles and it does not appear to have been followed up with hospital – the hospital has no record of this being brought to the attention of doctors or nurses</i></p> <p>PMHW wrote letter to CYPS outlining her involvement with Ms A over 16 months and observations with child A</p>
██████.06	Islington Children & Families provide background information – Ms A and brother were themselves placed on the child protection register and that MGM received a caution for physically hurting her son (possibly 1990)
22.12.06	Initial child protection conference: child A registered under categories of Neglect and Physical Abuse, child █████ registered for Neglect (██████ children were not registered)
27.12.06	Unannounced home visit by CYPS: 'home untidy and smell of urine'. Ms A and MGM with children
██████.06	<p>Letter from legal services to CYPS. Threshold for ICO met. LA not intending to pursue legal proceedings as Ms A co-operating. Premature to return child A home prior to risk assessment and ongoing police investigation</p> <p>SW1 told Ms A that child A may be able to return home following her return to police station on █████.07</p>
██████.07	FWA initial visit to prepare Individual Support Plan (ISP). █████ children seen; █████; FWA worker expressed concern re smell of dog urine in home
██████.07	Child A attended CHC with friend – <i>presumably Ms J</i> . Weight increase to 50-75 th centile and recovered from bruises. Thrush again on buttocks and groin – <i>latter not communicated to GP or SW1</i>
██████.07	MPS met with CPS: CPS required police obtain further medical evidence as to injury causation and dating of bruising
██████.07	FWA FSW1 expressed concerns about family home to TM1 and made requests for funds to purchase a clothes dryer <i>Nature of concerns not specified in chronology</i>
10.01.07	Core Group meeting: clarified role of FWA and health visitor in protection plan <i>HV1 present but appears not to have shared information re thrush School did not attend and reason not recorded</i>
██████.07	Report from Whittington received at GP1 practice: 'some bruising may be finger tip bruising' and 'combination of bruising very suggestive of NAI'
██████.07	<p>SW1 telephoned Ms J to arrange for her to take child A for hospital appointment the next day for repeat of x-rays (poor quality of previous ones). Some confusion due to Ms J reporting that TM1 had said child A would return home on █████, so Ms A could take him. Ms J said she would consider after discussion with TM1</p> <p>Discussion between SW1 and TM1 appears to have been inconclusive: TM1 stating she said child A could not return home until discussion with police and that service manager suggested return home with written agreement, but police disagreed. <i>No record of discussion with service manager or between TM1 and Ms J</i></p>

■■■■.07	Carer telephoned Whittington Hospital and said she was unwell and did not attend for arranged X-ray. SW1 saw Ms J, Ms A and all ■■■ children at home visit. Child A described as having good attachment to his mother. The rooms were re-arranged and house said to feel fresher 'but still smell of urine'. SW1 agreed to discuss with police child A 's return home and letter of support to housing
■■■■.07	Ms A and Ms J attended hospital with child A. X-ray taken, poor quality films and no abnormality seen
■■■■.07	FWA1 expressed concern to CYPS regarding child ■■■'s involvement in adult conversations and that Ms A is not attending Sure Start
■■■■.07	FWA1 undertook a home visit and subsequently discussed the case in supervision. Focus was on poor home conditions (smell of dog urine and steep stairs) and on practical tasks
■■■■.07	Ms A attended appointment with PMHW: very low, angry that child A not yet home and requesting counselling for children
■■■■.07	Ms A requests counselling for children. GP1 advised for her to bring them to surgery so their needs can be assessed (<i>not discussed with social worker</i>)
24.01.07	Review strategy meeting held: CAIT awaiting CPS decision if Ms A to be charged with ABH. Consultant paediatrician unable to age bruising. If NAI, not clear who is the perpetrator. View of meeting was that child A to be returned home when Ms A makes alternative arrangements for the dog <i>Paediatrician was invited but was on leave</i>
■■■■.07	Child A seen by GP1: nappy rash, impetigo both groins
26.01.07	Child A returned home. Social worker visited to ensure dogs removed – apparently given to a friend. HV1 also visited. Agreed referral to Mellow Parenting in line with CP plan Ms A saw PMHW and reported pleased that child A home, anger with doctors and CYPS; finding male friend very helpful. Wanting divorce – believes stress and depression result of ongoing marital difficulties. Refused psychotherapy – PMHW wrote letter to SW1 providing <i>above but appears not to have included information on 'male friend' (though this was shared at the initial conference)</i>
■■■■.07	Ms A provided date of Mr. A's departure from family home as ■■■■■.06
■■■■.07	CYPS case transfer to SW2 Safeguarding team
■■■■.07	All children seen by GP. Child A showed no signs of neglect. Child ■■■ happy and no concerns about 'domestic problem' so GP to discuss with referrer (<i>presumably PMHW</i>) need for counselling
■■■■.07	YCAT 1 home visit. Ms A moving next day. Mr A visited home
■■■■.07	Ms A declined FWA appointment on grounds of moving house
■■■■.07	Ms A told PMHW she does not want psychotherapy, but agreed to consider Health in Mind for future counselling – may ask new GP for referral. Ms A reported to be brighter in mood and pleased to be moving
19.02.07	Family move to new house

██████.07	Ms A attended Mellow Parenting – session 3 with child █, but not child A
██████.07	Home visit by FWA FSW2.Children A and █ playing and ‘appeared happy’. <i>Worker did not notice any rash (see below): Ms A reported rash to worker in a telephone call on ██████.07</i> Child A seen by GP; had urticaria, started am, covered all over in a rash
██████.07	Ms A did not attend Mellow Parenting session 4
██████.07	Ms A attended A & E department at NMUH with ██████. Ms A named Mr H as her next of kin and recorded him as ‘friend’
██████.07	Social worker’s home visit – saw all children alone and with Ms A, but no record of children’s comments or views
██████.07	Police investigation (of December 2006) re-allocated within MPS CAIT
██████.07	SW2 referral to SCHC for paediatric assessment before next CPC on ██████.07; Ms A attended Mellow Parenting session 5 with child █, not A
██████.07	FWA FSW2 telephoned Ms A who declined appointment as was too busy with appointments for children; Ms A attended school 2 and completed admission form -no record children on CPR
██████.07	Children DNA clinic appointment
██████.07	Ms A attended Mellow Parenting session 6 with child █, but not child A
01.06.07	SW2 visited family and saw all children; child A had marks/bruises on his face which Ms A explained were caused by another child; social worker faxed CAIT, DC responded and requested if any suggestion of NAI at the child protection medical, ‘police should be contacted and police protection taken’; if no suspicions, s.20 to be considered Child protection assessment at NMUH. Social worker present throughout. NMUH records provide 2 versions of Ms. A’s explanation involving rough play with another child and bumping into the wooden frame of a sofa; grab marks found on right lower leg, which Ms A attributed to her grabbing child A to prevent him falling off a sofa Child A observed during consultation to have good bond with Ms A, to play happily, banged his head once and fell twice during consultation; agreed child A go home with mother, with Ms J staying over the week-end; the situation was to be reviewed on ██████.07
██████.07	Paediatric assessment received by CYPS
██████.07 (██████.07) ██████.07)	HV3 contacted Ms A re clinic appointment and was told of Friday’s events. Ms A said that she was to have no unsupervised contact with child A HV3 attempted to speak with SW2, who was off sick, and her manager, who was unavailable
04.06.07	Police CAIT records indicate that the DS established that the examination of ██████.07 indicated NAI. Police requested a strategy meeting that afternoon at 15.30 attended by DC2, TM2 and STM2. SW2 was off sick. Discussion re obtaining an EPO, but disagreement if threshold met. Agreed a s.47 enquiry and plans made to supervise child A’s safety through alternative care arrangements Ms A was unhappy for children A & █ to stay with Ms J as Ms J no longer has accommodation. Ms J to stay with family overnight

██████.07	Specialist Children's Health service (SCHC) accepted SW referral and allocated to Special Advisory Community Clinic (SACC)
██████.07	Ms A arrested when she answered bail on 2006 investigation. Ms A provided variety of possible causes for injuries
██████.07	TM2 CYPS contacted SCHS and told that child A is on the waiting list for an appointment, likely to be ██████. TM2 stressed urgency of referral and that child A subject to child protection plan (<i>this information from CYPS chronology, not PCT</i>)
██████.07	Ms A and Ms J signed written agreement for Ms J to stay at family home and Ms A not to have unsupervised contact with child A. Ms J to be paid for this arrangement. Childminder to look after children A & ██████ on specified days and times. Ms J to alert CYPS of any concerns about the children
██████.07	PMHW wrote letter to SW2 advising of discharge of Ms A and that she does not want any further counselling at present
██████.07	SW2 updated DC2 on arrangements. DC2 queried progress on legal planning meeting, but SW2 unaware of this part of plan and would check with TM2 Police requested witness statement from examining doctor Police need to photograph bruising: SW2 unable to arrange time with Ms A and suggested police make direct contact – photographs taken on ██████.07
██████.07	HV3 spoke to SW2 and was updated. Child A seen at clinic. Weight 25 th -50 th centile. 3 rd triple and MMR outstanding. Hair loss in places and comments column suggests weight loss; child ██████ also had weight loss, but no details provided. PCT comments state ██████ was borderline re. ██████ weight in ██████ 2006. Child ██████ also had bruise on cheek, said to be caused by a fall
██████.07	DI1 contacted STM2 to express concern over the lack of legal planning meeting and discussed use of an EPO. STM2 assured police of actions taken to protect child A and to hold a legal planning meeting. DI1 agreed to expedite both police investigations SW2 met separately with Mr and Ms A to discuss content of CPC report Ms A attended Mellow Parenting session 7 with child ██████, but not child A Child A attended GP with unidentified 'abrupt and argumentative lady' for immunisation. Advised to return for MMR in 1 month
08.06.07	Review CPC: Registration continued as previously. Plan included minimum of fortnightly home visits, legal planning meeting
██████.07	FWA FSW2 called Ms.A & was told of incident of ██████.07; FSW2 phoned SW2 for update prior to home visit on ██████.07- no response by SW2
15.06.07	FWA FSW2 visited home. Children at school / with childminder. Mr H (described as a family friend) was present. Ms A said Ms J witnessed child A falling and bumping his head. No liaison with SW2 before or after this visit. Ms A too busy the next week, so next visit to be arranged
██████.07	Childminder called CYPS reporting brown bruise under chin. STM2 advised to check recent CP medical – mark similar to that on body map. Ms A confirmed it was same mark
██████.07	Legal Services chronology on ██████.07 refers to legal referral form for a planning meeting, but date of receipt unclear

	CYPS chronology states form faxed on [REDACTED].07. Meeting finally occurred on [REDACTED].07. CYPS report that delay caused by email sent to SW2 on [REDACTED].07 asking for dates, and the response only provided an [REDACTED].07
[REDACTED].07	Children [REDACTED] commenced school 2 Childminder reported child [REDACTED] hungry and child A was dirty with a dirty nappy on arrival Ms A complained to SW2 that child A was sick after evening meal since he attended childminder
19.06.07	1 st record of children being seen by SW2 since 01.06.07. Saw children A & [REDACTED] at childminders with 3 other children
20.06.07	Core Group meeting. Both parents, HV3 and SW2 attended
[REDACTED].07	Ms A and children A & [REDACTED] attended Mellow Parenting session
[REDACTED].07	Ms A left message for SW2 that 'it was her birthday and she would be taking the children away' ; Ms A did not attend Mellow Parenting, having reported she had to look after a 'sick uncle'
[REDACTED].07	Children [REDACTED] were on authorised absence from school week beginning [REDACTED].07 Message from childminder to SW2 that Ms A had taken the children away SW2 tried to contact Ms A on 3 occasions, but no reply
02.07.07	SW2 called Ms A again twice, but no reply. Ms J also unavailable. SW2 spoke to Ms A who said she was in Cricklewood with her unwell uncle and would be home either on 4 th or 9 th depending on his health. She had been too busy to take child A to GP re sore scalp
[REDACTED].07	Discussion between SW2 and TM2 re. Ms. A's absence. TM2 advised Ms A to be encouraged to return home as there was probably little she could do for uncle with [REDACTED] children
[REDACTED].07	Ms. A, children A & [REDACTED] attended Mellow Parenting session 11
[REDACTED].07	DC2 met with independent medical review consultant, who supported findings suggesting NAI, but could not take review of evidence any further
09.07.07	SW2 contacted Ms A (appears to be 1 st contact attempt since 02.07.07). Ms A reported family back home, child [REDACTED] had a cold and she was at a walk in clinic for child A (reason not stated but report sent to GP confirms attendance was due to ear ache and discharge, child A said to have fungal infection to head and prescribed antibiotic and fungal cream)
[REDACTED].07	SW2 saw all the children at home visit; child A's ear looked red and sore and SW2 saw his medication prescribed at a walk in clinic
[REDACTED].07	FWA worker called SW2 and left message; no response
[REDACTED].07	Ms A and child [REDACTED] attended Mellow parenting session 12
[REDACTED].07	SCHS appointment for 01.08.07 sent to Ms A (copy to referrer and health visitor)
18.07.07	HV3 told SW2 that Ms A had taken children A & [REDACTED] to health clinic; child A's ear infected and had a small bruise under the chin, reported to be caused when he struggled as Ms A was cleaning his ear; had lost weight (additional / different detail in HV3 records was that he had scabs on his scalp, bruising around ear (as opposed to chin); child [REDACTED] had bruise under the eye

	<p>Child A had “extended infection on his scalp”; he had bruises in “front of his left ear on bony part”, “faint bluish”. He had “bruises between his shoulder blades extending slightly to the nape of his neck” “numerous, possibly 10-15” “faint bluish except two which were slightly red”. Explanation given by mother and Ms J was that he tended to bang his back against his cot.</p> <p>The information was not communicated to the SW. Report of this appointment faxed from Health to CYPS on [REDACTED].07: the delay was due to child A’s death</p>
02.08.07	<p>Ms A informed by DC2 in presence of SW2 that police investigations closed on advice of CPS; STM2 decided to provide last childminder payment as result of this decision</p>
[REDACTED].07	<p>Ms A spoke to FWA FSW2 and said that she did not want appointments in August as she wanted to enjoy the school holidays and CYPS would fund a holiday. Agreed to contact her prior to next CPC on [REDACTED].07</p>
[REDACTED].07	<p>Child A brought to NMUH by ambulance at 11.50, bruises to face and injury to scalp; assessed immediately and attempted resuscitation until 12.10 when parents informed of child A’s death</p> <p>Police, CYPS and Coroner’s office informed; siblings were taken into Police Protection and placed with foster carers; Ms A and Mr H were arrested</p> <p>Strategy meeting held; medical assessment on all [REDACTED] siblings found evidence of gross neglect</p>

5 SUMMARY OF EACH AGENCY'S INVOLVEMENT

5.1 BACKGROUND

PARENTAL HISTORY

- 5.1.1 The only information provided on the background of either parent relates to Ms. A. It is derived from London Borough of Islington files for Ms A and her brother (), the Core Assessment and child protection conference records.
- 5.1.2 The family lived in Leicester until 1984, when Ms A's parents separated. It is understood that their relationship was violent and that Ms A and her brother witnessed domestic abuse.
- 5.1.3 Ms A and her mother (MGM) moved to London, whilst Ms. A's brother and father remained in Leicester. The Islington records provide information that Ms. A's father died unexpectedly in 1988 and the brother joined his mother and sister. However, the initial child protection conference record in December 2006 refers to .
- 5.1.4 The full integrated chronology cites a grandfather's involvement at various times (visiting or taking a child for a medical appointment): it is not known if this refers to maternal or paternal grandfather.
- 5.1.5 Ms A's brother's behaviour was challenging and he was reported to be violent at school and at home towards Ms. A. He truanted and started offending, In May 1990, Ms. A's brother's name was placed on the child protection register for physical abuse, . MGM was cautioned. There is also reference in child protection conference records to MGM .
- 5.1.6 .
- 5.1.7 Ms. A's name was on the child protection register under the category of neglect in 1991 and 1992. Concerns included neglect of her 'physical presentation', her 'personal hygiene' and some suspicion of abuse. There is a reference in the initial conference record in December 2006 to Ms A having been . The allegation of is also mentioned in the Core Assessment.
- 5.1.8 Ms A was referred to 'Child Guidance' and she attended a boarding school in 1993.

FAMILY HISTORY

- 5.1.9 According to information provided to the police by Mr. A, he and Ms A met when she was sixteen years old [1997 or 1998] and they married in [REDACTED].
- 5.1.10 It is understood that they lived with MGM until [REDACTED]. Following child [REDACTED]'s birth in [REDACTED], Mr A described Ms A as struggling to cope with domestic chores and her maternal responsibilities. After child [REDACTED]'s birth in [REDACTED], Mr A said Ms A suffered from postnatal depression and struggled to cope with her [REDACTED].
- 5.1.11 Mr A told police that [REDACTED] 2003 was a turning point in the couple's relationship: he came home having been drinking, had a row with Ms. A's mother (MGM) over her rough handling of child [REDACTED] and he left the family home to stay with [REDACTED].
- 5.1.12 Subsequently the marital relationship became strained, according to Mr. A, [REDACTED].
- 5.1.13 Mr A told police that in 2004, Ms A befriended a disabled man, and thought herself to be in love with him, but the man only offered her friendship.
- 5.1.14 In 2005 Ms A had another [REDACTED] pregnancy, but as the year progressed, Mr A said the marital relationship continued to deteriorate.

Housing history

- 5.1.15 Mr and Ms A approached the Homeless Unit for assistance with housing on [REDACTED].01, when they were staying with a relative of Mr. A. Between [REDACTED].01-[REDACTED].05 the family lived in temporary accommodation and moved three times.
- 5.1.16 The Strategic and Community Housing IMR describes Ms A as being 'vigilant in supplying relevant documentation on the births of each of her children and in a timely fashion'.

Schools' history

- 5.1.17 Schools involvement commenced with the family in [REDACTED], with child [REDACTED] admitted to nursery at [REDACTED], child [REDACTED] was admitted the following year at [REDACTED]. The school had little recorded information about the [REDACTED] prior to [REDACTED], and no evidence of concerns about their welfare.

Children's health history

- 5.1.18 Between [REDACTED] 2002 Child [REDACTED] had [REDACTED], which was diagnosed as [REDACTED]. Parents co-operated with medical treatment, attending appointments at North Middlesex University Hospital (NNUH).
- 5.1.19 Child [REDACTED] was presented at the Whittington Hospital with [REDACTED] [REDACTED] which was treated.

5.2 PREGNANCY WITH CHILD A: [REDACTED] 2005 – [REDACTED].06

- 5.2.1 Ms A was referred to NNUH for midwifery / obstetric care in [REDACTED] 2005 and subsequently attended ante-natal appointments regularly. She spoke to the midwives of feeling 'down', sleeping badly and seeing a counsellor for fortnightly support. From the chronology and IMR provided for this case review, the pregnancy appears to have been unremarkable.
- 5.2.2 At the same time Ms A commenced sessions with a Primary Mental Health Worker (PMHW) and saw her on ten occasions during her pregnancy.
- 5.2.3 Ms A spoke to the PMHW about her history of post natal depression and her current mood usually described as feeling low and sleeping badly. She referred to conflicts in her marital relationship, [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
- 5.2.4 On one occasion ([REDACTED].05) Ms A spoke of feeling upset and 'used' due to a male friend seeing another woman. At the subsequent session a week later she mentioned she had asked her husband to leave and that he had suggested family therapy. Ms A referred to her own abuse of alcohol.
- 5.2.5 The PMHW records refer variously to a referral to Sure Start, provision of contact details of the Samaritans and referrals / signposting to SPACE (a voluntary organisation offering family support), and family therapy. The rationale for these various referrals / signposting is unclear and there is no evidence of any contact with these agencies.

Children

- 5.2.6 This period was uneventful in terms of agency involvement with children [REDACTED]
[REDACTED]
- 5.2.7 Child [REDACTED] attended various appointments relating to [REDACTED] receiving [REDACTED] and was admitted to hospital for [REDACTED]. [REDACTED] also attended [REDACTED] appointment, but the outcome of this is not clear from the information provided.

- 5.2.8 Child ■ presented at A & E Whittington Hospital in ■ 2005, reported to have fallen asleep on a chair the previous day, falling and hitting ■ elbow – an X-ray detected nothing abnormal, ■ was given ■.
- 5.2.9 The GP was consulted on ■ about child ■. ■ was referred to a ■ but failed to attend the appointment on ■. By this point Ms A was over forty one weeks pregnant. It is not clear from the information provided if and how child ■'s ■ was treated, or the significance of this condition.

5.3 POST NATAL PERIOD: ■.06 – ■.06

- 5.3.1 Child A was born on 01.03.06 following a normal delivery. He was cuddled at birth and breast fed on demand. Ms A was recorded as psychologically stable and she and her son were discharged on ■.06 when a referral was made to the health visitor providing the history of post natal depression.
- 5.3.2 During this period Ms A and child A had contact at home with the midwifery service and the health visitor. Both described Mr A as 'supportive', both provided advice regarding smoking and the need to see the GP for child A's thrush. Ms A followed the latter advice and obtained medication.
- 5.3.3 The health visitor also noted that the home was untidy. She wrote to the GP seeking information regarding input of PMHW and was advised to contact the PMHW directly.
- 5.3.4 Having missed a March appointment with the PMHW, Ms A met her on ■.06 and spoke of feeling tired and anxious, with an urge to make herself sick. She said that Mr A was providing 'help'.
- 5.3.5 At the child health clinic that day child A was recorded as being on 2nd – 9th centile and Ms A reported feeling well. She appears not to have mentioned that she had given up breast feeding, although she had told the PMHW that she felt guilty about doing so.
- 5.3.6 Ms. A's six week check with the GP was recorded as satisfactory.

5.4 ■ 2006

Parental relationship

- 5.4.1 The main indication of the parents' relationship is derived from Ms. A's sessions with the PMHW (see below). She referred to her new supportive male friend for the first time on ■.06 and again on ■.06: the name of this man is not given in the chronology of the PMHW's records.

- 5.4.2 The Strategic and Community Housing IMR states that Ms A informed staff that they separated on [REDACTED].06 and she was filing for divorce. In [REDACTED] Ms A told the PMHW she was not looking forward to going on holiday with her 'separated husband and children'.
- 5.4.3 The PCT IMR refers to Mr A appearing to still be in the home on [REDACTED].06 despite Ms A having asked him to leave.

Ms. A's mental health

- 5.4.4 The most consistent agency contact during this period was between Ms A and the PMHW: Ms A kept nine appointments in this seven and a half month period. Her mood was variable but by [REDACTED] she had been diagnosed with depression by her GP and [REDACTED]. This followed her feeling let down by a friend [REDACTED].
- 5.4.5 The health visitor wrote to PMHW in [REDACTED] 2006 and they spoke in June. The PMHW communicated that Ms A had been [REDACTED] but her low mood had recently improved.
- 5.4.6 By [REDACTED] Ms A had returned from a holiday and was reported to be 'brighter in mood' and off medication. Once again she told PMHW of her new supportive male friend.
- 5.4.7 A month later Ms A was tearful and feeling low, saying she was coping with the children with the support of MGM. The PMHW referred her to HARTS (Family Welfare Association) due to depression over housing issues and a difficult marital relationship.
- 5.4.8 By [REDACTED] Ms A reported she was back on medication and feeling better, but by [REDACTED] her mood was described as low again with what was described as an 'ongoing bulimic urge'. She said she was taking her medication, but had ongoing relationship problems.

Child A's health & development

- 5.4.9 Child A was brought to the child health clinic in [REDACTED] and was still on the 2nd – 9th centile, although according to the health IMR gaining weight. This was the only time he was weighed between [REDACTED] and [REDACTED] 2006.
- 5.4.10 At [REDACTED], [REDACTED] Ambulance Service was called by a cousin to an address in [REDACTED]: Child A was vomiting after feeds and was taken to a Primary Health Care Centre. The triage GP was informed he had just had his 1st immunisation (although this does not appear in HtPCT's chronology and CAE has been unable to ascertain the accuracy of the claim). The GP recorded 'impression gastroenteritis' and advised 'oral sips overnight'.

- 5.4.11 Child A was not seen by any health professional again until [REDACTED].06. This followed telephone calls in [REDACTED] (when his incomplete immunisations were discussed and advice given to bring him to the child health clinic), [REDACTED] and [REDACTED], when an appointment with Ms A was agreed.
- 5.4.12 Ms A failed to keep the appointment on [REDACTED].06, but the health visitor undertook a home visit. Child A had thrush on his buttocks, but was described as appearing well. However his 2nd and 3rd immunisations were recorded as being outstanding and he had not been weighed since [REDACTED].06.
- 5.4.13 Ms A did bring child A to the GP on 19.09.06, when a nappy rash and cough were noted on the six month old baby. Ms A mentioned that child A bruised easily and she was concerned she might be accused of hurting him. The GP records do not indicate if child A had any bruises at this point, or what had prompted the discussion.
- 5.4.14 The next professional contact was when child A was brought to the GP on 13.10.06 following what was said to be an accidental fall downstairs the previous day. No injuries were noted on clinical examination, but he had a bruise on his left breast and left cranium. Ms A was advised to obtain a stair gate.
- 5.4.15 Four days later Ms A returned to the GP when child A was diagnosed with an upper respiratory infection and thrush of the groin.

Other children in the family

- 5.4.16 Ms A expressed concern to the school [REDACTED]
[REDACTED]
[REDACTED].

Provision of family support

- 5.4.17 Ms A did not respond to initial attempts made by HARTS (see 5.4.7) to arrange a home visit, but a home visit was undertaken on [REDACTED].06. The circumstances were assessed as 'low risk' and the family put on the waiting list for allocation. Ms A requested support in resolving housing issues and accessing a solicitor for divorce proceedings. She mentioned domestic abuse and that she suffered with depression.

5.5 INCIDENT 1: CHILD A'S HEAD INJURY & RESPONSE: DECEMBER 2006

Presentation of injury & referral to Children & Young People's Service: [REDACTED].06

- 5.5.1 On 11.12.06 Ms A took child A to her GP with a history of a swelling on his head since 10.30 am. The GP additionally observed bruises to child A's right breast, sternum and shoulder and referred him to the Whittington Hospital.

- 5.5.2 Child A was seen by the paediatric registrar who documented what the IMR refers to as 'a number of bruises'. Ms A attributed these bruises to child A climbing and falling. The IMR indicates that given the extent of the bruises and the lack of clear indication of how they occurred, there was a concern 'that they could have been as a result of a non-accidental injury'.
- 5.5.3 Child A was admitted to the paediatric ward. Ms A was able to stay with him and contacted Mr A and MGM.
- 5.5.4 A referral of an 'unexplained swelling' on the forehead was faxed to Children & Young People's Service (CYPS). CYPS appropriately referred this to the Police CAIT, carried out agency checks and convened a strategy meeting at the hospital the following day.
- 5.5.5 CYPS records provide further detail of the referral information i.e. child A had bruising on his bottom and back; Ms A stated child A bruises easily and head butts; the paediatrician diagnosed bruising suggestive of non accidental injuries; MGM was said to have cared for child A prior to the injuries.

Enquiries & investigation of injury

- 5.5.6 A strategy meeting was convened at the hospital on 12.12.06. The police record of this provides details of bruising to forehead, right cheek, upper right chest and right buttock. The Police chronology points out that the minutes mention Mr H's first name, as a friend who helps Ms. A.
- 5.5.7 After the meeting, the detective constable (DC1) interviewed Ms A under caution at the hospital to obtain an initial account of events. Ms A denied she or MGM were responsible for the injuries and suggested a series of possible explanations including rough handling of child A, that he fell from the settee, that he head butts, that two dogs knocked child A over or that it was a consequence of rough play between children.
- 5.5.8 The social worker sought clarification from the consultant paediatrician about the cause of the various bruises and was told that it might not be possible to state categorically which were non accidental. CYPS chronology on [REDACTED].06 refers to the 'skeletal survey normal' (provisionally), but also to 'abnormalities in skeletal survey could be due to vitamin deficiency, healed fracture or bleeding between joints'. However the Whittington Hospital record says that 'this combination of bruising is very suggestive of non-accidental injury'.
- 5.5.9 The next day ([REDACTED].06), the police officer and social worker saw children [REDACTED] at the school. They gave no indication that Ms A hit them nor of any males in the household following Mr. A's departure. Additionally the teachers did not communicate any concerns about the children.
- 5.5.10 CYPS records state a home visit was undertaken by the social worker that day to see Ms A and MGM. The content of this meeting is not recorded.

- 5.5.11 On [REDACTED].06 the consultant paediatrician faxed a report to CYPS which included reference to the following:
- Concerns that child A had a number of significant bruises with no clear explanation
 - Bruising on body would suggest rough handling
 - Bruising on cheek – children do not easily bruise accidentally there
 - Bruising on the buttocks was quite unusual – children rarely sustain bruising to buttocks in normal household accidents
 - ‘Combination of bruising is very suggestive of non-accidental injury’
- 5.5.12 On [REDACTED].06 X-rays were undertaken and nothing significant was detected, but the consultant paediatrician planned to repeat a skeletal X-ray on the abnormal right tibia and on the left tibia for comparison.
- 5.5.13 Islington Children & Families provided background information on [REDACTED].06 that Ms A and her brother had been subjects of child protection plans and that MGM had received a caution for physically hurting her son.
- 5.5.14 The health visitor informed the social worker on [REDACTED].06 of Ms A’s post natal depression and said [REDACTED]. The health visitor had no concerns about the children’s care and confirmed Ms A attended clinic to weigh child A, though immunisations were not up to date.
- 5.5.15 Police arrested Ms A and MGM on [REDACTED].06. Both denied any assaults, and whilst providing possible explanations for the injuries did not specifically state the cause of each bruise. The interviews confirmed the household composition and that this did *not* include an adult male. MGM was understood to be the only other adult who stayed at the home.

Plans for child A’s placement on discharge from hospital

- 5.5.16 The record of a CYPS case discussion on [REDACTED].06 between the social worker and three managers indicated that child A would be accommodated under s.20 Children Act 1989 pending completion of s.47 enquiries and child protection medicals. A possible placement in South London was identified.
- 5.5.17 The social worker informed the parents on [REDACTED].06 that child A would be accommodated unless an alternative carer was identified by them. Ms A said she would not allow MGM to baby-sit again, that she would prefer child A to be placed with his father or with a friend, Ms J. Mr A offered to take time off work and obtain a reference from his employer.
- 5.5.18 It is unclear how and when the decision was made about who should care for child A on discharge on 15.12.06. School records (for the elder siblings) indicate the social worker told staff of the plan for him to be discharged to father’s care. Later the same day child A was discharged to Ms J’s care, and with a written agreement signed by Ms A, Ms J and CYPS. Ms J agreed to supervise contact with Ms A and with MGM and inform CYPS of any concerns.

- 5.5.19 CAE has been informed that this change in plan arose following Ms A telling the social worker that Mr A used to hit the children prior to attending a practical parenting course.

Siblings

- 5.5.20 The [REDACTED] siblings remained at home with their mother, but child protection paediatric assessments were undertaken on [REDACTED].06.
- 5.5.21 No injuries were documented on children [REDACTED]. Child [REDACTED] presented as 'a little dirty – especially socks' and had some scratch marks, reportedly sustained from playing with the two dogs in the home. Children [REDACTED] and child [REDACTED]'s MMR overdue. Child [REDACTED] was also reported to be unclean and in need of a bath.
- 5.5.22 It was observed that the siblings all played well together and the [REDACTED] [REDACTED] were described as having a normal loving relationship with their mother.

5.6 INITIAL CHILD PROTECTION CONFERENCE AND PROTECTION PLANNING

- 5.6.1 An initial child protection conference was held on 22.12.06. The conference record states that the consultant paediatrician reported that the combination of bruising to child A was 'very suggestive of non accidental injury.'
- 5.6.2 The professional observations of Ms A's relationships with her children and the relationships between siblings were positive, although the social worker did report concern about the lack of supervision with the young children.
- 5.6.3 The conference chairperson stated that all [REDACTED] children were to be considered for registration and summarised as follows:
- The paediatrician's view was that the injuries were non accidental in nature
 - The other children 'appear fine and the school reports that they are doing well'
 - Ms A 'engages on a good level'
- 5.6.4 Child A's name was placed on the register under the categories of neglect and physical abuse. Child [REDACTED]'s name was also placed on the register under the category of neglect. The [REDACTED] names were not registered.
- 5.6.5 There was a consensus about the need for child A to be registered under neglect, but some debate over the category of physical abuse. Most participants agreed that child [REDACTED] being [REDACTED] was also vulnerable to the risk of neglect. No conference member supported the registration of the [REDACTED].

5.6.6 The protection plan outlined at the conference included:

- A commitment that the Core Assessment to be completed
- Legal Services to be contacted if any of the children suffer further injuries
- Ongoing HARTS input about specific parenting and housing issues
- A full assessment of MGM's role
- Ongoing involvement of PMHW to provide support to Ms A and consider the need for psychotherapy
- Fortnightly announced and unannounced home visits by the social worker

5.6.7 Although not included in the written plan, the conference record also indicated that Ms A 'agreed to get rid of the dogs'.

5.7 IMPLEMENTATION OF PROTECTION PLAN: [REDACTED]06 – [REDACTED]07

Police investigation

5.7.1 Police liaised with the Crown Prosecution Service (CPS) in [REDACTED] [REDACTED] 2007. The CPS view was that the medical information provided needed clarification and review as regards causation and ageing. The consultant paediatrician advised that on the basis of research findings (see 6.3.9) she was unable to do this, that she had nothing else to add to the reports and that a request for further / other information needed to be put in writing. The CPS advised that an independent medical review be obtained.

Child A's return home

5.7.2 Legal advice provided on 29.12.06 confirmed that the threshold for an Interim Care Order was met, but that given Ms A's co-operation the local authority did not intend to pursue this. It was advised that it would be premature to return child A home before a risk assessment and 'due to ongoing Police investigation.'

5.7.3 On 24.01.07 there was a review strategy meeting between Police and CYPS. The Whittington paediatrician had been invited but was on annual leave. Given the lack of definitive timescale in resolving the outcome of their investigation, Police agreed with the decision for child A to return home as CYPS staff were concerned further delays might impact on child A's re-integration into his family.

5.7.4 This decision was contingent on Ms A making alternative arrangements for the dogs, and was communicated as such to Ms A's solicitors. Ms A reported she had given them to a friend and child A returned home on 26.01.07.

Changes of circumstances

5.7.5 On [REDACTED].07 the case transferred to the Safeguarding Team in CYPS.

- 5.7.6 The family moved to a four bed room home on 19.02.07. This move resulted in a change of health visitor for the children.

Children's health and development

- 5.7.7 The health visitor saw child A and Ms J at the clinic on [REDACTED].07. He was said to have increased weight, and on 50-75th centile, had recovered from bruises but had thrush on buttocks and groin.
- 5.7.8 The social worker visited on [REDACTED].07 and noted child A's good attachment with his mother. The dogs appear to have remained in the household, with Ms A reporting they were only allowed in certain areas.
- 5.7.9 Following child A's return on [REDACTED].07 observations by health visitor, GP and social worker of child A and his siblings were generally positive.
- 5.7.10 Child A received his 2nd immunisation on [REDACTED].07 and the GP saw all the children on [REDACTED].07, when child A was noted to be happy and showing no signs of neglect. The new social worker visited on [REDACTED].07 and noted mother's spontaneous affection for the children and on [REDACTED].07 that Ms A was able to pacify child A when he was seen to head butt the floor. The health visitor noted on [REDACTED].07 child A and child [REDACTED] were physically thriving.
- 5.7.11 The FWA worker (FWA1) expressed some disquiet to CYPS on [REDACTED].07 regarding (unspecified) concerns about the state of the family home and child [REDACTED]'s involvement in adult conversations. In February Ms A declined and avoided making further appointments with FWA1.

5.8 INCIDENT 2: CHILD [REDACTED] - [REDACTED].07

- 5.8.1 A school nurse reported to CYPS on 05.03.07 that she had seen Ms A shout at child [REDACTED] and hit [REDACTED] on the face and that child [REDACTED] had a yellowing bruise under [REDACTED] right eye.
- 5.8.2 Following discussion with her team manager, the social worker saw Ms A and child [REDACTED], speaking to each on their own. Mother and [REDACTED] provided a consistent account of the circumstances leading to Ms A's smacking child [REDACTED] i.e. that [REDACTED] persistently kicked [REDACTED] mother's friend's twenty year old son on the way to school (see 6.4 for further discussion of this incident). No marks or injuries were observed according to the CYPS IMR.

5.9 1ST REVIEW CHILD PROTECTION CONFERENCE & PROTECTION PLANNING

- 5.9.1 The review child protection conference on 16.03.07 heard of the family's move to more spacious accommodation, elder [REDACTED]' regular school attendance, some emerging neglect issues and concerns about child [REDACTED]'s development.

- 5.9.2 The social worker reported that at an unannounced home visit on [REDACTED].07 both Ms A's and a third dog (said to be Ms J's) were present. On [REDACTED].07 the social worker visited again and expressed concern about the dogs, in particular a boisterous one. Additionally it was observed that the stair gate narrowly missed child A's face when child [REDACTED] tried to close it.
- 5.9.3 The conference record refers to Ms A's intention to 'maintain the dogs' and that 'Social Services cannot force me to get rid of the dogs'.
- 5.9.4 At the conference, child [REDACTED] was reported to have missed [REDACTED] appointments on [REDACTED].07 and [REDACTED].07. Child A was reported to have missed a clinic appointment on [REDACTED].07. Child A's third vaccine and 'mumps, measles and rubella' (MMR) remained outstanding and the paediatrician at the conference referred to his urgent need for these due to a local measles outbreak.
- 5.9.5 The incident on 05.03.07 was discussed along with the report from school indicating some concerns about child [REDACTED]'s progress and development, including [REDACTED],
- 5.9.6 Children A and [REDACTED] remained subjects of child protection plans under the existing categories and child [REDACTED] was also made subject of a protection plan under the category of physical abuse, as a result of the 05.03.07 incident.
- 5.9.7 The protection plan outlined at the conference on 16.03.07 included:
- Child A to be referred to the Specialist Child Health Service by the health visitor, so as to assess his pain threshold and behaviour
 - Health to see all children once prior to conference to ensure developmental milestones met
 - Ms A to attend Mellow Parenting course, re-book child [REDACTED] appointment, take child A to GP surgery (within ten days) for his third immunisation and MMR and take child [REDACTED] to [REDACTED]
 - HARTS to undertake several specific practical tasks and to 'identify concerns about child [REDACTED]'
 - Weekly visits by social worker, both announced and unannounced
 - Referral to CAMHS (by the paediatrician) for family counselling
 - Joint risk assessment by social worker and RSPCA with regard to the return of the dogs
 - An update from Police about investigations of child A's injuries
- 5.9.8 Within the next fortnight:
- Children A and [REDACTED] were seen at the child health clinic: there were no concerns about their weight or development, though child A's immunisations remained incomplete and to be arranged with the GP
 - The social worker contacted the RSPCA about the joint assessment
 - A core group meeting was held (attended by both Ms A and Ms J)

5.10 INCIDENT 3: CHILD A'S HOSPITALISATION IN APRIL 2007 & FOLLOW UP

- 5.10.1 On Monday 09.04.07 child A was presented at NMUH at 16.37 hours. NMUH records refer to 'post head injury' and a 'large boggy swelling to the left side of the head, neck stiffness and multiple bruising'. Body maps indicate bruises and scratches on face, head and body. He and his siblings all had obvious head lice.
- 5.10.2 The history provided was that child A had been pushed by another child on Thursday previously and hit his head on a marble fireplace. He cried and then settled. Faint bruising developed next day and he was groggy at the week-end, recovering from a head cold. On Monday morning he woke with neck pain and was walking off balance. Swelling developed during the day and he became hot to touch with a rash on his face and neck.
- 5.10.3 NMUH admitted child A and informed the local authority Emergency Duty Team (EDT) of the head injury, that Ms A had delayed seeking medical advice and the presence of further bruising to face and back. No explanation was provided in relation to these marks. [REDACTED]. Child A was prescribed antibiotics and admitted to the ward for observation. Good interaction between mother and son was reported by the hospital.
- 5.10.4 The LBH EDT record states the '[NMUH] child protection summary sheet indicating no need for investigation' (see 6.5 for discussion of this response).
- 5.10.5 The next day ([REDACTED].07) the social worker told NMUH she would discuss the case with her manager and decide if a discharge planning meeting was needed. She consulted the team manager and later phoned to say child A could go home when medically fit. CYPS planned to provide a 'follow up' once he was home.
- 5.10.6 Child A was discharged on 11.04.07 as he was settled, [REDACTED].
- 5.10.7 The social worker saw child A at home on [REDACTED].07, but there is no evidence the circumstances of his hospital admission was discussed or that there was ever any CYPS follow up to this hospital admission.
- 5.10.8 Police were not informed of the hospital admission or the injury. The health visitor was informed of the incident by NMUH, though there appears to have been no liaison between health visitor and social worker.

5.11 INCIDENT 4: CHILD A'S INJURY 01.06.07 & FOLLOW-UP

- 5.11.1 At an unannounced home visit on 01.06.07 the social worker saw child A had facial marks / bruises, which Ms. A said were caused by another child. The social worker informed the police, arranged a child protection paediatric assessment and attended the assessment with Ms A and child A.

Paediatric assessment

- 5.11.2 The NMUH chronology cites the two explanations of the injuries provided by Ms. A: a twenty two month old child's rough play (between [REDACTED].07 – [REDACTED].07) and bumping into the wooden frame of a sofa (on [REDACTED].07).
- 5.11.3 NMUH records state multiple bruises and scratches were found of different ages, some of which could be explained by normal play and falls. There were grab marks on child A's right lower leg, which Ms A said occurred when she grabbed him to prevent him falling off a sofa.
- 5.11.4 Child A played happily, was very active and was observed to bang his head once and fall twice during the examination. He was described as appearing to have a good bond with Ms A and, according to NMUH records, the social worker was 'happy for child A to go home with Ms A and a friend will be staying with the family over the week-end'.

Enquiry & investigation

- 5.11.5 The HtPCT chronology refers to Ms A informing the health visitor of events on [REDACTED].07 (a Sunday, so the date is likely to be incorrect). Ms A acknowledged to the health visitor she was to have no unsupervised contact with child A.
- 5.11.6 The strategy meeting of 04.06.07 was attended only by Police CAIT and CYPS managers. The social worker was off sick and there was no health representation (it is not known if they were invited) although the paediatric assessment in the form of a 'child protection summary sheet' had been provided.
- 5.11.7 Police records refer to the social worker saying (early on [REDACTED].07) that the examination on Friday indicated non accidental injuries (NAI). The social worker was off sick that day, so this communication was presumably with another CYPS member of staff.
- 5.11.8 When the medical was read out at the strategy meeting, Police records indicate it suggested non accidental injury. Police records also indicate disagreement about whether the threshold for obtaining an Emergency Protection Order (EPO) was met and the plan agreed was to:
- Initiate a s.47 enquiry
 - Hold a legal planning meeting
 - Obtain a fast track paediatric assessment
 - Arrange that children A and [REDACTED] be looked after by a family friend within the family home
 - Complete a written agreement with Ms A
 - Enlist a childminder to assist with the children

- 5.11.9 Police arrested Ms A on [REDACTED].07 when she answered bail regarding the December 2006 investigation (following child A's presentation at the Whittington Hospital). She was interviewed and provided a variety of possible causes for the injuries presented at NMUH on 01.06.07. The next day Police emailed NMUH for a witness statement from the examining doctor and on [REDACTED].07 photographs were taken of child A's injuries.
- 5.11.10 When the social worker updated the detective constable about events on [REDACTED].07, she was unaware of the agreed strategy to hold a legal planning meeting, having been absent due to illness. She agreed to discuss it with her manager. The detective constable recorded that the meeting was still needed as the Police view was that child A should be removed from his mother's care during the investigation.
- 5.11.11 The detective inspector followed this up on [REDACTED].07 in a telephone discussion with a senior manager at CYPS, concerning the possible use of an EPO. The CYPS view was that an EPO would not be granted on the basis of the medical examination and confirmed that the way ahead was in line with the plan agreed at the strategy meeting.
- 5.11.12 The social worker liaised with the health visitor about the s.47 enquiry on [REDACTED].07. The health visitor saw children A [REDACTED] at the clinic later that day. Child A was noted to have weight loss, hair thinning and scabs on his head due to hives. Child [REDACTED] also had significant weight loss (from 75th to 25th-50th centile) and bruising noted to [REDACTED] right cheek, explained by an unidentified 'friend' [presumably Ms G] as a result of a fall. There is no evidence that the health visitor sought advice about the weight loss, hair thinning or bruising or that the social worker was informed prior to the conference on [REDACTED].07.
- 5.11.13 The social worker contacted the school on [REDACTED].07, presumably with information of the s.47 enquiry, but the record refers only to discussion of children [REDACTED].

Supervision of Ms A's contact with child A

- 5.11.14 On [REDACTED].07 Ms A and Ms J signed a written agreement to the effect that Ms J would stay in the family home and ensure that Ms A and child A did not have unsupervised contact. Ms J was to receive payment and alert CYPS of any concerns. The arrangement was to be reviewed after two weeks. Additionally a childminder was to be sought to look after children A [REDACTED] on specified days and times.
- 5.11.15 There was no written record of a review of the arrangement after two weeks, although the payments to Ms J ceased. Para. 6.6.26 provides further information on the revised arrangements CAE has been informed were implemented.

5.12 2ND REVIEW CHILD PROTECTION CONFERENCE & SUBSEQUENT EVENTS

Child protection conference

- 5.12.1 The second review conference on [REDACTED].07 maintained the children as subjects of child protection plans under the same categories as the previous conference.
- 5.12.2 Other than the school nurse, no health professional attended the conference, although there had been two hospital presentations since the last conference. The health visitor sent apologies and although invited, the consultant paediatricians at NNUH and the designated nurse from the PCT did not attend.
- 5.12.3 In accordance with the arrangements in place at that time, the designated and named doctors did not receive standard invitations to all conferences. Despite child A's referral to the SCHS, no invitation was sent to the doctor responsible for that service.
- 5.12.4 The social worker reported that Ms A 'seems able to address all her children's needs according to their age'. The children were described as happy and sociable, [REDACTED]
- 5.12.5 The conclusion of the medical was reported at the conference as a 'reasonable probability that injuries sustained were caused by child abuse'.
- 5.12.6 The team manager informed the meeting that the 'department is looking at holding a legal planning meeting (within the next week) to inform future decision making'.
- 5.12.7 Ms A reported that she only allowed the dogs into the home when the children were asleep.
- 5.12.8 The conference chairperson pointed out:
- If the injuries to child A were the result of him being clumsy, one would expect a continual level of injury to him, which had not been the case
 - There are safety mechanisms in place (a family friend in the home and the use of a childminder) but it needs to be explored how long these can be sustained

Child protection plan

- 5.12.9 The protection plan outlined at the conference included:
- The social worker and health visitor to follow up referral to the SCHS and 'consideration to be given to moving the appointment forward'
 - Police to communicate with the social worker about the outcome of investigations

- Ms A to make the children's 'red books' available to health professionals and key worker; to keep the [REDACTED] appointments made for children [REDACTED] and [REDACTED]; to chase [REDACTED] appointments for child [REDACTED] and to take child A for his MMR immunisation within the next month
- The health visitor and GP to monitor child A's weight loss and refer to GP/ paediatrician if any further loss
- A meeting to be arranged between the school and Ms A regarding the concerns about child [REDACTED]
- The key worker to visit at minimum two weekly and conduct direct work with the children
- A legal planning meeting to be arranged within ten working days and key worker to review future protection / supervision arrangements of child A
- A risk assessment to be conducted in conjunction with the RSPCA

5.12.10 Both parents attended the core group meeting of 20.06.07, with the health visitor and social worker. HV3's details provided in the chronology include the date of a SCHS appointment as [REDACTED].07 and that father's capacity with children was to be assessed. However, the core group record indicates the date for the SCHS appointment had *not* been received and makes no mention of any assessment of father. No plan was formulated to address the lack of appointment (see 6.13 for further discussion of the SCHS appointment).

5.13 IMPLEMENTATION OF CHILD PROTECTION PLAN

Legal planning meeting

- 5.13.1 CYPS faxed the referral for the legal planning meeting on [REDACTED].07, [REDACTED] working days after the conference and [REDACTED] working days after the strategy meeting. It is unclear when Legal Services received the referral as it was not date stamped on receipt.
- 5.13.2 On [REDACTED].07 the social worker was emailed to ask for suggested dates for the meeting. Police chased up the progress of this meeting on [REDACTED].07 and on [REDACTED].07 the social worker emailed possible dates, which Legal confirmed on [REDACTED].07.
- 5.13.3 The meeting was held on 25.07.07 and advice given that the threshold for Care Proceedings was *not* met.

Professional contact with family

- 5.13.4 The FWA worker visited the family on 15.06.07. The children were at school or with the childminder, but Ms A was at home with Mr H, who was described as a family friend. She mentioned that Ms J was present and witnessed child A falling and bumping his head.

- 5.13.5 The social worker saw children A and ■ at the childminder's home on 19.06.07 and noted that they interacted well with the other children present and no concerns were expressed. However, the previous day the childminder had said that child ■ was hungry on arrival and that child A was dirty.
- 5.13.6 Ms A attended Mellow Parenting on ■.07 and ■.07, accompanied by children A and ■ on each occasion. There is no evidence of communication by either social worker or health visitor with Mellow Parenting about the child protection enquiry or the child protection plan.
- 5.13.7 The social worker saw child A at home on ■.07. The social worker next saw all the children at home and on their own on 30.07.07. Child A appeared alert and smiled, but was noted to be overtired. He had white cream on his head for the infection and his ear was 'sore and slightly inflamed'. Children ■ liked their new school, appeared well, but their hair needed brushing.
- 5.13.8 Ms A attended the SCHS with child A on 01.08.07. The paediatrician at the SCHS was, according to the chronology provided, unable to carry out the assessment due to child A being 'unwell, miserable with runny nose' and 'had a temperature for 24 hours'. CAE has been informed that the medical report states that child A was 'afebrile' (i.e. without a raised temperature) but that Ms A reported he had a temperature over the previous twenty four hours. The appointment was re-arranged for three weeks time and a prescription provided for anti-fungal cream and antibiotics (see 6.13 for further discussion).

Potential concerns

- 5.13.9 The childminder contacted the social worker on ■.07 regarding a bruise under the chin [presumably of child A]. This was discussed with a manager and the social worker was advised to check the recent body map from the medical on 01.06.07: this showed a similar mark. Ms A confirmed it was the same bruise. No further enquiries were made or advice sought on the likelihood of such bruising still being present more than two weeks after the injury.
- 5.13.10 On ■.07 Ms A left a message for the social worker that she was taking the children away as it was her birthday. She did not attend Mellow Parenting that day as she reportedly had to look after a 'sick uncle'.
- 5.13.11 The children were authorised to be absent from school for a week beginning ■.07.
- 5.13.12 The childminder informed the social worker on 29.06.07 that Ms A had taken the children away. The social worker tried to contact Ms A, three times on ■.07 and twice on 02.07.07, before managing to speak to her on the third attempt on 02.07.07.

- 5.13.13 Ms A said she was in Cricklewood with her unwell uncle, and depending on his health she would return on the [REDACTED]. Meanwhile she had not had time to take child A to the GP for his sore scalp. The social worker informed her team manager and was advised, according to records, to encourage Ms A to return home.
- 5.13.14 There is no evidence that details were obtained of the Cricklewood address, that the local Children's Social Care was informed of the presence of the children (they were subject of child protection plans), that other agencies were informed, or that Mr A was contacted. The next recorded contact with the social worker was on 09.07.07, although it is likely that the family returned earlier as they attended Mellow Parenting on [REDACTED].07.
- 5.13.15 Children A and [REDACTED] were seen by the health visitor on 18.07.07. Child A's ear was infected and he had a bruise noted around the ear which Ms A reported to have been caused while she was trying to clean his ear. He had lost some weight. Child [REDACTED] had a bruise under [REDACTED]. Ms A was advised to return to the walk in clinic regarding the scabs on child A's head, where she said she had gone previously and obtained antibiotics.
- 5.13.16 The health visitor told the social worker of the above issues. The social worker discussed the case with her manager who advised to discuss the issues raised by the health visitor with Ms A. On [REDACTED].07 Ms A explained she intended to return to the clinic that day and that child [REDACTED]'s bruise was the result of falling out of bed and hitting [REDACTED] face on a toy box.
- 5.13.17 Ms A took child A to the walk in clinic and was prescribed antibiotics and fungal cream for what was thought to be a fungal infection of child A's head. She later took him to NMUH A & E department where it was recorded he looked grubby, had an infected scalp, itchy hives and head lice.
- 5.13.18 Ms A announced [REDACTED] at the final session of the Mellow Parenting course on [REDACTED].07. She had stated at the initial interview that she had no partner and there were no records of any discussion about a new relationship. The news of [REDACTED] appears not to have been communicated to CYPS or health colleagues.
- 5.13.19 On 23.07.07 the childminder told the social worker that, due to complaints from other parents about child A's scalp infection, she could not care for the children until the infection was cleared. She thought child A's ear appeared to be worse. The social worker informed Ms A and advised her to go to the GP.
- 5.13.20 Ms A reported on [REDACTED].07 that she attended the GP that day and that he thought it might be an allergic reaction to medication for lice. According to the chronology from the PCT, the GP saw Ms A and child A the *next* day and there is no indication within the record that an allergy to treatment for lice was considered.

Police investigations

- 5.13.21 On [REDACTED].07 the CPS advised, following a review of police evidence, no further action with respect to any criminal proceedings.

5.14 CHILD A'S DEATH AND SUBSEQUENT DEVELOPMENTS

- 5.14.1 Child A was brought to NMUH A & E by ambulance at 11.50am on 03.08.07 and although staff tried to revive him he was pronounced dead at 12.10 pm that day. Ms A and her friend Mr H accompanied child A to hospital. Mr A arrived later.

- 5.14.2 On initial examination he was found to have bruising to his face and body, a tooth missing, a torn frenum and marks to his head. Police, CYPS and the Coroner's Office were informed.

Police investigation

- 5.14.3 The following information is provided in the Police IMR, written on [REDACTED].07 and indicates the information, reports and allegations obtained by the investigative team at that point in time.

- 5.14.4 Whilst the relationship between Ms A and Mr H was unknown, Ms A put him down as next of kin at NMUH on 03.08.07 and the Police IMR indicates that 'it appears that he had been residing at the address for the previous six months and at the time of the death'.

- 5.14.5 Police enquiries established that Mr H's brother, [REDACTED] of his children and his fifteen year old girlfriend had also been staying at the house since 17.07.07.

5.14.6

[REDACTED]

5.14.7

[REDACTED]

5.14.8

[REDACTED]

5.14.9

[REDACTED]

[REDACTED]

5.14.10

5.14.11

5.14.12 Mr H disclosed to police that he had lived with Ms A since February and she

5.14.13 The Police IMR refers to a comment made by one person in the police investigation that Mr H had, in his past, regularly tortured and killed animals.

5.14.14 Police have been told that Ms A and Mr H put child A to bed around 7.00pm on 02.08.07. Mr H's brother and children went to bed around 11.00 pm and Ms A and Mr H around 1.00 am. Mr H got up in the morning to let the dogs out and eventually checked on child A and found him to be dead. He called his brother, who told Ms A (who was still in bed). She called the ambulance.

5.14.15 Mr H also provided an alternative account in which he had *not* spent the night at child A's address but had come home sometime on the morning that child A was found apparently lifeless.

6 ANALYSIS: ISSUES & THEMES

6.1 INTRODUCTION

- 6.1.1 The following analysis of agency contact summarised in section 5 includes, but is not limited to the issues identified in the terms of reference.
- 6.1.2 This section considers the:
- Possibility of unidentified concerns prior to December 2006 (see 6.2)
 - Key decisions in response to incidents of concern (see 6.3 – 6.6)
 - Main issues and themes emerging from the history of involvement of professionals with the children (see 6.7 – 6.24)
- 6.1.3 Whilst reference is made to all [REDACTED] children, the analysis highlights those themes relevant to child A. There were many examples of appropriate or commendable professional practice acknowledged below. Inevitably there were also decisions made and actions taken that were flawed. These are discussed here and inform conclusions drawn and recommendations made in sections 7 and 8 respectively.

6.2 POSSIBLE UNIDENTIFIED CONCERNS PRIOR TO DECEMBER 2006

- 6.2.1 With the benefit of hindsight it is possible that Ms A's contact with the GP in September 2006 was the first recorded indication that there might be welfare concerns i.e. Ms A saying that six month old child A 'bruises easily and she might be accused of hurting him'.
- 6.2.2 The computerised summary sheet does not specify if any bruises were seen on examination or if the GP tried to explore the reason for the comment. There is no evidence of subsequent liaison with child A's health visitor or other community professionals regarding Ms A's concern.
- 6.2.3 Despite Ms A being an experienced parent good practice should have involved full exploration of such comments. This was particularly pertinent as there has been a change of circumstances within the family. It is not known if the GP was aware that Ms A had mentioned to the Primary Mental Health Worker that Mr A had moved out and that she had a 'new supportive male friend' (this may have been Mr H).
- 6.2.4 The GP saw child A on 13.10.06 and was told that the toddler had fallen downstairs the previous day and recorded bruising to his 'left breast, left cranium'. No other bruises or injuries were noted on clinical examination. The GP's response advising the obtaining of a stair-gate was appropriate, but additionally, given child A was only seven months at this point and presumably not yet a 'toddler', there should have been further clarification sought and recorded about the circumstances of him falling down the stairs.

6.3 DECISIONS & RESPONSES TO UNEXPLAINED HAEMATOMA: 11.12.06

HEALTH

- 6.3.1 When Ms A took child A to the GP on 11.12.06 with a haematoma on his forehead, the GP appropriately referred the child immediately to Whittington Hospital and commendably also faxed a referral to CYPS.
- 6.3.2 Hospital staff provided an effective response; the paediatric registrar consulted the 'named doctor for child protection', an immediate written referral was faxed to the hospital Children's Social Care, who in turn informed Haringey's CYPS and liaised with the health visitor. Child A was admitted to the children's ward for further investigation and to ensure his safety.
- 6.3.3 The paediatrician promptly provided a written report which stated that the 'combination of bruising is very suggestive of NAI'.

CHILD PROTECTION ENQUIRY & INVESTIGATION

- 6.3.4 CYPS responded promptly, informed the police Child Abuse Investigation Team (CAIT), commendably convened a strategy meeting at the hospital, invited both a school representative and health visitor (who were unable to attend) and planned to carry out full agency checks.
- 6.3.5 During this joint investigation there was a sound working relationship between CAIT and CYPS, with good information sharing between those agencies and debate about the plans for child A, resolved through formulation and implementation of an agreed strategy. Joint interviews were undertaken of the two elder siblings (each seen separately) and CYPS undertook a home visit without Police, as agreed at the strategy meeting.

Police investigation

- 6.3.6 The Police IMR points out early shortcomings in its investigation:
- The injuries to child A should have been photographed at the earliest opportunity, rather than relying on the body map and the descriptions of injuries in the medical notes (this was acknowledged on the CRIS report during a supervision entry, but by then it was too late to rectify)
 - A joint home visit with the social worker would have been useful
 - Photographs should have been taken of the family home as a potential 'scene'
 - Recording weaknesses, especially in the latter stages of the investigation whilst trying to obtain the medical review (see 6.24.14)
 - The investigation appears to have 'drifted' (see below)

- 6.3.7 The only suspects in the investigation were Ms A and her mother. No information was provided or obtained about anyone else staying at the home and Mr A had not recently seen the children. The investigating police officer was aware of Mr H as a friend, but there was no suggestion at that time that he stayed at the home or ever looked after the children.
- 6.3.8 Police liaised with the Crown Prosecution Service (CPS) in [REDACTED] 2007 and were requested to seek clarification and review of the medical evidence as regards causation and ageing.
- 6.3.9 The paediatrician appropriately declined to attempt to age the bruise: the Police IMR points out that current research indicates that 'a bruise cannot accurately be aged from clinical assessment in vivo or on a photograph' (*Can you age bruises in children? A systematic review*: S Maguire, MK Mann, J Sibert and A Kemp).
- 6.3.10 Following further liaison with the CPS an independent medical review was commissioned in [REDACTED] 2007. The Police IMR explains that this process took longer than it should due to delay in getting specialist approval and to a breakdown in communication between DC1 and the DS2 when the detective constable moved to a new position outside the Command on [REDACTED].07. By the time DC1 was transferred, the specialist had been identified to help the Police review the medical evidence for the CPS. However, the specialist had no further contact from the police until July 2007, despite emailing to enquire what was happening with the case.
- 6.3.11 Whilst the case should have been formally handed over prior to DC1's transfer, this did not occur and DC1 was still shown as the investigating officer until DC2 was allocated the case on [REDACTED].07.
- 6.3.12 On becoming the investigating officer, DC2 promptly reviewed the case, obtained an update from DC1 and DS2 and was briefed by DS1 on outstanding tasks, beginning by seeking the medical X-rays taken whilst child A was in hospital. DC2 is to be commended for [REDACTED] pro-active response.
- 6.3.13 Within a couple of weeks a second Police investigation was commenced (see 6.6) and subsequent work was undertaken as part of that investigation and progressed rapidly. However, on 31.07.07 the CPS advised no further action.

S.47 enquiry

- 6.3.14 CYPS undertook most of the relevant agency checks, including background information from Islington. The CYPS IMR points out that checks were not undertaken with mental health services, though both Ms A and the health visitor provided information about Ms A's depression. Fortunately the PMHW herself made direct contact with the social worker once Ms A had told the PMHW of the CYPS involvement.

- 6.3.15 The CYPS considered the welfare of the siblings, arranged paediatric assessments and convened a child protection conference.
- 6.3.16 Good practice was followed in convening a second strategy meeting on 24.01.07, though attendance was limited to Police and CYPS. It is unclear which other agencies were invited as it is not possible to record apologies on electronic records of strategy meetings; the Whittington Hospital IMR author established that its paediatrician was invited, but was on leave.
- 6.3.17 Given the central significance of medical opinion in this case it would have been better practice for the meeting to be held when a paediatrician from the Whittington Hospital was able to be present and for the meeting to have been convened at hospital to facilitate such attendance. Alternatively the attendance of the designated doctor at this second strategy meeting *might* have provided an alternative source of independent medical advice.

CYPS decision making

- 6.3.18 CYPS decided to convene a child protection conference, not to initiate legal proceedings and for child A to be placed with Ms J on discharge from hospital. The point at which these decisions were made and their rationale were not consistently and clearly documented.
- 6.3.19 Records do make it clear that managers decided appropriately, given the uncertainty about the cause of his injuries and the outcome of the Police investigations that it would be premature for child A to return home.
- 6.3.20 Following attendance at the initial child protection conference Legal Services advised the threshold for initiating Care Proceedings was met, but that given Ms A's co-operation legal proceedings were not pursued. Given the absence of previous concerns about the children, Ms A's co-operation and the need to undertake assessments this was a reasonable judgement.
- 6.3.21 The decision making process about child A's move to Ms J's on [REDACTED].06 is not clearly documented in the CYPS IMR (nor presumably child A's CYPS records). The chronology shows that:
- A foster placement was sought
 - Mr A offered to care for his son
 - The elder siblings' school was informed on [REDACTED].06 that Mr A *would* be caring for his son
 - Ms A made allegations that day that her husband used to hit the children prior to attending a parenting course
- 6.3.22 The relevant CYPS team manager has confirmed to CYPS management (during the SCR process) that the changed decision was influenced by the allegations and because Mr A was not perceived to be 'putting himself forward strongly' to care for child A. It would have been good practice for this to be discussed with Mr A prior to making a decision and the rationale for the decision recorded.

- 6.3.23 The allegation that Mr A hit the children was not communicated to the Police: if it had been it *might* have led to Mr A being seen by Police as part of the investigation.
- 6.3.24 Child A moved to Ms J's care, with a written agreement signed by both Ms A and Ms J confirming that contact with Ms A and maternal grandmother (MGM) would be supervised and that CYPS be informed of any concerns. Once Mr A had been discounted as an option, this arrangement appears to have been a reasonable attempt to maintain child A's links with his family during the s.47 enquiry and Police investigation. What is not apparent within this arrangement is the extent of assessment undertaken about Ms J's suitability for the task (see 6.14).
- 6.3.25 At the second strategy meeting on 24.01.07, the decision was taken for child A to return home. The rationale for this was the lack of a definitive timescale for resolving the Police investigation. Police agreed with the decision for child A to return home as CYPS was concerned that further delays might impact on his re-integration into the family.
- 6.3.26 Although the question of how child A received his injuries was not resolved and non accidental injury was still suspected, this decision was understandable given that the youngest [REDACTED] children were now subject to a child protection plan, the other children were said to be fine and Ms A was reported to have a good relationship with her children and to be co-operating with the protection plan.

6.4 DECISIONS & RESPONSES TO INCIDENT ON 05.03.07

- 6.4.1 On 05.03.07 the school nurse made a commendably timely and appropriate verbal and written referral after witnessing Ms A slap child [REDACTED] on the face.
- 6.4.2 On management advice, the social worker followed it up by speaking separately to Ms A and to child [REDACTED], who provided consistent accounts of the circumstances, including that Ms A admitted hitting child [REDACTED] after losing [REDACTED] patience with [REDACTED].
- 6.4.3 Given that there was still a Police investigation into the 2006 incident and that children in the family were the subject of child protection plans, the Police should have been notified and a strategy discussion held to agree if and how the matter would be investigated.
- 6.4.4 Police were not present at the child protection conference of 16.03.07, when the incident was discussed and only learnt of the incident when they received a faxed referral form and conference record on [REDACTED].06.

- 6.4.5 Police decided not to interview and formally caution Ms A with regard to slapping child ■ on the face and left it as a single agency investigation by CYPS. By this point the social worker had interviewed mother and daughter, Ms A had admitted the matter, no injuries were observed and agreement had been reached for Ms A to attend a parenting course. The officer reasonably concluded that any further action would have been disproportionate.

6.5 DECISIONS & RESPONSES TO CHILD A'S HOSPITAL PRESENTATION ON 09.04.07

- 6.5.1 NMUH appropriately admitted child A on 09.04.07 and made a referral to CYPS via the Emergency Duty Team (EDT), commendably raising possible child protection concerns about the delayed medical opinion and asking CYPS about the need for a discharge meeting.
- 6.5.2 NMUH accepted the CYPS decision not to hold a meeting and its assurances that a home visit would be undertaken and the concerns followed up after discharge. The visit took place some two weeks later, on 24.04.07, and there is no evidence that there was any follow up of the concerns with Ms A or the children.
- 6.5.3 The London Child Protection procedures clearly state the requirement of a strategy discussion prior to discharge when abuse is alleged, suspected or confirmed in children admitted to hospital (see 4.4.28 edition 2 and 4.5.18 edition 3).
- 6.5.4 The NMUH and CYPS IMRs do not analyse issues about agency practice in relation to this hospital admission and the CYPS report does not explain the absence of a discharge meeting, Police notification of the injury or of a strategy discussion (to decide whether a s.47 enquiry was warranted).
- 6.5.5 In response to CAE concerns about the lack of such responses, there was considerable debate and discussion within the serious case review sub-committee. Following draft reports, new information was provided by both NMUH and CYPS verbally (in sub-committee meetings) and/or in writing. The most recent new information was received on ■■■■■.08. The following sections describe what has emerged from these discussions.

Referral to CYPS

- 6.5.6 Exploration of the referral process has revealed that the written referral from NMUH to CYPS did not adequately present the concerns.
- 6.5.7 NMUH faxed a standard CYPS referral form and a child protection summary sheet. The referral form provided basic information about child A and his attendance at hospital, including that he was subject to a child protection plan. The accompanying 'child protection summary sheet' gave further details of the bruising and explanations provided, but did not sufficiently communicate the child protection concerns nor provide medical opinions.

- 6.5.8 The summary sheet appears to accept Ms A's explanation for the injury as a matter of fact ('sustained head injury while playing on 05.04.07... hit head on side of fire place...') and no opinion is provided as to the consistency or plausibility of the injury.
- 6.5.9 The summary sheet makes no reference to delay in seeking medical opinion and provides no explanation (or comment) for the other bruises seen on the face or back.
- 6.5.10 The conclusion of this form involves specific questions, but the responses provided are ambiguous. Most critically for CYPS was the answer to 'there is reasonable probability that this incident is due to Child Abuse, and it requires further investigation...': it appears the response was 'No' ('Yes' was circled but then crossed out).
- 6.5.11 During the latter stages of the review process (April), CAE was informed that the 'child protection summary sheet' was an internal document and sent to CYPS in error. This sheet was also sent after child A's subsequent NMUH presentation on [REDACTED].08, indicating a more general confusion within NMUH about referral processes.
- 6.5.12 There was debate within the sub-committee about the adequacy of the NMUH referral form in April. If it had been presented (as apparently intended) without the summary sheet, it would not have communicated sufficient details of the hospital presentation, nor have specified concerns (other than child A being subject to a child protection plan) or provided medical opinions. This discussion highlighted basic differences in understanding between agencies about the expectations of the referral process.

CYPS response to NMUH referral

- 6.5.13 EDT received the referral and recorded 'child protection summary sheet indicating no need for investigation'. This misunderstanding of the referrer's concerns is likely to be associated with the way both the referral form and the 'child protection summary sheet' were completed, as described above.
- 6.5.14 The social worker sought advice from her manager about the use of a discharge meeting and the decision was made that there was no child protection concern.
- 6.5.15 CYPS has explained in written submissions on [REDACTED].08 and [REDACTED].08 that this decision followed a conversation with a nurse and with a paediatrician at NMUH, who according to CYPS records, appear to have accepted Ms A's explanations as to the cause of the injury:
- The nurse was asked specifically if there were any child protection concerns and apparently replied that 'there was not because his mother had stated the injury was caused by him being pushed by another child'

- The nurse also apparently confirmed that child A was only staying in hospital due to having a virus and the paediatrician confirmed that child A had some spots consistent with meningitis, but does not have meningitis
 - The paediatrician is cited as confirming that it was common for bruising to occur later [presumably explaining the delay in seeking treatment]
 - No child protection concerns were indicated by the paediatrician, although he did ask if there was a need for a discharge meeting
- 6.5.16 As a consequence of the content of the referral and subsequent discussions, the perception within CYPS was that there were no child protection concerns and consequently no need to hold a strategy discussion with the Police.
- 6.5.17 This decision did not give sufficient weight to the history and possible concerns relating to the hospital presentation: child A was subject of a child protection plan, there was an unresolved Police investigation, there were new unexplained bruises, a swelling on the head and a delay in obtaining treatment.
- 6.5.18 In accordance with child protection procedures (see 6.5.3) there should have been a strategy discussion with Police and NMUH and a s.47 enquiry considered to investigate the circumstances of the injury (with regard to the possibility of physical abuse and/or neglect) and the delay in obtaining medical advice.
- 6.5.19 There was no follow up to this incident, and when the social worker next visited the family, some thirteen days after discharge, there is no evidence the circumstances of the hospital admission were directly discussed with Ms A or any family members. Reasons for this remain unknown.

Impact of the lack of strategy discussion, s.47 enquiry and/or further assessment

- 6.5.20 A strategy discussion, s.47 enquiry and/or further assessment may have led to more information on the household composition and family dynamics. It might also have provided further details and explanations of the circumstances in which child A suffered his head injury.
- 6.5.21 Had the Police been informed this may have influenced their ongoing investigation and subsequently the view of the CPS.

6.6 DECISIONS & RESPONSES TO CHILD A'S INJURY ON 01.06.07

INITIATION OF S.47 ENQUIRY AND POLICE INVESTIGATION

- 6.6.1 The social worker appropriately recognised that the Police needed to be informed of the marks and bruises she had observed in child A and faxed details to the CAIT. In such circumstances of possible physical injury, a telephone call is required in addition to the fax.

- 6.6.2 The police officer (DC2) recognised that the fax referred to an ongoing Police investigation and immediately (and commendably) contacted the social worker and expressed the need to question the mother's account of the injury.
- 6.6.3 Police records show that DC2 indicated that if there was any suggestion of non accidental injury at the child protection medical, 'police should be contacted and police protection taken'; if no suspicions, s.20 to be considered. It is understood that this response was based on the fact that child A had been injured previously and should be out of the home whilst the circumstances of the injury was being investigated.
- 6.6.4 Internal communication within CAIT was good and in line with the level of concern perceived by the Police. DC1 briefed DC2 before leaving duty and DC2 rang the CYPS team manager at 4.15pm, when the social worker was en route to the paediatric assessment, to emphasise the Police view that child A was not to return home and the willingness of the Police to exercise 'Police Powers of Protection' at any suggestion of non accidental injury. DS1 and DC2 remained at the Police station late that Friday evening, but by the time DS1 left at 9pm there had been no contact from CYPS.
- 6.6.5 It is not known why CYPS did not communicate with the Police on the Friday evening and hold a telephone strategy discussion. CAE has been advised by CYPS that there is no recollection in that department of the telephone discussion at 4.15pm and that SW2 reported to the STM that the doctor 'had said it would be very difficult to be 100% certain about the cause of the injury; mother gave a clear account.'
- 6.6.6 The rationale for the CYPS decision for child A to return home on [REDACTED].07 is not clear, other than that the social worker had arranged for a friend (Ms J) to stay with the family over the week-end. It is important that managers involved in such critical decisions ensure the records reflect the decision making process.

Strategy meeting

- 6.6.7 DS2 appropriately initiated contact on [REDACTED].07 to obtain an update and request an immediate strategy meeting as a priority. This meeting, involving DC1 and the CYPS team manager and senior team manager discussed the medical report, which the Police clearly understood to include the opinion that the injuries involved suspected NAI.
- 6.6.8 The child protection procedures in place at that time (London Child Protection Procedures edition 2), indicate at 6.6.9 that 'Where issues have significant medical implications, or a paediatric examination has taken place or may be necessary, a paediatrician should always be included'. In this case there was no paediatric input to the meeting.

- 6.6.9 No NMUH paediatrician attended and it is not known if one was invited (attendance was not facilitated as the meeting was held at CYPS). The absence of a paediatrician to advise on the findings of the medical examination and need for any further assessments e.g. X rays / scans, was a critical omission and contributed to differing perceptions of risk outlined below.
- 6.6.10 The designated doctor was not included in the strategy discussion and her advice was not sought prior to or after the meeting. Given the repeated nature of child A's injuries and the referral to SCHS, a medical perspective at this point was necessary.
- 6.6.11 The detailed plan for child A formulated at the meeting included:
- Initiating a s.47 enquiry and Police investigation
 - Arranging a legal planning meeting (understood in Police records to take place within the week)
 - Implementing interim measures to safeguard child A's safety
 - An urgent paediatric assessment of his propensity to bruise (see 5.11.9).
- 6.6.12 The major omissions of the plan were the absence of:
- Interviews with the [REDACTED] children to try to explore the circumstances of the injuries and assess home circumstances
 - Agreement to hold a further strategy meeting to review progress of investigations and maintain or vary the safeguards implemented
 - Involvement of Mr A in enquiries

Different perceptions of risk

- 6.6.13 Responses to the incident on 01.06.07 appear to provide evidence of a different perception of the risk to child A by the CYPS and by the CAIT.
- 6.6.14 With what appears to be a clear understanding that child A had suffered no accidental injuries for the second time (and without knowledge of either the additional April hospital presentation or - due to misfiling - the March incident), the Police view appears to be that an Emergency Protection Order (EPO) should be considered, but CYPS staff were doubtful of the chances of obtaining one.
- 6.6.15 The CYPS IMR, chronology and report provides less detail and explanation for the decisions made. The IMR's reference to the outcome of the paediatric assessment on 01.06.07 as being 'inconclusive' indicates less certainty that child A had suffered non accidental injury. This view is supported by CYPS confirmation during the SCR that the senior team manager present at the strategy meeting thought there were no grounds for an EPO.

- 6.6.16 Reasons for this apparent difference between CAIT and CYPS remain unknown. The social worker was present at the paediatric assessment and may at the time have obtained a different understanding of its conclusion.
- 6.6.17 Alternatively it may be that some of the details of the 'child protection summary sheet' sent by NMUH led to less certainty about the outcome. Despite a conclusion indicating there is a reasonable probability the incident is due to child abuse, all subsequent options are 'ticked' i.e. it is both likely to be an accident / medical condition and that it is not, and that some of the medical findings support and some do not support the allegation. This was presumably an accurate description of all the possibilities, as the answers were addressing several bruises. However, in this instance the form's design and completion did not lead to the communication of a clear message, and may have contributed to the differing perceptions.
- 6.6.18 Respective perceptions of the outcome of the medical examination are likely to have influenced the views and actions of the two agencies. With less certainty about the likelihood of non accidental injury, CYPS may have considered these injuries as further evidence of Ms A's negligence, rather than that child A was at risk of serious injury through the deliberate actions of others. Consequently greater emphasis may have been put on the historical positive observations of Ms A's relationship with her son and her co-operation with professionals.

Subsequent Police role

- 6.6.19 Subsequently Police were commendably pro-active, chasing CYPS to hold the legal planning meeting and referring the delay in convening it to detective inspector level. During June, the DC continued to ask about the progress of the legal planning meeting.
- 6.6.20 It would have been helpful if the Police had requested a second strategy meeting to review the progress and future of the safeguarding plans made at the original strategy meeting.
- 6.6.21 Police meanwhile progressed their investigation, arresting and interviewing Ms A on [REDACTED].07, taking photos of child A's injuries and the home, interviewing a witness (mother of children playing with child A) and reviewing the medical evidence obtained with the independent specialist. Unfortunately they were not aware that the FWA worker had been told that Ms J was a witness and she was not interviewed.
- 6.6.22 The photos of child A show only minimal marks, possibly due to a delay of a week in taking them. The statement of the witness appeared to partially support Ms A's account of rough boisterous play between the children.
- 6.6.23 The Police interview of Ms A did not specifically ask who lived in the home, presumably due to an assumption that this information was known already and that any change to this would have been known. Whilst an understandable assumption, such basic information needs always to be checked.

- 6.6.24 Siblings might have provided further information about family circumstances, but were not provided with an opportunity. The investigating officer did not consider it necessary at the time as Ms A's appeared to be open in discussing the circumstances and the witness supported her explanation.
- 6.6.25 This omission is considered unlikely to have impacted on the outcome of the investigation, as when provided with the opportunity, the children did not share details of Mr H's involvement in the family in either December 2006 or immediately following child A's death.

Children & Young People's Service role

- 6.6.26 CYPS did progress the plan (as outlined in 5.11.14):
- A child-minder was supplied on specified days and times
 - A written agreement was signed with Ms J and Ms A, confirming Ms J was to receive payment for two weeks (representing compensation for loss of earnings) and stay in the house supervising contact between Ms A and her son
 - An attempt was made to chase up the SCHS paediatric assessment (see 6.13 for further discussion)
- 6.6.27 A weakness in the responses to the concerns of 01.06.07 was the lack of clarity about the processes, plans and outcomes of the s.47 enquiry.
- 6.6.28 It was planned to review the written agreement with Ms J and Ms A after two weeks, though there is no evidence of how this occurred in the records provided in the IMR and chronology. CAE has subsequently been informed that the arrangement was revised (on the basis that the children were at school / childminder during the day) to one of Ms J being present in the evening and bedtime. The arrangement with Ms J remained in place and was discussed at the core group on [REDACTED].07, but was not reviewed in the light of the childminder's withdrawal and the school holidays.
- 6.6.29 The delay in the legal planning meeting taking place, despite the child protection conference also emphasising its importance, was a major shortcoming in the local authority's response and is discussed separately (see 6.8).
- 6.6.30 There is evidence that the social worker phoned the school and the health visitor and attempted to speak with the child protection nurse about the Mellow Parenting Programme. This may have been to inform them of the s.47 enquiry and undertake agency checks, but the recording does not make this purpose clear. There is no evidence that the FWA was contacted.
- 6.6.31 Following the discovery of child A's bruising on 01.06.07, the social worker did not visit the home during the rest of June, (though did see child A at the childminder's) and first saw children [REDACTED] when she visited the home on [REDACTED].07. Consequently there does not appear to have been any timely opportunity to explore with them the cause of child A's injuries.

Lack of second strategy meeting

- 6.6.32 Critically, there was no second strategy meeting to review progress of enquiries (and Police investigations) and consider the outcome of / progress in arranging a legal planning meeting, or effectiveness and future of the arrangements implemented to safeguard child A.
- 6.6.33 The review child protection conference held on 08.06.07 shared information and upheld the protection plans implemented by the s.47 enquiry. It did not review the *outcome* of enquiries, as these were (or should have been) ongoing and this forum could not replace a second strategy meeting.
- 6.6.34 A second *multi-agency* strategy meeting should have been convened to review what (with the benefit of hindsight) seem to be deteriorating circumstances, including:
- Ms A disappearing on [REDACTED].07 for what was initially said to be her birthday, but then became to look after a 'sick' uncle in Cricklewood (moreover the relevant local authority was not informed of the presence of children subject to a child protection plan)
 - Child A's sore, scabbed and infected scalp, itchy hives, head lice, infected ear, two reported bruises, loss of weight
 - Ms A's [REDACTED] (although known only to Mellow Parenting)
- 6.6.35 During this period, the trust in Ms A appears to have been maintained, and her word accepted without question regarding the bruise seen by the childminder on [REDACTED].07 (see 5.13.9) and the bruise observed by the health visitor on 18.07.07 (see 5.13.15-16). In these circumstances of an ongoing s.47 enquiry and Police investigation, the presence of these bruises should have been reported to the police, child A seen and the paediatrician consulted, with consideration given to a further medical examination. .

6.7 OUTCOME OF POLICE INVESTIGATIONS & LACK OF IDENTIFIED PERPETRATOR

- 6.7.1 DC2 is to be commended for progressing the December 2006 and June 2007 investigations quickly following the discovery of the injuries on 01.06.07 and resolved them within eight weeks of the 2007 case being reported. However the CPS advice on 31.07.06 was for 'no further action'.

CPS knowledge of March and April 2007 incidents

- 6.7.2 The CPS made the above recommendation based upon knowledge of two events only i.e. the injuries to child A in December 2006 and June 2007.
- 6.7.3 The CPS lawyer has advised that knowledge of the March incident (Ms A's assault of child [REDACTED]) would not have affected this decision, but knowledge of the April incident *might* have influenced the decision to charge (if it had been investigated as assault or neglect) on the basis of three incidents in six months.

Impact of delay on December 2006 investigation

- 6.7.4 The delay in completing the 2006 investigation meant that the CPS, after six months, lost the option (reported to have been under consideration) to charge an identified perpetrator with common assault.
- 6.7.5 Any further consideration of the impact of the delay in progressing the Police investigation is hypothetical. However, had Ms A (or any other person) been charged with common assault, it is possible that this would have had an affect on the CYPS perception of the case and might have made it more likely that all the subsequent incidents were reported to the Police and that (arguably) child A might have been more effectively safeguarded following the June injuries.

6.8 LEGAL ADVICE

Delay in obtaining the advice

- 6.8.1 Section 6.6 describes the differing perspectives Police and CYPS took following discovery of injuries to child A on 01.06.07 and the debate about the need for legal action. According to Police records, CYPS believed the evidence at that point would not enable such action to be taken but that legal advice would be sought as a matter of urgency on 04.06.07.
- 6.8.2 The legal planning meeting finally occurred on 25.07.07, over seven weeks later. The sequence of events was as follows:
- The social worker (who was off sick at the time of the strategy meeting on 04.06.07) was unaware of the agreement to hold this meeting when [REDACTED] spoke with the Police on 06.06.07, but agreed to discuss with a manager
 - The child protection plan agreed at the review child protection conference on 08.06.07 provided for a legal planning meeting to be arranged within ten working days
 - CYPS faxed the referral to Legal Services on 15.06.07, (five working days later)
 - On 21.06.07 (four further working days later) the social worker was asked by Legal Services for suggested dates,
 - Three weeks later on 12.07.07, the social worker suggested dates (17.07.07 and 25.07.07) and the Legal Services subsequently confirmed the latter
- 6.8.3 The explanation attributed to the team manager in the CYPS IMR for the delay in requesting the meeting and then in suggesting dates, was of workload pressures at that time.
- 6.8.4 The IMR from the Legal Services was unable to explain the delay in response to CYPS. Staff usually action a legal planning meeting on the day a referral was received. In this case the space on the referral form for proposed dates and times was blank, so some delay was perhaps inevitable.

Advice provided

- 6.8.5 A locum lawyer attended the meeting and advised that the threshold was not met for legal proceedings. The lawyer prepared a memo confirming the advice on the morning of 03.08.07, but this was not sent to the social worker as the file was frozen following child A's death. The memo was later sent to the team manager on 10.08.07.
- 6.8.6 The locum lawyer's view explained in the Legal Services IMR was that there was insufficient evidence to initiate Care Proceedings at that time, but she would reconsider once she had seen further papers. Accordingly the lawyer requested the medical report, the outcome of the Police investigation (thought to be due very soon) and the SCHS assessment.
- 6.8.7 The IMR from Legal Services also explains that it is preferable for advice in legal planning meetings to be provided by lawyers with ample previous experience of acting for a local authority in Care Proceedings, but due to recruitment difficulties this had not always been possible.
- 6.8.8 The Legal Services IMR had difficulty commenting on the appropriateness of this advice as a result of insufficient recording of the legal planning meeting, but does suggest the advice could have been more clearly expressed and that the lawyer should have indicated she was unable to advise definitely without sight of the medical report.
- 6.8.9 Moreover, the IMR states that 'It is likely that the threshold criteria were met at the time' of the legal planning meeting (LPM) but 'it may not have been appropriate to issue proceedings if there were adequate safeguards in place to protect [child A] pending the outcome of further investigations'. There is no evidence to suggest that CYPS at this point recognised any shortcomings in the adequacy of the safeguards implemented.

Impact of delay

- 6.8.10 Given the advice provided (that the threshold was not met), the impact of the delay in holding this meeting relates to the possibility of holding a timely second meeting to review progress, with full background material supplied. The important learning point from this relates to the need for meetings to be held without delay, with provision of *full* relevant background material.

6.9 CONTACT & COMMUNICATION WITH THE CHILDREN

- 6.9.1 Generally professional contacts with the children from several agencies, providing a range of services to the family at home, or in other settings, provided consistent descriptions of:
- Ms A's positive and trusting relationship with all her children
 - The children playing happily together
 - Child A's high level of activity, some level of clumsiness and observed head banging

SCHOOLS

- 6.9.2 Children ██████ attended school regularly and were seen consistently without other family members. ██████ children of this age often speak, draw and write about their families and friends whilst at school, but the school records do not contain any relevant information on family relationships.
- 6.9.3 It is not known if this is because the children provided no relevant insights into Ms A's relationships and new members of the household or if such information would have been perceived as irrelevant for school records.

POLICE

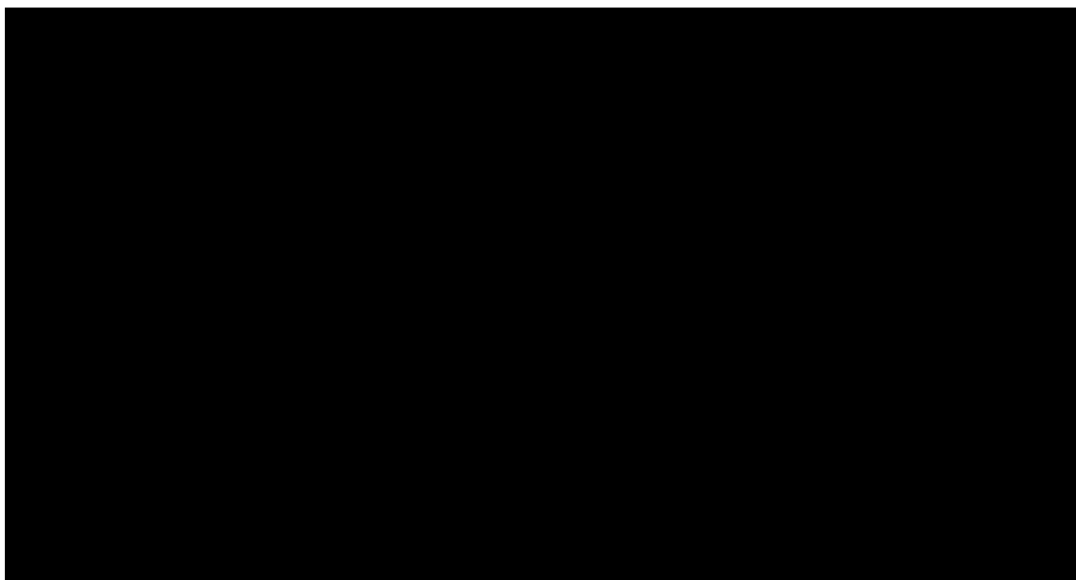
- 6.9.4 The Police appropriately saw the elder children, with the social worker, as part of the December 2006 investigation.
- 6.9.5 As the Police were not informed of any other concerns until 01.06.07, the only other potential opportunity for further direct contact was during this second investigation. As described previously (see 6.6.24), the children were not provided with this opportunity.

CHILDREN & YOUNG PEOPLE'S SERVICE

Contact: implementation of child protection plan

- 6.9.6 Chart 1 provides an overview of the contact between social workers and each child between January and July 2007.

Chart 1: Monthly social work contacts with ██████



- 6.9.7 Chart 1 is derived from table 1, which provides the detailed breakdown of the contact social following the child protection conference on 22.12.06. It was not always clear from the chronology if the visit was pre-arranged, but it has been assumed that this was the case, unless records confirm an unannounced visit.

- 6.9.8 The initial conference planned for fortnightly visits to children A and ■, both announced and unannounced.
- 6.9.9 During January the frequency of contact with children A and ■ was consistent with the protection plan. All visits are assumed to be announced and there is no record that any of the children were seen on their own during these visits.
- 6.9.10 Following child A's return home on 26.01.07 and case transfer on ■.07 there is no record of a social work visit until ■.07, though the social worker is to be commended then for seeing the children on their own.

Table 1: CYPS – contact following child protection conference on 22.12.06

Announced home visits (children seen)	Unannounced home visits (children seen)	Contact at other location (children seen)	Visits cancelled by Ms A	Comment
		24.12.06 (A seen)		At Ms J's home by EDT
	27.12.06 (■ seen)	A also seen @ Ms J's home		
29.12.06 (A, ■)				<i>Assumed announced</i>
■.07 (A, ■)				<i>Assumed announced</i>
■.07 (A & ■)				<i>Assumed announced</i>
■.07 (A, ■)*				
■.07 (A, ■)				<i>Assumed announced</i>
		05.03.07 (■)*		At the office
	■.07 (A, ■)			
08.03.07 (A & ■)				
???				■.07: home visit scheduled, but no record of completion
24.04.07 (A, ■)				Assumed announced Children appeared well and playing
21.05.07 (A, ■)*				
	01.06.07 (A, ■)			Unannounced
		19.06.07 (A & ■)		Childminder's home
	■.07 (A, ■)			N/K if announced or unannounced
30.07.07 (A, ■)*				
TOTALS				
9 or 10	4	4	0	

* children/ren seen on own by professional visitor

- 6.9.11 In March there was a high level of contact, with three (or four see [REDACTED].07) home visits (one unannounced) and an office interview with child [REDACTED].
- 6.9.12 The protection plan of the first review conference on 16.03.07 increased the proposed schedule of social worker visits to weekly, although not specifying the purpose of such visits.
- 6.9.13 The chronology provided by CYPS questioned the justification for increasing the visiting frequency: if this was considered unrealistic or unjustified at the time it should have been discussed with managers and/or child protection advisors and recorded. There is no evidence this occurred.
- 6.9.14 However, instead of home visits increasing to weekly in line with the plan, they reduced to an announced visit, once a month in April and May, despite the further head injury suffered by child A on or before 09.04.07. The social worker did however see the children on their own at the May visit.
- 6.9.15 Following the unannounced visit on 01.06.07, child A became subject to a second Police investigation and s.47 enquiry as well as complex safeguarding arrangements. In such circumstances one would have anticipated that professional contact with child A would have increased, but only three contacts were recorded in the next two months.
- 6.9.16 Surprisingly the child protection conference of 08.06.07 reduced the minimum visiting schedule to fortnightly. At this point weekly visits would have been more appropriate. However, it also appropriately specified direct work with the children.
- 6.9.17 From this point the social worker saw child A at approximately three weekly intervals, rather than the fortnightly visits determined in the child protection plan.
- 6.9.18 The extent to which direct work was undertaken is difficult to assess, as the records are not sufficiently detailed. Following the child protection conference plan of 08.06.07, which specified such intervention, the elder children were seen on [REDACTED].07 and 30.07.07. The chronology entry of 30.07.07 provides an indication of such work being undertaken with them.

Contact in relation to specific incidents of concern

- 6.9.19 The social worker was appropriately involved with Police in interviewing the elder siblings alone as part of the December s.47 enquiry.
- 6.9.20 Whilst social workers had regular subsequent contact as outlined above in chart & table 1, consistent contact and communication with the children did not occur as part of planned responses to incidents of concern.
- 6.9.21 Child [REDACTED] was seen alone following Ms A slapping [REDACTED] on 05.03.07, but there was no contact with the children immediately following child A's injuries on 09.04.07 or to seek their comments about the injuries observed on 01.06.07.

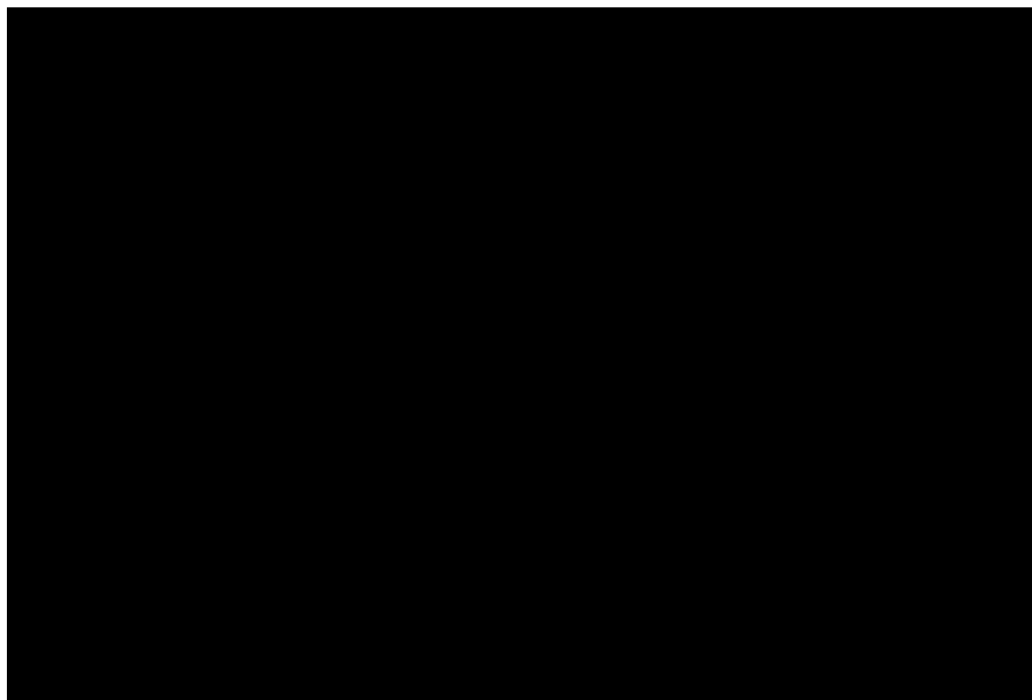
Overall CYPS contact

- 6.9.22 Overall, there were seventeen (or eighteen) contacts with the children in just over seven months: one or more of the children were seen at nine (or ten) announced home visits by the social workers, four unannounced visits and on four occasions at other locations. Child A was seen on three of the unannounced visits.
- 6.9.23 Whilst the visiting level was good or very good until the end of March, from that point the contact with the children was not in accordance with the child protection plan, in spite of the increased levels of concern that should have existed following the April and June injuries.
- 6.9.24 Ms A co-operated with all visits, never cancelled or otherwise prevented the social worker seeing the children, except for declining a visit on [REDACTED].07 when she was about to move home.
- 6.9.25 At the last visit on 30.07.07, the social worker saw all the children, but despite seeing them on their own, the older [REDACTED] did not provide any information about the other people currently staying in the home. This does appear to support the impression that the children were very guarded in the information they communicated.

HEALTH

- 6.9.26 Chart 2 shows the overall contact by health professionals with the [REDACTED] children.

Chart 2: Monthly health contacts with [REDACTED]



- 6.9.27 Chart 2 is derived from the detailed information in table 2, which shows the health contacts following the initial child protection conference. This shows three home visits (presumed announced) by the health visitor and thirty four health contacts at clinics, hospital, GP and Mellow Parenting. Children were present on all these occasions and child A was present for all the home visits and twenty of the other contacts. This level of contact was higher than anticipated within the protection plans.
- 6.9.28 In addition to these frequent contacts Ms A did not keep or cancelled seven appointments with the health visitor (not unreasonable for the mother of young children). There is no evidence that she was reluctant for health professionals to see child A. On the contrary, even in the last month of child A's life, Ms A presented him at seven health sessions, including the walk in clinic, NMUH A & E, the GP, the child health clinic and twice at Mellow Parenting sessions and finally, two days before he died, the SCHS.
- 6.9.29 Table 2 does not include information provided to CAE in March 2008, of two possible appointments at SCHS, understood to be offered by telephone to Ms A, and declined (see 6.13.19-20). If Ms A did reject these appointments, this may have been an indication of a lack of co-operation with the child protection plan. However, this information was not in child A's SCHS file and not communicated to CYPS.

Table 2: Health - contact following child protection conference on 22.12.06

Announced home visits (children seen)	Contact at clinic / surgery / school (children seen)	Appts. cancelled or did not attend	Comment
	.07 ()		Medical at health clinic
	.07 (A)		'Friend' (assumed to be Ms G) presented A at child health centre
	.07 (A)		Examined by GP
.07 (A&)			Health Visitor
	.07 (A)		GP gives 2 nd immunisation
	.07(A,)		Seen by GP
	.07 ()		Mr A took to ENT clinic
.07 (A,&)			Appears social worker & health visitor met (? by chance) at A's home
	05.03.07 ()		Health assessment at school
		.07	Ms A indicates unable to attend clinic, no new date agreed
		.07	Failed to bring A to clinic, new appt. made for .07
	.07 (A)		Child A checked at clinic, outstanding immunisations to be arranged with GP
	.07 ()		Checked over at clinic
	09.04.07 (A)		Brought to A&E by Ms A
	.07 (A)		Consultant at hospital examines child A
	.07 ()		Seen at Mellow Parenting session 2
	.07 ()		Assessment by school nurse

██████████.07 (A & ██████████)			Refers to DNA recent appointment for immunisations, unclear when
	██████████.07 (██████████)		Seen at Mellow Parenting workshop session 3
	██████████.07 (██████████)		Mr A brought child C to ENT clinic
	██████████.07 (A)		GP: child A covered in rash, ██████████ ██████████
		██████████.07	Failed Mellow Parenting session 4
		██████████.07	DNA clinic – DK which child
	██████████.07 (██████████)		Mellow Parenting session 5, child A not present
		██████████.07 (A)	DNA at Child Health Clinic (CHC)
	██████████.07 (██████████)		Mellow Parenting session 6 (A not present)
	01.06.07 (A)		Presented to A&E at NMUH
		██████████.07	Ms A did not attend appointment with health visitor – said she forgot
	██████████.07 (A & ██████████)		Health visitor at CHC saw both children; GP saw child A for immunisation
	██████████.07 (A)		Child A receives 3 rd immunisation from GP
	██████████.07 (██████████)		Mellow Parenting session 7, child A not present
	██████████.07 (██████████)		Mellow Parenting session 8, child A not present
	██████████.07 (A&██████████)		Mellow Parenting session 9
		██████████.07	Mellow Parenting session 10, 'had to look after sick uncle'
	09.07.07 (A)	Health record indicates appt postponed to 16.07.07	Attended walk in clinic a/c to CYPS [no record in Health material supplied]
	██████████.07 (██████████)		School nurse health review
	██████████.07 (A&██████████)		Mellow Parenting session 11
		16.07.07	Ms A cancelled CHC. Re-scheduled for 18.07.07
	██████████.07 (██████████)		Mellow Parenting session 12
	18.07.07 (A & ██████████)		Attended CHC. Saw health visitor
	18.07.07 (A & ██████████)		Walk in clinic
	██████████.07 (A & ██████████)		NMUH A & E
	██████████.07 (A&██████████)		Mellow parenting session13
		██████████.07	Ms A forgot CHC appointment
	26.07.07 (A)		GP surgery
	01.08.07 (A)		SCHS appointment
TOTALS			
3	34	10	

FAMILY WELFARE ASSOCIATION

- 6.9.30 FWA contact is shown in table 3 and demonstrates its worker undertook five home visits (presumed announced) in the seven months following the 22.12.06 conference, seeing child A on one occasion only at home. A further chance meeting in the street on ██████████.07 provided an additional contact.
- 6.9.31 Evidence from the FWA chronology and IMR indicates Ms A cancelled or declined five further appointments as well as saying she was too busy to see the worker over the summer. Reasons for this avoidance remain unknown, though the role of the FWA service is discussed further (see 6.17).

6.9.32 Currently the HARTS service in Haringey priority is to support the adult in ways which benefit the children and help sustain their tenancy. This may include direct work with the child/ren if this is specified, but that was *not* the case with this family and consequently the limited contact with the children is not significant.

Table 3: Family Welfare Association - contact following child protection conference on 22.12.06

Announced home visits (children seen)	Children seen on the street	Visits cancelled / declined by Ms A	Comment
██████.07 (██████)			
██████.07 (██)			Assumed announced
		██████.07	Ms A moving house so too busy a/c phone conversation w/c 14.02.07
		██████.07	Ms A cancelled appt.'A has chicken pox'
██████.07 (no children present)			
		██████.07	Re-arranged for 09.05.07
		09.05.07	Ms A said to be unwell
██████.07 (A & █)			
		██████.07	Ms A declined to make appointment
		██████.07	Declined by Ms A not responding to message
		██████.07	Declined by Ms A not responding to message
██████.07			
		Early July	Declined by Ms A not responding to message
	██████.07 (A)		Accidental meeting on street
TOTALS			
5	1	9	3 cancelled, 3 declined attempt to make appt, 3 declined by not responding to message

6.10 INVOLVEMENT OF FATHER

December 2006

6.10.1 Despite Mr A's presence in the hospital when child A was admitted in December 2006, he appears not to have been included in the initial stages of the case, and there is no evidence that:

- He was informed of events and concerns by either Police or CYPS
- Information was sought from Mr A as part of s.47 enquiries and Police investigations
- He was invited to the initial child protection conference, shown reports prepared for the conference or supplied with the conference record

- 6.10.2 Mr A agreed to take time off work to care for his son in December 2006 and according to school records this was the plan on [REDACTED].06. Child A was instead discharged to the care of Ms G. No explanation was found in CYPS records, but CAE have been advised that the change in plan was a consequence of allegations made by Ms A that Mr A had, prior to attending parenting classes, hit his children. It is of concern that it was not discussed with Mr A, reported to police and no further assessment undertaken.

March 2007

- 6.10.3 Following the transfer of the case within CYPS the new social worker to her credit, discussed with Ms A her views on Mr A attending the review conference and visited Mr A in March, inviting him to the conference three days later (which he could not attend).
- 6.10.4 At this visit the social worker learnt from Mr A that:
- Ms A had a boyfriend (Mr H) whom Mr A had met at the family home
 - Mr A was in frequent (daily) telephone contact with his children, but had last seen them on child A's birthday nearly two weeks previously and
 - Mr A would like to see his children more often: the record does not say if there were obstacles in his path to more frequent contact.
 - There were incidents of violence in the family home between himself and MGM and with Ms A: it is not known if Ms A's allegation that he used to hit the children was discussed.
- 6.10.5 It is possible this visit was undertaken as part of the Core Assessment, although the assessment document (commenced on 01.03.07) does not include a reference to this interview as a source of information and provides little evidence of his involvement.

April 2007

- 6.10.6 Mr A was very clearly involved in his son's life as demonstrated again in April when resident in the hospital and according to NMUH records 'giving all care'. It does not appear though that he was consulted on his views as to the causes of child A's injuries.

June 2007

- 6.10.7 Mr A was not informed of the bruises to child A on 01.06.07 and information was not sought from him as part of the s.47 enquiry or Police investigation. As a father (with parental responsibility) he should have been told of the concerns as a matter of priority. Given his frequent contact with the children it is possible that he might have been able to provide relevant information.

- 6.10.8 Even more critically, during the debate between Police and CYPS whether or not child A should be placed outside the family home, no consideration appears to have been given to the potential for Mr A to provide child A with care. He was not consulted or informed of proposed arrangements.
- 6.10.9 Mr A was however involved immediately after this, as the social worker met him to discuss the content of the conference report on [REDACTED].07. CAE has been advised that at this meeting Mr A was asked his views of the recent injury and he replied he would await the results of the Police investigation.
- 6.10.10 Mr A attended the conference and said that he only got to see the children once a month, due partly to his work commitments and partly because he was no longer allowed to have contact at their home address.
- 6.10.11 Mr A attended the subsequent core group on 20.06.07. Although not in the social worker's notes, the health visitor recorded that the core group decided that father's 'capacity with the children to be assessed'. Unfortunately no progress appears to have been made on this plan.

July 2007

- 6.10.12 Mr A was involved in the core group meeting of 30.07.07.

Subsequent information & Implication of lack of involvement of Mr. A

- 6.10.13 Mr A met with CYPS managers on [REDACTED].08 and the purpose and process of the serious case review were explained. Mr A said at this meeting 'No one knew what was going on in the house, [Ms A] kept everyone out.'
- 6.10.14 The manager did not feel it was appropriate for her to explore his comments, and without his direct contribution to the serious case review process, it is not possible to say what further information might have been available about the home circumstances.

6.11 INVISIBILITY OF MOTHER'S PARTNER

- 6.11.1 Arguably the most significant feature of this case is the ignorance of all the professionals working with the family of the nature of the relationship between Ms A and Mr H. He was, according to information from the Police investigation, living in the family home from February 2007, and from the PMHW's records it appears that he was friendly with Ms A from [REDACTED] 2006.
- 6.11.2 In her communications with the PMHW Ms A mentioned her new male friend who was very supportive ([REDACTED].06), her new supportive male friend ([REDACTED].06) and finding a male friend very helpful ([REDACTED].07).

- 6.11.3 The identity of this new friend is not apparent within the PMHW's records, but there were several references to Mr H by his first name in other records, notably:
- The December 2006 strategy discussion at the hospital made reference to him as a friend who helps Ms A
 - The PMHW mentioned him in her report to conference and again at the conference (and consequently in the conference record)
 - Mr A mentioned to the social worker (at the first and only home visit to him) that Mr H was Ms A's boyfriend, but Ms A denied this
 - In [REDACTED] 2007, Ms A named him as her 'next of kin' and recorded him as a 'friend' when she attended the A & E department at NMUH with [REDACTED]
- 6.11.4 There were attempts to establish the household composition and the possibility of Ms A having a relationship with anyone. The Police investigation of December 2006 did explore these issues with the children but the investigating DC was clear Mr H did not stay at the home, was not in a relationship with Ms A and did not look after the children.
- 6.11.5 On [REDACTED].07 Ms A told the Mellow Parenting co-ordinator that she had no partner at present and when the social worker asked about Mr H on [REDACTED].07 she denied Mr H was her boyfriend, but indicated she would like to go out with him.
- 6.11.6 There is no further record of any professional discussion with Ms A about the possibility she might have a partner, or be involved in a relationship with someone.
- 6.11.7 The only subsequent reference to Mr H is when the FWA worker visited on [REDACTED].07. Mr H was present and described by Ms A as a family friend.
- 6.11.8 Ms A's announcement [REDACTED] in [REDACTED] 2007 was not communicated to CYPS or other health professionals by Mellow Parenting. Had this happened it should have prompted professionals to:
- Question the belief in Ms A's honesty and openness
 - Realise that there may be another adult whose relationship with the children needed to be assessed and
 - Recognise the existence of another adult whom the Police could have investigated as a possible perpetrator of the injuries
- 6.11.9 It has not been possible to determine the veracity of Mr H's assertion of when he moved into the family home and if so, whether Ms A purposefully concealed the facts of the relationship and ensured that the children and Ms J also hid the existence of this relationship. Presumably these circumstances will become clearer following the criminal proceedings.

- 6.11.10 Whilst professionals knew of Mr H's role as a 'supportive' friend of Ms A, the denial of a relationship between them appears to have stopped subsequent exploration of Ms A's personal relationships, the meaning of Mr H being 'supportive' and what this might signify in terms of his (or other's) involvement with the children.

6.12 ASSESSMENT PROCESSES

- 6.12.1 One of the major difficulties for professionals in this case was the uncertainty in the outcome of the various assessment processes and the consequent confusion about the nature of the risks within the family.

PAEDIATRIC ASSESSMENTS / CHILD PROTECTION MEDICALS

- 6.12.2 The outcome of the child protection medical at Whittington Hospital in December 2006 was known to the Police and CYPS. It clearly indicates that child A is likely to have suffered non accidental injury: 'combination of bruising is very suggestive of non accidental injury'.
- 6.12.3 The outcome of the next paediatric examination in April 2007 is less clear (see 6.5). Whilst NMUH provided a child protection summary sheet in recognition that child A was subject to a child protection plan and possibly due to the delay in hospital presentation, the completion of this form indicated to CYPS staff that there was no further need for investigation. The paediatrician presented Ms A's explanations for the injury as a matter of fact and did not provide explanations (or raise questions) about the cause of the additional bruises noted.
- 6.12.4 There are differing perceptions as to the conclusion of the last child protection medical that was completed in June 2007 as described in 6.6.13-18. Police appear to have understood that non accidental injury was indicated whilst CYPS was less sure.
- 6.12.5 In this case the child protection summary sheet provided by NMUH had 'ticked all the boxes' in its attempts to provide a comprehensive response to all the bruises seen. This may explain the different understandings. It does refer to not all bruising being explained as accidental and the need for further investigation. However, the form also refers to the incident likely to be due to an accident / medical condition and that some findings support and others do not support the allegation.
- 6.12.6 The absence of strategy discussions and/or discharge meetings which included paediatricians in April and June 2007, limited the opportunity to clarify the meaning of such medical assessments and to consider the need for any further medical assessments, such as X-rays and scans.

POLICE INVESTIGATIONS

- 6.12.7 Police appropriately initiated investigations in December 2006 and June 2007 when they were informed that child A had presented at hospital with injuries.

- 6.12.8 There was sufficient confidence that the paediatric assessments indicated non accidental injury for the Police to refer the investigations to the CPS. However, the investigative process was unable to establish sufficient evidence for a prosecution and with the benefit of hindsight did not discover the likely identity of the perpetrators of the abuse.

INTEGRATED CHILDREN'S SYSTEM ASSESSMENTS

- 6.12.9 The relevant assessment processes defined in the Integrated Children System (two strategy discussions, two s.47 enquiries, an initial child protection conference and the Core Assessment) were convened or undertaken by CYPS, using the nationally specified recording formats.
- 6.12.10 The December strategy discussion clearly assessed the need for a s.47 enquiry and police investigation. The second meeting in January whilst providing clear outcomes in terms of plans for him, was less clear in terms of a conclusion about the nature of the risks to child A.
- 6.12.11 This confusion was reflected in the discussions about registration categories in the initial child protection conference, with some professionals (including the social worker and police officer) suggesting child A be subject to a child protection plan under the category of neglect only (as opposed to neglect and physical abuse).
- 6.12.12 The conference record provides a statement from the chairperson that 'child A has significant physical injuries with no explanation and it is more luck than judgement that child ■ was not also injured.' This may reflect a perception that the risks were primarily about neglect and was perhaps explicable given the circumstances: a lack of previous concerns; positive observations of Ms A's parenting and co-operation'; inability to identify a perpetrator of the suspected non accidental injuries (other than rough play with other children).

Core Assessment

- 6.12.13 The perception in the preceding paragraph was clearly articulated in the Core Assessment, commenced on 01.03.07. In the section explaining the reasons for undertaking the assessment, the newly allocated social worker wrote:
- 'The view from C&YP Services was that the injuries to [child A] were most likely the result of lack of supervision and it is likely that [child A] could return home if [Ms A] gets rid of her dogs'
- 6.12.14 It is not known if and how this became the view of CYPS, but appears to underpin much subsequent practice. CAE has been informed that the social worker obtained this understanding from the decisions of the January 2007 strategy meeting and that this was a quote from the record of that meeting.

- 6.12.15 It is possible to see that this understanding of the home circumstances is consistent with the lack of any concerns about the [REDACTED] children prior to December 2006 and the assessment of Ms A reached in the Core Assessment i.e.:
- Co-operative helpful woman, who complies with requests
 - Able to provide good basic care for her children
 - A caring loving mother able to interact appropriately with her children, providing spontaneous affection
 - Perceives her children as individuals, in a positive light and provides them with activities to promote stimulation and support their development
- 6.12.16 The Core Assessment recognised that child A appears to be an active child observed to throw his body around and head butt family members and physical objects. Consequently a referral was to be made to the SCHS for investigation (see 6.13 below).
- 6.12.17 The Core Assessment provides the possible explanation provided by Ms A that she was perhaps not fully focused on her children following her separation from Mr A.
- 6.12.18 The predominant focus of the assessment was on Ms A and observations of her relationship with her children. Although the newly allocated social worker had, to her credit, initiated contact with Mr A, he had not been included in the assessment process. His allegation of Ms A's relationship with Mr H was not addressed in the assessment (although previously discussed with Ms A – see 6.11.3) and Ms A's recorded reluctance to allow Mr A into her new home was not discussed with Mr. A as part of this assessment.
- 6.12.19 Because the assessment appears to focus on child A, there was no direct work undertaken with the [REDACTED] siblings which might have provided insights into family dynamics, household composition and important people in the children's life.
- 6.12.20 Ms J was not involved directly in this assessment process, despite her ongoing involvement in the household and her key role in caring for child A in [REDACTED] 2006. MGM was also not involved, even though it was known she had previously played a significant part in the children's lives.
- 6.12.21 The Core Assessment lists involved agencies or professionals as HARTS, Mellow Parenting, the health visitor and the social worker. The contribution of agencies other than CYPS in the assessment process, appears to be in the information provided in the s.47 enquiry and with regard to child A's weight and immunisation status. Best practice would involve a more active multi-agency role in the process, but from CAE experience, the practice in this case represents the typical level of multi-agency involvement to be found in Core Assessments.

- 6.12.22 The Core Assessment did not adequately analyse the information that was collected e.g. the implication for Ms A's parenting of her own experience of abuse in childhood, her relationship with Mr A and the nature of her relationships with extended family and close friends, including Ms J and Mr H. The CYPS IMR refers to the ICS pro forma which can be unhelpful in limiting the opportunity for information to be recorded in an analytical way.
- 6.12.23 Overall the Core Assessment did not provide sufficient understanding of family structure and functioning. This was in part due to its starting point that concerns were only about neglect (as explained in 6.12.13), in part due to its limited focus and in part to insufficient analysis.

LACK OF SUBSEQUENT ASSESSMENTS & EVALUATIONS

- 6.12.24 In April 2007 the need for a strategy discussion was not recognised, due to the trust placed in Ms A's explanations by NMUH and CYPS (consistent with the Core Assessment and its underlying belief that the cause of child A's injuries was lack of supervision, rather than any deliberate harm).
- 6.12.25 In June 2007 it appears that this same understanding of the home situation persisted and underpinned the different perspectives of the medical by CYPS and Police. The lack of medical expertise at the strategy discussion limited the potential to challenge the CYPS view.
- 6.12.26 Although safeguards were implemented at this meeting, low priority was given to monitoring their efficacy, organising the legal planning meeting and chasing up the SCHS appointment. This low priority was perhaps the result of a belief that the nature of concerns was primarily neglect, not deliberate harm by an adult: injuries were perceived to be the result of lack of supervision resulting in accidents and rough play with other children. Within this perception the risks to child A may have been perceived to be relatively minor injuries.
- 6.12.27 In a review of forty five inquiry reports, Eileen Munro (1996 and 1999) described a major problem of professionals being 'slow to revise their judgements despite a mounting body of evidence against them' and the need for judgements to be reviewed and sometimes changed as a case progresses and in the light of new information.
- 6.12.28 In this case, the CYPS conclusion at the end of the first s.47 enquiry (see 6.12.13) combined with the Core Assessment findings of Ms A as a co-operative, caring mother, with an exceptionally active and 'clumsy' toddler formed the basis for interpreting and understanding subsequent events.
- 6.12.29 This is an example of what Reder & Duncan (2000) describe as 'selective interpretations' of the information available to them, 'only registering that which confirmed their preformed view about the case and, in certain instances, these views appeared to become 'pervasive beliefs' that organised all professional responses to the family'.

6.13 SPECIALIST CHILD HEALTH SERVICE (SCHS) APPOINTMENT

- 6.13.1 Child A was reported by his mother and repeatedly observed by professionals to be a very active clumsy child who frequently indulged in head banging and appeared to have many accidents and a high pain threshold. Consequently both the Core Assessment and the child protection plan outlined at the review conference on 16.03.07 included a referral to the Specialist Child Health Service (SCHS) to 'assess his pain threshold and behaviour'. The responsibility for referral was allocated to the health visitor at the conference.
- 6.13.2 This plan for a developmental paediatric assessment of child A became increasingly the predominant strategy to progress the case, fitting into the 'pervasive belief' (see 6.12.29) following the Core Assessment i.e. that child A's injuries were the result of his own behaviour.

DELAYS IN REFERRAL PROCESS

- 6.13.3 Despite the importance of this appointment in resolving the cause of the injuries, it was not initially perceived to be urgent and there was considerable delay in making the referral.
- 6.13.4 There was an initial delay of over three weeks before on [REDACTED].07 the health visitor sent a written referral to the SCHS. This was received on [REDACTED].07 and provided information about child A's head banging / butting, concerns of his mother and the social worker and that he was subject to a child protection plan.
- 6.13.5 The referral was considered at an intake meeting ten days later, on [REDACTED].07, but considered incomplete with insufficient details. A standard letter was sent to the health visitor that day seeking further information, for a developmental issue to be identified and for specific information about e.g. abilities, social skills, and concerns.
- 6.13.6 At the core group of 02.05.07, CYPS records show that the health visitor planned to provide the SCHS with more information. The HtPCT chronology demonstrates that she phoned on [REDACTED].07, left a message and on [REDACTED].07 a telephone message was left for the health visitor from the administrator that the referral of child A did not satisfy 'the criteria'.
- 6.13.7 When the health visitor sought more information on [REDACTED].07, she was told the case had been discussed at the intake meeting and felt to be more appropriate for CAMHS. It would be reconsidered if more information was provided about why child A should be seen. The health visitor liaised with the social worker and PCT records indicate the social worker agreed to 'consider' the referral and get back to the health visitor. By then there had been nearly two months delay since the health visitor was first tasked with obtaining the appointment.

- 6.13.8 Commendably the social worker decided to progress the matter herself and faxed a referral to the SCHS on [REDACTED].07, stating child A was subject to a child protection plan and requesting a paediatric assessment prior to the next child protection conference on 08.06.07, so the outcome could be shared at that forum. The SCHS accepted this more detailed referral and allocated it to the Special Advisory Clinic (SACC) at SCHS.
- 6.13.9 The social worker had provided some details of child A's head butting, lack of response to pain or danger, the known history and that the family had also been referred to CAMHS for other reasons. The social worker specifically stated that the concern was that there may be an organic reason for child A's behaviour and would wish this to be explored.
- 6.13.10 Neither the health visitor nor the social worker provided the SCHS with any of the following information:
- Information about child A's previous hospital presentations of December 2006, April and June 2007
 - Names of siblings who were known to SCHS, due to previous child protection medicals
 - Child protection conference records
 - Details of the child protection plan

PROVISION OF AN APPOINTMENT

- 6.13.11 There was considerable debate within the serious case review sub-committee about the process following the social worker's referral on [REDACTED].07, with conflicting evidence and perspectives provided to CAE.

Relevance of s.47 enquiry on waiting time?

- 6.13.12 Following the strategy discussion on 04.06.07, the team manager (according to CYPS records) chased up the referral on [REDACTED].07 and was told that child A was on the waiting list and may be offered an appointment in either July or August. The team manager stressed the urgency of the referral and that child A was subject to a child protection plan. This telephone call was not recorded within the SCHS records.
- 6.13.13 There is no evidence that CYPS informed the SCHS of the recent bruising, child protection medical, the fact of a s.47 enquiry being initiated and that this paediatric assessment was one of the strategies agreed as part of these enquiries (in addition to being part of the ongoing child protection plan).
- 6.13.14 Discussions as part of this review process have established that:
- Knowledge of the s.47 enquiry within SCHS would have led to child A being seen within 24-48 hours
 - CYPS staff had no knowledge of the possibility that such holistic paediatric assessments (as opposed to emergency child protection medicals) can be undertaken in response to a s.47 enquiry

Child protection plan 08.06.07: moving the appointment forward

- 6.13.15 At the child protection conference on 08.06.07, the delay in the appointment was discussed and the protection plan provided for the social worker and health visitor to follow up the referral and 'consideration to be given to moving the appointment forward'. Unfortunately this did not occur.
- 6.13.16 Given the perceived urgency of this appointment, it would have been helpful if the outline child protection plan action point (of 08.06.07) had been expressed in stronger terms and managers of the social worker and health visitor had chased up the appointment after the child protection conference.

Waiting time for appointment

- 6.13.17 The 'SCHS Operational Policy' refers to the 'current standard that all new patients referred to consultant-led clinics must be seen within 11 weeks of the referral being received'.
- 6.13.18 The letter provided by the 'consultant in community health' (see 2.5.7) at GOSH points out that with reference to the appointment on 01.08.07:
- 'this was not seen as an urgent child protection medical and he was seen about 8 weeks later. Unfortunately, due to recent staffing problems at the SCHS this is far from being an exceptionally long wait and, in the circumstances, I think the correct priority was attached to this referral'
- 6.13.19 In the course of this serious case review, the consultant paediatrician / designated doctor for child protection Haringey PCT & GOSH discovered within the appointment diary that:
- An appointment was offered to Ms A for [REDACTED].07 but she declined it
 - A further appointment was recorded for [REDACTED].07 and it is unclear what happened to this
- 6.13.20 Since this above information was provided to CAE [on 07.03.08], the following further comments / information have been provided. They illustrate agencies' confusion about the process of accepting the referral within SCHS and the provision of an appointment:
- In written comments to CAE on [REDACTED].08 Health state that 'there wasn't delay in provision of appointment; he only waited a couple of weeks...'
 - GOSH's addendum to the HtPCT IMR supplied on [REDACTED].08 refers to the referral by the social worker being received on [REDACTED].07 [as opposed to the correct date of [REDACTED].07], apparently accepted 'as a re-referral' on [REDACTED].07 and reportedly also accepted 'for a re-referral' on 04.06.07
 - GOSH's addendum to the HtPCT IMR refers to an 'Appointment arranged for 1st August 2007' on [REDACTED].07 [this appears inconsistent with the appointments initially offered, as described in 6.13.19, although it is understood that the external medical reviewers would not have had access to the information from the appointments diary]

- 6.13.21 On the basis of the above conflicting information it is not possible to be precise as to the waiting time for the offer of an appointment. From the point the referral was received on [REDACTED].07, there was a waiting time of six and a half weeks prior to [REDACTED].07 (the earliest date suggested in 6.13.19 above) or ten weeks (according to the dates provided in the GOSH addendum to the HtPCT IMR).
- 6.13.22 Both these waiting times satisfy the standards defined by the Operational Policy (see 6.13.17 above). However, the Operational Policy 'waiting list management' section does *not* indicate criteria based on the child's needs that would provide a rationale for prioritising referrals.
- 6.13.23 In fact, this was a long wait in the circumstances of child A i.e. a very young child subject to a child protection plan, suffering injuries for which an assessment was needed to inform ongoing enquiries, and who had been waiting (if the health visitor's inadequate referral was taken into account) since [REDACTED].07. However, the limited information provided to SCHS referred to bruising, rather than injuries: this led to a lower perception of the urgency of the appointment.
- 6.13.24 Despite an attempt to expedite the appointment by the CYPS manager and a child protection plan specifying the social worker and health visitor following up the appointment and considering 'moving it forward', an early appointment was not provided. Contributory reasons were the *lack* of:
- Follow up by CYPS and by the health visitor
 - A SCHS record of and response to the team manager's phone call on [REDACTED].07
 - Communication by CYPS to SCHS of the fact of child A's previous hospital presentations
 - Communication by CYPS to SCHS of the fact of the June s.47 enquiry and that this assessment was part of the strategy agreed with the Police to investigate the injury
 - Criteria for prioritising referrals of children subject to child protection plans within SCHS Operational Policy
- 6.13.25 Had the appointment taken place earlier it might have provided explanations for child A's perceived behaviour, or ruled out organic explanations. The outcome might have included a recognition of a need to focus intervention on the role of parenting and home circumstances in child A's behaviour and contributed to a shift in the assessment of the causes for concern.

LIAISON BETWEEN SCHS, REFERRERS & OTHER HEALTH SERVICES PRIOR TO APPOINTMENT

- 6.13.26 Paras. 6.13.9 and 6.13.10 detail the information available to SCHS from the referrals of the health visitor and social worker. It is not entirely clear what communication occurred between the SCHS and the health visitor and CYPS following the acceptance of the referral on [REDACTED].07.

- 6.13.27 Agency records for the [REDACTED].07 core group show further discrepancies. The health visitor refers to the appointment on [REDACTED].07 but the social work notes (not provided to the health visitor) refers to child A 'to attend the appointment once a date has been received'. It is not known if the source of the health visitor's knowledge was SCHS or Ms A.
- 6.13.28 Neither the health visitor nor the social worker appear to have had any communication about the appointment on [REDACTED].07 but, according to SCHS records both were informed of the appointment on 01.08.07. CYPS has confirmed that it did receive this notification.
- 6.13.29 Given the appointment was known to be part of a child protection plan and for CYPS and the Police, formed part of the strategy of a s.47 enquiry:
- CYPS and the health visitor should have liaised with SCHS to expedite the appointment (see 6.13.12)
 - CYPS should have liaised with SCHS to ensure that the assessment was undertaken with full knowledge of circumstances, including all new bruising since the referral, the s.47 enquiry and the safeguarding arrangements temporarily in place
- 6.13.30 As the SCHS was aware that child A was subject to a child protection plan, it should have liaised with referrers prior to the appointment to:
- Communicate *all* offers of appointment to Ms.A (including those termed as 'choose and book')
 - Ensure referrers were aware of Ms A declining appointments offered
- 6.13.31 The SCHS did not have copies of the previous child protection medical reports on child A undertaken at Whittington Hospital and NMUH. This highlights the need for the SCHS to be able to identify such contacts and access the records.

CONDUCT OF SPECIALIST CHILD HEALTH SERVICE APPOINTMENT

- 6.13.32 On 01.08.07 Ms A and Ms J brought child A for his appointment at the SCHS. It is understood Ms J introduced herself as child A's foster carer which contributed to the paediatrician's trust in the care provided.
- 6.13.33 The examining doctor was aware that child A was subject to a child protection plan, but did not have the previous child protection medical reports from the Whittington Hospital or NMUH. It is not known if s/he was aware of the previous hospital presentations and the diagnosis of abuse; these were not mentioned in the social worker's referral letter.
- 6.13.34 The examination was not completed as the paediatrician judged that child A was unwell and miserable, with a runny nose due to a possible viral infection. His scalp infection was described as partly healing and his weight was on the 9th centile. Numerous bruises were noted though not drawn on a body map.

- 6.13.35 The doctor completed detailed contemporaneous notes of the examination and child A's history of recurrent bruising and infections, his history of abnormal behaviours (aggression, head banging and butting and hyperactivity).
- 6.13.36 The doctor decided to offer a follow up appointment in three weeks to complete the paediatric assessment and that Ms A should take child A to the GP or hospital A & E should he continue to be miserable the next day. Ms A confirmed that she had an appointment with the GP the next day.
- 6.13.37 The doctor arranged for blood tests to be undertaken [REDACTED]
[REDACTED] referred child A to the metabolic team at GOSH, to the paediatric dietician and speech and language therapist.
- 6.13.38 Ms A was pleased with this help and immediately phoned the social worker. They agreed that as she had seen the paediatrician there was no need to go to the GP. It would have been prudent for the social worker to have first checked the paediatrician's view.
- 6.13.39 The GOSH addendum to the HtPCT IMR refers to the desirability of a social worker accompanying the child for a paediatric assessment. Whilst this may be ideal, the critical issue is less the physical presence of the social worker at the actual examination, than *direct* communication between the social worker and paediatrician.
- 6.13.40 In this case there was no such contact prior to, during or following the appointment. The social worker remained unaware of the extent of the bruising to child A and the paediatrician remained unaware of the nature of the child protection concerns, including the previous hospital presentations and the s.47 enquiries and the fact that Ms J was not a foster carer.

Report to CYPS

- 6.13.41 In November 2007, CYPS received a written report of this appointment including further details of bruises, not provided by the HtPCT chronology:
- In front of child A's left ear on the bony part
 - Between his shoulder blades extending slightly to the nape of his neck
 - Possibly 10-15 'faint bluish except two which were slightly red'
- 6.13.42 The explanation for the bruises provided by Ms A and Ms J (described as the foster carer) was that child A tended to bang his back against his cot.
- 6.13.43 CYPS provided a supplementary entry for its IMR chronology to cover this new communication and commented that given child A was subject to a child protection plan, CYPS would have expected to be contacted on the same day about the bruising, a strategy discussion held and consideration given to the need for a child protection medical to establish the cause of the bruises.

Expert commentary on the appointment

- 6.13.44 The letter provided by the consultant in community health (see 2.5.7) at GOSH points out that this appointment was arranged because child A reportedly exhibited behaviour that caused him harm and had been witnessed by people other than his mother. Thinking that Ms J was a foster carer, the doctor understood she was a further independent witness to child A's self injurious behaviour and that the function of the appointment was to investigate his behaviour, rather than the bruises.
- 6.13.45 The consultant comments 'In retrospect this was probably incorrect, but was not unreasonable in the light of what she knew at the time.....I consider this to have been a reasonable course of action'. S/he also considers that in the light of these circumstances, an 'urgent referral to CYPS was not indicated.'
- 6.13.46 The [REDACTED].08 addendum to the GOSH HtPCT report is based on the independent medical review of the child protection practice of the paediatrician who saw child A on 01.08.07 appointment. The findings of this review provide a clear opinion that a diagnosis of physical abuse should have been made and intervention initiated to safeguard child A.
- 6.13.47 This addendum points out that 'there were clear indicators that this child had been abused and probably also neglected and emotionally abused. The facial bruising and bruising on the back were both typical of bruising due to physical abuse. The pattern was unlike a coagulation disorder. It was also implausible that child A could have caused the bruising on the back by hitting itself in throwing the head back in temper. The facial bruising is especially typical of abuse'.
- 6.13.48 The independent medical reviewers believed that 'such a combination of injuries should have raised the likelihood of physical abuse in any child. However, in a child on the child protection register, this is especially likely. This diagnosis should have been made by a trained paediatrician; indeed it would be one that should have been made by any doctor who sees children amongst his or her patients'.
- 6.13.49 Furthermore, the GOSH addendum states that 'There was more of concern than just the failure to diagnose physical abuse with this case. A child should not have a large fungal lesion for over two months (or indeed any lesion). This should have raised the possibility of neglect in the context of this bruised child on the CPR. This lesion would have needed more than just local treatment but also systemic treatment'.
- 6.13.50 It is pointed out that it was probable 'that these symptoms of behaviour disturbance were in fact due to emotional abuse and not a metabolic disorder or other developmental cause'.

6.13.51 Most critically, the addendum report states that 'Taking as a whole we believe that Child A should have been urgently investigated and taken into a Place of Safety which should have been a hospital paediatric ward where:

- Coagulation studies should have been done
- A skeletal survey and bone scan should have been performed
- The scalp lesion could be treated
- The behaviour assessed
- A CT scan could be considered'

6.13.52 The independent medical reviewers also considered the setting where the child was seen and the isolation of the paediatrician, having no contact with the social worker or health visitor, no nurse to discuss the case with and without evidence in the notes of previous admissions to hospitals.

6.14 USE OF FAMILY FRIEND AS A CARER FOR CHILD A

6.14.1 The use of Ms J as a short term carer for child A demonstrated a clear commitment to working in partnership with Ms A to safeguard child A whilst maintaining his position in the family. It enabled frequent contact and as a short term strategy during the s.47 enquiry presented a good option.

6.14.2 The weakness of this arrangement stems from the decision to use Ms J rather than Mr A without sufficient discussion with child A's father (see 6.3.22-24) and adequate assessment of both options.

6.14.3 Information provided within the CYPS IMR and chronology show checks of Ms J were undertaken with the Police, but the plan to obtain references from Ms J's employer was not realised.

6.14.4 CAE was informed during the review process that the team manager confirmed a home visit was undertaken, the home felt to be 'clean and appropriate' and Ms J had appropriate equipment for caring for a baby. A further document provided by CYPS to the SCR sub-committee on 15.05.08 gave additional clarification that Ms J had a cot and baby equipment; had previously cared for child A [REDACTED].

6.14.5 Ms J's claims that her mother was an approved foster carer for 'LBH' and able to care for child A during the day were not checked at the time; when CYPS did this in August 2007 no records were found for Ms J's mother. Though not a foster carer, the CYPS document of 15.05.08 confirmed that Ms J's mother and family had involvement with a young person previously looked after by Haringey, who refers to Ms J as a foster sister.

6.14.6 There appears to be no explicit assessment of the relationship between Ms A and Ms J and Ms J's ability to be able to prioritise child A's needs over and above those of her friend Ms A.

- 6.14.7 Legally it was Ms A's choice, in [REDACTED] 2006 / [REDACTED] 2007, for her son to stay with Ms J [REDACTED]. CYPs and Ms A decided that child A should stay with Ms J, rather than with Mr A or foster carers. CYPs formulated a written agreement and decided when child A could return home in January 2007, following some [REDACTED] weeks with Ms J. No formal status was ascribed to the arrangement (which was considered to be 'family support'), although it became by default, a private fostering arrangement.
- 6.14.8 The [REDACTED] 2007 arrangement was initially agreed for two weeks and was then to be reviewed. There is no specific evidence of such a review, but the IMR chronology has been amended to show that financial support ceased after a fortnight and CAE has been advised that the arrangement was varied so that Ms J's presence was during evenings and bedtimes. This remained the arrangement until child A's death.
- 6.14.9 Ms J was entrusted with considerable responsibility, expected to supervise contact with Ms A and report any concerns. She was entrusted with this responsibility apparently without assessment of her ability to undertake this task and without any subsequent monitoring or evaluation. It is not known if CYPs staff were influenced unduly by Ms J's professional background and role in the community, and if such trust would have been given to others without further assessment and monitoring.
- 6.14.10 A worrying aspect of this arrangement was the false confidence that may have been engendered in professionals in all agencies, in terms of relying on Ms J to provide independent and reliable accounts of child A's behaviours and to have the skills to be able to safeguard his welfare.
- 6.14.11 There is evidence within the IMRs of some confusion about Ms J's role in some health settings:
- Whittington Hospital on [REDACTED].06 referred to Ms J as a foster carer
 - HtPCT chronology for [REDACTED].07 records 'child A discharged, voluntarily accommodated'
 - The letter provided by the consultant of community health at GOSH (see 2.5.7) refers to the belief of the examining doctor on 01.08.07 that Ms J was a foster carer and consequently in her independence
 - The HtPCT addendum of [REDACTED].08 provides information from the notes of NMUH and SCHS including that child A was 'placed in foster care' ([REDACTED].06), returned to mother from foster carer ([REDACTED].07)
- 6.14.12 The CYPs document written on 15.05.08 points out that the agencies that attended strategy discussions and child protection conferences should have been clear from these meetings that Ms J was a family friend and not a foster carer. Whilst the professionals attending these meetings may have been clear about Ms J's role, evidently there was some confusion within some records and with some staff.

6.15 SAFEGUARDING SYSTEMS AND PROCESSES

- 6.15.1 Information provided for this SCR demonstrates that there are multi-agency child protection structures and processes operating within Haringey, with:
- Consistent referrals to CYPS made by GP and hospital staff concerning injuries to child A
 - Use of initial and second strategy discussion on the s.47 enquiry in December 2006 (though only an initial strategy discussion in June 2007)
 - The December 2006 initial strategy discussion being held at the hospital and involving a paediatrician
 - NMUH demonstrating awareness of the use of pre-discharge meetings
 - Appropriate and timely initial child protection conference and subsequent conferences
 - Reasonable decision making in conferences (although it is arguable that all the children within the family should have been made subjects of a child protection plan)
 - Reasonable child protection planning at conferences and identifying the individual responsible for actions (but with insufficient contingency planning at the review conferences)
 - Core groups held regularly (10.01.07; 27.02.07; 29.03.07; 02.05.07; 20.06.07 and 30.07.07) and attended consistently by the allocated health visitors and social workers
- 6.15.2 Within CYPS, there was evidence of legal advice obtained in December 2006 and a planning meeting held (after some delay) in July 2007.
- 6.15.3 The lessons to be learned in this case are less about the systems that exist, and more about aspects of their implementation e.g. the need for re-assessments in line with new information, CYPS's *consistent* information sharing with Police of concerns, clarity in inter-agency communication of child protection referrals and most critically, the arrangements for and conduct of the paediatric assessment at the SCHS.
- 6.15.4 There is scope for further improving multi-agency systems and processes by ensuring that front line staff observe good practice through *consistently*:
- Including all relevant professionals at strategy discussions and holding them at the hospital (if required) to facilitate hospital staff attending – the record should show who was invited, even if this involves an amendment to ICS exemplars
 - Consistently holding second and if required further strategy discussions to monitor progress of enquiries and investigations and ensure agreed outcomes
 - Ensuring records of multi-agency meetings are accurate and circulated
 - Reviewing the progress of plans consistently at conferences,
 - Identifying expected outcomes and contingency plans as part of the child protection plan

6.16 MULTI-AGENCY COMMUNICATION

- 6.16.1 There was ample evidence of good and frequent communication between professionals, but also specific instances where communication was poor, non-existent or misunderstood.
- 6.16.2 Some of the weaknesses in multi-agency communication originated in the trust in Ms A (see 6.20) and her very good communication skills. A pattern emerged of professionals accepting her provision of information as reliable and not verifying it with other professionals. Generally, the information she provided on injuries, illnesses, health appointments and medications provided was consistent with what was understood by professionals.
- 6.16.3 In terms of the tragic outcome of this case, the most significant example of poor or non-existent communication concerned child A's appointment at the SCHS (see 6.13 and 6.16.5 – 6.16.8).
- 6.16.4 Also notable are the omissions in CYPS information sharing with the Police (see 6.16.9 below) and the NMUH referral in April 2007, (see 6.5).

SCHS appointment

- 6.16.5 The appointment at SCHS was perceived to be pivotal in the assessment of the causation of child A's injuries, both for the child protection plan and the s.47 enquiry strategy discussion of 04.06.08. In spite of its importance, it was associated with major communication weaknesses.
- 6.16.6 *Prior* to the appointment there was a:
- Possible lack of communication by SCHS of two appointments declined by Ms A (see 6.13.19-20)
 - Lack of direct liaison between CYPS and the paediatrician
- 6.16.7 Whilst SCHS was informed by CYPS that child A was subject to a child protection plan and of concerns about his behaviour, the facts of the previous hospital presentations and diagnosis of non accidental injury were not provided. SCHS did not have access to child A's records held within Health Trusts i.e. copies of child protection conference records and medical assessments undertaken at the Whittington and NMUH.
- 6.16.8 Though it is understood that the paediatrician did not recognise child protection concerns on 01.08.07, it is of critical importance that s/he did not immediately communicate her/his observations of bruises to CYPS, despite knowing child A was subject to a child protection plan.

CYPS information sharing with Police

6.16.9 The social worker shared with the Police incidents which were recognised as reaching the s.47 threshold. However there were several other incidents of concern that either were not shared with the Police at all, or not shared in a timely manner:

- Ms J's comment on [REDACTED].06 that child A had bruises to his testicles (this was also not discussed with the paediatrician to establish the truth of Ms J's comment that the marks were caused by hospital staff)
- Ms A's allegations of domestic abuse
- The observation by a professional that Ms A had slapped child [REDACTED] in March 2007 (despite the ongoing criminal investigation this was not initially communicated to the Police)
- Injuries to child A on 09.04.07 and that Ms A delayed seeking medical advice
- The fact that the childminder had reported a brown bruise under child A's chin – nor was this checked with the paediatrician (Ms A confirmed it was same mark as seen at hospital on 01.06.07)
- The health visitor's report to the social worker on [REDACTED].07 that child [REDACTED] had a bruise under the eye (Ms A explained that [REDACTED] had fallen out of bed and hit a toy box)

6.16.10 During this period the children concerned were subject of a child protection plan (or had a sibling who was) and there was an ongoing criminal investigation. In these circumstances good practice would have involved sharing information with the Police and together (with the paediatrician) considering the need for further action, strategy discussions, enquiries and /or investigations (see also 6.19 Procedural Compliance).

NMUH referral to CYPS in April 2007

6.16.11 NMUH and CYPS liaised about child A's hospital presentation and admission in April 2007. However, as described in 6.5 each agency had a differing understanding of the meaning of such communication and the written referral was confusing.

6.16.12 The debate within the serious case review sub-committee about this referral highlighted differing understandings of agencies about the information required in such a referral.

Other communication issues

6.16.13 Whilst not critical in this case, the following issues (some of which were highlighted in the IMRs provided) indicate areas for practice improvements.

- 6.16.14 On occasions, CYPS did not inform all involved professionals / agencies of incidents / injuries or when the allocated social worker changed e.g. the:
- School did not know of the change in social worker, even though it was part of the core group
 - Health visitor and the FWA worker learned of the June injury from Ms A
 - Mellow Parenting Group organisers were not informed of the June enquiry, although there was evidence of an attempted contact
- 6.16.15 At the final session of the Mellow Parenting Programme on [REDACTED].07, Ms A disclosed [REDACTED]. The information was not shared with the social worker or any other health professional, despite its relevance in families with child/ren subject to child protection plans. If it had been communicated within the professional network, it might have led to a recognition Ms A had clearly been less than open about her circumstances and provided Police with another possible perpetrator of the injuries to child A.
- 6.16.16 The current Mellow Parenting information leaflet provided for parents guarantees confidentiality, and is clearly in need of reviewing.
- 6.16.17 The HtPCT IMR refers to the fact that the social worker requested information from the GP, but it is unclear from the computerised patient summary sheet if there was any response.
- 6.16.18 Following the initiation of the June s.47 enquiry, the health visitor did not communicate a bruise on child [REDACTED]'s right cheek to the social worker on that day, accepting the explanation provided by the 'friend' (presumably Ms J) that [REDACTED] had fallen. The information was provided in the health visitor's report for conference on 08.06.07.
- 6.16.19 The first school did not transfer the child protection files to the second school, although the head teacher recalls contacting the second school a week after transfer and providing information to the acting deputy head teacher. The communication is confirmed by the second school, but they did not record it and do not recollect any information about child protection registration status being supplied.

6.17 FAMILY WELFARE ASSOCIATION ROLE

- 6.17.1 HARTS are commissioned by LBH to provide a borough wide tenancy support service and FWA provide family support services to families as part of this service. The family were referred by the GP on [REDACTED].06: HARTS assessed the family and transferred the case to FWA on [REDACTED].06.
- 6.17.2 The FWA role within the child protection plan was to provide practical family support and advice to support the assessment, monitoring and safeguarding work being led by the statutory agencies.

- 6.17.3 The FWA IMR refers to the broadness of some of these tasks and the need for more detail to be provided to enable the service to review its work and to help the family understand the role. This should have occurred through the work of the core group.
- 6.17.4 After seeing the FWA worker twice, as shown in 6.10, table 3, Ms A appears to have subsequently avoided several appointments and over the next six months, only saw the FWA workers on four occasions, one of which was a chance meeting in the street. FWA do not feel that Ms A specifically avoided contact, but that perhaps there was less need of their service as the practical tasks had been largely addressed.
- 6.17.5 The FWA workers (especially the second worker) appear to have been somewhat marginalised within the professional network, although part of the core group. This may be associated (according to CYPS core group records) with the FWA only attending the January and February core group meetings and the December 2006 initial child protection conference.
- 6.17.6 There was no FWA representation or apologies provided at subsequent conferences, according to the conference record. The March core group was missed apparently due to confusion over venues. The FWA worker recalled that she had attended the May meeting, but was late. This may be the case, but her presence was not in CYPS or the school's record of the meeting. The FWA IMR refers to her being unaware of another core group meeting and the FWA have commented that the worker attended all meetings s/he was invited to attend.
- 6.17.7 The FWA IMR refers to the lack of contact by CYPS and other service providers outside review meetings. The FWA worker appears to have operated in isolation: she was apparently not sent records of meetings held and did not request them; she was not asked about the progress in her work with Ms A and did not inform the social worker of the cancelled visits.
- 6.17.8 Most critically, the social worker did not inform her of child A's injuries and did not respond to the FWA worker's telephone calls for clarification. The FWA worker became aware of the injuries via Ms A herself (in a telephone conversation on [REDACTED].07) and subsequently tried to speak with the social worker on [REDACTED].07 and on [REDACTED].07 but received no response to her messages.
- 6.17.9 When she visited the home on 15.06.07, the FWA worker met Mr H, who was described as a family friend and was told that Ms J witnessed child A fall and bump his head. Unfortunately this information was not communicated to the social worker or to the police. Ms J was not interviewed as a witness and there was no knowledge of Mr H's presence at the family home.

6.18 MENTAL HEALTH WORKER'S ROLE

- 6.18.1 The Primary Mental Health Worker (PMHW) saw Ms A for what is referred to as 'low intensity psychological therapies'. This was provided in regular sessions over an extensive period, dating from [REDACTED].05 (when Ms A was pregnant with child A) to [REDACTED].07.
- 6.18.2 The referrer, the reasons for referral and the objectives of this service provision are not clear, but *prior* to the first injury to child A in December 2006, the PMHW was the only professional with consistent contact with Ms A, seeing her on:
- Ten occasions during her pregnancy with child A
 - Ten occasions between child A's birth and end of November 2006
 - Four times after his first known injury in period January - March 2007
- 6.18.3 Ms A appears to have shared with the PMHW her history of post natal depression [REDACTED], her dissatisfaction with her marriage, her allegations of domestic abuse and her own abuse of alcohol when pregnant.
- 6.18.4 She also spoke of her feelings of being 'used' when a male friend was seeing another woman and began making references to a new male friend from [REDACTED].06. There is no evidence in the records that she ever disclosed the nature of their 'friendship', but the initial child protection conference record shows that the PMHW shared with conference members that Ms A has the support of MGM and her friend Mr H.
- 6.18.5 The PMHW is to be commended for the full records she maintained of her sessions with Ms A. She recognised the need to check with her client the impact her depression was having on her care of her children but accepted Ms A's re-assurances that with the help of MGM she was able to cope.
- 6.18.6 During Ms A's pregnancy there was no evidence that there was any contact between the PMHW and the midwifery service and no evidence of seeking consultation / supervision regarding the potential child welfare concerns i.e. Ms. A's having [REDACTED] young children and [REDACTED], mentioning previous post natal depression and domestic abuse, and current alcohol misuse.
- 6.18.7 Following the birth of child A, the PMHW did not initiate contact with the health visitor, but *once approached* shared information with the health visitor and subsequently initiated contact with the social worker and shared information with the child protection conferences and the social worker.
- 6.18.8 Ms A continued seeing the PMHW until [REDACTED] 2007, before missing her last two appointments and declining alternative support offers.

6.19 PROCEDURAL COMPLIANCE

- 6.19.1 The following comments refer to compliance with London Child Protection Procedures (edition 2), which were current in the period under review, though have since been replaced by edition 3.
- 6.19.2 Generally, referrals were made by health professionals to CYPS in accordance with the London procedures, but no referral was made to CYPS at or following the 01.08.07 appointment at the SCHS, because abuse was not recognised. This is discussed in detail in 6.13.
- 6.19.3 Police and most CYPS responses were in accordance with procedures.
- 6.19.4 One area of concern was the deficiency in information sharing with Police (see 6.16.9), in particular the failure to communicate that Ms A hit child ■ on the face on 05.03.07. Presumably, CYPS decided the circumstances did not meet the threshold criteria for a s.47 enquiry. However, 6.3.13 of the London procedures indicates 'A police referral must be made whenever an allegation is made that may also constitute an allegation of crime, irrespective of the decision made by SSD [sic] about s.47 enquiries thresholds.' This event clearly involved an allegation that a crime had been committed.
- 6.19.5 The other bullet points in 6.16.9 refer to circumstances that are less clear with regard to the allegation of a crime or whether threshold criteria for a s.47 enquiry were met. Section 6.3. of the London procedures refers to the variables a manager should take into account in this decision including repetition or duration of concerns; vulnerability of child through age; if a child in the household is already subject of a child protection plan. In the circumstances, it is clear a s.47 enquiry should have been considered in all these instances, and *at a minimum* concerns discussed with the Police.
- 6.19.6 A second area of concern relate to some inadequate arrangements for strategy discussions.
- 6.19.7 Section 6.5.3 details the procedural requirement of a strategy discussion prior to hospital discharge when abuse is alleged, confirmed or suspected in children admitted to hospital (London procedures 4.4.28). This requirement was not satisfied in April 2007, because CYPS concluded there was no abuse suspected. Such a conclusion should not have been determined without a strategy discussion with Police.
- 6.19.8 The fact of an ongoing criminal investigation, whilst not specifically stated within London procedures, is also relevant to the need to share information and should be included in future procedures.
- 6.19.9 Furthermore in June 2007 a strategy discussion was undertaken without paediatric involvement (see 6.6.8). The London procedures indicate at 6.6.9 that 'Where issues have significant medical implications, or a paediatric examination has taken place or may be necessary, a paediatrician should always be included'.

6.20 COMPLIANCE OF MOTHER

Perception of a high level of compliance

- 6.20.1 One of the major factors influencing all professionals and agencies in contact with the family was Ms A's apparently positive response to help. She largely co-operated with the child protection plans, keeping appointments, having a high level of contact with professionals, communicating regularly and informing professionals of new health appointments and any new hospital attendances.
- 6.20.2 She was observed universally to have a positive relationship with each of her children and discussed concerns openly, seeking help to understand child A's behaviour which involved head butting and a reportedly high pain threshold.
- 6.20.3 Ms A was perceived to be a caring parent experiencing difficulty looking after her children following the break up of her marriage, wanting the best for them and herself seeking understanding of how to help them and prevent child A's injuries.
- 6.20.4 Given the failure to discover any alternative causes for the bruising, Ms A's apparently plausible explanations of child A injuring himself and being injured through rough play with other children became accepted. The support of witnesses to some incidents and Ms A's acceptance of responsibility as the carer for child A confirmed this view. The focus of intervention became obtaining a paediatric assessment to explain why child A injured himself.

Limited evidence of non-compliance

- 6.20.5 Within her 'low intensity psychological therapies' with the PMHW, Ms A was able to express her anger and irritation with the high level of contact she felt forced to have with professionals. This feeling was not apparent in her responses to the social worker or health professionals and may or may not have been a contributory factor to her partial avoidance of the FWA worker. Unfortunately this possible area of non compliance was unknown to the social worker.
- 6.20.6 Further evidence of non compliance was Ms A's attitude towards relinquishing her dogs. Having apparently agreed at first to do so, the dogs were subsequently discovered to be at the home again. It is unclear if this was ever resolved satisfactorily. Ms A stated she did not let the dogs into the main part of the house whilst the children were downstairs. Again, the trust in Ms A meant there was no subsequent evaluation of the reality of such an arrangement and the risk assessment was not progressed because the RSPCA felt (as not trained in this form of assessment) unable to assist.

- 6.20.7 During the last five weeks of child A's life, Ms A's whereabouts were briefly unknown, before she reported she was in [REDACTED]. It was unusual for her not to have let the social worker know of her plans, and it is unclear if, when she did make contact, she ever supplied the actual address. Also at this time Ms A spoke of being too busy to take child A to the GP about his sore scalp - itself of concern.
- 6.20.8 The trust in Ms A, based on her previous behaviour, was such that there appears to have been no visit undertaken to her in [REDACTED] (a relatively short journey), no notification of the family's presence to local agencies in the area and no attempts to assess the suitability of the arrangements for children both subjects of child protection plans. This was despite the fact that the arrangements made at the strategy discussion of 04.06.07 had not been explicitly reviewed, were still [partially] in place and no second strategy meeting held to agree outcomes to the enquiry.
- 6.20.9 On the family's return to Haringey some days later Ms A sought medical help for child A on several occasions and appeared to be concerned at his deteriorating health and there were no further indicators of non-compliance *known* by the social worker.
- 6.20.10 It is understood that Ms A rejected one (or possibly two) offers of appointments at the SCHS (see 6.13.19). If they were declined without good reason it may indicate non compliance. However, the circumstances of these entries and cancellations in the SCHS diary are unclear and the social worker was not informed of such offers of appointment.

Disguised compliance?

- 6.20.11 There has been discussion within the serious case review sub-committee meetings about whether Ms A's compliance was genuine or was, as variously described, 'apparent' or 'false' compliance.
- 6.20.12 With the advantage of hindsight, the lack of knowledge of Mr H's presence in the family home might be seen to suggest that Ms A's co-operation was superficial and that she consciously hid information from professionals.
- 6.20.13 Information provided within IMRs (and subsequently) does *not* support such a simplistic analysis. There is no record of any attempt to update basic information on household composition by any agency or to re-assess the family following the March 2007 Core Assessment. Ms A actually provided Mr H as her 'next of kin' at a hospital attendance for herself in [REDACTED] 2007. Thus, although it is possible that Ms A hid her relationship with Mr H, it may also be that she was not asked the pertinent questions.
- 6.20.14 The London Child Protection Procedures (edition 3) section 10 provides guidance about working with 'unco-operative' families and refers to those whose compliance is apparent rather than genuine, providing assistance in the recognition of four types of 'unco-operativeness': ambivalence, avoidance, confrontation and violence.

- 6.20.15 This guidance would not have been relevant to professionals working with this family as Ms A's behaviour was not consistent with any of these descriptions of unco-operativeness.
- 6.20.16 Brandon et al (2008) in a biennial study of serious case reviews (2003-2005) identified 'disguised or partial compliance' as an example of lack of co-operation, which 'wrong-footed professionals' and might:
- Prevent or delay understanding the severity of harm to the child, with professionals tolerating the lack of progress in the protection plan over the years and/or
 - Disguise the 'way in which a parent engineers the focus away from allegations of harm to focus on the child as the problem'
- 6.20.17 Brandon et al refer to lack of progress in a protection plan over the years. This was not a feature of this case. Much of the child protection plan had been implemented (according to child protection conference records). Any lack of progress was a function of months not years. Moreover, such lack of progress was largely due to difficulties in service provision, rather than the result of insufficient co-operation by Ms A e.g. paediatric developmental assessment, risk assessment of the dogs, timing of legal planning meeting and review of safeguards implemented in June 2007.
- 6.20.18 Though Ms A's compliance did deflect the professional focus from abuse to child A's behaviour, professionals' observations, unlike the case example cited in Brandon et al, were consistent with Ms A's descriptions of her son.
- 6.20.19 Reder & Duncan (1995 and 2000) describe the process of 'covert warnings' and 'disguised compliance' i.e. when parents defuse professionals' attempts to take a more authoritative stance through pre-emptive acts of apparent co-operation. Such temporary compliance was sufficient to persuade workers of their willingness to be more open.
- 6.20.20 Reder & Duncan state (1995):
- 'Clearly, a vast number of parents present to physicians with psychosomatic complaints.....it is only in retrospect that we are able to claim that such parental behaviour was a covert warning of impending fatal abuse. However, it does point to the need for increased vigilance and suspiciousness by professionals....in the context of child abusing behaviour by the parents, professionals should be aware that requests for care, displaced health inquiries about the child, or psychosomatic complaints may signal escalating abuse and require wider assessment'
- 6.20.21 Ms A's presentations of child A at various health settings may be consistent with this process, but involved real physical health problems, not psychosomatic complaints. That said, the lack of improvement over time, despite diagnosis and treatment at various health settings should have indicated risk in a child subject to a child protection plan.

- 6.20.22 The most relevant indicators that Ms A's compliance may have been disguised were as described in 6.20.5-10 above. In the face of predominant compliance by Ms A, the challenge for professionals was to consider the significance of her non co-operation i.e. her insistence on keeping her dogs (see 5.9.3) and her trip to [REDACTED]. Even if parents are trusted, an open and inquisitive attitude by professionals needs to be maintained at all times.
- 6.20.23 It appears that many of the features of disguised compliance described above did not exist in this case (recognisable ambivalence, avoidance, confrontation or violence) or did not present in the ways described by Brandon et al and by Reder & Duncan.
- 6.20.24 The extent to which the concept of 'disguised' or 'apparent' compliance is relevant to Ms A's behaviour therefore remains unproven, though the criminal proceedings may shed more light on the relevance of it.

6.21 SIGNIFICANCE OF EVENTS IN THE LAST WEEKS OF CHILD A'S LIFE

- 6.21.1 CYPS records provide some indication that Ms A's level of compliance declined at [REDACTED] 2007, with the family's disappearance to [REDACTED] and delay in seeking medical treatment for child A's sore head.
- 6.21.2 On her return to Haringey, the CYPS, NMUH and HtPCT records show she repeatedly sought medical treatment for child A during the last three weeks and presented her son at the SCHS on 01.08.07.
- 6.21.3 It is significant that during this period he was seen by a number of professionals, none of whom noted major concerns about his health and development i.e. the:
- Family Welfare Association worker on [REDACTED].07 and [REDACTED].07
 - Health visitor on 18.07.07
 - Walk in Clinic at NMUH on 19.07.07
 - Mellow Parenting workers on [REDACTED].07
 - NMUH A & E department on 19.07.07
 - GP on [REDACTED].07
 - Social worker on 30.07.07
 - Community paediatrician on 01.08.07
- 6.21.4 During the last two weeks of child A's life there was a reduction in the family's regular monitoring. It was the end of the school term, the Mellow Parenting programme was completed and the childminder had decided not to care for child A until his scalp infection was cleared. The Police investigation indicates this coincides with the arrival of Mr H's brother, girlfriend and [REDACTED] children. This change of circumstances may have impacted on the quality of the care provided.

- 6.21.5 The social worker saw child A and his siblings at home on 30.07.07, and spoke to them on their own. The children provided no indication of changed home circumstances. They told the social worker that they had stayed at their father's home the previous week-end. Child A was in his buggy ready to go to the park with siblings and a friend: he is said to have smiled in response to SW2 speaking to him and appeared alert.
- 6.21.6 A key issue is whether child A's health and welfare had deteriorated to such an extent by this stage that it could have been observed by any of the professionals who saw child A during the last two weeks in July.
- 6.21.7 CAE requested an expert paediatric opinion on the above matter, but it was decided that the court proceedings should provide clarity about the cause of death and child A's health in the preceding period, and if appropriate these findings may form part of a supplementary report. The 28.05.08 addendum to the HtPCT IMR (provided by GOSH) addresses this issue in relation to the paediatric assessment of 01.08.08 (see 6.13).

6.22 NEGLECT ISSUES

Supervision

- 6.22.1 One of the major concerns at the initial child protection conference was due to Ms A's lack of supervision of child A and the consequent risk of injury due to accidents. .
- 6.22.2 Despite the ongoing recurrence of such injuries, the focus increasingly turned to whether the injuries were non accidental or associated with child A's own behaviour. Resolving this question became the focus of intervention, whilst the impact on child A of continuing injuries and need for protection (without regard to causation), were not addressed. This preoccupation may have been perpetuated by a perception that the risk to child A was of relatively minor injuries and bruises.
- 6.22.3 Regardless of the cause of child A's injuries, the ability of Ms A to safeguard her son from injuries should have been considered more fully. This would have involved clearer consideration of the continued presence of dogs in the house and the level of supervision provided in relation to accidents and fights with other children.

Hygiene

- 6.22.4 The child protection medical in December 2006 referred to child ■ having some scratches from the dogs and 'dirty especially socks' and the medical on 03.08.07 found evidence of 'gross neglect' with regard to child A's siblings. ■

- 6.22.5 What is less clear is the extent to which such neglect factors were a usual condition. If such neglect had been ongoing, one would have expected it to be mentioned by the school and other professionals as a concern. This was not the case which suggests that the 'gross neglect' observed on 03.08.07 was relatively recent.

Persistent head lice and scalp conditions

- 6.22.6 The children appear to have suffered continuously with head lice, [REDACTED].
- 6.22.7 The problems of head lice and hair loss persisted in this family and child A in particular suffered with hair loss, sore scalp, wounds and scabs said variously to be a fungal infection, irritation from the lice treatment and an allergic reaction.
- 6.22.8 Mindful of the possibility that the continuing scalp conditions were associated with parental neglect of child A's health, CAE sought an expert medical opinion.
- 6.22.9 The HtPCT IMR authors commented that repeated infestation of head lice is not uncommon and that child A's hair loss and scabs were not attributed to head lice but seen as secondary to an allergic reaction for which Ms A sought treatment. Health services documented six occasions in the last two months (four of which occurred in the last two weeks of life) on which child A was presented for assessment and treatment at both acute (hospital) and primary care (GP and health clinic) settings. Treatments provided included [REDACTED] for the scalp and ear infection. The conditions were noted to be responding to treatments and the SCHS paediatrician observed child A's scalp to be 'partly healing' in August.
- 6.22.10 The HtPCT IMR's authors judge that:
- 'Health professionals gave advice and prescribed treatment for child A's ailments, and may well have thought positively of Ms A's actively seeking advice and treatment for her son. However, it is known that there is a tendency for practitioners working with families where neglect may be a feature, to see a positive report as effectively cancelling out a concern, and in retrospect, this may have occurred in response to Ms A's apparent engagement with health services'
- 6.22.11 The GOSH addendum to the HtPCT IMR (see 6.13.47) suggests that the existence of a large fungal lesion for over two months should have raised the possibility of neglect and would anyway have needed systemic treatment, not just local treatment.

- 6.22.12 There was notification of the various acute NMUH walk-in clinic and A & E presentations to the health visitor, GP and social worker, but there is no evidence that health professionals directly communicated about child A's health conditions. What appears to be missing was an overall medical review of the efficacy of the various treatments for child A, to what extent Ms A was persisting with any one treatment and whether or not neglect was indicated in the persistence of child A's scalp problems. There is no evidence of any direct discussion between health professionals about the persistence of child A's scalp infections.
- 6.22.13 There has been considerable debate within the serious case review sub-committee about the lessons to be learned from the above. No evidence has been presented to support or refute the suggestion of negligence in terms of Ms A compliance with the various treatments prescribed.
- 6.22.14 CAE considers this case illustrates a need, in the context of ongoing medical difficulties, for co-ordination and review of those interventions.

General health & development issues

- 6.22.15 Child A's weight increased following his discharge from the Whittington Hospital to Ms J's care and he was on the 50-75th centile on [REDACTED].07. Following his return to Ms A's care child A initially continued to put on weight and on [REDACTED].07 was noted to be on the 75th centile.
- 6.22.16 When the health visitor saw children A and [REDACTED] on [REDACTED].07, she knew about the recent injuries, but appears not to have sought advice or raised concerns about child A's hair and weight loss (2 centiles), outstanding third triple and MMR vaccinations. By this point child A's weight had dropped to the 25th-50th centile.
- 6.22.17 Child A was seen again by the health visitor on 18.07.07 when he had dropped a further centile, with many scabs on his head, a red possibly infected ear and bruising around the ear. Whilst this was reported to the social worker, no advice was sought about possible neglect issues relating to child A's health and this was not raised as a concern that could have been investigated in the forthcoming SCHS appointment.
- 6.22.18 Parallel growth charts (an essential tool in monitoring changes in growth patterns) were not used to monitor child A's height and weight, despite the ongoing concerns about him.

6.23 MANAGEMENT ISSUES

- 6.23.1 The following analysis does not cover all agencies, and reflects the extent to which these issues were raised within IMRs or are evident from the information supplied within the chronologies.

Children & Young People's Service

- 6.23.2 The involvement of managers, both team managers and senior team managers, was evident in the decision making at all points in this case, including the response to each incident of concern.
- 6.23.3 What was less clear was the role of managers in:
- Specifying the components of the Core Assessment required
 - Providing reflective supervision of the case (only one supervision note on the file, suggesting little in depth consideration of the nature of the case)
 - Facilitating the monitoring and review of child protection plans and of the safeguards introduced as part of the strategy of the s.47 enquiry
- 6.23.4 The child protection conference records show a consistent conference chairperson providing some effective management of the decision making process, ensuring child A was registered for physical abuse (as well as neglect) and initially highlighting risks to child A with a plan including contacting Legal Services if any of the children suffered further injuries.
- 6.23.5 The June conference record demonstrates that the chair appeared to recognise the risks in the situation at the time, pointing out that if child A's injuries were the result of him being clumsy, one would expect a continual level of injury and questioning how long the protective arrangements of Ms J and a childminder could be sustained.
- 6.23.6 The chair's summaries within each conference indicate [REDACTED] recognised the risk of physical abuse, as well as neglect, and attempted to formulate relevant outline plans to address such risks (see section 5).
- 6.23.7 There was scope for more effective management of implementation of the protection plans by CYPs managers between conferences. Examples of elements not implemented fully or within timescales included:
- Use of Legal Services to be contacted if further injuries ([REDACTED] 2006)
 - Risk assessment of the animals ([REDACTED] and repeated in [REDACTED] 2007 despite the social worker apparently unable to arrange via RSPCA)
 - Consistent two weekly ([REDACTED]) / weekly ([REDACTED] 2007) visits to children including direct work
 - Expediting the SCHS appointment ([REDACTED])
 - Legal planning meeting within ten working days ([REDACTED]) and
 - Review of future protection / supervision arrangements ([REDACTED])

- 6.23.8 Any inability to implement elements of a protection plan should be referred back to the conference chairperson by social workers and their managers.

Police

- 6.23.9 There is evidence that management was involved in making decisions about the first investigation and liaising with the CPS in January and February 2007.
- 6.23.10 Following the transfer of the allocated DC to another Command on [REDACTED].07, there was a period of over two months before the case was transferred. During that period, without management intervention to ensure its transfer, the investigation drifted.
- 6.23.11 Once the case was re-allocated the DS realised the need to resolve the matter and briefed the DC on the required tasks.
- 6.23.12 Following the discovery of further injuries on 01.06.07, the DS and DI are to be commended in providing effective support to the DC and intervening directly with CYPS managers.

Haringey Teaching Primary Care Trust

- 6.23.13 Health visitors are supported in their work with families whose children are subject to child protection plans by regular, planned supervision. In this case child protection supervision was recorded on four occasions between health visitor and team leader. On each occasion the notes were brief, at times unclear and did not provide evidence of risk analysis or clear planning.
- 6.23.14 There was no record of any child protection supervision of the school nurse in child [REDACTED]'s record, although the comments about supervision of health visitors applies equally to school nurses.

Family Welfare Association

- 6.23.15 6. 17 describes the relative isolation of the FWA staff within the professional network, despite being on the core group implementing the child protection plan.
- 6.23.16 The manager should have been aware of, established the causes and addressed the lack of communication between FWA workers and others professionals, whilst ensuring consistent FWA representation at significant meetings.

6.24 RECORDING & ADMINISTRATION

- 6.24.1 Agencies addressed this issue to varying extents within their IMRs. The comments below partly reflect that diversity in approach and consequently the performance of each agency cannot be compared.

MULTI-AGENCY RECORDS

- 6.24.2 The records of multi-agency forums, are the responsibility of CYPS to complete and circulate.
- 6.24.3 Some child protection conference records contained a variety of inaccuracies including the:
- First review conference record (on p.6) referred to the social worker's involvement over seven months (as opposed to three months)
 - Record of [REDACTED].07 incorrectly showed Ms A as having been charged
 - Protection plan for 08.06.07 incorrectly includes child A's 'registration category' [sic] as Neglect and Emotional Abuse (instead of Physical Abuse)
 - Invitation for one of the review conferences has the wrong family address
- 6.24.4 Chronologies and IMRs within some agencies indicate that no conference record and /or strategy discussion record was located: it is not known if the record had been sent and subsequently lost or misfiled, or if it was never sent.
- 6.24.5 CYPS have clarified that its policy is to send conference records to all those invited, but HtPCT has confirmed that the SCHS did not receive minutes of any child protection conferences and none have been found on siblings' files, despite a paediatrician attending the conference on 22.12.06, following the children's child protection medicals.
- 6.24.6 The CYPS IMR points out that the Integrated Children's System record used for strategy meetings does not enable the recording of apologies. The Whittington Hospital's paediatric consultant is clear that although invited and sending apologies to the January 2007 strategy meeting, she did not receive any record of the decisions made.
- 6.24.7 There appears to be no *common multi-agency* record of the June strategy discussion, as opposed to the varying detail of each agency's individual record. CAE are advised that CYPS did complete the required electronic record, but presumably this was not provided for the police.
- 6.24.8 Core group meetings are referred to within CYPS records, but only two sets of minutes were on file. Contemporaneous notes were taken of all the other meetings, and been provided to the overview authors. However, they would not have been available for members of the core group to guide their implementation of the protection plan.

CHILDREN & YOUNG PEOPLE'S SERVICE

- 6.24.9 Whilst some recording of home visits was described by the IMR author as very good, three visits were not recorded at the time and the records of some critical contacts were missing e.g. joint interview of the older children on [REDACTED].06 and the home visit by the social worker that day.

- 6.24.10 The referral form for a legal planning meeting provided inaccurate information as to the child protection 'registration categories' of child A and did not refer to the previous legal advice of December 2006.

FAMILY WELFARE ASSOCIATION

- 6.24.11 Several of the contacts entered into the chronology were not recorded on the case file but 'recalled' by the worker in 'debrief' following child A's death.

LEGAL SERVICES

- 6.24.12 There is evidence of a number of administrative and recording weaknesses within Legal Services including the absence of:

- Records of the December 2006 legal involvement, due to the work not being filed or saved in the legal case management system
- Systematic date stamping on the referral, reports and assessments
- An administrative record of telephone discussions and filing of emails
- Notes by lawyers of internal legal discussions, other than handwritten annotations on the referral form.
- A record of the legal planning meeting including details of the areas discussed and advice provided (CYPS appear to only have a memo confirming the advice provided and legal have an additional handwritten file note)

NORTH MIDDLESEX UNIVERSITY HOSPITAL / GREAT ORMOND STREET HOSPITAL

- 6.24.13 Documentation was judged by the IMR authors to be 'overall very good' and mention was made that:

- Notes were in chronological order
- All nursing and medical interventions were clearly documented
- Communication with and observations of family had been documented
- Inter and intra agency communication were documented
- Demographic details were checked and confirmed
- Child protection plan status was checked appropriately and his status highlighted

POLICE

- 6.24.14 There are recording weaknesses in the Police investigation (prior to its re-allocation in May 2007) including:

- No notes of the questioning of Ms A on 11.12.06 other than the Crime Reporting Information System (CRIS) report
- Lack of clarity about the date of the school visit
- The recording of actions, times, notes of conversations, events and supervision should have been more detailed

SCHOOLS

- 6.24.15 The schools' records provide information on the progress and welfare of the ■ elder siblings who attended school. There are no records of any concern or changes with regard to home circumstances. This may mean that the children did not speak or write about such matters, or that these would not be deemed relevant for school records.
- 6.24.16 The first school's discussions and meetings were written on sheets of paper in the absence of any agreed format for schools comprehensive recording of such information.
- 6.24.17 There is no evidence of any written records in the second school records and no evidence in either school of a telephone conversation between them, when the first school provided information of child protection status a week after transfer. The child protection files were not transferred at the time.
- 6.24.18 The 'pupil admission form' for the second school was not completed fully and staff did not record if the children's proof of date or birth or address were checked. No record was made if the children were subject to a child protection plan.

TEACHING PRIMARY CARE TRUST

General Practice

- 6.24.19 It is unclear from the computerised patient summary if there was any communication with the social worker in response to a request for information.
- 6.24.20 Entries in patient summary sheets were noted to be clear and any retrospective entry has been clarified and dated. Mental health concerns were recorded appropriately in the GP record.

Health visitors

- 6.24.21 The health visitor records were legible, though there was a lack of written evidence of decision making in the records. There was scope to use a more structured approach to care planning and a clearer separation between the family and child related information.
- 6.24.22 Parallel growth percentile charts were not used, despite the concerns about growth and the children being subject to a child protection plan.
- 6.24.23 The detail of information shared with other agencies was not always evident on the records.

School nurses

- 6.24.24 Records for ■ school age children were legible, in good order and included parallel growth percentile charts, which had been maintained.

Primary Mental Health Worker

- 6.24.25 Note taking and planning was evident from the patient notes kept by the PMHW and she maintained detailed records of the sessions with Ms A.

GOSH paediatricians at SCHS

- 6.24.26 The records when child A attended for a paediatric assessment on 01.08.07 were legible, clear and in good order, with all investigation forms completed on the day and a report dictated. However, a body map was not used.
- 6.24.27 The paediatric records of child A's [REDACTED] siblings are legible, clear, dated, signed and in good order. All recording and administration were completed as required at child protection medicals.
- 6.24.28 There was no record of the telephone call reported to have been made by the team manager at CYPS to the SCHS.
- 6.24.29 During the process of this case review it was discovered that the appointment diary provided evidence of two possible earlier appointments for child A. These are not in the child's file.

WHITTINGTON HOSPITAL

- 6.24.30 The copy of the child protection medical did not reach the named doctor: two copies were sent via the health visitor, and one was marked for the Named Doctor. Both copies were found on Haringey health visitors' records.

7 CONCLUSIONS & LESSONS LEARNED

7.1 INTRODUCTION

- 7.1.1 This section provides conclusions and the lessons learned from this serious case review. 7.2 details general conclusions, 7.3 those of relevance to the work of more than one agency and 7.4 those of relevance to the agency specified.
- 7.1.2 Numerous examples of good practice have been acknowledged in the analysis provided in section 6. The following conclusions are inevitably focused primarily on the scope for improved policies, systems or practice.

7.2 GENERAL

- 7.2.1 Following the first concern about child A in December 2006 he appropriately became subject to a child protection plan and was seen regularly by professional staff in several agencies until his death on 03.08.07.
- 7.2.2 In the last three weeks of his life, child A was seen on eight different occasions by professional staff including the GP, health visitor, staff at NMUH A & E and the Walk in Centre, a community paediatrician, social worker, Family Welfare Association worker and Mellow Parenting staff. During these three weeks none identified immediate risks to child A's health and well being.
- 7.2.3 The opinion of medical experts commissioned by GOSH is that when child A was seen by a paediatrician on 01.08.07 there was a 'failure to diagnose physical abuse' and recognise the possibility of emotional abuse and neglect. Following the criminal proceedings when it can be anticipated that more information will emerge about child A's injuries, there may be a need for further consideration of the quality of the professional observations during July.
- 7.2.4 The lack of concerns about child A and any of his [REDACTED] elder [REDACTED] prior to December 2006 tended to provide re-assurance for professionals about Ms A's parenting skills.
- 7.2.5 This was reinforced by Ms A's open manner and:
- The observations by professionals of her positive relationship with all her children
 - Her general co-operation with the child protection plan and with most professional visits and appointments
 - Her positive responses to offers of help and frequent requests for advice about child A's health and development
 - Her frequent initiation of communications with professionals, often relaying information between them

- 7.2.6 Professional confidence in the overall situation was further confirmed by:
- The lack (according to schools records) of any exceptional comments by the [REDACTED] about their home circumstances and
 - A perception of Ms J as a trustworthy professional source of support who could be relied upon to communicate to CYPS any concerns about the welfare of the children
- 7.2.7 As a consequence of the predominantly positive professional perceptions of Ms A, and the inability to identify a perpetrator of the abuse, child A's injuries were perceived to be largely a consequence of insufficient supervision and of his observed behaviours (i.e. clumsiness, head butting, throwing his body around and rough play with other children).
- 7.2.8 Having come to this view, professionals did not revise their judgements in the light of further injuries or information; instead circumstances tended to be interpreted in the light of existing understandings of the family dynamics.
- 7.2.9 Within this perspective, the primary strategy to determine the cause of child A's injuries was the provision of a developmental paediatric assessment, which would consider the possibility of organic causation of bruising and injuries. Despite the central importance of this assessment to the child protection plan formulated on 16.03.07, and subsequently in June to the s.47 enquiry, there was a delay of four and a half months in its implementation.
- 7.2.10 The Police investigation following child A's death indicates that Mr H moved into the household in [REDACTED] 2007 and it is not known whether he played a significant part in the family prior to this date. He was known to be a friend but despite announced and unannounced home visits, interviews with Ms A, her children and family friends, neither Mr H's intimate relationship with Ms A nor his presence within the household had been acknowledged by Ms A or discerned by any of the professionals.

7.3 MULTI-AGENCY

- 7.3.1 The nature of responses made to incidents of concern indicate to the satisfaction of the serious case review sub-committee that safeguarding structures do exist across Haringey agencies, and offer a sound framework for the implementation of child protection procedures. There is though, scope for improving the detailed application of some processes.
- 7.3.2 There was an effective multi-agency response to the December 2006 incident by the GP, staff at Whittington Hospital, Haringey Children & Young People's Service and the Metropolitan Police Service, with prompt referrals, consultation, agency liaison, strategy discussions, s.47 enquiry and Police investigation.

- 7.3.3 There is scope to develop procedure and practice in relation to the involvement of paediatricians at *all* strategy discussions concerning potential non accidental injury. This should consider the role of the designated and named doctor as well as any involved paediatrician.
- 7.3.4 There is a need for the consistent use of second (and if necessary subsequent) multi-agency strategy discussions to review progress of s.47 enquiries and associated Police investigations and consider whether or not an outcome has been achieved and if any temporary safeguards should end or be varied.
- 7.3.5 There were examples of good multi-agency communication, including between the PMHW and professional colleagues, between the Police and CYPS during parts of the s.47 enquiries and between the hospitals and CYPS. There was however a number of areas of poor communication in relation to:
- Transmission of information to the Police CAIT
 - The content of the referral from NMUH to CYPS in April 2007
 - Liaison and information flow between the SCHS, CYPS and other health services – see below
 - Information flow between other core group members and the Family Welfare Association
 - Information flow between core group members (particularly health visitor and social worker) and the Mellow Parenting Group leaders
- 7.3.6 The SCHS appears to have been relatively isolated within the professional network, as illustrated by the:
- Lack of access to information on child A held by other health service providers
 - Lack of professional understanding of the SCHS need for full information as part of the referral, as illustrated by the health visitor's inadequate referral and the limited background provided by the social worker's referral
 - Differences of understanding between CYPS and health professionals of the SCHS care pathway arrangements providing emergency developmental assessments for children subject to a s.47 enquiry
 - Lack of liaison and communication between SCHS and CYPS prior to, during and immediately after the assessment
 - The absence of a system in SCHS that could have awarded priority to a child because s/he was subject to a child protection plan and (due to an inadequate first referral in this case) had already experienced delay
- 7.3.7 Standards in the administration of child protection conferences, core group and strategy meetings require clarification and improvement to ensure accuracy, that records are sent out in a timely fashion to all those invited and that agencies maintain and store records securely.

7.4 AGENCY SPECIFIC

CHILDREN & YOUNG PEOPLE'S SERVICE

- 7.4.1 Good practice was demonstrated in December 2006, with a child protection (s.47) enquiry initiated, a strategy agreed in liaison with Police and hospital staff, consideration given to the safety of child A and his siblings and a second strategy meeting held to agree outcomes and further plans. This good practice would have been improved if all required agency checks had been completed.
- 7.4.2 The June 2007 s.47 enquiries were less satisfactory, lacking paediatric input at the strategy discussion and having no second strategy discussion to review progress, agree outcomes and consider if the plans implemented to safeguard the children should continue after the planned two weeks. The significance of these weaknesses was increased by the failure to convene a timely legal planning meeting and delay in the provision of the Specialist Child Health Service appointment.
- 7.4.3 In April 2007 CYPS appear to have accepted an ambiguous referral from NMUH without exercising sufficient challenge around the circumstances and recognising the need for (at minimum) a strategy discussion to obtain further information and evaluate the need for a s.47 enquiry.
- 7.4.4 An incident involving child ■ and several additional reports of bruises and marks on child A should have been communicated to the Police and consideration given to the need for further exploration or an enquiry.
- 7.4.5 The failure to initiate such action appears to have been based on the trust placed in the explanations provided by child A's mother, or in one instance in the family friend caring for child A.
- 7.4.6 Whilst there was reasonable communication with some professionals, there was no systematic transmission of information about significant events to *all* members of the core group and those providing services as part of the child protection plan e.g. communication of a change of social worker and the fact of a s.47 enquiry.
- 7.4.7 From the reports provided for the purpose of this serious case review, managers were involved in all major decisions on this case, though little evidence was seen of reflective supervision, specification of the components of assessment or of monitoring and review of implemented plans. Overall, there was an insufficiently consistent audit trail of the rationale for decisions made.
- 7.4.8 The Core Assessment appears to have commenced with an understanding that the CYPS view was that the injuries to child A were most likely to be the result of lack of supervision: this was not the subject of re-consideration within the Core Assessment or in response to any subsequent reported incidents or concerns.

- 7.4.9 From the outset in December 2006, child A's father was insufficiently consulted and included in assessments and arrangements about his children's welfare, though following case transfer there was evidence that the social worker was beginning increasingly to involve him. Moreover, there was inadequate consideration of his potential as a carer for child A in both December 2006 and June 2007.
- 7.4.10 Use of a family friend as a carer for child A demonstrated good partnership working with the family and enabled child A to maintain his apparently positive relationships with mother and siblings. However, insufficient assessment was undertaken of Ms J's abilities, background, relationship with Ms A and the extent to which she communicated any concerns.
- 7.4.11 There was a seven week delay in holding the legal planning meeting which had been agreed (on 04.06.07) as urgently required. This arose mainly due to delays in CYPS requesting the meeting and subsequently in suggesting dates. Given the advice eventually provided i.e. that the threshold was *not* met for legal proceedings, the delay in itself is unlikely to have had a decisive impact on child A's death.
- 7.4.12 Social workers saw the children regularly, both with their mother and at times on their own. There were seventeen contacts in just over seven months, though the visiting pattern was not always consistent with the child protection plan (which specified weekly or fortnightly visits) and did not take place consistently following incidents of concern.
- 7.4.13 There was evidence of the social worker seeing the children on their own, though not as an integral part of the Core Assessment process or in response to the reported concerns about child A in 2007.
- 7.4.14 There is a need to improve accuracy of information provided within documents (e.g. category of child protection plan) and the consistent recording of home visits and contacts with professionals.

SCHOOLS

- 7.4.15 The [REDACTED] elder children attended school regularly and there is no evidence they gave any indication of their mother having a new partner or of any incidents within the family that would have suggested welfare concerns (teachers are well positioned to observe, record and communicate to key workers any comments / writings / drawings made by children who are subject to a child protection plan and it is assumed the absence of any such reports in this case was because no such relevant observations were made).
- 7.4.16 The individual management review from Schools indicates:
- A delay between schools in communication of information on the children's child protection status and transfer of relevant files
 - The admission form at the second school was incomplete and staff did not confirm key documents were seen

- A need for clarity within schools about the content and format of records of pupils subject of a child protection plan

FAMILY WELFARE ASSOCIATION

- 7.4.17 The contact with Family Welfare Association provided the only evidence of child A's mother possible reluctance for agency involvement, with half of the suggested visits declined or cancelled.
- 7.4.18 The Family Welfare Association worker was part of the core group, though she appears to have been marginalised within the professional network with little communication between her and other agencies and limited attendance at conferences and core group meetings. It appears that the worker was not consistently informed of the core group meeting dates.
- 7.4.19 The impact of this professional isolation was that the Family Welfare worker was not informed of the s.47 enquiry, did not receive a response to her telephone calls to the social worker after Ms A informed her of the new injuries and did not inform the social worker or Police of a reported witness to the injury or that a male friend of Ms A was present at the home.
- 7.4.20 There appears to have been no management recognition of, or response to, the worker's apparent marginalisation within the professional network. Given the limited nature of her role with respect to the child protection plan this may have been perceived as a low priority, but should have been clarified.
- 7.4.21 There is a need to ensure consistent case recording of contacts and meetings.

HEALTH

- 7.4.22 The children, and child A in particular, were seen regularly by health professionals, including health visitors, GP, paediatric staff, A & E, Walk-in Centre and Mellow Parenting staff.
- 7.4.23 When a parent is concerned that her/his non-mobile child bruises easily and that s/he may be accused of hurting the child, it is important that as a minimum such comments are fully explored by the health professional, recorded, bruises documented and that there is liaison between the primary health professionals involved.
- 7.4.24 The written referrals from NMUH in April and June 2007 do not adequately communicate the child protection concerns and indicate the need for improvements to both the structure of the form and its completion by staff.

- 7.4.25 There was little evidence of communication between the health visitors and colleagues providing the Mellow Parenting Group. The latter remained unaware of the s.47 enquiry in June and the safeguards in place and did not communicate in July to health colleagues or to the social worker that Ms A [REDACTED]. This information may have led to doubts about Ms A's openness and would have provided the Police with another adult to consider as a possible suspect in relation to child A's injuries.
- 7.4.26 There is a need for a review of the arrangements for developmental paediatric assessments, to ensure that the service provided is well integrated in safeguarding processes and:
- Has access to relevant information from within Health services
 - Provides appointments based on the urgency of the child's needs, taking into account the priority to be awarded to children subject to a child protection plan or child protection concerns
 - Documents all professional communications about a child subject to a child protection plan and discusses any issues arising, including professional requests for appointments to be expedited
 - Undertakes relevant professional liaison prior to an appointment including all offers of appointments
 - Communicates safeguarding concerns immediately to CYPS
 - Uses body maps within assessments
- 7.4.27 Prior to December 2006, the professional in most frequent contact with Ms A was the mental health worker. Whilst it would have been helpful for her to have initiated the sharing of information with midwifery and health visiting, once approached she shared information appropriately within the professional network and is to be commended for initiating contact with the social worker in December 2006.
- 7.4.28 In the last weeks of his life child A was seen on several occasions by acute and primary health care professionals for a variety of apparently chronic scalp-related conditions and was provided with a variety of treatments. What appears to be missing is an overall medical perspective on causation and an assessment of whether Ms A was consistently following medical advice.
- 7.4.29 There is scope to improve supervision systems for school nurses and health visitors, to ensure that they receive regular planned sessions, which are recorded clearly and provide evidence of risk analysis.
- 7.4.30 There was a lack of written evidence of decision making in the health visiting records.
- 7.4.31 GP computerised patient summaries need to provide clear confirmation when a response has been provided to a request for information.

- 7.4.32 There is a need for health visitors' consistent use of parallel growth charts whenever there are concerns about the health or development of a child and/or if the child is subject of a child protection plan.

LEGAL DEPARTMENT

- 7.4.33 There is scope to increase efficiency to ensure:
- Consistent filing and entry into the legal case management system of all communications on cases
 - Improved administrative systems that track dates referrals and documents are received
 - All background information is obtained and read prior to the legal planning meeting
 - Internal discussions and the meeting are adequately recorded
 - Advice provided verbally and in writing is clearly expressed
 - Timely written advice following legal planning meetings
- 7.4.34 There had been a shortage of lawyers with relevant experience able to attend legal planning meetings and in this case a locum lawyer attended.
- 7.4.35 The legal planning meeting of 25.07.07 was held without the solicitor being provided or having obtained sufficient background information prior to the meeting and the advice provided [that the threshold for legal proceedings was not met] was therefore not fully informed. In the light of that advice, the delay in the meeting cannot be concluded to have been decisive.
- 7.4.36 Legal Services acknowledge that on the face of it the threshold criteria were, from the information provided, satisfied, but that it may not have been appropriate to issue proceedings if there were adequate safeguards in place to protect child A pending the outcome of investigations. Had this advice been provided in an earlier meeting, it might have highlighted the need to ensure the safeguards were monitored and reviewed.

METROPOLITAN POLICE SERVICE

- 7.4.37 Police initiated investigations on each occasion they were informed that child A had suffered injuries. However, investigations were unable to establish sufficient evidence for a prosecution and did not discover the likely identity of the perpetrator/s of the abuse.
- 7.4.38 The December 2006 investigation demonstrated good partnership working with CYPS although the conduct of the investigation would have been improved if it had been progressed and concluded in a shorter time frame.
- 7.4.39 Police are to be commended for their responses on 01.06.07 and 04.06.07, which recognised the potential risks to child A, offered support (and appropriate challenge) to Children & Young People's Service and ensured that a strategy was agreed to safeguard child A.

- 7.4.40 The subsequent Police investigation was reasonable, but unfortunately there was a week's delay before photographs were taken, the elder siblings were not interviewed and Ms A was not asked specifically about the household composition.
- 7.4.41 Despite consistency in the views of two senior paediatricians that the medical findings strongly suggested that child A had suffered non accidental injury, the CPS reluctantly made a decision of 'no further action'. Ms A's accounts of innocent ways the injuries could have occurred and the supporting statements of such explanations from Ms A's friend and professionals (observations of child A's behaviour) meant that the evidence fell far below that required for a criminal prosecution.
- 7.4.42 Even if the photographs had been taken in December 2006 and immediately on discovery of the injury in 2007, the likely response would have been that a decision of no further action would still have occurred, (though might have happened faster with regard to the first investigation).
- 7.4.43 The omission of interviews with the children was in retrospect an error, but is considered unlikely to have impacted on the outcome of the Police investigation since the children did not share details of Mr H's involvement in the family with any professional.
- 7.4.44 This case has highlighted the need for more detailed record keeping by investigating officers and supervisors of conversations, events and supervision.

8 RECOMMENDATIONS

8.1 INTRODUCTION

- 8.1.1 Consistent with government guidance in *Working Together to Safeguard Children* 2006, CAE tried to minimise the number of recommendations, ensure those provided were derived from the evidence emerging from this case review and that they are specific and capable of being implemented (by the date at the end of each individual or multiple part recommendation).
- 8.1.2 If the criminal proceedings present new evidence for the partners represented by the Local Safeguarding Children Board it is recommended that the serious case review sub-committee consider the need for an addendum to the main report. Any such further work should be undertaken by external consultants in accordance with chapter 8 of government guidance - *Working Together to Safeguard Children*.
- 8.1.3 The following recommendations include, but are not restricted, to those provided by the individual IMRs and are divided into those of relevance to some or all agencies and those applicable to a single agency.
- 8.1.4 The accompanying action plan provides details of the implementation dates of the recommendations.

8.2 LOCAL SAFEGUARDING CHILDREN BOARD (LSCB)

- 8.2.1 The LSCB should initiate a multi-agency review of joint protocols and practice for referrals, strategy discussions, core group meetings and child protection conferences in respect of:
- The need to clearly state concerns and professional opinions in referrals
 - Multi-agency involvement and attendance in discussions, meetings and conferences
 - Involvement of paediatricians and/or named or designated doctors at strategy discussions / meetings (of particular importance if there are different perceptions of the risk and a potential need for further independent comment)
 - The use of second, and if required, further strategy discussions
 - Ensuring the designated or named paediatrician is invited to a child protection conference if a referral for a paediatric assessment has been made / is being considered
 - Administration (to include timing, accuracy, circulation of records and secure maintenance of such circulated records)
 - Periodic multi-agency audit of administrative processes
 - Ensuring that core group members are informed within five days of any change in an agency's allocated worker [by 31.12.08]

- 8.2.2 Single and multi-agency training programmes for those undertaking supervision in safeguarding work should emphasise the need for all staff to:
- Be constantly vigilant
 - Have an open and inquisitive approach, regardless of any assumptions arising from previous assessments
 - Be aware of the need to re-assess following new and cumulative incidents and changes of circumstances (such assessment to include checking the accuracy of basic information e.g. household composition)
 - Challenge colleagues within partner agencies if required [by 31.01.09]
- 8.2.3 Haringey's Local Safeguarding Children Board should ensure that the Primary Care Trust has in place robust arrangements for each child subject of a child protection plan to have active oversight and monitoring of her/his medical treatment. The monitoring role should be undertaken by an appropriately trained medical professional i.e. a GP who should receive medical support from the 'lead GP for child protection' and when necessary, the 'named' or 'designated doctor' [by 31.03.09]
- 8.2.4 Haringey's Local Safeguarding Children Board should recommend to the London Safeguarding Children Board that the London Child Protection Procedures be revised to require Children's Social Care, to share information with Police if any new safeguarding concerns arise in the context of an ongoing criminal investigation of abuse or neglect [30.11.08].
- 8.2.5 Following the completion of court proceedings and identification of any additional lessons Haringey's Local Safeguarding Children Board should ensure these are disseminated by holding multi-agency briefing sessions for staff [30.11.08].
- 8.2.6 The LSCB should provide training and written guidance for relevant staff on the management and completion of IMRs, so as to ensure there is consistency between agencies in the scope, detail and overall quality of the reports [by 31.03.09].

8.3 AGENCY- SPECIFIC

FAMILY WELFARE ASSOCIATION

- 8.3.1 FWA management should be more consistently proactive in ensuring clarity about directions for FWA work from safeguarding meetings and, if there is insufficient clarity or absence of notes, must communicate this concern to line managers [completed].
- 8.3.2 FWA family support staff and management must be more consistently proactive in communicating all issues of concern or apparent relevance to the key statutory agencies [completed].

- 8.3.3 FWA staff and management need to be more consistently proactive in addressing communication and participation difficulties within the professional network [completed].
- 8.3.4 All casework recording in respect of a child subject to a safeguarding process must be kept up to date and contain an analysis of events and actions in addition to clear chronologies and information about the service being provided [completed].

HEALTH AGENCIES

- 8.3.5 When Haringey children are seen in hospitals and there are child protection concerns or they are subject to a child protection plan, medical reports should be copied to Haringey's Safeguarding lead professionals and the designated doctor for Haringey [by 31.08.08].

Great Ormond Street Hospital (GOSH): responsible for the SCHS following transfer to GOSH on 01.04.08

- 8.3.6 The SCHS should, in liaison with referring agencies, review the current referral process for assessments to ensure that it is clear:
- That referrers need to be explicit about the nature and purpose of the referral
 - What information and documents are to be provided
 - That, when a child is known to be subject to a child protection plan, the SCHS paediatrician should endeavour to obtain all relevant information, liaise directly with the social worker and consider the advisability of her/his attendance at the appointment [by 31.08.08]
- 8.3.7 The SCHS service should review its Operational Policy (dated August 2007) with a view to:
- Developing a waiting list priority system that acknowledges the needs of the child, including the implications of a child subject of a child protection plan and
 - Requiring referrers and any involved social worker to be consistently informed of any appointments offered and of any that are declined
 - Facilitating CYPS to fully understand the care pathways and its implications with regard to a s.47 enquiry
 - That ensures all communications from any professional regarding children waiting for an appointment are included within the child's record [by 31.08.08 with audit ongoing throughout 2008]
- 8.3.8 All GOSH doctors involved in any clinics but particularly in core services within Haringey, Enfield and Camden should contact the original referral person if they require further information or clarification [by 31.08.08 with audit throughout 2008].

- 8.3.9 When concerns about child safeguarding arise during the course of GOSH lead clinical assessments children should not leave the assessment unit / clinic / ward unless those concerns have been resolved or an agreed plan for their safeguarding is in place [immediate with ongoing training / briefing programme throughout 2008].
- 8.3.10 Bruises and any other injury on any child should be documented on a body map by SCHS / GOSH examining doctors [completed with ongoing audits throughout 2008]

Haringey Teaching Primary Care Trust

- 8.3.11 GPs and other practice based staff should be reminded of the importance of sharing any early concerns raised by parents / carers about health issues that could reflect safeguarding concerns, with other health professionals involved, particularly health visitors, school nurses and community paediatricians – the GP practice training programme and briefing cycle should raise this recommendation [for implementation throughout 2008].

GOSH – responsible for GOSH in Haringey (Children, Young People and Families Community Health Services) since 01.04.08 ²

- 8.3.12 The Mellow Parenting programme should review current practice regarding the recording and sharing of information emerging from group focused work to ensure that relevant information is passed to health visitors and social workers – this should include reviewing the information leaflet to parents, which currently guarantees confidentiality [completed].
- 8.3.13 Health visiting and school nursing should continue with their plans to develop the standards for service delivery to complex families and those families with children subject of a child protection plan, review the child protection supervision policy and arrangements and review layout and format of records [completed].
- 8.3.14 Parallel growth percentile charts should be introduced by health visitors / school nurses and maintained in the records of children where there are concerns about growth, and those subject of a child protection plan and the growth policy should be updated to reflect this [completed].

GOSH at North Middlesex University Hospital (NMUH): responsible for, and managing paediatric staff at NMUH

- 8.3.15 NMUH should review, in consultation with CYPS and the Metropolitan Police, the structure and completion of its child protection referrals to ensure:
- All concerns are included
 - Fact is distinguished from parental explanations / assumptions

² GOSH has already instituted immediate interim measures to ensure that all its child protection assessments are undertaken at the child protection unit at GOSH@NMUH. The independent medical review commissioned for this case has also informed the formulation of a comprehensive development plan currently being implemented

- Professional opinions are provided
- The intended purpose of the 'child protection summary sheet' is clarified i.e. internal and/or external communication
- The content of 'child protection summary sheet' reviewed to maximise its efficacy [by 31.08.08 and audit throughout 2008]

HARINGEY CHILDREN & YOUNG PEOPLE'S SERVICE

- 8.3.16 The Service should ensure that Police are informed of any new incidents of concern about a child if an allegation may constitute a crime and / or if the child is subject of a child protection plan and /or there is an ongoing police investigation [by 31.08.08].
- 8.3.17 The Service should develop detailed guidance regarding the use of family friends as temporary carers for children, during s.47 enquiries, involving a clear description of status and minimum standards of assessment, monitoring and evaluation [by 31.08.08].
- 8.3.18 Managers should ensure that all known parents are informed of concerns about their child, consulted about plans, invited to child protection conferences and included on core groups (and if a decision has been taken to exclude them from any part of this process, the rationale should be recorded) [by 30.09.08 and audit throughout 2008].
- 8.3.19 Managers should ensure that for children subject to a child protection plan:
- All elements of the child protection plan should be implemented in accordance with the terms specified in the conference record and should there be any need to vary arrangements, such action must be authorised and recorded by the senior team manager in consultation with the conference chair
 - Any change of circumstance, including temporary change of accommodation, should be subject to an assessment as to its suitability and the need for any alternative safeguards [by 31.07.08 and audit throughout 2008]
- 8.3.20 When a conference recommends a change to the frequency of visits in the child protection plan the chairperson must state the rationale for the change [completed].
- 8.3.21 If a child protection conference decides (exceptionally) not to make all the children in a family subject of a child protection plan, the chairperson must ensure the rationale for the decision is recorded [completed].
- 8.3.22 If a child subject to a child protection plan, changes school, a core group meeting should be convened at the new school within ten working days [completed].
- 8.3.23 The service should review and update its guidance in relation to case recording, and set out how this will be monitored and audited [by 31.07.08].

- 8.3.24 To improve the conduct of child protection enquiries, managers and social workers should be reminded that:
- Agency checks and information sharing should be undertaken for *each* s.47 enquiry, even for a child already subject of a child protection plan
 - A telephone call should accompany faxed or e-mailed reports to police in urgent cases
 - All relevant agencies should be involved in the strategy meeting / discussion, with a flexible venue to facilitate attendance
 - Paediatricians are to be invited to all strategy discussions that involve physical injuries
 - The strategy meeting decision sheet should be distributed to all invitees
 - The plan devised includes a strategy to discover the circumstances of any concern and this should usually include speaking with children in the household and checking household composition (even if known) [by 31.07.08 and ongoing audit throughout 2008]
- 8.3.25 To improve safeguarding practice, managers and social workers should also be reminded that:
- All agencies involved in the delivery of services, as part of a child protection plan, need to be informed of new or repeated concerns and the initiation of any s.47 enquiry
 - Regardless of conclusions of previous assessments each new incident / injury should prompt consideration for the need to share information and to initiate a s.47 enquiry
 - All decisions taken about safeguarding a child, and their rationale, must be recorded; managers must ensure the records reflect the decision making process [by 31.07.08 and ongoing audit throughout 2008]
- 8.3.26 Senior team managers should monitor the progress of an enquiry and ensure that further strategy discussions (and if appropriate meetings) are convened for all s.47 enquiries to:
- Review the progress of s.47 enquiries and associated police investigations
 - Consider the continued need for any safeguards to be in place
 - Agree any additional enquiries to be made
 - Identify unresolved issues
 - Agree outcomes of the s.47 enquiry [by 31.07.08 and ongoing audit throughout 2008]
- 8.3.27 If any child is referred for a paediatric assessment as part of a s.47 enquiry or as part of the child protection plan, the social worker must ensure that:
- The paediatrician is informed of all relevant history, including any previous paediatric assessments and their conclusion and any past or current s.47 enquiries

- There is direct communication with the paediatrician and discussion of the need for a social work presence during the examination [by 31.07.08 and ongoing audit throughout 2008]

8.3.28 The Heads of Service should remind all relevant staff of the procedure in relation to legal planning meetings including:

- The requirement to adhere to agreed timescales and propose dates accordingly
- Provision of all relevant documents and details of previous legal involvement [completed]

Schools

8.3.29 CYPS should circulate to all relevant schools and centres the requirement that all child protection related documents must be transferred to a child's new school or setting within five working days of it being identified [by 30.09.08].

Haringey Children & Young People's Service & Legal Services

8.3.30 Legal Services and CYPS should review cases involving a legal planning meeting every 6 weeks at 'legal casework meetings' [completed].

LEGAL SERVICES

8.3.31 All staff in Legal should be reminded of the need to comply with case management and performance standards at all times including accurate recording, filing and adherence to agreed timescales [completed].

8.3.32 The Legal Services office manual should be amended to clarify that related matter checks should include both specific case files and general advice files [completed].

8.3.33 To facilitate effective monitoring, Legal Services should introduce a specific file category for legal planning meetings on its case management system [completed].

8.3.34 A pro-forma legal planning meeting memo and guidance should be drafted for use by the lawyers [completed]

8.3.35 Legal planning meeting memos should be sent within two working days of the meeting and copied to the lawyer's line manager, senior lawyers, social work team manager and senior team manager [completed]

8.3.36 Legal planning meeting advice given by recently recruited lawyers (temporary and permanent) should be checked and approved by the senior lawyer during the first three months of conducting legal planning meetings after joining the team [completed].

- 8.3.37 Pending a strategic review, Legal Services should ensure that sufficient numbers of lawyers with strong experience of acting for a local authority in childcare proceedings are recruited or alternative methods of service provision are explored [completed].

METROPOLITAN POLICE SERVICE

- 8.3.38 Officers within the SCD5 Command should be reminded of the need to ensure that they accurately record all information during criminal investigations, including the need for photographs of scenes (including victims) in line with Standard Operating Procedures [completed].
- 8.3.39 SCD5 Quality Assurance officer should review by 'dip sample' Haringey CAIT investigations to assess if these two investigations are reflective of the team's general standards [completed].
- 8.3.40 Officers of the SCD5 Command should be reminded that they have the capability to request follow up strategy discussions during complex or protracted investigations [completed].

GLOSSARY

ABH	Actual Bodily Harm
CDC	Child Development Clinic
CHC	Child health clinic
CPC	Child protection conference
CPS	Crown Prosecution Service
CYPS	Children & Young People's Service
DC	Detective constable
DNA	Did not attend
EPO	Emergency Protection Order
FWA	Family Welfare Association
GOSH	Great Ormond Street Hospital
HARTS	Haringey Tenancy Support for Families
HtPCT	Haringey Teaching Primary Care Trust
ICPC	Initial child protection conference
ISP	Individual Support Plan (FWA)
MGM	Maternal grandmother
NAI	Non accidental injury
NMUH	North Middlesex University Hospital
PMHW	Primary Mental Health Worker
SCHS	Specialist Child Health Service
SPACE	A local voluntary organisation providing family support
UTI	Urinary tract infection
YCAT	Young Children's Assessment Team

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APPENDIX 1: TERMS OF REFERENCE

OBJECTIVES AND PURPOSE OF SERVICE

Haringey Local Safeguarding Children Board has commissioned Children Act Enterprises (hereinafter referred to as The Consultant) to author a Serious Case Review on its behalf, following the death of Child A on 3rd August 2007.

CONSULTANTS' OBLIGATIONS – TERMS OF REFERENCE OF THE REVIEW

The Consultant shall receive a composite chronology of the case and the actions taken by each agency with a direct involvement in the case from 1st June 2005 to August 9th 2007. Additional contextual information will also be provided.

The Consultant shall establish whether inter-agency procedures throughout the period were followed.

The Consultant will consider the extent to which the mother's seeming compliance with services affected agency decision-making.

The Consultant shall consider the significance of events in the last two weeks of the life of Child A.

The Consultant shall consider whether there are lessons to be learned from the fact that none of the involved agencies were aware that the mother had a boyfriend living in the house.

The Consultant will consider how inter-agency communication affected the case.

The Consultant will consider whether the perception of the role of a family friend as "foster carer" had an impact on professional judgement.

The Consultant shall establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children.

The Consultant shall identify clearly those lessons, how they will be acted upon and what is expected to change as a result; and as a consequence to improve inter-agency working and better safeguard children.

The Consultant shall interview professionals and staff as necessary.

The Consultant shall invite, if appropriate, the child's family to contribute to the review.

Additional terms of reference added 12.12.07:

- Contact and communication with the children
- The gap between the referral to the Child Development Centre and the appointment offered.
- The medical examination of 1st August

THE SCOPE OF THE REVIEW

The review is in respect of all family members and will consider services provided to child A, his mother and his siblings.

THE PROCESS

The Local Safeguarding Children Board (LSCB) shall set up a Review Panel representing the following;

- Police;
- Health; and
- Children & Young People's Service

The composition of the Panel should be independent of the case.

The Consultant shall manage in partnership with the Review Panel, the review process in line with policy and practice procedures.

If appropriate, the Consultant shall meet with the family members wishing to contribute to the Review process

The Consultant shall meet with professionals involved with the case as required.

The Consultant shall draft an overview report for consideration by the Review panel.

The Consultant shall finalise the overview report for consideration by the Panel.

The Consultant shall be involved in the dissemination of the report at the end of the process. It is understood that this may mean an extension to the maximum number of days stated in Schedule 2, 1.1.

HARINGEY LSCB OBLIGATIONS

Haringey LSCB shall provide a merged composite chronology for consideration by the Review Panel.

Haringey LSCB shall ensure access by The Consultant and the Review Panel to all necessary files and documentation as required.

Haringey LSCB shall ensure that The Consultant receives the individual management reviews from agencies in relation to the case.

Haringey LSCB shall provide a venue for panel meetings.

Haringey LSCB shall determine the composition of the Review Panel.

Haringey LSCB shall set up any necessary briefing of specific organisations, groups or individuals in advance of the work of the review.

Haringey LSCB shall facilitate any interviews of professionals and family as required.

Haringey LSCB shall be responsible for completion of Individual Management Reviews and individual agency chronologies

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