Croydon and Lewisham

Safeguarding Children Boards

Serious Case Review

Children R, S, W

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1 Introduction

1.1 This is the overview report of a Serious Case Review (SCR) jointly commissioned by Croydon Safeguarding Children Board (CSCB) and Lewisham Safeguarding Children Board (LSCB) following the serious injury of Child W, a 6 month old baby girl. In April 2015 Child W was presented to hospital vomiting blood; she had multiple injuries and the appearance of neglect and as a result of her injuries she required specialist neurosurgical intervention. Child W and her siblings were in the care of their mother and her new partner at the time. The injuries remain unexplained, but were suspected to be non-accidental. At the time of writing the report care proceedings were on-going and Child W and her siblings were placed in foster care.

1.2 A criminal investigation was started at the time the injuries were discovered and both mother and her partner were arrested on suspicion of Grievous Bodily Harm (GBH). The investigation concluded in March 2016 with no charges or prosecutions being brought due to difficulties in establishing firm evidence in how the injuries were caused.

1.3 The case highlights and pertains to:

- The serious injury to Child W whilst in the care of her mother and her mother's partner
- The identification and recognition of neglect over the lifetime of very young children
- The frequency with which the family moved between at least 3 London boroughs
- Concerns about the long term impact of domestic abuse and mother's mental health problems, largely associated with childhood trauma
- The challenges faced by young parents (20 and 21 at the time) caring for 3 children who at that time were aged 4 and under.

1.4 The following is a summary of the events leading up to Child W's injuries.

1.5 This very young family of mother, her 3 children and her partner (father to the youngest two children) were living together in Lewisham. In January 2015 police attended an incident when the father had allegedly tried to strangle the mother and also tried to kill himself. As a result the London Borough of Lewisham commenced s47[1] enquiries. Before the enquiries were concluded the family left Lewisham to take up residence in Croydon, but soon after moving their mother went to stay with a new partner at another address in Croydon taking the 3 children with her.

1.6 At the conclusion of the s47 enquiries Lewisham made all 3 children subject to Child Protection Plans for Neglect. However, following their Initial Child Protection Conference (ICPC) on 25.2.2015 mother and the three children were reported as missing as no one knew of their exact whereabouts. Lewisham and Croydon Children's Social Care were then in communication about the transfer of case responsibility from Lewisham to Croydon.

1.7 On 13.04.15 her mother and her mother's new partner presented Child W, aged 6 months, to hospital. She was vomiting blood, having sustained multiple injuries, and had the appearance of neglect. Her injuries which were life threatening included 26 bruises on her body; she also had very bad nappy rash and appeared malnourished. Further tests revealed a number of suspected non-accidental injuries including trauma to the head causing bleeding on the brain, healing rib fractures and healing fractures to bones in the right leg and foot. These injuries were so severe they required specialist neurosurgical intervention.

1.8 All 3 children were removed into foster care and Lewisham commenced care proceedings. Croydon subsequently accepted case responsibility and took over in the early stages of the proceedings.

1.9 The children's mother and her new partner were arrested on suspicion of GBH to Child W. As stated in paragraph 1.2 the police investigation concluded with no further action.

1.10 Child W has since made a full recovery from her injuries.

[1] S47 enquiries refers to section 47 of the Children Act 1989 which places a duty on the Local Authority to investigate where they suspect that children are suffering significant harm

2 Arrangements for the Serious Case Review

2.1 After the serious injury to Child W, CSCB took the view that the criteria for an SCR had been met which is entirely consistent with the guidance in 'Working Together'[2] (WT) 2015. As much of the work with the family had taken place in the London Borough of Lewisham, a collaborative approach was agreed upon between the two LSCBs and a joint SCR process commenced. CSCB agreed to take the lead and host the review with appropriate representation from Lewisham's Board to inform and contribute towards the process.

2.2 The case meets the two criteria below set out in WT:

5(2)(a)	Abuse or neglect of a child is known or suspected

and

5(2)(b)	(ii) a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child

2.3 Working Together (2015) Chapter 4 Para 11 states a Serious Case Review should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;

[2]*Working Together to Safeguard Children* (Working Together) is the government's overarching guidance on safeguarding.

- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

2.4 The purpose of the review is to;

- Look at what happened in the case and why and what action will be taken to learn from the review findings
- Identify actions that result in lasting improvements to those services working to safeguard and promote the welfare of children.
- Provide a useful insight into the way organisations are working together to safeguard and protect the welfare of children.

2.5 Arrangements were made to appoint the independent people who are required to contribute to the conduct of SCRs. Ms Sally Trench was appointed as the Chair of the SCR panel. Sally has had a lengthy career in local authority social work, in adult mental health and children and families services. As an independent consultant, she now acts as both Chair and author of Serious Case Reviews, and is accredited as a reviewer using the Social Care Institute of Excellence (SCIE) Learning Together model. Ms Jane Doherty was appointed to produce this overview report. Jane is an Independent Social Work Consultant with a considerable background in Child Protection and Quality Assurance. As an independent consultant she now specialises in multi-agency learning reviews including partnership reviews and SCRs.

2.6 CSCB appointed a Review Panel to manage and oversee the review. The membership of the panel is set out below:

Name/Designation	**Organisation**	**Role**
Sally Trench	Independent	Chair of the panel
Jane Doherty	Independent	Overview author
Designated Doctor for Child Protection, Croydon Health Services NHS Trust and NHS Croydon CCG	Croydon Health	Panel member
Head of safeguarding/Designated Nurse, Children Croydon CCG	Croydon Clinical Commissioning Group	Panel member

Associate Director of Nursing, Integrated Women's, Children and Sexual Health Directorate	Croydon Health	Panel member
Named Nurse	South London and Maudsley Trust (SLaM)	Panel member
Review Officer, Specialist Crime Review Group	Metropolitan Police Service	Panel member
Head of Service, Safeguarding and Quality Assurance	Social Care and Family Support Croydon	Panel member
Head of Service, Early Intervention	Social Care and Family Support Croydon	Panel member
Head of Service, Safeguarding and Quality Assurance	Lewisham	Panel member
Board Manager	Croydon Safeguarding Children Board	Panel member
Business Manager	Lewisham Safeguarding Children Board	Panel Member
Development Officer	Lewisham Safeguarding Children Board	Panel Member
Named Nurse Safeguarding Children	Lewisham and Greenwich NHS Trust Trust lead Named Nurse	Panel Member
Assistant Director of Quality (Children) Designated Nurse Safeguarding and Looked After Children	NHS Lewisham Clinical Commissioning Group	Panel Member

2.7 It was determined through the emerging facts of the case that the following agencies had had contact with the family and should therefore contribute to the review:

Agency	**Nature of contribution**
Croydon Children's Social Care	Chronology and IMR
Lewisham Children's Social Care	Chronology and IMR
Croydon Health Services (covering Health Visiting, Croydon University Hospital and)	Chronology and IMR
South London and Maudsley Trust	Chronology and IMR
Lewisham and Greenwich NHS Trust	Chronology and IMR
Chelwood Nursery Lewisham	Chronology and IMR
Metropolitan Police Service	Chronology and IMR
NHS England (GPs)	Chronology and IMR

Kings College Hospital	Summary Report
Guys and St Thomas Hospital	Summary Report
Lambeth Children's Social Care	Summary Report
London Ambulance Service	Chronology

2.8 The Terms of Reference (ToR) agreed by the Panel were that the period under detailed review would be from 1 October 2013 to 20 April 2015 with the proviso that agencies would summarise any other relevant information pre-dating this period, to add context and background to their report. In line with this some background information about events prior to October 2013 and the current position of the siblings is also included in the report.

2.9 The methodology used by the CSCB in this review is a hybrid model, in that each agency was asked to complete a chronology, and undertake an Independent Management Review (IMR). Those agencies who have had minimal contact were asked to complete an Agency Summary Report (see table at 2.7)

2.10 The CSCB held a series of SCR Panel meetings, chaired by the Independent Chair, where all the agencies and the overview author contributed to the process of gathering and analysing the material provided.

2.11 Two consultation and learning events were held in November and December 2015 to enable those practitioners who worked with the family to contribute to the overall findings and lessons from the review. Two separate events were held – one in Croydon and one in Lewisham.

2.12 A further joint event was held in February 2016 prior to the final publication of the report to feedback findings from the Review and to ensure views from the practitioners had been captured. Where relevant their views have been incorporated throughout the report.

2.13 CSCB plan to hold further learning events at the conclusion of the review both for practitioners and other staff from the children's multi agency workforce as well as other board partners.

3 Family Contribution

3.1 In line with expectations laid down in WT consideration was given to involving the family in the review process and family members were advised that the review was underway. Despite many attempts to contact them, family members did not feel able to contribute at this stage and therefore the report has been prepared without their input. Whilst this was not ideal, the panel were satisfied that all avenues to try to include family members' views had been explored. Due to their very young ages it was not thought appropriate to seek the views of the children.

4 Methodology used to draw up this report

4.1 This report is informed by:

- The agency chronologies, IMRs and summary reports
- Background information from agencies involved in the review
- Panel discussions and analysis
- Dialogue with IMR authors
- Input from practitioners via the consultation and learning events held on the 12th November 2015, the 8th December 2015 and the 18th February 2016
- Research findings.

4.2 The report consists of:

- A factual context
- Analysis of how the agencies worked together from the information provided in their IMRs
- Commentary on the family situation
- Key themes and lessons learned
- Recommendations

4.3 The review has been conducted and written with the benefit of hindsight, which often distorts the reader's view of the predictability of events, which may not have been evident at the time. It is important to be aware as Munro (2011) states just how much hindsight distorts our judgement about the predictability of an adverse outcome. Once an outcome is known we can look back and believe we can see where practice, actions or assessments were critical in leading to that outcome. This is not necessarily the case, and information often becomes much clearer after an event has occurred. The review is therefore sensitive to this 'bias'.

4.4 The review is also sensitive to pressures on agencies and the demands of the work which are sometimes overwhelming for even the most capable of workers. It is therefore important to disseminate the learning and reflect on how the lessons from this review can help support better practice, rather than apportion blame to agencies or individuals.

5 Factual Narrative Chronology

Family Structure

Names	Age at the time of the incident	Gender	Relationship	Ethnicity
Child W	6 months	F	Subject	White British
Child S	1 year, 6 months	F	Subject	White British
Child R	4 years, 1 month	F	Subject	White British
Ms A	20	F	Mother	White British
Mr C	21	M	Father of Child S and Child W	White British
Mr B	18	M	Father of Child R	White British
Mr D	18	M	Mother's new partner and where children were staying at time of incident	White British
Ms E	36	F	Maternal Grandmother	White British
Ms F	61	F	Maternal Great Grandmother	White British
Mr G	N/k	M	Paternal Grandfather to Child R	White British
Ms H	35	F	Paternal Grandmother to Child R	White British

Background Information

5.1 Each of the agencies involved in this review submitted a detailed chronology of their involvement with the family members in the period under review. Those submissions have been coordinated into an integrated chronology which is summarised here. Further factual information is provided in some subsequent sections where relevant.

5.2 All the adults involved in this review (Ms A, Mr B, Mr C and Mr D) grew up in Croydon. All but Mr C were known to CSC at some point in their childhood.

Ms A and Mr B

5.3 Ms A and Mr B (father to Child R) met when they were very young and Child R was born when they were 16 and 14 respectively. The multi-agency professional network in Croydon had known Child R since her birth in March 2011 when Croydon CSC completed an assessment.

5.4 The parents had somewhat troubled childhoods. Ms A's mother (Ms E) had very serious mental health problems and consequently Ms A spent much of her childhood living at her grandmother's home. At 16 Ms A had her own social worker due to the risk of being homeless whilst pregnant. Mr B had his own social worker as he and his siblings were subject to Child In Need (CIN) services in Croydon at the time of Child R's birth and had previously been subject to Child Protection Plans. Mr. B had also lived with his grandmother under a Special Guardianship Order (SGO) until 2010 when his grandmother died and he moved back to live with his mother. He was subject to the SGO due to his own mother's difficulties with substance misuse.

5.5 When Child R was born in 2011 the family were in receipt of services under s17 (Children Act 1989) from Croydon CSC for a period of approximately 8 months. In that time both Initial and Core Assessments[3] were undertaken. The concerns raised were about the very young age of the parents, their unstable relationship, the basic care and safety of Child R and Ms A's partial engagement with services.

5.6 The assessments conducted took account of both parents' vulnerabilities (as above). It was also noted as a significant factor that both parents' childhoods had been disrupted by lengthy periods of living with extended family e.g. grandparents, due to their own parents' difficulties.

5.7 The assessments concluded that Child R was not at risk of significant harm and that the parents had demonstrated some progress over time and had become more confident in their parenting. Child R was said to be meeting her developmental milestones and it is recorded in the assessment that there were 'no concerns about her attachment'.

5.8 By November 2011 Ms A and the baby were living with a friend and her mother and this was seen as a more stable and supportive arrangement. As a consequence of this change in circumstance Child R's case was closed to CSC. Mr B remained living in his family home but continued to have some contact with Child R.

5.9 The IMR provided by Croydon CSC does however note that it is possible that Child R fell between two sets of social workers who were allocated to the parents and she was not allocated a social worker in her own right. The assessment was conducted by the same social worker allocated to Mr. B and his siblings with whom the social worker had an established relationship. The IMR makes the point that this may have led to an over optimistic assessment of the parents' parenting capacity. Nonetheless it is a pattern throughout the review period that with consistent periods of involvement with professionals Ms A did make progress.

[3] In 2011 Local Authorities were required to assess families in need under the National Assessment framework (NAF) which consisted of initial and core assessments. These have since been replaced by the Single Assessment Process

5.10 The Family Nurse Partnership (FNP)[4] were involved for the first two years of Child R's life and offered an intensive amount of support over that time.

5.11 Throughout the period of this review Ms A lived in at least 3 London boroughs Croydon, Lambeth and Lewisham. The exact details of the moves have not been established for the review but rough timelines indicate that Ms A moved from Croydon to Lambeth at some point during 2013 (possibly earlier) when she was pregnant with Child S. Just prior to Child S being born the family moved to Lewisham and in February 2015 the family moved back to Croydon.

Mr C

5.12 Mr C was not known to services as a child and it is not currently known where he and Ms A met.

Mr D

5.13 Mr D, his siblings and half siblings, have a long history of involvement with Croydon CSC and he and five of his siblings were removed from their mother's care permanently. At the age of 3 Mr D was made subject to a full Care Order (s31 Children Act 1989) and subsequently adopted.

5.14 Mr D was however living with his birth mother when Ms A moved herself and her children into Mr D's mother's house in February 2015. Their presence in the household made it substantially overcrowded and it transpired during the investigations surrounding the injuries to Child W that there was a seven year old half sibling of Mr D also living in the house.

[4] The Family Nurse Partnership (FNP) is an evidence based, voluntary home visiting programme run by the NHS for first time young parents, aged 19 years or under. A specially trained family nurse visits the parents regularly, from the early stages of pregnancy until their child is two. Their role to educate and advise on parenting.

Practice Episode 1: (17th September 2013 – 31st December 2013)

5.15 The ToR for this review start at the beginning of October 2013; however as there was a significant event in September 2013 (an assessment was conducted by Lambeth CSC), this practice episode begins at that point. At the time of the referral the family resided in Lambeth but it would appear that they (Ms A, Mr. C and Child R) had moved to Lewisham by the end of September that year. Ms A was heavily pregnant with Child S who was due in the middle of October and a referral had been made to Lambeth CSC by Midwives from KCH.

5.16 The midwives had originally made the referral via a Common Assessment Framework (CAF) in March 2013. At that time it was practice to commence a pre-birth assessment after 26 weeks but it is not clear why the assessment was not followed up by Lambeth CSC until September when Ms A was due in October. The referral was made as the midwives were concerned about Ms A's low mood and the fact that she had missed some antenatal appointments. Lambeth CSC allocated the family to a social worker for a pre- birth assessment.

5.17 The Lambeth Social Worker concluded the assessment at the end of October having seen the family twice (at their Lewisham address) and made the decision that the family should transfer to Lewisham CSC for support under a CIN plan. Lewisham CSC reviewed the information in January 2014 and assessed that the family would be better supported by a Team Around the Family (TAF) and did not open the case to CSC.

5.18 At this time Ms A was receiving a service from the Perinatal Team[5] as she had been referred by her GP in August 2013 having presented to him with what was described as a 'severe depressive episode'. As well as the referral to the Perinatal Team the GP had also prescribed sertraline[6] to assist with her mood and anxiety.

5.19 Ms A had disclosed to the Psychiatrist in the Perinatal Team that she was repeatedly raped by a 'previous partner' during their relationship and this was causing her some considerable distress which manifested itself in the form of anxiety, flashbacks, hallucinations and ultimately in severe depression. Practitioners from the Perinatal Team visited Ms A at home for a period of 7 months (August 2013 to March 2014) though towards the end of this period Ms A had largely withdrawn from their service.

[5] The Perinatal Team operated by SLaM specialise in the treatment of antenatal and postnatal mental illnesses. The service is for women who develop or have a relapse of serious mental illness during pregnancy, and women who have developed postnatal depression, post-partum psychosis (also known as puerperal psychosis) or have had a relapse of serious mental illness following the birth of their baby.

[6] Sertraline is a medication used to treat the symptoms of depression and anxiety disorders including PTSD.

5.20 On the 17th October Child S was born at home and immediately transferred to hospital where they were discharged after two days. Mother and baby were both medically fit on discharge. Despite an agreement between the Perinatal Team, the midwife and Lambeth CSC that a Discharge Planning Meeting should take place before mother and baby were discharged home no such meeting took place.

5.21 There were several visits by professionals following the birth from the midwives, the health visitor (HV), the Lambeth Social Worker and the Perinatal Specialist Nurse. Child S was seen throughout these visits, but Child R was often not seen and parents reported her to be with either PGM, MGM or with her cousins.

5.22 Ms A did not keep a planned home appointment by the Perinatal Nurse Specialist on the 12th November and instead a telephone review was conducted. The plan was that Ms A should be discharged from this service as there did not appear to be any further concerns in relation to her mental health. As a result of this the nurse arranged for a review by the psychiatrist for the beginning of December.

5.23 The HV conducted a home visit 2 days later and Child R was present in the home. The HV recorded that the flat was untidy and smelt heavily of cigarette smoke. The HV advised the parents of the health risks particularly to children through smoking inside and suggested they smoke outside and if possible try to cut down. Child S was weighed and noted to be gaining weight slowly. The HV also advised parents to increase the feeds and although Ms A agreed, she was apparently reluctant to do so.

5.24 The family was seen twice at the beginning of December – once by the GP at the surgery and once by the HV the following day. It is however significant to this review that between the birth of Child S and the end of December the family had DNA'd[7] or cancelled a total of 6 health appointments (3 with the Perinatal Team, 1 with the HV and 2 with the New Born Hearing Clinic for Child S).

Practice Episode 2: 1st January 2014 – 31st March 2014

5.25 In January 2014 the family continued to reside in Lewisham and the HV conducted a home visit. Child R was present but the health visitor was unable to assess her speech as she would not engage. The HV was again concerned about the condition of the flat as it was in a disheveled state with takeaway containers and cans lying around. Despite advice on the previous visit, the flat again smelt heavily of cigarette smoke. Child S was said to be developing within normal limits and her weight gain was improved. The parents had not accessed any of the supports such as the Children's Centre also suggested at the last visit.

[7] DNA'd – Did Not Attend

5.26 The Perinatal Team also visited the same day and although there were no concerns about Ms A's mental state they also noted concerns about the state of the flat.

5.27 As a result of this visit the Perinatal Team made contact with CSC in Lewisham regarding Ms A's DNAs and their concern about the conditions of the home. CSC reported that the case was not open to them and that Ms A seemed to be engaging in a TAF process and they were not planning to open it.

5.28 The HV made plans for more formal early intervention via a CAF including referring Child R for a paediatric assessment of her development. The HV was concerned about her speech delay and her interaction with adults was limited possibly due to lack of stimulation. Despite the HV's attempts to engage the parents in help from the Children's Centre and secure childcare for Child R under the government's Early Education Scheme for two year olds,[8] the parents were not proactive about arranging this. As a result the HV became concerned about the amount of stimulation and play Child R was receiving.

5.29 On the 7th February 2014 Child R and Child S were accommodated for a brief period as they were being cared for by their MGM (Ms E) when she suffered an episode of mental ill health while out in Croydon with both children. She became aggressive and was sectioned under the Mental Health Act and taken to a psychiatric hospital. It transpired that Ms A and Mr C had gone away for a few days and were not contactable. As a result the children were in foster care for 3 days and Lewisham CSC commenced an assessment under s17 Children Act 1989.

5.30 An assessment of the parents was completed by Lewisham CSC which concluded that there was no further role for them and the children returned home. The social worker recommended Targeted Family Support (TFS), but the family did not take up this service at this time.

[8] This is a scheme that allows eligible children to receive free early education from the funding period after their second birthday. This is part of a national offer from the Department for Education (DfE) and has been developed to improve outcomes for identified two year olds who would benefit from access to high quality early years and childcare provision

Practice Episode 3: 1st April – 31st December 2014

5.31 Ms A became pregnant with Child W (her third child) at some point early in 2014 with the baby due in November. Ms A had her booking appointment with the midwife at the end of April and disclosed some details about her past including recent involvement with CSC and her depression. As a result of the disclosure the midwife made a referral to the Perinatal Team and they became involved once more. They visited Ms A in May when she told them that she did not feel the need for their input at present and she was referred back to her GP. During the visit she presented as guarded and suggested that she was being 'checked on'. Ms A told them that she continued to take her medication (sertraline) although this medication had not been prescribed at that time.

5.32 As the parents had not taken up the offer of the Early Education Scheme earlier in the year, in April the HV completed an application for a nursery placement for Child R. When it became apparent that the parents had not been proactive in pursuing this place either, the HV facilitated communication between the two parties and both parents attended a pre-admission interview at the nursery on the 19th June. Child R was also present. The outcome of the interview was that Child R was allocated a priority place to commence as soon as a vacancy became available.

5.33 At the interview the nursery were concerned about the parents' presentation in the meeting and in particular about Ms A's reluctance to share any information. In addition the parents were unwilling to give emergency contact numbers and this remained an issue throughout the coming months.

5.34 In July the previous social worker from Lewisham made another referral to TFS. The parents reluctantly engaged with a key worker from that service who was assisting them with Housing Benefit arrears.

5.35 On the 2nd of September the parents, along with Child R, attended a welcome day at the nursery for new starters. The nursery were again concerned about the parents' presentation as the family all had a strong odour about them. Child S was not present and Child R was said to be 'blank and emotionless'.

5.36 As a result of their concerns the nursery staff planned a home visit for the following day (3rd September) as a pre-admission home visit. It is not clear if this is standard practice or they visited because they had concerns. Again Child S was not present in the home and there was no satisfactory explanation about where she was. The home was unclean and the parents were reluctant to engage.

5.37 The nursery made a referral to CSC in Lewisham as they were concerned about neglect of the children. The referral wasn't progressed to assessment at that stage as the Targeted Family Support (TFS) team were already involved.

5.38 Throughout this period Ms A and Mr C were erratic with attending various appointments – Child S missed her developmental review and Ms A did not attend one of her antenatal appointments. The parents DNA'd two appointments in respect of Child R – one was her developmental assessment and the other was her Speech and Language Therapy (SALT).

5.39 Child R started nursery on the 10th September and her attendance was also erratic. It would appear that the nursery, the HV and the TFS team were now in communication and a picture of concerns and the type of support the family may need was building.

5.40 As a result of the growing concerns, the first Team Around the Family (TAF) meeting was held at the nursery on the 23rd October 2014. The lack of engagement by the parents and Child R's poor attendance at nursery (among other issues) were discussed. The key worker allocated to the family from TFS shared that she had been assisting the family with rent arrears, which had accrued to £6000 due to non-payment of Housing Benefit. Ms A and Mr C had attended court and she had attended with them. The family was still facing the prospect of eviction although the key worker reported at the meeting that they had had a reprieve at court when the eviction notice was put back by ten weeks.

5.41 The meeting set out a plan of action which included ensuring that Child R got to nursery every day to enable her to take up a full time place by Christmas. TFS would continue to support the parents with their housing situation.

5.42 Ms A's pregnancy progressed well throughout this period and Child W was born, with no complications, on the 25th October, two days after the TAF meeting Mother and baby were discharged home to the care of the midwives who visited a number of times during the latter part of October and the beginning of November. Agencies were in communication with one another but there was no formal Discharge Planning Meeting planned. The HV completed her new birth visit on the 7th November where Child S and Child W were seen but Child R was said to be with her PGPs. She was however present at a subsequent visit on the 14th November.

5.43 Ms A cancelled a planned visit by the HV early in December due to 'family problems' but she attended the Child Health Clinic (CHC) the following week.

5.44 A further TAF meeting was held on the 16th December and improvements were noted. Child R had made the transition from part time to full time nursery and was much more settled. The family's housing problems had largely been resolved by some of the arrears being paid and they were no longer facing imminent eviction. The younger children (Child S and Child W) had begun to attend a play session at the nursery with the parents each week, though it was mainly Mr C. who attended.

Practice Episode 4: 1st January 2015 – 20th April 2015

5.45 On the 10th January a domestic incident occurred whereby Mr C called the Police to say he had assaulted Ms A as he believed she was cheating on him. He stated that he had held a knife to his own throat as he was worried that he would go back inside the house and kill her. Police attended and Mr C was arrested.

5.46 When interviewed Mr C said he regretted what had happened and admitted that three months before, he had started to self-harm (not clear what form this was taking). Ms A refused to press charges but later the same day she called the police to say that she wasn't coping with the children and wanted CSC to look after them. Lewisham CSC were consulted and advised the police that the children would be best remaining with their mother. Officers visited the address and Ms A changed her mind during the course of the conversation and the children remained at home.

5.47 As a result of these incidents Mr C was given a formal police caution for common assault and criminal damage and a referral was made to MARAC in Lewisham. A strategy discussion between the police and CSC resulted in a decision to commence a single agency S47 enquiry to be conducted by Lewisham CSC

5.48 On the 19th January Mr C attended a GP appointment ostensibly for advice for a physical problem and whilst there he asked for help with anger management. In response to this request the GP gave Mr C information to be able to self-refer to Improved Access to Psychological Treatment (IAPT). It is not clear how Mr C pursued this as there were differing explanations from the parents as to what happened to the application form. Ms A told professionals that she assisted Mr C in filling in the form and posting it, whilst Mr C told professionals he had filled in the form but it had not been posted as it was the day that the family were moving house.

5.49 A TAF meeting was held on the 26th January and was attended by the allocated social worker conducting the s47 enquiries. Ms A was present but not Mr C. According to Ms A the couple had reconciled, though she acknowledged that she was finding this hard and it was reported at the meeting that the family were again faced with eviction. This was due to happen at the end of January.

5.50 Throughout January Child R's attendance at nursery had once again become poor and the nursery staff were unable to contact the parents to ascertain why Child R was not attending.

5.51 On the 1st February the parents and all 3 children moved to an address in Croydon. It is not clear if they were evicted but they were assisted in their move to a private tenancy by the worker from TFS. Lewisham agreed to pay their arrears which were less than the £6000 originally thought and the family were given an Incentive Scheme grant operated by Lewisham Housing of £1000 to cover their new deposit.

5.52 Lewisham CSC continued with the s47 enquiries they had started earlier on in the month and an ICPC was held in Lewisham on the 25th February. Croydon CSC were invited to attend but this was not possible due to the amount of requests of this nature and pressures of workload. Mr C but not Ms A attended the conference. The 3 children were made subject to Child Protection Plans (CPP) under the category of neglect.

5.53 At the ICPC it transpired that Ms A had left the family home in Croydon with the 3 children and no one (including Mr C) knew of her whereabouts. Ms A and the 3 children were reported as missing to the police. Mr C told the conference members that he believed Ms A was having a relationship with Mr D and named him in the meeting.

5.54 Mr C also disclosed at the ICPC that before leaving the family home Ms A had accused him of sexually assaulting Child S. The discussion and concerns around this issue were not fully reflected in the minutes of the ICPC and were not the subject of an action to be completed in the outline Child Protection Plan.

5.55 The allegation was not followed up immediately after the ICPC as Ms A and the children were missing. When they were found at Mr D's address in Croydon on the 3 March there was a further delay and the investigation was not carried out until the 2 April when Lewisham CSC and the police undertook a joint s47 investigation. This was as a result of Croydon CSC requesting this outstanding action be completed before accepting the case for transfer. The outcome of the investigation was No further Action (NFA) as Ms A denied having made the allegation and Child S made no disclosures.

5.56 Lewisham CSC continued to hold case responsibility for the family but over the course of March and the early part of April the two boroughs (Lewisham and Croydon) were in communication about transferring the case from one to the other. This proved to be a protracted process and the request for a Transfer in Conference (TIC) was not officially accepted by Croydon until 13 April, the same day that Child W presented to hospital with her injuries (see below). Croydon CSC agreed to hold a Child Protection Conference but did not accept case responsibility at this stage stating that the decision would be made at the TIC.

5.57 On the 13 April Ms A and Mr D presented Child W to hospital. She was vomiting blood. On examination at hospital, Child W was observed to have 26 bruises on her body, very bad nappy rash and appeared malnourished. Further tests revealed a number of suspected non-accidental injuries including trauma to the head causing bleeding on the brain, healing rib fractures and healing fractures to bones in the right leg and foot. Her injuries required specialist neurosurgical intervention. Ms A and Mr D were arrested on suspicion of GBH and interviewed by police.

5.58 All three children were removed to foster care and Lewisham CSC commenced care proceedings which were subsequently taken over by Croydon CSC.

6 Key themes identified by the review process

6.1 Thresholds for intervention when assessing neglect over time

6.1.1 As described in the background information Child R and her parents received statutory services under a Child in Need plan for a period of 8 months after she was born. The input demonstrated some progress over time before the case was closed. Ms A (not sure if it included Mr B) also received an intensive service from the FNP for a period of two years as per their remit. It is not clear what impact the FNP services had on the family but it is perhaps significant that a referral to CSC was made in April 2013 (to Lambeth) towards the end of their input. Child R would have been 2 years old and Ms A was pregnant with Child S.

6.1.2 The hospital midwives made a referral to Lambeth CSC via a CAF, as Ms A's mood was low. The referral was not dealt with by Lambeth until September that year when it was allocated for a pre-birth assessment. Ms A was 8 months pregnant at this time and was also being supported by the Perinatal Team, the midwives, the HV and the GP.

6.1.3 The assessment conducted by Lambeth CSC which concluded in November 2013, made the recommendation that the family (having recently moved) should transfer to Lewisham CSC under a CIN plan. Lewisham CSC however did not accept the assessment and instead it was deemed that as the family were responding to Early Intervention Services they should continue to engage and be supported in this way. There is in fact scant evidence that the family were engaging and progressing so it is not clear how this decision was reached.

6.1.4 A number of professionals were concerned about neglect of the children throughout the period under review and between November 2013 and September 2014 at least five contacts or referrals were made to CSC in Lewisham in connection with their concerns. Only one of these referrals resulted in a formal assessment. Despite these referrals and the one assessment that was conducted, the family continued to be offered services from Universal Services or Early Intervention teams. This changed in January 2015 when s47 enquiries commenced and the family were presented to ICPC.

6.1.5 In the IMR presented by Lewisham CSC the author makes the point that the decision not to make the family subject to CIN plans after receiving the assessment from Lambeth was a 'flawed decision' and prevented Lewisham from making a fuller assessment and providing more co-ordinated services. This pattern seemed to repeat itself in the decision-making around the assessment undertaken by them in February 2014 when again a formal CIN plan for the family would have been beneficial.

6.1.6 The concerns were serious in both episodes. The former was about the state of the home and Ms A's mental health difficulties, which had been a concern for some time, and the latter when the parents went on holiday leaving the children in the care of their MGM who suffered with serious mental health problems.

6.1.7 In the latter instance the children came to the attention of CSC because the arrangement broke down when the MGM became unwell and was sectioned under the Mental Health Act 1983. As a result the children were accommodated for a period of 3 nights. The parents were not contactable during this period which added to the concerns.

6.1.8 The assessment, whilst containing some good analysis and identification of risk, reached the wrong decision. Although some positives were also included the IMR author identifies that the body of the assessment was at odds with its conclusions. The identification of several risk factors indicated a co-ordinated multi-agency response under the auspices of a CIN plan would have been beneficial. These factors included the following:

- The parents leaving the children with someone they knew to be suffering with longstanding mental health difficulties
- The parents' lack of availability during this time
- Domestic abuse
- Mental Health problems (mother)
- Developmental delay in Child R
- The parents' basic mistrust of professionals
- Information from other agencies which indicated concerns of neglect

6.1.9 In the event, the support that was offered to the family via the Targeted Family Support (TFS) Service was not taken up at this time and it is a concern that mechanisms which could have led to the family being reconsidered as needing more targeted support were not deployed.

6.1.10 Two possible mechanisms could have been used to step the family back up to statutory services, the first being an Early Intervention Panel (EIP) which would have re-considered the family's needs. This would have potentially facilitated a new contact with the Referral and Assessment service and opened the door to reallocation following the failure of the family to take up services with TFS. The panel would have been able to reflect on the family's lack of engagement and consider how this impacted on the risk assessment. In the event the family were not referred to the panel and this left them without the recommended support. The second possible pathway to the provision of services at this stage was for a TAF meeting to have been convened. This also did not happen until much later in the year.

6.1.11 Referrals to CSC in Lewisham made by the Perinatal Team and the nursery in January and September 2014 respectively were not considered to reach the threshold of intervention for statutory services other than early intervention. This was despite them having similar concerns about the conditions in the home, the partial engagement of the parents and the ability of the parents to provide adequate care and stimulation to the children. It is not clear therefore if the referrals were considered in light of the other information held about the family or if the length of time these concerns had persisted was considered a significant risk factor.

6.1.12 The referrals that were responded to and assessed by Lewisham CSC were those where a specific event had occurred – e.g. the parents leaving the children with MGM in February 2014 and the domestic abuse referral in January 2015. Of significant concern given Ms A's mental health needs and other prominent issues, there were no pre-birth risk assessments undertaken to plan for the needs and protection of the children once they were born.

6.1.13 The length of time the family were supported by Universal Services rather than more targeted services was problematic and is explored further in the following paragraphs.

6.1.14 As the outcome for the children was poor it is necessary to analyse the reasons the family did not appear to reach the threshold for statutory intervention at an earlier stage. Ofsted provide some insight into this issue in their report published in 2014 'In the child's time: professional responses to neglect', when they state that:

'Incidents, rather than the child's on going experiences, were assessed and chronologies were either not used or were not robust enough to evidence the level of neglect and the impact of support.'

6.1.15 In this particular case reasons may also include:

- The erratic nature of the concerns which were not static – e.g., at times the family presented as being able to cope while at other times concerns were heightened
- The isolated nature in which professionals were working with the family and therefore no one professional had a complete picture of the history and presenting concerns
- A perception in 2014, particularly by Lewisham CSC, that the family were involved in Early Intervention services when in fact they had refused many of the services offered
- The lack of a co-ordinated chronology detailing risks and strengths over time

- The nature of the services offered was voluntary and when the parents did not engage it was difficult for professionals to impose services where they had not been requested.
- When the parents did engage they made progress, leading professionals to be optimistic about their level of engagement.

6.1.16 It is evident with hindsight that the family would have benefitted from more statutory intervention carrying more weight at an earlier stage. The family would no doubt have tried to resist this but there is evidence to suggest that Ms A, at least, responded to a consistent, authoritative approach.

6.2 The challenges faced by young parents

6.2.1 Ms A was 16 when she became pregnant with her first child (Child R) and by the time Child W was born, Ms A and Mr C were 20 years old and caring for 3 children aged 3 and under. The difficulties associated with this for parents especially those barely out of childhood themselves should not be underestimated. Ms A had a complex personal history and had herself experienced poor parenting from her mother who had mental health difficulties. This undoubtedly impacted on her day to day functioning and the accumulated effect of this on her parenting was largely un-assessed by professionals.

6.2.2 These factors should have been considered much more closely as they are potentially major risk factors. This review has sought to understand what information professionals knew and understood about the parents' particular circumstances and has found significant gaps. For example the Perinatal Team held significant information about Ms A's childhood experiences but this information was not shared with other professionals (except the GP) and when she began to withdraw from services this was not followed up with other professionals involved with the family.

6.2.3 The review has highlighted that Ms A's vulnerability was not sufficiently recognised or responded to especially in light of the fact that she was caring for 3 very young children. Other SCRs have highlighted the issue of young parents and the lessons are repeated here in terms of the depth of knowledge about Ms A's mental health problems, how she was assisted to address them and how this affected her parenting. The Perinatal Team, for example, diagnosed Post Traumatic Stress Disorder (PTSD) but did not provide treatment to address this.

6.2.4 The cause of the PTSD has not been completely clarified for this review, which may be symptomatic of the fact that professionals did not have a clear understanding of this. This may have been because Ms A disclosed that she had had some counselling and repeatedly said that she felt much better and therefore did not feel the need for mental health input.

6.2.5 Ms A also claimed that she was prescribed (and was taking) sertraline. The evidence from this review would suggest that this was in fact not the case and that one prescription of sertraline was provided in 2013 but then was not prescribed thereafter.

6.2.6 In its summary of findings of SCRs dealing with children under one year old Ofsted identify a number of common shortcomings, including the lack of pre-birth assessment; underestimation of the needs of young parents and insufficient support being provided, bearing in mind the vulnerability of babies.[9]

6.2.7 Evidence that the parents were struggling was apparent when professionals noted the poor home conditions, the partial engagement from Ms A and more crucially the uncertain whereabouts of the children at particular times. There were numerous occasions when one or more of the children were not present in the family home (or at appointments) and were said to be with relatives (usually grandparents). Although practitioners noted this and enquired about them this was rarely followed up. On one occasion when it was followed up by the nursery in September 2014, when they were concerned about the whereabouts of Child S, the parents gave differing vague accounts of where the child was.

6.2.8 Through the practitioner events more information came to light that some family friends had looked after the children and appeared to be very supportive to the parents. They did not however make themselves known to CSC until the care proceedings were well underway.

6.2.9 Mr C's mental health difficulties which became apparent in January 2015 when he disclosed to the police that he had begun to self-harm are not well known about or documented by professionals. This adds to the complex picture of young vulnerable parents and their needs.

[9] OFSTED, (2011) Ages of Concern: Learning Lessons from Serious Case Reviews a thematic report.

6.3 The role of Early Intervention in cases of neglect

6.3.1 A theme of this review, also connected to the issue of the young age of the parents caring for very young children, is one of the role of Early Intervention services. The Department for Children, Schools and Families (now known as the Department for Education (DfE) 'Getting Maternity Services Right for pregnant teenagers and young fathers' document summarises the complexities of assessing the root causes of negative outcomes for teenage parents and their children thus:

"*There has been considerable debate over whether poor outcomes for teenage mothers and their babies are a consequence of the mother's age, or of her often disadvantaged circumstances, or of limited uptake of antenatal care. Current research suggests that all three factors can contribute to poor outcomes, but that timely access to appropriate care and support can help to overcome the risks of poor outcomes and can maximise young people's potential for achieving a healthy and happy transition to parenthood." (DCSF 2009)*[10]

6.3.2 Over this review period practitioners did provide some helpful services to the family and their limited success was not through lack of trying to support and engage them. The second referral to TFS in July 2014 appears to have come about as a result of some informal liaison between the team and the social worker who completed the assessment in February of that year. Although the family did reluctantly engage with them it is also significant that no formal TAF meetings took place until October 2014. This was the first time all practitioners involved came together to look at what they could offer collectively, share information and make a plan.

6.3.3 This approach did seem to work to a certain extent and at the second TAF meeting in December 2014 some progress had been made – e.g. Child R was in nursery full time, the couple's housing situation was on its way to being resolved and the other two children were attending a play session at the nursery.

6.3.4 There is a question as to why there was a lack of a more co-ordinated response prior to this time. The family were known to several agencies throughout 2014 and there was some limited communication between them – e.g., the HV kept the GP updated about her concerns via regular link meetings and liaised with the Children's Centre.

[10] Getting Maternity Services Right for pregnant teenagers and young fathers' DCSF p4

6.3.5 The HV did some proactive work and completed a CAF which was sent to the Children's Centre in order to try and engage the parents in groups that would provide support for them and an outlet for Child R to spend time in the company of other children. When the parents failed to engage with this the HV insisted that the family register with the nursery by 'almost frog marching them over there' (recorded in the ICPC minutes dated 25.2.2015). This is perhaps an indication of how committed professionals were to assisting the family and how frustrated they became when offers of help were rejected.

6.3.6 The catalyst for the more formal early intervention appeared to be the involvement of the nursery and their concerns which were immediately apparent on meeting the family. TFS became involved and the co-ordinated, supportive approach seemed to have an impact at least in the short term.

6.3.7 Over this period practitioners did provide some helpful services to the family. Their limited success was not through lack of trying to support and engage them but what was lacking was a comprehensive multi-agency assessment detailing the accumulative risks over time. WT makes the point that:

'*The assessment of neglect cases can be difficult. Neglect can fluctuate both in level and duration. A child's welfare can, for example, improve following input from services or a change in circumstances and review, but then deteriorate once support is removed. Professionals should be wary of being too optimistic. Timely and decisive action is critical to ensure that children are not left in neglectful homes' (WT 2013 p24)*

6.4 The impact of childhood trauma on parenting capacity

6.4.1 It has been established during the course of this review that Ms A had a troubled childhood. Her mother had serious mental health difficulties which were severe and enduring and led to her being sectioned at least once during the time period of this review. Ms A spent much of her childhood living with her grandmother. She became pregnant with Child R at 16 and the baby's father was younger still at 14.

6.4.2 What is less clear are the circumstances around an alleged rape in her teenage years.

6.4.3 The trauma associated with this event however, manifested itself in her becoming anxious, experiencing derogatory auditory hallucinations, flashbacks and nightmares. In particular Ms A described these symptoms becoming worse when she became pregnant with Child S as they reminded her of the event. The revelation of this resulted in a diagnosis of PTSD as mentioned earlier in the report

6.4.4 The impact of Ms A's mental distress was not assessed in terms of her capacity to care for the children and although therapeutic support such as psychotherapy was discussed Ms A did not pursue this option. The risk factors associated with maternal mental health problems were missed and despite often visiting the family on the same day, the HV who had most contact with the family had no knowledge of the Perinatal Team's involvement.

6.4.5 Further to this Ms A was seen a number of times by her GP throughout the period under review, when her mental health was not assessed nor was her medication reviewed. The issue of medication is worthy of note as it would appear that Ms A told a number of professionals that she was prescribed (and taking) sertraline. There is, however, no indication Ms A ever took regular anti-depressants from when she was first started on treatment at the end of 2013 by her GP. This was never addressed by the GPs who saw her throughout her pregnancy with Child W and during the postnatal period.

6.4.6 The routine assessment of Ms A's mental health may have been overlooked by the GP Practice in Lewisham because the original assessment (when she was presenting with severe symptoms) was conducted by the GP Practice in Lambeth and so therefore they had not noted this as a problem worthy of regular monitoring. They were however proactive in referring her back to the Perinatal Team once she became pregnant with Child W.

6.4.7 Neither of the GP practices screened for domestic abuse and this may have been because Ms A was often accompanied by either Mr C or the children. There were however at least two occasions when Ms A attended on her own and these opportunities could have been taken.

6.4.8 There was good communication about the family between the HV and the GP by virtue of their GP Liaison Meetings which were introduced to Lewisham GP practices in 2010. The meetings were held approximately every 6 weeks and although they acted as a good source of information sharing they did not result in any actions to support the family.

6.4.9 The GP Practice had not applied ‘safeguarding codes’ on the family’s records so when notifications came in such as DNAs for medical appointments these were not highlighted as being significant and therefore not always followed up. DNA’d appointments should have been viewed as a wider indication of neglect as the children were not having their health needs attended to.

6.4.10 The IMR provided by the GPs surmises that there may have been many assumptions by the GP practice about the care Ms A was receiving. For example, there may have been an assumption that she was already under the care of the Perinatal Team and that the HV had taken steps to bring in support from TFSS. Later on the children were also on CP Plans and the practice may have assumed that services were engaging the family. There was an opportunity to clarify these matters via the liaison meetings and the author of the GP IMR makes a helpful recommendation about how these meetings can be strengthened.

6.5 Interpretation of procedures when families move across Local Authority boundaries

6.5.1 The delay of the transfer of this case between Lewisham and Croydon CSC has been a source of much discussion among panel members and practitioners alike. In order to analyse it clearly it is necessary to take account of the facts which are set out below.

6.5.2 The family moved to Croydon from Lewisham on the 1st February 2015 and according to information from the Lewisham CSC IMR they had been planning to move to Croydon for some time. The exact details are not clear but it would appear that the housing arrears accrued on their Lewisham property were paid off and the family were assisted with the deposit to put down on another property in Croydon. It is not clear if they were actually evicted from the Lewisham property but they did have an address to move to.

6.5.3 The s47 enquiries taking place in Lewisham due to the domestic violence incident began in mid-January prior to the family moving to Croydon. Lewisham exercised good practice and continued to undertake the assessment despite the family having moved to another borough.

6.5.4 At the conclusion of their assessment when the decision to present the family to ICPC was made, the social worker and manager sought advice from a Child Protection Advisor (CPA) as to whether or not to go ahead with the conference on account of the family's move. Again good practice prevailed and as the children were deemed to be at risk of significant harm the decision was to go ahead with the ICPC, invite colleagues from Croydon and then to transfer the case as a Transfer in Conference (TIC) in accordance with the London Child Protection Procedures (LCPP). This would ensure consistency of CSC involvement and continued risk assessment for the family.

6.5.5 Lewisham made contact with Croydon Multi Agency Safeguarding Hub (MASH) team on the 9th February to inform them that the family had moved to their area. The conference took place on the 25th February; colleagues from Croydon CSC were not able to attend but a HV from Croydon did attend.

6.5.6 The children were all made subject to CP Plans under the category of neglect. Mr C attended the ICPC but not Ms A and it was at the conference where plans were made to report Ms A and the children missing – an action that was taken immediately following the conference. Ms A and her children were located at Mr D's address at the beginning of March and from 9th March Lewisham began the process of case transfer.

6.5.7 A series of transfer in requests and telephone conversations took place between Lewisham and Croydon and they were turned down. Requests for a TIC were received by Croydon on the 9th and 13th March and on the 8th April. It is likely that there was much more contact between the boroughs than has been recorded but what it clear is that it was a source of great frustration for both sets of practitioners and impacted on other work.

6.5.8 It is important to note that the requests came into the MASH team in Croydon. MASH is a non-case holding team whose core task is to filter requests for services and signpost them to the most appropriate place. The team have a period of 24 hours to make a decision as to where a case should be located and there is an emphasis on ensuring that cases are dealt with in a timely manner.

6.5.9 MASH teams across London are under immense pressure due to the number of referrals received. By the nature of how they are set up and resourced they are not equipped as a service to deal with cases on a medium or long-term basis.

6.5.10 The TIC request from Lewisham on the 9th March was not rejected as such – the worker dealing with the call asked for clarification of the address and some additional information so that the request could be processed. The case was however closed whilst Croydon awaited the extra information. In this process the practitioner sent incorrect forms to Lewisham and this is likely to have caused some confusion. This erroneous practice has now been addressed.

6.5.11 The information requested was provided to Croydon and Lewisham made a further request to transfer the case across on the 13th March. In this process they tried to ascertain why the TIC request had not yet been accepted. This request appears not to have progressed at this time, due to the manager's annual leave and the fact that there was no one taking responsibility for their work whilst they were absent. Staff vacancies and the lack of a Deputy Team Manager impacted further on the delay.

6.5.12 On the 24th March the manager in Croydon reviewed the information and made the decision that the case could not transfer in at this time for two reasons. One was that the family had not made an application for housing in Croydon and the current address for Ms A and the children was overcrowded and not a long term option. The other was in relation to an allegation that Ms A was said to have made about Mr C sexually assaulting Child S. Mr C had disclosed this information at the ICPC and this had not yet been investigated. The manager's view was that it was Lewisham's role to investigate and this outstanding task needed to be undertaken before the case could transfer.

6.5.13 The allegation of sexual assault notwithstanding, the issue of housing is a complex one. Whilst Croydon were correct in being guarded against a family whose current accommodation was totally unsustainable due to overcrowding, they overlooked the fact that the family already had an address in Croydon. Not only that but also that Ms A had grown up in the area, had family connections and had been planning to move back for some time.

6.5.14 The break-up of Ms A's relationship with Mr C was the catalyst for the move in with Mr D but in actual fact the family had already made their move at the beginning of February. They were renting accommodation privately and therefore had an assured tenancy in the Croydon area. It is also worthy of note that there was disagreement between professionals about the suitability (size wise) of Mr D's address as it was a large three bedroomed house. Although technically it was overcrowded the property was deemed big enough to absorb the extra occupants at least in the short term.

6.5.15 The London Child Protection Procedures (LCPP) make no distinction between permanent and temporary accommodation but in the text of the procedures 'permanent' is defined in brackets as 'more than 3 months'. (LCPP 6.4.1). This is confusing as on the one hand there is a very clear statement in the procedures that children are (with some defined exceptions) the responsibility of the borough in which they live, be it temporarily or permanently. On the other hand the addition of the 3 month rule skews that clarity in that it suggests a more permanent arrangement should be in place before a case is accepted.

6.5.16 In any event the nuances of this case render the procedures unhelpful as the family's circumstances changed completely after they had moved and should have been subject to reassessment after the move due to the circumstances and new adults now involved in the children's lives. These difficulties were exacerbated by the lack of shared understanding between the two boroughs of the family's intentions. Lewisham were clear that Ms A (who had the children with her) intended to stay in the area with her new partner whilst Croydon maintained that this could not yet be determined due to the unsuitability of Mr D's address.

6.5.17 It is not clear if Croydon were consulted on their view of the suitability of the accommodation not only in terms of overcrowding but also given their past knowledge of Mr D and his background. This may have given rise to a 'negotiated alternative' as described in 6.1.6 (LCPP) given the information Croydon held. In any event the suitability or otherwise of Mr D's address was overlooked in the dialogue between the two boroughs and this led to a delay in the identification of risk. This is a significant factor given it would appear that Child W sustained her injuries whilst staying at that address.

6.5.18 It is significant to note that the transfer of case responsibility between HVs went smoothly with an exchange of verbal and written information very quickly following the family moving into the borough. That said, the children were not seen by a Croydon HV during this period and it was a source of frustration for the Lewisham social worker that no HV attended the core groups.

6.5.19 The internal transfer between HV teams within Croydon once Ms A moved to Mr D's address proved to be a stumbling block in allocating the family to a HV. A HV assessment to assist the social worker in terms of the children's health and development and in particular the impact of the latest moves would have been helpful.

6.5.20 Although lack of engagement has been highlighted as an issue, this review has revealed no evidence that any of the family's moves (other than possibly the move to Mr D's) were precipitated by avoidance or detection by statutory services. The threat of eviction triggered the final move to the Croydon address though it is understood that the family's preference had been to move to Croydon for some time.

6.5.21 Two things may have helped resolve this dispute at an earlier stage. One difficulty lay in the fact that the Croydon MASH team held on to the information, which was not the most appropriate place for it to be held. Due to the nature of the team and the way they function it was not possible for them to deal with the technicalities of where the case should belong.

6.5.22 A system whereby the process of considering and arranging a TIC can be more effectively managed other than in the MASH team would be beneficial and the Croydon CSC's IMR makes a helpful recommendation about which other staff could assist in this process.

6.5.23 The other beneficial addition to this process as pointed out in the IMR provided by CSC would have been consultation with a CP advisor (as advised in the LCPP) who then could have been tasked with negotiating between the two boroughs whilst keeping the children in mind. That said it is to Lewisham's credit that they continued to make attempts to progress the CP Plan from a distance and without knowledge of local resources.

6.5.24 The spirit of the LCPP is encapsulated in Para 6.1.2 which states 'In order to provide mobile families with responsive, consistent, high quality services, London local authorities and agencies must develop and support a culture of joint-responsibility and provision for all London children (rather than a culture of 'borough services for borough children')'. Child focused solutions are at the core of that statement but the burden on front line services coupled with ever dwindling resources places an enormous pressure to restrict the flow of cases requiring a service from CSC.

6.6 The voice of the child

6.6.1 The three very young children in this family had many contacts with professionals over the review period and their voice does not stand out strongly in the IMRs provided. Sections 6.1 and 6.3 cover aspects of professionals' responses to neglect and notes that agencies did not assess risk over time. Therefore the accumulative effects of long term neglect and the children's lived experience were missing.

6.6.2 Professionals did identify support needs for the children especially in relation to Child R and her apparent developmental delay. Services were offered to help with her difficulties but when these weren't accepted the children's needs were not assessed in isolation from the needs of the parents. The ICPC held in Lewisham in February 2015 was the first time that the impact of the parents' lifestyle on the children had been considered fully. The impact of the frequent moves was specifically referenced as a risk factor. The outcome was the decision to make the children subject to CP Plans and the outline plan although brief was outcome focused and child centred.

6.6.3 The nursery were proactive in identifying Child R's emotional needs from the outset and the TAF process was initiated and this led to Child R being more stable and settled in nursery albeit for a short period.

6.6.4 The IMRs provided by agencies are largely silent on the subject of the children's lived experience, including what security was provided to the children, but the paragraph below gives some indication of this.

6.6.5 The nursery provided a helpful insight into the world of Child R for this review where they describe her as a child with significant difficulties in making relationships with peers. As she settled into nursery she became more confident but would prefer to spend time with familiar adults and found sharing their attention challenging. The nursery noted in January 2015 following the domestic abuse incident and subsequent police involvement, Child R became reluctant to go home and was on several occasions very distressed when she was collected.

7 Lessons learned

7.1 Assessment of neglect

7.1.1 Neglect of children is generally not a single event and the negative effects of emotional and physical neglect accumulate and become compounded. Responses from CSC were incident led and opportunities were missed to assess the children's needs over time to assist in measuring the impact of the help already offered. As a result the children did not receive the help they needed in a timely fashion.

7.2 Interface between Early Help services and statutory intervention

7.2.1 This case has highlighted the need for Local Authorities to have clear 'Step Up/Step Down' procedures in relation to families who reject offers of Early Help. The mechanisms for ensuring that families receive the appropriate service did not work as intended in this case.

7.3 The vulnerability and needs of young parents who are caring for very young children

7.3.1 The parents' needs in this case were great. Less is known about Mr C but in relation to Ms A agencies held significant information particularly around her mental health needs. The risks for the children arising from the parents' own needs were underestimated and this case has highlighted the need for Adult services and GPs to be fully involved in Early Intervention processes. A full assessment of Mr D incorporating his history was not undertaken by any agency prior to Child W presenting with her injuries.

7.4 Interpretation of procedures

7.4.1 Policies and procedures, whilst designed to be helpful, are not always sensitive to the demanding nature of Child Protection work. In this case there was a different interpretation of the London Child Protection Procedures between the two boroughs (Croydon and Lewisham) and local nuances influenced practice. This ultimately led to a delay in assessing the new circumstances in which Ms A and the three children lived when they moved in with Mr D and his mother. As this is where Child W was living when her injuries were discovered this assessment was a significant omission.

7.5 The children's lived experience

7.6 It is important that the focus of any assessment or work with a family has the child or children at its core. There are often barriers to engaging with children, but some means of engagement are necessary in order to get a sense of who they are, what their daily experiences are and how living with neglect impacts on them. The children's lived experience was poorly assessed and this may have been as a consequence of how difficult the family as a whole were to engage. On occasions when professionals did engage with the children (particularly Child R) they were unresponsive. The adults in this family were often uncooperative and defensive making it more difficult to keep the children's needs in mind.

8 Recommendations for the LSCBs

These should be read in conjunction with recommendations from the agency IMRs

8.1 Lewisham LSCB

8.1.1 The LSCB to oversee a review of arrangements of the 'Step up/Step Down' procedures to ensure that families who need help but reject offers of 'Early Help' do not slip through the net.

8.1.2 The LSCB to develop (or review if one exists) a multi-agency strategy for dealing with families who experience neglect.

8.1.3 The LSCB to oversee a review of 'repeat referrals' to MASH specifically to ensure that families who are subject of repeat referrals to the MASH receive the appropriate service.

8.1.4 The lessons from this review to be shared with members of the Safeguarding Adult Board to ensure a joint approach to vulnerable adults who are also parents can be established.

8.2 Croydon LSCB

8.2.1 CSCB to review the current arrangements for managing the process of Transfer-In Conferences.

8.3 Croydon and Lewisham LSCBs

8.3.1 The LSCB to review its learning programme to ensure it includes multi-agency training on ensuring that the voice of the child is central to any contact or assessment.

8.3.2 The LSCB to develop a range of resources of Direct Work tools for practitioners to draw on when assessing children's needs, including very young children (who may be pre-verbal)

8.3.3 A joint letter from both Boards to be sent to London Children Safeguarding Board to seek clarity regarding consistent practice to children and families moving across LA's particularly (but not exclusively) London boroughs. This is to ensure that guidance is in line with Working Together 2015.

Jane Doherty
Independent Social Work Consultant
March 2016

APPENDIX 1

Recommendations from agency IMRs

Children's Social Care - Croydon

Agency	Recommendations	Action	Date	Lead	Outcome (what must be achieved)	Evidence & RAG Rating
Croydon Children's Social Care	1.Strengthen Management Support	Review management support & cover arrangements for leave of duty manager			Strengthened Management Support when duty manager on leave	
Croydon Children's Social Care	2.Strengthen Oversight on duty cases	Review process for monitoring & reviewing cases held on duty			Process for monitoring & reviewing cases held on Duty strengthened	
Croydon Children's Social Care	3.MASH should consider seconding social workers for a time limited period or identify opportunities for continuation of practice skills in working with families	Role of social worker in MASH reviewed			MASH social workers continue to have practice experience working with children/families	
Croydon Children's Social Care	4. Ensure cases are escalated to Senior Managers and CP Advisor involved in line with LCCP Professional Conflict Resolution	Review and strengthen current arrangements in relation to TIC			Monitoring in place to ensure cases are escalated appropriately to senior managers and CP Advisor in line with LCCP Professional Conflict Resolution	
Croydon safeguarding Board with Children's Social Care	5.Croydon Safeguarding Board support LSCB CP Advisors Group in clarifying transfer in conference requests for Mobile Families & Housing	Letter to London Children Safeguarding Board to support more consistent practice to children and families moving across LA's particularly London boroughs			Agreed understanding and more consistent practice to TIC particularly between London boroughs to mobile families and housing issues	
Croydon Children's Social Care	6.Information sharing should include relevant information including history of fathers/male partners and paternal extended families	Supervision/audits. Ongoing relevant training			Relevant information on fathers & male partners and their families is included in information sharing. Assessments have family trees and genograms.	
Croydon Children's Social Care	7.Basic information on ESCR is kept updated	Audit			Clarity of roles & responsibilities on ESCR recording when cases have transferred	
Family Justice Centre	8.Mandatory training programme Risk identification Checklist 'Safe lives' continued	Monitor attendance by practitioners/ Managers on programme			Increased knowledge and consistent approach to risk assessment where domestic abuse across social care	

Children's Social Care – Lewisham

- Transfer arrangements between the Referral & Assessment service and the Family Social Work team for children in need should be reviewed to give assurance that systems promote allocation of these cases in line with need.

- A review of the step down process from Referral and Assessment to Early Help services with a particular focus on the management of risk should be undertaken.

- A process review for Early Help services to refer back to the Referral and Assessment Team in the event of non-engagement of families should be undertaken, to ensure appropriate follow up is made as required.

- The Lewisham Safeguarding Children Board conflict resolution process should be reissued to promote use at an earlier stage in the event of problematic case transfers.

- An audit of Children's Social Care service thresholds should be included in the thematic audit programme as part of on-going Quality Assurance activity.

Health Overview Report (Lewisham)

Each health IMR completed has its own recommendations that will be followed up by the individual organisations and the LSCBs involved.

The following recommendations are in addition to these: -

- To evaluate the maternity pathway to improve the communication between maternity services in out of borough districts and the patient's local health services.
- The Lewisham Health Overview Author suggests that the recommendation by the NSPCC 2015 to change the name 'Did not attend (DNA)' to 'Was not brought' since this may identify vulnerable children more readily.
- Review of health professional's supervision as requested by Lewisham LSCB.

Action: The audit will be presented to the LSCB March 2016. This audit is coordinated by the author of this health overview report.

- The health overview author suggests that the recommendation by the NSPCC 2015 to change from using the phrase "Did Not Attend" (DNA) to "Was Not Brought" since this may identify vulnerable children more readily.

Action: The author will discuss this suggestion with the LSCB in Lewisham as part of the revision of the DNA LSCB fact sheet.

- The Lewisham LSCB requested an audit of health safeguarding supervision to explore whether there are cases of vulnerable families not being discussed at supervision. This audit began in September 2015.

Action: This audit is in progress and includes GP services, LGT and SLaM. This audit will be presented to the LSCB in March 2016, by the author of the health overview.

Health Overview Report (Croydon)

- All organisations to consider how the convening of discharge planning meetings is strengthened in order to sure that there is a robust multi agency plan in cases where there are safeguarding concerns and/ or complex needs.
- Perinatal services to consider how they can ensure that other key health professionals are made aware of cases which raise significant concerns and that information is shared effectively.(SLaM)
- Croydon health services to consider how a standard can be developed which ensures that information from MARAC is responded to effectively and in a timely fashion. (CHS)
- All organisations to consider how they can support staff in their safeguarding practice and encourage them to challenge other professional's views when there are differences.
- Strengthen the Croydon IMR author's recommendation re child protection allocation in order to ensure that it is also child focussed. (CHS)

Chelwood Nursery School

If they do not already exist – better cross borough procedures for managing the support/ safety of vulnerable children families who move from one borough to another is needed to ensure continuity of support and prevent needs going unaddressed or a sharp fall-off in support.

Where such procedures do exist they need better implementation / monitoring/ system of oversight to ensure they are sufficiently robust to avoid children in vulnerable circumstances being put at further risk when their support networks are removed in this way.

Croydon Health Services NHS Trust

1. Child protection allocation process to be more robust.
2. Transfer of records within and out of Health service 1 to be more robust.
3. All staff employed by Health Service 1, including volunteers and contracted staff, need to understand their responsibilities in relation to Domestic Abuse and Sexual Violence. This includes understanding actions to be taken when information liaised out from MARAC.

4. All staff employed by Health Service 1, including volunteers and contracted staff, need to understand their responsibilities in relation to ill parental mental health.

South London and Maudsley NHS Foundation Trust

Recommendation 1
There is an audit of Perinatal Team and MAPPIM records to evaluate whether service users are being asked appropriate questions about domestic violence during pregnancy. This should be followed up by an action plan where standards fall below those expected.

Recommendation 2
The expectation of robust communication with Children's Social Care and the documentation of MDT discussion should be addressed in supervision with members of the Perinatal Team.

General Practice (Croydon and Lewisham)

Previous serious case reviews in Lewisham have resulted in learning about areas which are highlighted in this Review i.e. mental health assessment and domestic violence screening during antenatal and postnatal contacts, about maternity-related safeguarding risk factors, and about importance of having a DNA policy. In addition, importance of coding using recommended child safeguarding codes, and the importance of having regular HV-GP safeguarding meetings and working as part of a multi-disciplinary team to improve early intervention processes to safeguard children, all have been highlighted in training and in Practice Leads supervision meetings. Thus recommendations for Lewisham GPs are an extension of previous recommendations in these areas and an assurance of implementation by practices.

Problem	Recommendation	Action	Measure of implementation	By whom	Due date	RAG
1.The practice did not record actions resulting from HV-GP meetings	HV-GP meetings must have minutes and an action log, which is reviewed at each meeting, and where appropriate, recording of discussion and actions on patient records.	Named GP will disseminate this recommendation. After 3 months, all GP safeguarding leads to send to Named GP the minutes of their last HV-GP meeting.	90% of practices can show minutes are taken and there is an action log	Named GP Safeguarding Leads	March 2016	

				Named GP		
2.Mental health assessment and screening for domestic violence is not regularly being carried out by GPs during antenatal and postnatal contacts	Increase awareness of domestic violence and mental health screening and assessment during antenatal and postnatal periods through training and supervision.	The antenatal and postnatal templates which includes questions on mental health and DV screening will be disseminated again. Survey monkey for GPs and PNs specifically around mental health and DV issues during pregnancy will partly be used to inform content of training. Include in Level 3 training for 2016-18 specific emphasis on DV screening and assessing mental health during pregnancy and postnatal periods. IRIS to be commissioned for Primary Care in Lewisham and Practice 2 to be in Phase 1 of implementation.	Survey monkey will be repeated 1 year later.	Named GP	April 2016 for survey monkey and development of Level 3 training for 2016-18. June 2017 – review of survey monkey results.	
3. DNAs (children missing appointment) were not acted on.	Every practice should have a DNA policy for children.	There is an on-going DNA audit being carried out. This will be completed.	A report from the audit will be completed.	Named GP	December 2015	

4. Mental health needs of Mr C were not explored fully.	The role of male figures in serious case reviews should be highlighted more in training.	Role of men and mental health screening for men will be included in Level 3 training in 2016-18	Content of Level 3 training for 2016-18 will be passed to the training (PTT) sub- group of the LSCB once it has been developed.	Named GP	April 2016	

Recommendations for GPs in Croydon

9.2 This Review did not involve any GP practices in Croydon. However, the learning from this Review can be extended to the GPs in Croydon.

9.3 Each practice in Lewisham has a Safeguarding Child Practice Lead who attends bimonthly supervision meetings with the Named GP. The Lead signs a form which states their responsibilities for this role. The lead participates in audit, ensuring staff training, dissemination of safeguarding information received from the Named GP, and ensuring the General Practice Safeguarding Standards are implemented. If Croydon practices do not have practice leads for children safeguarding, it is recommended that this system be introduced.

9.4 HV-GP meetings every 4-6 weeks to discuss vulnerable families is now firmly implemented in Lewisham. Both doctors and health visitors find these meetings useful in order to exchange information and formulate plans for early intervention to help support these families. An action log and good minutes is important for each meeting.

9.5 A practice DNA policy for children who miss hospital appointments and surgery appointments for immunisations is strongly recommended. The Lewisham suggested policy is available for practices to follow[3].

9.6 Increasing awareness of mental health problems and domestic violence during pregnancy and the postnatal period is needed amongst GPs and PNs. This should be incorporated in Safeguarding training specifically delivered for general practice. Commissioning of a training and screening program such as IRIS (Identification and Referral to Improve Safety) may be considered.

Greenwich and Lewisham NHS Trust

- Training staff to recognise signs of neglect and understand the impact this can have on a child
- Training of staff to recognise and understand the impact that mental health and domestic abuse has on families
- Review Health Visitor Guidelines to clarify criteria and expectations of all levels of health visiting support that are offered to families
- Training of staff to enable them to feel confident about challenging families or other agencies
- Review Safeguarding Supervision Policy

Guys and St. Thomas's NHS Foundation Trust

Health Visitors to maintain centile charts for all children as opposed to writing narrative in the progress records of a child.

Kings College Hospital Foundation Trust

No recommendations

Metropolitan Police Service

No recommendations