Croydon Safeguarding Children Board

Serious Case Review
Child J and Child K

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1. INTRODUCTION

1.1 This serious case review concerns a four year old child (Child J) and their sixteen year old half-sibling (Child K)[1]. The reason for the review is that in November 2015 Child J was admitted to hospital with serious malnutrition and medical reports identified that Child J's condition could have been fatal if medical treatment had been delayed for a further 24 hours.

1.2 Following investigations within the hospital there were concerns that the care at home had contributed to Child J's condition and the mother and maternal grandmother (who lived in the family home) were arrested. The police investigation concluded that no further action should be taken in respect of any criminal offences.

1.3 In January 2016 London Borough of Croydon obtained an interim care order and Child J was placed in foster care. Child J's condition deteriorated again and after a further episode in hospital Child J was placed with another set of carers where they remained whilst care proceedings continued. A final court hearing in May 2017 concluded that Child J had suffered significant harm and this was attributable to the care they had received from Mother and Maternal Grandmother. A care order was granted to the local authority and Child J now lives in a permanent home away from their family.

1.4 A request for a serious case review was made to Croydon Safeguarding Children Board in March 2016 by the Cafcass children's guardian due to concerns that Child J had been unwell for a considerable length of time and this had not been identified by any of the involved professionals.

1.5 Following consideration of all available facts, the Chair of the Safeguarding Children Board agreed that the criteria for a serious case review[2] had been met. This decision rested on the serious long term emotional and physical harm caused to Child J as well as concerns about the way in which professionals had worked together both before and during their admission to hospital.

2. THE SERIOUS CASE REVIEW PROCESS

2.1 The review has been led by two experienced independent reviewers, Edi Carmi and Jane Wonnacott. Edi Carmi was appointed Chair of the review panel and Jane Wonnacott the author of this report.

[1] Ages at the time of the serious incident
[2] The criteria for undertaking a serious case review are set out in Working Together to Safeguard Children (DfE 2015)

2.2 It is important to note that it was agreed the review should also cover Child J's half sibling, who although age 16 at the time the review was commissioned, was still a child and had been resident in the family home since Child J's birth.

2.3 A panel of senior professionals was appointed from organisations working with Croydon families, none of whom had direct involvement in the case[3]. The role of the panel was to work with the lead reviewer and contribute to the gathering and analysis of information as well as scrutinising the final report.

2.4 The review panel considered questions for the review in the light of other learning that was taking place within Croydon at that time. The overarching questions were:

- What are the challenges (and how might they be overcome) in keeping a focus on the child(ren) where there is acrimony between parents?
- What might inhibit the safeguarding system from recognising and responding to failure to thrive and risk of life associated with child neglect?

2.5 All agencies that had records of contact with Children J and K provided a chronology of their involvement between 1st April 2013 – 13th April 2016 and details of any significant involvement prior to that date. They also provided a summary of issues arising for their agency from an analysis of their records and any immediate action taken to improve services.

2.6 Permission was sought to access records relating to adult family members and the following agencies contributed information to the review:

- Cafcass
- Contact centre
- Croydon Children's Social Care
- Croydon Health NHS Trust (health visiting)
- GP's for Mother, Father, Child J and Child K
- Hospital 1
- Hospital 2
- Metropolitan Police
- Pre-school attended by Child J
- Primary school attended by Child J
- School attended by Child K

2.7 In order to understand professional practice from the perspective of practitioners involved, the lead reviewer and a member of the panel met with practitioners who had worked with the family either individually or in small

[3] One exception was a safeguarding nurse from Hospital 2 who attended two meetings but then withdrew due to potential conflict of interest.

groups. The information from these meetings was discussed by the whole review panel and has informed this final report.

2.8 Family members were invited to contribute to the review and the lead reviewer met with Child K, Mother, Father and Maternal Grandmother. The serious case review panel are very grateful for their time and the helpful observations they made about the children's circumstances during the period under review. These views have been thoroughly considered and used to inform the findings and recommendations. Not all family members agreed with each other about all the facts of the case and it is not the purpose of this report to adjudicate on the truth or otherwise of the various views. The report does however aim to highlight where there are differences of opinion which have significance in relation to how well the safeguarding system worked to protect the children.

2.9 All information was considered by the panel and a final draft report was agreed. All practitioners who had contributed to the review were invited to a meeting to read and comment on the final draft report.

2.10 The final draft report was agreed by the panel and presented to the serious case review sub group who requested a number of amendments. This request was considered by the lead reviewers and the panel and the final report agreed by the sub group on 19th September 2017. The report was considered and accepted by the Croydon Safeguarding Children Board on 27th October 2017.

2.11 The review has been carried out in parallel with the criminal investigation and family court proceedings. Both had finished by the time the review was presented to the Safeguarding Children Board and their findings informed the final report.

2.12 This report has been written with the expectation that it will become a public document. Family background and details are only included where they are relevant to a review of professional practice as well as being essential to understanding the findings and recommendations of the report.

3. FAMILY BACKGROUND

3.1 This report refers to the following family members:

		Age at April 2016	*Ethnicity*
Child J	Subject of this review	4 yrs 8 months	White British/Asian

Child K	Maternal half-sibling of Child J and subject of this review	16 yrs 8 months	White British/Asian
Mother	Mother of Children J and K		White British/Asian
Father	Father of Child J		White British
MGM	Maternal grandmother of Children J and K		Indian
Mr O	Father of Child K		White British

3.2 The family unit referred to in this report consists of Maternal Grandmother, Mother, Children J and K. Maternal Grandmother moved into the home shortly after Child K was born and she has therefore been an important influence in the upbringing of both children. Neither father has lived for any length of time in the household.

3.3 It is notable that there are no significant records regarding Child K's childhood, their development was within the normal range and Child K achieved well at school. Child K was 12 when Child J was born in July 2011.

4. INVOLVEMENT WITH SERVICES IN CROYDON

4.1 This section of the report summarises and comments on the contact that various services in Croydon had with the family in the period under review. Personal family information, including details of the children subject of the review, has been kept to a minimum and only included when it is relevant to the services being provided.

Health Services July 2011 – October 2013

4.2 At the new birth visit carried out by the health visitor when Child J was 13 days old Child J was noted to be breast fed and gaining weight (records show Child J was 3.14kg and on the 9th centile). Records also noted that Mother had declined the Guthrie test[4] for both her children; this is very unusual[5] but the reasons for this were not explored further by any health professional either at the time or later. This may or may not be significant in relation to later events but was an early opportunity to explore Mother's attitudes and beliefs in relation to medical intervention.

4.3 Mother was assessed to receive universal health provision which should have included five contacts (pre-birth, new birth, six-eight weeks, one year and two

[4] This is often known as the heel prick test and is designed to detect a number of health conditions. It is carried out by a midwife at home 5 days after birth.
[5] From 2015 to 2016 in the southwest London region less than 0.2% parents declined the testing

years). Although health visitors were expected to provide this service in accordance with the healthy child programme[6], this was at a time where there was a national recognition that health visitor numbers needed to increase and the programme designed to deliver this had only just started[7]. As a result, not all aspects of the healthy child programme were being implemented in Croydon and this may have been the reason for a delay in Child J being seen for their one year check.

4.4 Prior to the formal one year developmental check Child J was weighed at the age of six months and at this stage there was no reason to be worried about Child J's weight as at 7.01kg Child J remained on the 9-25th centile.

4.5 Child J's one year developmental check was carried out by the community staff nurse when 21 months old. At this check it was noted that Mother had refused the immunisation programme (as she had for her first child) and that Child J had dropped two centiles since last weighed and was on the 0.4th centile for weight. Mother was asked to take Child J to the clinic for weighing in 8-12 weeks. There is no record that Mother attended the clinic until the two year check which was carried out three months after Child J's second birthday.

4.6 At the two year check, which was carried out by a second community staff nurse, Child J was still on 0.4th centile for weight and 2nd centile for height but was noted to be in proportion and Mother and Father to be of slim build. The understanding that Child J was "following [Child J's] line" (i.e. they were steady on the 0.4th centile) and that their low weight (relative to the majority of children of the same age) was linked to family characteristic seem to have been key factors influencing professional health assessments from this point onwards. Finding One of this report explores in further detail the effectiveness of the professional system in responding to situations of faltering growth in babies and children.

Cafcass and Contact Centre involvement July 2011 – October 2013

4.7 Mother and Father's relationship ended soon after Child J's birth due to allegations by Mother about threatening behaviour by Father. Mother obtained a non-molestation order and prohibited steps order which prompted Father to apply to the family court for contact and a Cafcass officer was allocated to the case.

[6] Department of Health (2009) *Healthy Child Programme: pregnancy and the first five years of life.* *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf*

[7] 2011 Health Visitor Programme – call to action (Department of Health, NHS England, Public Health England and Health Education England)

4.8 Cafcass officers advise the family court in proceedings where the safety and/or wellbeing of a child may be of concern and in this case the officer's first task was to carry out an initial assessment. As a result of this assessment the Cafcass officer identified the complex nature of the case and recommended to the court that a fuller assessment (known as a section 7 assessment)[8] should be carried out. The court directed that this assessment should be undertaken.

4.9 Meanwhile, Father arranged for contact with Child J to be at a local contact centre. This was a private arrangement as is typically the case in private law situations and was for a "supported contact" arrangement which meant that Father saw Child J on his own, with the support of contact centre staff if required. The first contact took place in July 2012 by which time Child J would not have seen Father for four months.

4.10 The section 7 report was presented to the court in October 2012 and noted the main concern was alleged domestic violence perpetrated by Father and that more information should be obtained from the police by the court. This is discussed further in Finding Two of this report.

4.11 Generally contact continued uneventfully, although during the first half of 2013 there was increasing evidence of parental disharmony and Cafcass received information which raised some further concerns about the possibility of domestic violence. In such circumstances Cafcass has a duty to inform the court[9] and this was done via the required risk assessment documentation.[10] On receipt of the risk assessment, the court did not require any further work from Cafcass and the case was therefore closed. The court directed that supported contact was to continue with Father having permission to take Child J out and the final hearing regarding contact arrangements was to take place in September 2013. The outcome of this hearing in September was that a consent order was agreed to progress contact arrangements; commencing at a contact centre and then progressing to the paternal grandfather's home with handovers at the contact centre.

Child protection enquiries October – November 2013

4.12 At the end of October 2013, Mother took Child J (age 2 years 3 months) to the emergency department of Hospital 1 at 1am in the morning with a bruise to the buttock and thigh saying that it had occurred after a contact visit to Father. The hospital records note that "a CP referral was made, child discharged to care of

[8] A section 7 assessment and associated report derives its name from Section 7 Children Act 1989 which empowers the court to ask a Cafcass Officer to report to the court on matters relating to the welfare of the child in order to help the judge make a safe decision.
[9] Under section 16A of Children Act 1989
[10] It would be at the discretion of the court as to whether such a risk assessment was shared with either party in the case

mother". This referral referred to "ongoing concerns" and "parenting capacity issues". On receiving the referral children's social care started child protection (s47)[11] enquiries. A strategy discussion took place with the police, (although there is no record that health colleagues were included as would have been expected procedure) and a joint visit was carried out to the family home. Both Child J and K were spoken to. Maternal Grandmother was noted to be in the home but there is no record of a conversation with her as would have been best practice since she was a significant member of the household.

4.13 Father was arrested and spoken to by the police but this resulted in no further action in respect of any criminal proceedings.

4.14 During the section 47 enquiries, requests for information were sent to Child K's school and the family GP. It is clear from the GP's records that they were not aware of the nature of the concerns but sent a reply setting out their very limited involvement with the family, including Child J's failure to attend for immunisations. Child K's school sent a very positive report about Child K's progress and following a misunderstanding about what could be shared (explored in Finding Two below) Cafcass shared information about their involvement with the family.

4.15 Children's social care had asked the contact centre for information. There was a slight delay in their reply and when this was received the e-mail noted concerns regarding the relationship between Mother and Father but no concerns about the quality of interaction between Father and Child J.

4.16 Information was sought from the health visiting service and after some delay, information was received from the duty health visitor service that Child J did not have an allocated health visitor, had not been immunised but when seen in October 2013 there had been no concerns about Child J's development. This was followed by a telephone call from another health visitor who was informed that the police were taking no further action and children's social care were in the process of trying to close the case as there was no evidence to support allegations.

4.17 The assessment completed by the social worker identified the complex family dynamics including the detrimental impact that parental disputes were having on the children but the case was closed to children's social care due to "unsubstantiated concerns". Parents and relevant agencies were notified. A referral was also made by the social worker to a local mediation service to assist Mother and Father in managing their relationship but there is no evidence that this service was taken up.

[11] Under section 47 of Children Act 1989, the local authority has a duty to make enquiries where they have reason to believe that a child is suffering or likely to suffer significant harm.

4.18 The effectiveness of the child protection enquiries and decision making at this stage is explored further in Finding Two below.

Health visitor involvement February 2014

4.19 In February 2014 Child J (2 years 7 months) was seen by a health visitor in clinic. Child J's weight was recorded as 10.24kg and "consistent growth on 0.4th-2nd centile". Mother told the health visitor about the previous allegations of bruising by Father that had resulted in the section 47 enquiries and (wrongly) informed her that he was no longer having contact but the court wanted to start this again. The health visitor suggested Mother should talk to the GP about her concerns and left a message the next day to see whether she had done so. In order to give Mother more time to talk the health visitor followed this up with a home visit when Mother assured the health visitor that she had an appointment with the GP for the following week. (There is no evidence that this appointment took place).

Contact Centre, Police, Children's Social Care, Cafcass and GP involvement October - December 2014

4.20 In October 2014, Cafcass received a request from the court to file an addendum section 7 report limited to a question of whether Child J should spend time with Father overnight. The case was allocated to the same family court advisor who had worked with the family previously. There had been increasing tensions surrounding contact arrangements from July 2014 onwards and later in October an incident occurred at the contact centre which resulted in Father being charged and (later) convicted of an assault on Mother.

4.21 This incident resulted in a referral by the contact centre to children's social care and the case was allocated to a social worker who started an initial assessment.

4.22 As a result of the incident, whilst the Cafcass family court advisor could not advise Mother to breach the court order it was agreed that the Cafcass assessment would recommend to the court that contact with Father should stop and that he should complete a domestic violence perpetrators programme (DVPP). At this point the contact centre made the decision that they would no longer facilitate any contact arrangements.

4.23 Towards the end of November 2014 (when Child J was age 3 years 4 months), children's social care received a referral from a trainee GP who had seen Child J in surgery. According to GP records the GP had asked Mother to bring Child J in following concerns expressed by Maternal Grandmother about the incident

at the contact centre. Child J was seen alone and said they were scared of dad and did not want to continue seeing him. Child J was fully examined (undressed), no bruises noted and weight was recorded as 9kg and height 91cm. This was a low weight for a three year old child although at the time the trainee GP did not recognise this to be the case. Issues relating to the management of children with low weight are explored in Finding One.

4.24 The next day the family court advisor made contact with the health visiting service, spoke to a duty health visitor and was informed that "Child J's weight was fine when [Child J] had last been seen in February". This conversation was followed up by Cafcass sending a standard form for the health visitor to complete. This was completed without the heath visitor being fully aware of the nature of the current issues in the family and Cafcass received the completed form the day after they filed their report in court.

4.25 The report to the court recommended that:

- The court consider a Fact Finding Hearing
- If the court finds that Father has been domestically violent then he would need to complete a DVPP course before contact could be considered safe.
- The matter is not safe for mediation
- The report to be disclosed to Croydon Local Authority.

4.26 The court made an order dismissing the paragraph of the previous order which had directed that Child J should spend time with their Father. Following further information gathering, children's social care made the decision to close the case as no safeguarding concerns had been identified. The case was closed at the start of January 2015.

Pre-school involvement 2015

4.27 Child J started at pre-school in January 2015, three afternoons per week. Their records note that they had no prior involvement with other children their own age; they struggled to play with children and found it easier to engage with adults. Maternal Grandmother had the majority of the contact with the pre-school as Mother was attending a course and from the pre-school's perspective this was not unusual or notable. There are no exact dates given in the chronology but from January through to July 2015 the pre-school has informed the review that they had concerns about the amount of food in Child J's lunch box and that this was discussed with Maternal Grandmother. They also noted Child J wore several layers of clothing. Neither of these issues was recorded as a cause for concern. This is discussed further in Finding Three.

Cafcass involvement 2015

4.28 Cafcass closed the case in March as they were not required for the Finding of Fact Hearing in June. As a result of the court hearing, a court order was made requiring further work from Cafcass as the hearing had raised significant concerns regarding the impact of Father's behaviour. The case was reopened in August 2015 and the case plan noted that the assessment should be completed via telephone interviews as there was a need to produce the work quickly due to a delay in Cafcass receiving the order. During Cafcass enquiries they sent an e-mail to the pre-school asking for information about Child J. The reply from the pre-school did not refer to any concerns. The recommendations in the Cafcass addendum report were:

- indirect contact + information sharing
- Father to undertake a DVPP
- Mother to consider therapy for herself to explore the family history of fathering (this in response to Father's allegations of 'parental alienation').

Primary school involvement September 2015

4.29 Child J started primary school in September. School records note that at the start Child J was passive, emotionless and quiet with no curiosity in relation to learning. Child J needed "permission to participate", "didn't like to get messy" and would ask "is it home time yet?" After two full weeks Child J had settled and showed signs of enjoying them self. Child J's baseline assessment was "low personal, social and emotional development, very articulate and good knowledge of early maths – indicating at least average academically". It appears that assumptions were made about Child J's growth as, although Child J was noted to be short this was assumed to correspond with maternal grandmother's small height. Child J's behaviour was "overly good, is a people pleaser".

4.30 Child J's last day at primary school was 16th October 2015 as on 19th October Child J was noted to be absent through sickness (diarrhoea and vomiting).

Education, Health Police and Children's Social Care involvement in events surrounding Child J's first admission to hospital October 2015 – January 2016

4.31 Child J did not return to school after October half term and on the following Wednesday Child J was taken to the emergency department of Hospital 1 where Mother reported a six day history of loose stools, weight loss and reduced appetite. Child J was seen by an emergency department doctor who discussed Child J's condition with a paediatric registrar. Child J's weight was

recorded as 10.10kg, and records note that they were small but had “always followed their line”, the discharge summary included the phrase “looks thin”. No problems were found with Child J’s general health and Child J was discharged home with a note that the GP should follow up if loose stools continued or Mother should return to the emergency department if worried. It is important to note that both Mother and Grandmother have told this review that they believe they were told to wait for 7-10 days to see how Child J progressed. This is not recorded in the medical notes. There is no evidence that the family were given “red flag” information regarding what to look for in certain circumstances as would have been best practice.

4.32 Mother informed the primary school that Child J was not well and after further follow up by the school informed them via letter the following week that Child J had been seen in hospital and was still unwell.

4.33 The primary school had been told by Mother that Child J had no contact with Father but later the same week Father visited the school to discuss Child J and told the school he was not aware of any illness. The school subsequently made a referral to the education welfare officer (EWO)[12] who, after attempts to contact the family via telephone, visited the family home the following Monday. When the EWO visited the home she was very concerned about the physical condition of Child J (who was lying under a blanket) and sought assurance from Mother that she would take Child J to the GP. Mother assured the EWO she had an appointment the next morning and that the GP had the medical evidence regarding Child J’s condition. In fact there had been no GP appointment made for the morning (Child J saw the GP at 3pm) and Mother visited the school the next morning taking in information from the hospital consultation. Also on that morning the EWO sent an e-mail to MASH[13] asking whether the family were known to children's social care and was informed via e-mail the next day that the case was closed and any concerns should be sent via a referral form. It would have been more helpful if the EWO could have had a discussion with a social worker at this point in order to outline her concerns and the review team have been informed that other professionals have felt that it has not always been easy to have such discussions with social workers in Croydon. The current system should make this easier as there is a MASH consultation line which can be accessed by professionals with concerns about a family. This is discussed further in Finding Four.

4.34 At this stage the EWO did not feel that there were sufficient concerns to make a safeguarding referral without Mother’s permission as Mother had assured her that Child J was going to be taken to the GP.

[12] This education welfare officer is employed directly by the school one afternoon a week to provide support with attendance and safeguarding issues.
[13] MASH is the multi-agency safeguarding hub which receives all referrals of concern about a child.

4.35 By the time MASH responded to the EWO they would have received a referral from the GP who had seen Child J and was very concerned about Child J's weight and apparent malnourishment. The GP asked Mother to take Child J to Hospital 1 and the GP also contacted the hospital via telephone to alert them of their pending arrival. A referral was also made to children's social care citing concerns about neglect stating:

"Neglect. Child weights 10kg at 4yrs and 3months of age. Today was the fourth time seeing GP practice since birth. No immunisations. Mother seems to have little insight. Child is withdrawn. Father has history of domestic violence (doesn't live with them) 2 allegations towards child last in November."

4.36 The records of Hospital 1 state that Child J was admitted with severe malnourishment and a referral was made to MASH. The decision within MASH was that the case did not reach the threshold for child protection enquiries but Child J should be allocated to a social worker for a child in need assessment. This decision is discussed in Finding Four.

4.37 The consultant at Hospital 1 was extremely concerned at Child J's condition and requested a bed at Hospital 2 for specialist medical intervention. This bed became available four days later. On admission to Hospital 2, staff were shocked to observe Child J's condition and the immediate diagnosis was that Child J's symptoms were most likely to be a result of severe acute malnutrition. Child J was considered to be suffering from Kwashiorkor, a form of malnutrition most usually found in children in developing countries. The condition is unusual in developed countries such as the UK, although it can occasionally occur as a result of problems such as severe neglect, long-term (chronic) illness, a lack of knowledge about nutrition or a very restricted diet[14].

Child Protection Enquiries and action to safeguard Child J: December 2015 to March 2016

4.38 Child J made slow progress in hospital but was starting to put on weight as a result of a refeeding regime. Medical opinions began to move towards a likely cause of Child J's condition being lack of adequate food and Mother and Maternal Grandmother were noted by hospital staff to be limiting Child J's access to the food being offered. The deputy named nurse for safeguarding began to gather information including making contact with the pre-school who said they had concerns about the amount of food in Child J's lunchbox[15]. A professionals meeting was convened by the deputy named nurse on 4th December to discuss next steps. The meeting was attended by the social

[14] Kwashiorkor information NHS choices: www.nhs.uk

[15] They also informed the deputy named nurse that when Maternal Grandmother was challenged about food Child J's attendance dropped.

worker and staff from the pre-school and school as well as hospital staff who understood that the decision from this meeting was to start a formal child protection process.

4.39 It was on 8th December that there was a telephone strategy discussion between children's social care and the police. This was followed by a strategy meeting at the hospital which agreed that child protection enquiries should start. During these enquires the detective constable allocated to the case spoke to senior officers on the telephone and the decision was taken to place Child J under police protection and arrest Mother and Maternal Grandmother. Mother (who was at home with Child K) was arrested by a uniformed officer during the night and Maternal Grandmother (who had spent the night with Child J) was arrested on the ward the next morning. The process for police protection is discussed in Finding Five.

4.40 Following their arrest, Mother and Maternal Grandmother were released on bail with the condition that Child J's contact with Mother should be supervised and Maternal Grandmother should have no contact. Within the hospital there was initial uncertainty about contact arrangements and the social worker was unable to clarify what these were, as the timing of arrests had not been planned with children's social care. There was confusion once more at a later date when Mother arrived without a contact supervisor and hospital staff had to clarify with the social worker that children's social care had made the decision that contact no longer needed to be supervised. During this period hospital staff were doing their best to provide consistent emotional support and care for Child J but there were limitations in how well this could be achieved on a busy ward. This is discussed further in Finding Four

4.41 A legal planning meeting took place on 18th December which determined that the threshold for legal proceedings had been met and on 11th January the local authority filed an application for an interim care order. Child J was allocated a new social worker from the looked after children team.

4.42 A foster care placement was requested for Child J and from the information given to the business relationship team (BRT)[16], foster carers 1 were the first choice placement for Child J as they were a close ethnic match and had experience of children suffering from kwashiorkor syndrome. This did not take account of the fact that the family's first language was not English and the carers were likely to find the physical needs of Child J a challenge. The female carer visited Child J in hospital on two occasions before Child J was discharged to her care on 19th January 2016. Further issues relating to this placement are discussed further in Finding Six.

[16] BRT are the team responsible in Croydon for identifying foster care placements following a referral from the child's social worker.

4.43 The foster carers and the social worker became increasingly aware that the placement was not meeting Child J's needs. The court ordered a specialist assessment and the foster carer found it difficult to participate in these sessions due to lack of transport. In addition, Child J's legs would not support their body and Child J needed to be carried downstairs to the toilet during the night, a situation that was challenging for a carer. Child J also stopped eating and on 25th February was taken back to Hospital 2 by the social worker. Child J was readmitted to Hospital 2 weighing 11.98kg.

4.44 Whilst Child J was in Hospital 2 a new very experienced foster carer was found. She visited Child J daily and by the time Child J was medically fit for discharge Child J was also positive about the move to this new home.

5. REVIEW FINDINGS AND RECOMMENDATIONS

Finding One

The current system does not place sufficient emphasis on identifying, tracking and putting a clear plan in place when a child's weight is faltering.

5.1 It is not the function of this review to determine the cause of Child J's medical condition when Child J was admitted to hospital with severe malnutrition and in a critical condition. This review was triggered because there was sufficient concern that their condition was attributable to the care Child J had been given and the focus of this report is therefore whether the professional system was effective in identifying potential risks to Child J's health and wellbeing at an early enough stage.

5.2 Child J was admitted to hospital with severe malnutrition; a condition which is likely to have a negative impact on both growth and cognitive functioning. There is little published research on child malnutrition in the UK yet 20% of children hospitalised in the UK have been found to be at risk of the condition.[17]

5.3 One significant measure of whether a child is receiving adequate nutrition and growing in line with expectations is an analysis of their progress on centile charts. The current guidance on faltering growth from the National Institute for Health and Care Excellence[18] notes that:

[17] The Patients Association (2014) Project report on child malnutrition in the UK. *http://patients-association.org.uk/wp-content/uploads/2015/01/Child-Malnutrition-in-the-UK.pdf*

[18] https://www.nice.org.uk/guidance/GID-CGWAVE0767/documents/faltering-growth-recognition-and-management-of-faltering-growth-in-children-draft-scope-for-consultation2 (Final document expected October 2017)

The World Health Organization (WHO) has produced growth standards, based on longitudinal studies of healthy breastfed infants. These standards, along with UK full-term and preterm infant growth data, have been incorporated into UK-WHO growth charts for monitoring children's growth in the UK. A child's weight, length or height, and head circumference can be plotted to provide a visual representation of their growth over time. Epidemiological studies have shown that healthy children usually progress relatively consistently along a growth centile. Faltering growth can occur when a child's nutritional intake does not meet their specific energy requirements. Undernutrition may underlie relatively slow weight gain and movement across weight centiles on a growth chart. Faltering growth in early childhood may be associated with persisting problems with appetite and feeding.

5.4 There were opportunities to understand Child J's growth pattern through use of centile charts but these were not used effectively. This appears to be due to lateness in carrying out developmental checks, a failure to follow up faltering growth and a failure to plot weight and height on a chart.

5.5 Child J's one year developmental check was not carried out until Child J was 21 months old and there would have been no process for following this up as there were no concerns at this point. Information provided to the review indicates that late provision of developmental checks is not confined to this case. In the year 2016/7 only 33.4% of one year developmental checks were carried out on time, with health visitors needing to prioritise new birth visits in a situation where the birth rate has risen from 5000 per year in 2014-15 to 5800 in 2016-17. Croydon Safeguarding Children Board wish to compare the figures for completed developmental checks with national statistics but have found that this data is not easily accessible.

5.6 At the time of Child J's one year check health visitor caseloads in Croydon were 1100 whereas the national recommended figure is 400. Each health visitor in Croydon currently has a caseload of 750. Health visitors do report that the new system of GP aligned health visitors is making communication and management of their caseload more efficient, but the Safeguarding Children Board will therefore need to seek assurance that health visitor resources are sufficient to ensure that basic checks are carried out in order to identify potentially vulnerable children.

5.7 At the one year check Child J had dropped two centiles since last weighed and was on the 0.4th centile for weight. Mother was noted to be breastfeeding and the need for three meals plus healthy snacks was appropriately discussed with her. In view of the drop in centiles, Mother was asked to take Child J to the

clinic for weighing in 8-12 weeks but this was not followed up and Child J was not seen again until the two year check six months later.

5.8 Department of Health guidance states that:

> ……*sustained drop through two or more weight centile spaces is unusual (fewer than 2% of infants) and should be carefully assessed by the primary care team, including measuring length/height.*[19]

5.9 All practitioners working with children need to be aware of the need to consider growth over the whole life span of the child and in the future it is anticipated that the electronic parent held records (or e-red book) will help in this regard. However, there may be unintended consequences associated with the electronic record as although it will be easily accessible via the mother's phone it will not appear in the child's health record, meaning that if the phone is not available health practitioners will not be able to monitor development over time. This risk may be mitigated by a new electronic record but the Safeguarding Children Board will need to be assured that methods for monitoring growth and development are fit for the purpose of identifying children at risk of significant harm.

5.10 By the time Child J was seen at the two year check Child J's weight was still on the 0.4th centile. The previous drop in weight and lack of follow up was not identified as an issue and the focus of the discussion with the community staff nurse was Mother's concern that she had been made to feel "terrible that her child was so small" at the previous check. The staff nurse noted that Mother had explained that all the family were of slim build and Child J appeared healthy and was "in proportion." In discussion with current practitioners as to why there was a loss of focus on previous concerns it was thought that the fact that Child J was on the same centile as previously is significant as Child J would have been thought to be "keeping to [Child J's] line". In addition, Child J's weight would have been plotted on the chart for children age 1-4, whereas previous weights would have been plotted on the under 1 chart and unless this was reviewed the previous drop in centiles would not have been obvious.

5.11 It is possible that practitioners also became diverted from a focus on potential problems for Child J by the knowledge that Mother had been committed to breastfeeding, there had been no concerns about their older sibling and Child J came from an articulate family with strong views about immunisations and healthy eating.

5.12 There was further opportunity to consider whether Child J's weight was a cause for concern in November 2014 when the GP asked Mother to bring Child J in

[19] DoH (2009 *Using the WHO growth charts* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215564/dh_127422.pdf

for an examination following concerns expressed by Maternal Grandmother about the incident at the contact centre when Child J had been in Father's arms when he (allegedly at this stage) assaulted Mother. The GP (who was a trainee at that time) saw Child J alone and a full examination was carried out, no bruises noted and Child J's weight was recorded as 9kg and height 91cm. This weight was not plotted on a centile chart but had this been done it would have shown that Child J was now below the 0.4 centile; this the lowest measure on the centile chart. Department of Health Guidance states that[20]

Being very small or very big can sometimes be associated with underlying illness. There is no single threshold below which a child's weight or height is definitely abnormal, but only 4 out of 1000 children who are growing optimally are below the 0.4th centile, so these children should be assessed to exclude any problems.

5.13 It cannot be known whether follow up at this stage would have resulted in any further action but it would have been best practice to seek the opinion of a Paediatrician. This was not done as the GP did not identify that nine kilograms was a very low weight for a three year old child. The GP had recognised possible social problems and made a referral to children's social care and since the GP was a trainee it would have been good practice to discuss the case with his supervisor; this would have provided another opportunity to reflect on the significance of the extremely low weight.

5.14 The issue of GP paediatric experience has been discussed with this GP and paediatricians involved in this review. Although the GP curriculum is clear about the important role that GPs play in the care of children and young people and GPs should be competent in managing the health needs of children (including safeguarding), trainees are not required to have undertaken a specific paediatric placement and the trainee GP in this case had not done so. The consensus view is that paediatric experience is vital for GPs and possibly a community paediatric post would be particularly beneficial since GPs see a number of children with developmental concerns.

5.15 The significance of Child J's low weight was again not referred for follow up when Child J was taken to the emergency department of Hospital 1 in October 2015. Child J was weighed and the weight was recorded as 10.10kg, heart, respiratory rate and hydration levels were all normal. Records note that [Child J] was small but had "*always followed [Child J's] line"*: Again centile charts were not used to plot weight and had these been used it would have shown that Child J had dropped well below the 0.4th centile and was not continuing to

[20] DoH (2009 *Using the WHO growth charts* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215564/dh_127422.pdf Page 12

follow this line. Even without plotting on a chart a weight of 10.10 kg for a four year old child is very low.

5.16 The need to be vigilant in recording and analysing weight gain or loss in children and the importance of centile charts in this process is not necessarily particular to Croydon and has been a feature of other serious case reviews. For example the Daniel Pelka deeper analysis report commented that:

The fact that there was no expectation within health that children's height and weight was plotted over time (for example on a centile chart) and a record kept within their file meant that there was no means of the various health professionals having an easily available visual record that compared Daniel's good progress in his early years with dramatic decline in the year prior to his death (Page 6)[21].

5.17 Evidence has suggested that where growth is faltering too few children receive "multi-professional and multi-factorial support". The Safeguarding Children Board will need to be assured that within Croydon there is sufficient awareness of the importance of using a standardised format for analysing weight gain. This alone will not be enough. In addition, referral pathways to specialists need to be understood, available and consistently used as well as a range of services being available to families in need of help and support.

5.18 In November 2015, the GP quickly identified the significance of Child J's low weight (at this stage 10 kg) and considered this within the context of alleged domestic violence within the family, Child J's withdrawn demeanour and Mother's capacity for insight. At this point the system worked effectively to prevent any further harm and highlights the key role that GPs can play in bringing together and analysing all known information about a child within their family context.

5.19 The discussion in relation to faltering growth has at its heart the need for all professionals to be alert to the potential link with child neglect. As explored above, there were gaps in understanding and analysing the significance of Child J's low weight and little evidence that consideration was given at any time as to whether or not Child J was being neglected. This may have been influenced by a range of factors both relating to human biases (the family were articulate and there had been no problems with Child K) as well as lack of professional knowledge and confidence in identifying and working with neglected children. It is significant that there is no multi agency neglect strategy in Croydon and no work has been undertaken to develop practitioner's knowledge of the complex factors that underpin child neglect and develop tools to help identify and work with children where neglect is a cause for concern.

[21] Coventry LSCB (2014) *A deeper analysis of the findings of the Daniel Pelka serious case review.*

Recommendation One
Croydon Safeguarding Children Board should seek assurance from both commissioners and providers that health visitor resources are sufficient to carry out the recommended checks required to identify potentially vulnerable children.

Recommendation Two
Croydon Safeguarding Children Board should work with local health organisations to:

- disseminate information about the importance of considering weight and height measurements and using centile charts in hospitals and GP clinics in order to identify children with faltering growth
- ensure this information is included in local training delivery
- ensure that there is a well understood referral pathway to specialist assessment for such children
- evaluate the impact of electronic records on the identification of children who may be at risk of harm.

Recommendation Three
Croydon Safeguarding Children Board should inform the Department of Health and the organisation responsible for GP training of the findings of this review and encourage them to consider the importance of a paediatric placement as part of GP experience.

Recommendation Four
Croydon Safeguarding Children Board should bring the findings of this review to the attention of NHS England and ask them to consider how the use of centile charts can be promoted throughout the health community.

Recommendation Five
Croydon Safeguarding Children Board should work with partner agencies to develop a strategy to improve the identification of child neglect and a common understanding of how to work with children and families where neglect has been identified.

Finding Two

The impact of parental disputes, allegations of domestic abuse and conflict on children is not well understood and children living in these circumstances are not well served by multi-agency services. Child J did not reach the threshold

for ongoing services from children's social care and there was little focus on the impact of these issues on Child J or Child J's sibling.

5.20 Working with situations of disputes and/or conflict between parents can be challenging for all involved with an imperative to remain focused on the needs of the children. In this case there were also occasions when allegations of domestic abuse needed to be considered. Father feels strongly that the system is weighted towards a positive view of mothers and that his voice was not heard in interactions with professionals. Mother and Maternal Grandmother would take a different view, believing that there was insufficient scrutiny of the contact that Child J had with Father.

5.21 Assessments were carried out by both Cafcass and children's social care, each had a specific focus and neither organisation on the basis of information known to them at the time were able to fully identify the complexity of the family relationships and the potential harm these were causing both children of the family.

5.22 Alongside this, community health professionals (health visitors and community staff nurses) were unaware of the allegations of domestic abuse and could not take this into account in their contact with the family.

5.23 Assessments by Cafcass were in the context of family law proceedings and undertaken as directed by the Court in order to advise on matters relating to contact. The process for assessments within Cafcass has time constraints and in this case the advisor on one occasion went beyond usual expected practice by seeing Father face to face rather than conducting a telephone interview. When overnight stays were suggested the advisor did meet with paternal grandparents as Father planned to take Child J there during contact but there was no expectation or requirement, for an in depth assessment of Father's parenting capacity and assessment within his own home environment. Both Mother and Maternal Grandmother believe that this is a gap in the system.

5.24 The place where it could reasonably be expected that an assessment of parenting capacity would take place was during social work assessments conducted as part of child protection enquiries. The incident focused nature of this assessment precluded a more holistic approach and is discussed further below.

5.25 The family court advisor did alert the court in October 2012 to concerns about the impact of domestic abuse within the family but was not in a position to ensure action had been taken to obtain follow up information from the police. Cafcass could not obtain level 2 police checks[22] in respect of Father's wife

[22]A level 2 police check is a request by Cafcass for the disclosure, and provision by Police, of any relevant information held on databases of a local police force(s) including local intelligence, call out

without her consent and, as she had indicated that she would not give this, the matter was left with the court to follow up via court order. There is no evidence that this was done by the court and no mechanisms in place for follow up. Further concerns received by Cafcass regarding Father's potential for violence were noted in a risk assessment filed in court but could not be taken into account in court decision making as the complainant was not willing to give direct evidence.

5.26 It is the strong view of Mother that contact between Father and Child J in these circumstances should have been "supervised" rather than "supported" and that contact should not have progressed to a point where he could take Child J out of the contact centre for a whole day or for overnight stays. Father would have an alternative view and in the light of positive reports from other professionals about Child J's development, Cafcass did not identify the need for formal supervised contact. The focus was on allowing Child J to have contact with Father in a way where the relationship could develop naturally.

5.27 The issue of positive reports from other professionals to Cafcass is significant as the information given depended in part on whether the professional had a full knowledge of family circumstances and their understanding of the meaning of information requested. There were two main factors that came together in this case that prevented a comprehensive picture being obtained by Cafcass for their assessments.

- In November 2014 a duty health visitor reported to Cafcass that Child J's weight "was fine". This perusal of the notes by a duty health visitor did not identify the failure (by Mother and health professionals) to follow up the drop in centiles in April 2013. Heath professionals were unaware of the full extent of conflict within the family and would not have seen the request for information in this light.

- An e-mail sent to the pre-school asking for information about Child J did not elicit all potentially relevant information. This partly was because of paucity of record keeping in the pre-school (which is explored in Finding Three below) but also stemmed from a lack of understanding by the pre-school of the significance of a request by Cafcass and the implications that this could signify a parental dispute. It is of concern that the pre-school manager told this review that they would be reluctant to put anything negative in writing that may be shared with a parent. The inappropriateness of this stance is a lesson for the pre-school but organisations asking for information from settings that may be less familiar with their system should bear in mind how the

logs and domestic abuse records.
https://www.cafcass.gov.uk/media/241839/police_checks_handbook_external.pdf

request may be received. A conversation between Cafcass and the pre-school may have elicited better quality information.

5.28 Information sharing between Cafcass and children's social care was not always timely and indicates that there was some confusion about confidentiality and what could and could not be shared. During the child protection enquiries being carried out by children's social care in November 2013 there was a delay in receiving Cafcass information as a Cafcass duty officer mistakenly replied that not all information could be shared for reasons of confidentiality. When the allocated worker returned from holiday they ensured that all relevant information was shared. The Cafcass private law manager informed this review that this mistake would not happen today as all workers in the team are fully aware of the need to share information where there are s47 enquiries. Later in October 2014, children's social care delayed sharing their core assessment with Cafcass; again this appears to be due to confusion about boundaries of confidentiality. Whether there is understanding regarding sharing relevant documents and information between children's social care and Cafcass needs testing in order to ensure that a full understanding of the needs of the child is possible whoever is carrying out the assessment.

5.29 Assessments by children's social care came about as a result of safeguarding concerns and were focused on this aspect of Child J's life. The assessment following Child J being taken to hospital with a bruise in November 2013 was also hampered by insufficient sharing and analysis of all relevant information:

- As with Cafcass not all the information obtained by the contact centre was accessed. A conversation with the centre would have elicited a much fuller picture of family relationships and their impact on Child J than was contained within an e-mail. The contact centre informed the review that their impression is that they are not always seen as a full member of the professional network yet they have much important and relevant information about children using their service.
- Information sharing from the health visiting service to children's social care was late and limited. Health visitors spoken to for this review believed that this was partly due to a lack of allocated health visitor and no information sharing between the hospital and the health visiting service which would have prompted a family visit. In addition, the significance of the lack of follow up to the drop in centiles in April 2013 had become lost.

5.30 The assessment in November 2013 concluded that Mother had made a false allegation about Father causing the bruise. There are limitations in this assessment in relation to information sharing (as outlined above) and much significance was placed on Child J's lack of disclosure when they were seen on

their own. One of these occasions was with a police officer and once with the social worker. It was good practice to see Child J on their own but it is unlikely that such a young child would speak about abuse in these circumstances. Child protection guidance[23] at the time expected that section 47 enquiries would be carried out via an assessment that considered the child's needs, parental capacity to meet these needs and the impact and influence of wider family, community and environmental circumstances. The assessment in this case was incident focused, rather than exploring the wider context of Child J's life including the capacity of both parents to meet Child J's needs. A more holistic approach to the assessment would have enabled a greater understanding of all the factors that were affecting Child J's wellbeing. Case closure because no safeguarding concerns had been identified was a narrow approach to considering the needs of the children and failed to address adequately the impact on both children of the complex acrimonious family relationships. The social work assessment did acknowledge the impact of parental conflict on both children and referred Mother and Father for mediation but this was not taken up.

5.31 Children's social care practitioners in discussion for this review identified that their expectation would be that any services that Child J needed to promote their welfare as a result of the family conflict would have been linked to the family court proceedings. This is a mistaken impression and neither organisation provided an assessment and plan that looked holistically at the family and the needs of both the children in these circumstances.

Recommendation Six
Croydon Safeguarding Children Board should work with partner agencies to:

- develop professional knowledge and skills in relation to identifying where children caught up in parental disputes and/or parental conflict may be experiencing significant harm;
- disseminate information about the role, function and limitations of private family court proceedings;
- identify whether services available to such children are sufficient, well-coordinated and understood by all involved.

Finding Three

[23] Working Together to safeguard Children 2013

Child J was not identified at any stage as a child who may benefit from an early help assessment due to their physical and emotional needs not being met.

5.32 Early help assessments and services can play an important role in identifying what help the child and family require to prevent needs escalating to a point where intervention would be needed via a statutory assessment. The definition of neglect set out in statutory guidance[24] clearly states that neglect includes a failure to meet a child's basic physical needs (including the provision of adequate food) as well as neglect of emotional needs. In this case the main concerns over time related to whether Child J's physical and emotional needs were being met and the lack of a formal early help assessment meant that the potential for identifying neglect was lost.

5.33 Findings One and Two explore how Child J's physical needs and the complexity of family relationships that would have affected both Children J and K were not fully understood and responded to. A significant opportunity to understand what life was like for Child J and coordinate an early help assessment was during the seven months that Child J attended pre-school but the significance of accumulating concerns was not understood primarily due to poor record keeping. The setting has thought carefully about how their systems can be improved in the light of this case and these lessons will be of benefit to other similar organisations.

5.34 Child J attended pre-school three afternoons a week and the pre-school has informed the review that:

- At the point of registration no information was gathered about Father as they were told by Mother that there was no contact. Child J did not seem distressed by this and did not mention Father at all. When information was requested by Cafcass, the pre-school assumed that Child J was to start seeing Father but did not ask any further questions.

- Child J brought in small amounts of lunch and after Maternal Grandmother was spoken to about this the lunch increased slightly[25]. Maternal Grandmother stated that the reason for small lunches was that Child J had eaten before leaving home. As Child J was only in pre-school from 12-3 (three days a week) and did not seem particularly hungry when offered snacks later on at 2.30 (in fact Child J would need to be encouraged to take a snack) the pre-school staff did not feel that this was a particular cause for concern.

[24] Working Together to Safeguard Children 2015 Page 93
[25] The pre-school also informed the hospital that after challenging maternal grandmother about the content of lunches Child J's attendance dropped. (see paragraph 4.38)

- Child J would wear multiple layers such as a vest, long sleeve t-shirt, body warmer, big coat, even during warmer weather. This was not recorded as a cause for concern as, although Child J's reluctance to take clothes off inside was slightly unusual, parents are asked to dress their children in layers as the doors to the outside area are always kept open.
- Child J had a pattern of absence which was out of proportion for the reason given e.g. one week for a cold.
- Child J was an intelligent child but their personal and social development was lagging behind, and Child J was quiet and needed adult encouragement and attention.

5.35 There is some discrepancy between the accounts of Maternal Grandmother and the pre-school. The pre-school informed the review that only Maternal Grandmother picked up Child J whereas Maternal Grandmother's recollection is that on Mondays Child J was always picked up by Mother. If this is the case there would have been an opportunity for the pre-school to talk to Mother about any concerns such as the lunch box. Maternal grandmother also disputes the comments on absence stating that Child J only had three days off in seven months. Although the review has asked for copies of all the school attendance records, at time of writing only those for the first three months of Child J's time at the school have been forthcoming. It has therefore not been possible to verify this information one way or another.

5.36 The main issue for this review is not a view on the truth (or otherwise) or statements being made but the fact that the discrepancies cannot be verified as at that time the pre-school did not keep any records of "low level" concerns and there was no means whereby the potential for an early help assessment as a result of accumulating concerns could be identified. This has been an area of learning and there is now a system in place for recording issues that come to light on a day to day basis although there is no formal recorded review of causes for concern on a regular basis.

5.37 The lack of recording in the preschool also had an impact on the quality of information that was passed to Cafcass as there were no written records to review or specific information to be given in response to the e-mail.

5.38 The primary school noticed that Child J was quiet and sitting still when they visited the home prior to starting school (they felt this was unusual behaviour). When Child J started at school they needed a great deal of encouragement to participate in activities. However, there had been no formal concerns at the point of handover from the pre-school and it was only at the point that Child J became ill, within six weeks of starting school, that the school realised the extent of the parental conflict and issues within the family. Child K had attended

the same school and done very well and this is likely to have influenced the school's understanding of the family situation. Similarly to the pre-school, no details were recorded in respect of Father with Mother telling the school he did not want any involvement. This was accepted and the opportunity to understand the reality of the situations was therefore lost.

Recommendation Seven
Croydon Safeguarding Children Board should ensure through their learning and development programme that there is high quality advice and training available for pre-schools and that this includes the importance of recording and analysing all concerns about a child.

Recommendation Eight
Croydon Safeguarding Children Board should identify whether early help assessments are being used and are effective, with a particular focus on pre-school organisations.

Finding Four

Swift action was taken to save Child J's life once the seriousness of Child J's physical condition was realised. The system was slower to identify child protection concerns, take appropriate action to safeguard Child J from the possibility of future harm and plan to meet Child J's need for consistent parenting whilst in hospital.

5.39 The role of the education welfare officer (EWO) was crucial in this case and the EWO involved was contracted by the school via a private organisation to improve school attendance. This is over and above the statutory EWO service provided by the local authority and it is fortuitous that the EWO visited the school regularly one afternoon a week and was able to undertake a timely home visit and encourage Mother to take Child J to the GP (who was swift in diagnosing that Child J was very ill). The system within children's social care did not provide for swift access to telephone consultation with a social worker to discuss concerns although this should now be addressed via the MASH consultation line. Croydon Safeguarding Children Board will need to be assured that this system is effective.

5.40 Although Hospital 1 and 2 acted quickly to save Child J's life and stabilise their condition, there was delay between Child J's admission to hospital and child protection action. One perspective from social workers involved is that treating Child J as a child in need was the right decision at this stage as they initially did not understand whether there was an organic cause for Child J's condition and Child J was in a safe place. Doctors were working to ascertain the underlying

cause and social workers wanted to consider whether the issue was Mother's understanding of Child J's needs. The lack of strategy discussion was therefore attributed to lack of a firm diagnosis.

5.41 This is not in line with expected procedures[26] and there should have been an immediate strategy meeting at the point Child J was admitted to hospital as Child J was in a serious condition and the GP had clearly stated that neglect was an issue. This would have provided the opportunity to consider the immediate protection of Child J, plan any child protection enquiries, and agree contact arrangements within the hospital and a safe discharge plan.

5.42 As concerns expressed by the hospital developed, a multi-agency professionals meeting was called by Hospital 2 three weeks after admission. This was followed five days later by a referral to the Metropolitan Police Child Abuse Investigation Team and a subsequent strategy discussion. Issues relating to planning from this point are discussed in Finding Five below.

5.43 It is also important to note that the review was told that problems with the strategy discussion process extend beyond this specific case. At the first discussion in 2013 no health professional was involved and this has historically been a problem. Cafcass have also told the review that they are frequently not involved in strategy discussions where they have had (or currently have) extensive involvement and could share useful information. The Safeguarding Children Board will wish to be reassured that the system for managing the strategy discussion process is currently effective.

5.44 From this point, until the application for an interim care order five weeks later, there was no legal framework protecting Child J. The reasoning within children's social care was that Child J was in a "place of safety" but this placed too much responsibility on the hospital team to keep Child J safe without clarity regarding Child J's legal status. Best practice would have been to apply immediately for an interim care order in order to share parental responsibility with Mother and establish clear boundaries for contact. Ward staff caring for Child J have told the review that at times, contact arrangements with Mother were not clear, and even when she was given permission by the social worker to have unsupervised contact this was not sufficient to meet the needs of a young child who was in hospital for several weeks.

5.45 Whilst in hospital Child J's emotional and physical needs were mainly met by the hospital staff and Child J formed strong emotional ties to the nursing team. On a busy ward, although nurses did their best, they could not consistently meet all Child J's needs; for example for bedtime stories. This may be an issue

[26] London Child Protection Procedures (paragraph 3.4.1) which states that *whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, there should be a strategy meeting / discussion.*

for other children where there are unresolved child protection concerns, family contact is limited and a placement outside the family has yet to be finalised.

Recommendation Nine
Croydon Safeguarding Children Board should ask partner agencies to provide feedback as to whether the MASH consultation line is effective in providing an opportunity for professionals to discuss their concerns and share information about a child in order to determine next steps.

Recommendation Ten
Croydon Safeguarding Children Board should conduct an audit of cases where a child has been admitted to hospital and has been later subject of a child in need or child protection plan in order to ascertain:

- whether medical issues influence the decision to hold a strategy discussion/meeting
- whether all appropriate professionals are included in the discussion
- the extent to which plans have reflected the need for the child's emotional as well as physical needs to be met
- whether legal planning discussions have taken place as required in a timely way.

Recommendation Eleven
Croydon Safeguarding Children Board should build on the current work stream which is looking at child protection pathways in order to ensure that strategy discussions in Croydon are initiated and conducted in line with London Child Protection Procedures and that their effectiveness is reviewed.

Finding Five

The child abuse investigation system in Croydon lacks effective joint planning between police and social workers particularly where there is another sibling in the home.

5.46 The sequence of events after the referral to the police appears to be that there was a telephone strategy discussion between the detective sergeant from the police team and children's social care. This was followed by a minuted strategy discussion at the hospital between a team manager from children's social care, the allocated social worker and a doctor from Hospital 2. The decision was that s47 enquiries should start and the case was to be allocated to a detective constable to start investigations with the allocated social worker. At the hospital there were further discussions between the social worker, detective constable and hospital staff and the hospital notes record that the doctor advised that the

clinical diagnosis was not established but there was evidence suggesting neglect and he would not be happy for Child J to return home. The doctor did however feel Child J was benefitting from Mother being with Child J in the hospital. The police officer recalls that the possibility of police protection was discussed but no decisions were made at that point.

5.47 Maternal Grandmother was spoken to by a social worker and the police officer from the child abuse investigation team. It was after this that the detective constable spoke to senior officers on the telephone and the decision was taken to place Child J under police protection and arrest Mother and Maternal Grandmother.

5.48 The social worker was unaware that the plan within the police was to place Child J under police protection and the immediate arrest of Maternal Grandmother and Mother. Moreover, there was no joint planning as to how any impact on Child K would be managed and as a result, Child K was very upset when Mother was arrested in the home and taken to the police station. This is not acceptable and the arrest of Mother in the middle of the night leaving Child K alone in the house did not take account of the distress this might cause and failed to acknowledge Child K's needs as a child.

5.49 Whilst the imperative within the police is to ensure that arrests are made as soon as possible and any evidence is secured, it seems that there is no system that automatically triggers joint planning with children's social care where there are children in the home and an arrest is planned that is likely to leave the children alone and/or vulnerable.

5.50 In 2015, Croydon Safeguarding Children Board carried out an evaluation of practice for children subject to police protection which noted the need for improved communication between police and children's social care prior to or at the time of police protection. The report recommended the development of a joint protocol which would promote regular dialogue, joint visits and joint decision making; all issues that are relevant in this case. At the time of writing the action plan linked to the evaluation report indicates that this is work in progress and it would be sensible to bring the findings of this review to those finalising work on the joint protocol.

Recommendation Twelve
The review of strategy discussions should include consideration as to the effectiveness of joint planning where arrests are being made in a child abuse case and there are other children under 18 in the household.

Recommendation Thirteen
The Safeguarding Children Board should ensure that the findings of this review inform the developing protocol on police protection.

Finding Six

Once Child J was in the care of the local authority, the system for finding the best possible foster care placement to meet Child J's needs did not work well.

5.51 The referral from the social worker to the business relationship team requesting a placement for Child J did not give sufficient information regarding Child J's medical needs to enable the right placement choice to be made. From the information available, the placement team believed foster carers 1 to be the most suitable choice as they had experience of working with malnourished children and as Asian carers were believed to be a reasonable match for Child J who is described a White British/Asian. In fact the placement was not a good cultural or linguistic match as the foster carers first language was not English and it now transpires that the business relationship team were not aware of the extent of Child J's medical needs. With the benefit of hindsight the team would not recommend a family home with one downstairs bathroom since Child J needed to be carried downstairs in the night.

5.52 One aspect of the placement finding was the extent to which the views of those who knew Child J the best influenced the choice of carer. Nursing staff have told this review that from the start they did not feel that foster carers 1 were right for Child J. This was due to their age, lack of other children in the household and observations of interaction with Child J on the ward. It is a shame that the nursing staff did not feel confident enough to share their reservations either with the social worker or their own safeguarding lead, but equally the social worker could have been proactive in ascertaining the views of nursing staff and discussing this with the business relationship team who were sourcing carers. One inhibiting factor that prevented this, described by both hospital staff and the social worker, is the perception that there is a shortage of foster carers and there would be no other alternative alongside ineffective communication between fostering teams and social workers responsible for the child.

5.53 This latter issue has been identified in another recent serious case review in Croydon[27]. This review set out a number of recommendations for children's social care which are also relevant in this case including:

- Heads of service to explore the current relationship between the social work teams, examining any systemic organisational factors that may be having a detrimental impact on this relationship.

[27] Croydon Safeguarding Children Board serious case review "Claire"

- Heads of service to identify examples of good practice and to examine what factors are in place that facilitates this relationship. Learning to be shared across the services to promote improvements.
- Services to examine current meetings in place across the LAC and Fostering teams, establishing which of these meetings must involve both social workers, and taking steps to improve this area of work.
- Heads of service to review current guidance on this joint working and to make any necessary changes (including any changes to existing supervisory arrangements) to promote this joint working.

5.54 Once Child J left hospital the social worker soon became concerned about whether the placement could meet Child J's needs. It is not known if Child J stopped eating in order to secure a return to hospital where they had developed close relationships with several of the nursing staff. Once it became clear that Child J's health was deteriorating the social worker was proactive in taking Child J back to Hospital 2 and liaising with the business relationship team to introduce Child J to carers who were better able to meet Child J's needs.

Recommendation Fourteen
Croydon Children's Social Care should review the relationships and communication pathways between practitioners responsible for finding placements for children in care and the child's social worker. This review should focus on identifying the best way to make sure that placement planning focuses on all the child's needs. Assurance should also be provided to the Safeguarding Children Board that progress is being made in respect of the issues identified in the recent serious case review "Claire" Finding Nine.

6. SUMMARY AND CONCLUSION

6.1 Child J was admitted to hospital in a life threatening malnourished condition; a condition rarely seen in children brought up in the UK. Without the decisive action taken by the Education Welfare Officer and GP, Child J could have died.

6.2 There are many opposing views within the family and between the family and professionals as to how this situation came about but the final care proceedings establish that Child J had experienced significant harm and their needs had been neglected by those expected to care for them. This report has focused on why there was a lack of recognition that Child J's most basic needs were being neglected, and the professional response once malnutrition was recognised. It is this professional response that has had a profound impact on Child J's sibling who has also been the subject of consideration in this review.

6.3 This is not a case with a long detailed history of involvement by statutory agencies with numerous lost opportunities to intervene. It is however a case where a number of interacting factors came together and resulted in a situation with serious consequences. These factors point to areas where the safeguarding system as a whole for children can be improved. The key factors that came together in this case were:

- Recording and analysing weight where there are concerns about the health of a child is not sufficiently embedded in the training and day to day practice of health professionals.

- Child J and Child K lived in a family situation where fractured relationships between adults and disputes between Child J's mother and father tended to dominate contact with professionals. In these circumstances the impact on the children and their lived experience within the family was not always addressed. This was in part due to a lack of understanding between professionals about roles and responsibilities; in particular the role, limitations and potential for Cafcass involvement was not understood by social workers in the local authority.

- Record keeping within the pre-school did not include recording what appeared at the time to be minor concerns. This lack of recording meant that accumulating concerns were not recognised, other professionals were not aware of these concerns when asking the nursery for information and they were not passed on to the school.

- Child protection procedures where a child is admitted to hospital and there are concerns about possible neglect were not used appropriately with an over reliance on the child being safe in hospital. This appears to be an issue that extends beyond this case and in particular the use of strategy discussions in Croydon is not always compliant with the London Child Protection Procedures.

- There was ineffective communication between the team responsible for identifying foster placements and the child's social worker regarding Child J's specific needs. This contributed to the first placement breaking down and Child J being re-admitted to hospital.

6.4 Croydon Safeguarding Children Board is committed to learning and implementing lessons from this review and has developed a response and action plan. The outcomes of this plan and its impact on outcomes for children in Croydon will be kept under review.