Serious Case Review

Child I & Child M

Report Author

Jane Wonnacott

Director In-Trac Training & Consultancy

BA MSc MPhil CQSW AASW

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1. INTRODUCTION

1.1 This is the serious case review report in respect of two children known in this review as Child I and Child M. Child M died aged 2½ in January 2011 and along with his sibling was subject of a child protection plan at the time of his death. Child M's half-brother, Child I, died three months later in April 2011 at the age of 4½. He was understood to live with Maternal Grandmother but was in the sole care of Mother at Maternal Grandmother's house at the time of his death.

1.2 No charges have been brought in relation to either death, although a finding of fact in subsequent care proceedings did find that both boys had experienced neglect. The inquest into the deaths of Child I and M heavily relied on the finding of fact and resulted in an open verdict for both children.

Decision to undertake a serious case review

1.3 Child M's death on 6th January 2011 was considered by the Southampton Local Safeguarding Children Board serious case review sub-committee. It is the role of this committee to review serious cases and recommend to the Board chair whether the criteria for a serious case review have been met. On this occasion, it was agreed that there should be no serious case review but the case would be reconsidered after the post mortem results were obtained.

1.4 When further information was obtained, it was agreed that there was no indication that Child M's death was linked to the reason for his child protection plan and therefore the criteria for a serious case review had not been met. It was the view of the sub-committee that this was in line with the guidance in place at the time[1] which stated that a serious case review should be carried out when *a child dies **and** abuse or neglect is known or suspected to be a factor in the death*. This was a finely-balanced decision and did not involve consideration of additional criteria suggested within the guidance. These criteria included considering a review where the child was subject of a child protection plan and where the case indicated that there may be failings in one or more aspect of the formal safeguarding procedures. It could be argued that both of these criteria were present at that time.

1.5 Following the death of Child I on April 2011 the serious case review subcommittee noted that the case had met the criteria for a serious case review but the review should not start until further results from the post mortem and toxicology tests were available in order that the scope of the review could be determined.

1.6 The case of Child I was kept under review. The serious case review subcommittee agreed that as well as waiting for the toxicology results, a review should not be agreed until after a Finding of Fact in care proceedings relating to the surviving siblings. An initial Finding of Fact in July 2012 found that there was evidence of neglect, but no evidence that this had led to either child's death. It was therefore agreed that the criteria for a serious case review had not been met but a review of practice would take place. The way that this would be carried out was to be determined once the outcome of the decision of the Crown Prosecution Service

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[1] HM Government (2010) *Working Together to Safeguard Children*. London: TSO Paragraphs 8.9 & 8.12

(CPS) as to whether to charge Mother was known.

1.7 In May 2013 the CPS decided not to charge Mother with any offence and the serious case review subcommittee agreed that a review would be undertaken below the level of a serious case review.

1.8 Following a change of senior managers within children's social care and the departure of the Southampton Local Safeguarding Children Board Chair, the case was reviewed by the interim chair of the Board and it was agreed on 9th July 2013 that a serious case review should take place. This review is one of five reviews being conducted concurrently within Southampton.

1.9 This decision to conduct the review two years and three months after the death of Child I has inevitably hampered the process, with many staff within children's social care who had known the family no longer working for the organisation, and not being willing or able to contribute. The recall of others had been adversely affected by the passage of time. It has therefore not always been possible to understand with any degree of certainty why practice decisions were taken at the time.

1.10 This review has focused on events that occurred between three and seven years ago and since that time there have been many changes in practice and personnel within the agencies involved and efforts have been focused on improving many of the practice problems identified in this review. It is beyond the scope of this particular report to set out these changes in detail. The aim of this document is to identify as clearly as possible what the practice problems in this case were from 2007- 2011 and as far as it possible why they occurred as well as recommendations for practice change. The Southampton Local Safeguarding Children Board will set out in its response what specific action has been taken to address any of these issues.

2. REVIEW PROCESS

2.1 The review was carried out in line with the principles set out in statutory guidance (Working Together 2013). These are:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process.

- final reports of SCRs must be published, including the LSCB's response to the review findings, in order to achieve transparency. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections.

2.2 Jane Wonnacott and Kevin Harrington, experienced independent consultants, were appointed independent reviewers and a panel of senior managers formed to support the process. The panel was chaired by Kevin Harrington, and Jane Wonnacott wrote this report. Further information about the reviewers and the panel is set out in appendix A.

2.3 The terms of reference for the review were agreed and are appended to this report in appendix B. Following consideration of the most appropriate method for carrying out the review it was decided that organisations who had contact with the family should be asked to submit individual management reviews of their involvement for consideration by the independent reviewers and the panel. This method was chosen mainly due to the fact that the time frame for the review was 2006-11 and since that time many of the staff involved, particularly within children's social care, were no longer working for the organisation. Where involvement was limited, a short report for information was submitted.

2.4 In order to ensure that the review fully involved professionals who had worked with the family, individual management review authors were asked to ensure that any professional who had significant involvement should be invited to contribute, even if they had left the organisation.

2.5 All individual management review reports were accepted within the individual organisation and action taken to address any outstanding practice issues, whether at an individual or organisational level, that may be adversely affecting child protection practice currently.

2.6 Individual management review reports were received from:

- **CAFCASS** who had brief involvement as a result of Maternal Grandmother's application for a Residence Order in respect of Child I.

- **Hampshire Constabulary** who had various contacts with both Mother and the father of Child M and Sibling 1.

- **NHS England for Southampton GPs**. Mother, Father and all Mother's children were registered with GPs in the Southampton area.

- **Southampton City Council Legal Services** who were responsible for providing legal advice to social work teams involved in this case.

- **Solent NHS Trust** who provided health visiting and speech and language therapy services.

- **South Central Ambulance Service** who conveyed various members of the family, but most significantly the children, to hospital on several occasions. It should be noted that despite the best attempts of the panel to obtain

information about the involvement of the ambulance service, this report was surprisingly brief considering the level of contact with the family and did not assist the review a great deal in understanding the role the service played in this case. The panel made several attempts to obtain a fuller report but this was not forthcoming and at the time of writing the matter is being taken up with the ambulance service by the Chair of Southampton Local Safeguarding Children Board.

- **Southampton City Council Adult Social Care** who provided services to Mother via their learning disability team. These services included social work assessment and support, residential provision and domiciliary family support.

- **Southampton City Council Children's Social Care** who had extensive involvement with Mother during her childhood. The pathways (leaving care) team were involved with Mother at the time of her pregnancy with Child I and from that point onwards the intake and long term children’s social work teams were involved with a focus on supporting Mother to care for her children. There was also involvement by the hospital social work team and emergency duty teams.

- **Southampton City Council Children’s Services Prevention and Inclusion** who were responsible for early years provision including children’s centre services, playgroups and childminding.

- **Southampton City Council Housing** who provided housing to Mother following her move from supported accommodation.

- **Southern Health** who provided mental health services to Mother and Father and health learning disability nursing services to Mother.

- **Supported Housing Project** who provided supported housing to Mother when she was pregnant with Child I and immediately post birth. They then provided supported outreach at the point that Mother moved into independent accommodation.

- **University Hospital Southampton NHS Foundation Trust** who were responsible for accident and emergency, midwifery and paediatric health services.

2.7 In addition, a report for information was requested and received from the Crown Prosecution Service. This was received and provided a full explanation for the decision not to proceed with a prosecution following the death of Child I.

2.8 All individual management review authors were invited to attend two meetings of the panel in order to discuss their reports and hear from other individual management review authors.

2.9 Since this review has been one of five reviews taking place concurrently and covering similar time frames, the independent reviewers have met on three occasions the Chair of Southampton Local Safeguarding Children Board in order to

identify emerging themes that are relevant to all reviews and indicate deep-rooted issues within the safeguarding system. In addition, two of the independent reviewers were commissioned to undertake an analysis of the context within which practice was taking place since this was relevant to all reviews and did not need to be repeated within five separate reports.

2.10 In the light of the number of concurrent serious case reviews individual management review recommendations are not appended to this report as work is being done to identify common issues across all reports and develop a composite set of recommendations for each organisation. This will help in the speedy and efficient response to the issues identified and also enable the Safeguarding Children Board to more easily hold organisations to account for required changes in practice.

Family Involvement

2.11 Mother and Maternal Grandmother were invited to contribute to this review and considered whether they wished to take part. Maternal Grandmother did not wish to contribute but Mother agreed to meet the report author and the Southampton Local Safeguarding Children Board manager. Discussing events leading up to the deaths of two children is clearly an extremely sensitive and potentially distressing matter and arrangements were made for Mother to be accompanied by support of her choosing.

2.12 We are very grateful to Mother for her willingness to contribute to this review and her views regarding specific issues are included at relevant points in the narrative. The general points made by Mother were that:

- She asked for help when she could not cope with Child I but did not receive an adequate response from children's social care.
- The support she received did not always meet her needs. She frequently felt judged and criticised and felt that she was being told what to do but not why. There was no one there for her who was not going to judge her.
- It was hard to build up relationships with social workers as staff were always "chopping and changing".
- Services were very confusing and she did not know what to expect from people and what thy expected from her.

2.13 The father of Child M and Sibling 1 (known as Father in this report) was informed via the medical team responsible for his care that the review was taking place. The panel took advice from the mental health services as to the best way of involving him and contact was made via a member of staff who knew him well. Father was given further information about the review process but decided that he did not wish to contribute.

3. SUMMARY CHRONOLOGY

Feb 2006	Agencies were aware of Mother's first pregnancy (aged 20). Mother was known to have a learning disability and significant level of involvement with children's social care as a young person. At this time Mother had an allocated social worker in the adult learning disability team and was living in residential accommodation. Once the pregnancy was confirmed Mother moved to a supported housing project. The case was opened to children's social care.
Sept 2006	Child I born.
Nov 2006	Case closed to children's social care.
April 2007	Mother expressed worries about coping with Child I and this, combined with concerns at the supported housing project, resulted in the case being re-opened to children's social care.
June 2007	Mother and Child I moved to independent accommodation with floating support from supported housing.
Aug 2007	Case closed by adult social care learning disability team although agency support worker input continued.
Sept 2007	Case closed to children's social care.
Oct 2007	Evidence that Mother not coping and she was admitted to the Department of Psychiatry and the case was re-opened by children's social care and adult social care. Child I moved in with Maternal Grandmother.
Jan 2008	Mother pregnant. She had met Father whilst an inpatient at the Department of Psychiatry. Mother living at this time with adult placement carers. Child I remained with Maternal Grandmother who was encouraged to apply for a Residence Order.
June 2008	Court hearing regarding Residence Order, and all parties assumed order had been made although no evidence of the order has been found.
Aug 2008	Child M born. Mother stayed briefly with Maternal Grandmother and then moved back into independent accommodation.
June 2009	Child M taken to hospital by Mother and Father concerned he had ingested cleaning fluid. Subsequent visits to the home by social worker and health visitor identified hazards in the home.
Aug 2009	Case closed to children's social care.
Sept 2009	Mother pregnant with Sibling 1.
Oct 2009	Child M taken to hospital by Mother and her support worker concerned that he had ingested Sudocreme.
Nov 2009	Initial child protection conference in respect of Child M and unborn baby. This conference was as a result of an allegation made by Mother against Father and police concerns about care of Child M when they visited the home. Child

	M and unborn baby were made subjects of a child protection plan.
Feb 2010	Review child protection conference in respect of Child M and unborn baby. Child protection planning continued. Community child minding arranged for Child M.
April 2010	Sibling 1 born and admitted to hospital.
May 2010	Sibling 1 admitted to hospital twice: firstly at the age of two weeks with vomiting and low weight and subsequently with a rash, diarrhoea and vomiting.
June 2010	Legal planning meeting in Children's Services.
July 2010	Review child protection conference in respect of Child M and Sibling 1. This conference was not aware that the legal planning meeting had been held.
Aug 2010	Newly qualified social worker had taken over the case and identified concerns about neglect of the children. These concerns were not seen as requiring action by the senior practitioner managing the case.
Sept 2010	Change of health visitor. Child M started nursery.
Nov 2010	Sibling 1 taken to hospital with vomiting and diarrhoea and episodes of unresponsiveness. Concerns about state of the home expressed by the support worker. Mother found to be drunk in charge of Child M and Sibling 1 and children stayed temporarily with Maternal Grandmother.
Dec 2010	Mother asked social worker to remove Child M and Sibling 1.
Jan 2011	Death of Child M. Investigations did not identify any evidence that the death was suspicious. A strategy meeting was held following the death which agreed there was no need for section 47 enquiries. A review child protection conference was held in respect of Sibling 1 who remained subject of a child protection plan.
March 2011	Sibling 1 taken to hospital three times; on the first occasion with shortness of breath and on the second occasion unwell and vomiting. Ambulance staff commented to hospital staff on the second occasion that they were concerned about the home environment. Sibling 1 was noted to be unkempt. On the third occasion Sibling 1 was found to have low blood sugar and was noted to be hungry and thirsty.
April 2011	Child I died whilst in sole care of Mother.

4. CASE HISTORY AND EVALUATION OF THE WAY IN WHICH AGENCIES WORKED WITH THE FAMILY

4.1 This section of the report sets out a narrative of the contact that Mother, Child I and Child M had with both statutory and non statutory organisations. It seeks both to describe the help that was offered to the family and to comment on the effectiveness of this help in relation to identifying risk to the children and preventing significant harm. The nature of the contact with the family was at times intensive and the narrative seeks to explore the most significant aspects of involvement insofar as these were pertinent to protecting the children. Since this report will be publicly available, personal family details have been kept to a minimum.

4.2 The mother of Child I and Child M had a significant history of involvement with Southampton children's social care primarily as a result of concerns about the care she was receiving within her own family. This resulted in periods of accommodation by the local authority from the age15 to 17. The GP individual management review records issues which indicate a number of social and emotional needs relating to the care she had received as a child. In addition, Mother had been assessed as having a learning disability and from the age of 13 to 15 had regular contact with the NHS learning disability team. She was also diagnosed with a congenital health problem which requires regular medication throughout her life. Not taking this medication could result in an exacerbation of any learning disability, tiredness and low mood. Therefore, at the time of Mother's first pregnancy with Child I at age 20 she was known to have a number of vulnerabilities alongside a complex family history.

4.3 At the time of her first pregnancy Mother was in contact with:

1. Children's Services Pathways (leaving care) team who, under the Care Leavers Act 2000 was responsible for offering assistance and support until age 21. This support was offered via a 'duty' system. A specialist teenage pregnancy worker was also available but Mother did not take up this offer of support.
2. The Southampton City Council learning disability team who held and managed a care plan to support Mother. A risk assessment carried out by a social worker in this team concluded that Mother was unable to manage independently. As a result of this assessment, at the time of her pregnancy, she was living in a residential placement organised by adult social care.

4.4 From this point onwards Mother and her children were in contact with a number of different agencies who were charged with providing support either to:

- Mother as a vulnerable adult
- Mother in her role as parent
- The children; particularly in relation to ensuring that they were kept safe from harm.

4.5 The father of Child I played no significant part in his life during the time frame for this review. However, the father of Child M was involved with Mother and Child M post birth and known to health organisations (including mental health), police and children's social care. Like Mother he also experienced difficulties in his own

childhood and had a history of significant mental health issues from a young age. These at times resulted in violent behaviour.

4.6 It is a feature of this case that at times roles became confused and there were many different professionals involved with one or more aspects of Mother's life. It has been hard to unravel the full, accurate, picture of the work that was happening at any one time, with records, particularly within children's social care, being poorly kept and organised during the early stages of the period under review. Mother's input to the review has therefore been invaluable in clarifying the sequence of events. The picture that has emerged is a complex one and in order to be as clear as possible about the quality of services delivered at various points in time, the rest of this narrative is divided into seven specific timeframes:

1. Mother's pregnancy with Child I.
2. Emerging concerns about Child I (age 7-12 months).
3. Further concerns about the care of Child I and Mother's pregnancy with Child M.
4. Emerging concerns about the care of Child M (birth – 12 months).
5. Child protection planning for Child M (age 14-20 months) and Mother's pregnancy with Sibling 1.
6. Child protection planning for Child M until his death and action taken in respect of Sibling 1.
7. Events following the death of Child M until the death of Child I.

Agencies' response to Mother's pregnancy with Child I

4.7 Mother's pregnancy first came to the attention of the social care learning disability team who alerted the children's social care intake team who were the team responsible for taking referrals and the initial stages of work with children and their families. This was an appropriate course of action but Mother was already an open case to a children's services team (Pathways). Although Pathways did subsequently share information with the safeguarding team the recording within the pathways team made little reference to safeguarding issues in respect of the unborn and their responsibility in this aspect of the work. There was no protocol or procedure for managing and supporting pregnant care leavers who require a range of services or for managing situations where there might be a conflict of interests between the capability of the mother and the needs of the baby.

4.8 The social care learning disability team also wrote to the learning disability nurse who had previously had significant involvement with Mother between the ages of 18 and 20. The records of the learning disability nurse note that the pregnancy had implications for the residential placement as it was not registered for mothers and babies and that they advised the adult social care social worker that they should contact the GP and midwife to support Mother in relation to her health needs. There was good awareness of the need for information sharing by the learning disability

nurse at this point and she stated in a letter to adult social care that she felt it was important that she shared all her information as early as possible to contribute to future plans. It is unfortunate that she was not subsequently involved in any pre-birth meetings and the case remained closed at that point to the NHS learning disability team.

4.9 Once the GP became aware of the pregnancy they referred to the midwife. The GP records would have contained significant information about Mother's vulnerabilities and safeguarding history but according to the GP individual management review author "there is no evidence that the mother or father's health issues, their socioeconomic circumstances were shared at this point." The midwife, at booking, appropriately arranged obstetric-led care but there is no record of questions being asked about the presence of domestic violence or substance misuse as was expected good practice at that time.

4.10 It was the expectation of the adult social care learning disability team that a pre-birth assessment would be carried out by the children's social care team and information about Mother's significant history and care episodes was shared by the learning disability team with the intake team in order to facilitate this. Information sharing at this point was clearly crucial and it should have been possible for adults' and children's social workers to access each other's records since they did share the same database, although in line with data protection requirements access to each other's records was not automatic. A protocol was in existence that meant that a request could be made for access to records but this was not widely known about or used. However, despite this, it is clear from the records that the intake team had available to them all the information that should have alerted them to the need for a thorough pre-birth assessment.

4.11 Within the intake team there was delay in allocating the assessment to a social worker and the individual management review notes that this assessment was never properly completed. The reason for this is not clear, although the most likely explanation is pressure of work and a lack of effective management oversight. The liaison that might have been expected between children's social care and health colleagues did not take place and health records note that the first contact between the midwife and social worker was some seven months after Mother's pregnancy had been confirmed. This contact was instigated by the midwife. In addition, there is no evidence that the health visitor was invited to any planning meetings that took place prior to Child I's birth.

4.12 The opportunity to work effectively with health colleagues was further hampered by the lack of effective liaison between the GP, midwife and health visitor during Mother's pregnancy. The GP records would have contained significant information about Mother's own experience of being parented and her mental health history but this information does not seem to have been available to the rest of the health network. Had this been known it may have promoted a more proactive approach by health professionals in challenging the approach of children's social care.

4.13 Meanwhile, the adult social care learning disability team referred Mother to a supported housing project whose resources included a mother and baby unit and

floating support[2]. Mother moved into a room in the project four months before Child I's birth and met with a support worker two to three times a week. All records point to very good practice by the supported housing unit throughout their contact with mother. A high level of support was offered and any concerns about Mother's parenting were recorded and passed onto children's social care.

4.14 It is a feature of social work practice at this time that responsibility for case management was devolved to a senior practitioner and there is little evidence throughout the records of any discussions at key decision points with the team manager. The post-birth plan which was for Mother to stay with her own Mother (Maternal Grandmother) immediately post birth and then return to supported housing was therefore agreed by a senior practitioner in the intake team. The midwifery plan set out by the safeguarding midwife included more frequent home visits than usual and good liaison with the health visitor.

4.15 Child I was born in September 2006 and after spending time with Maternal Grandmother, Mother and Child I moved back to the supported housing project. There were no concerns about Child I's care or development post-birth and this may have contributed to the fact the community midwives did not adhere to the advice of the safeguarding midwife to undertake frequent home visits.

4.16 No concerns about Child I were identified at a Child In Need planning meeting which took place without any health input, and the case was closed to children's social care when Child I was less than two months old. It is unclear whether adult social care were aware that the case was closed as their individual management review notes that they believed that children's services were monitoring Child I. The risk assessment completed by adult social care prior to mother's pregnancy which concluded that she was unable to manage independently was not at this point influencing the thinking of children's social care, possibly due to a lack of understanding by children's social workers of the significance of this assessment and no one "event" that had identified a cause for concern.

4.17 *Summary – agencies' response to Mother's pregnancy with Child I*

There was a failure at this point to carry out a pre-birth assessment that integrated all known information about Mother's experience as a child and analyse this in terms of the support she was likely to need as a parent. This resulted in an inadequate understanding of risk and premature closure of the case to children's social care. Information that should have informed an assessment was known to professionals within the network, yet it was either not shared (as in the case of the GP's liaison with the midwife and health visitor) or its significance was not recognised (as in the case of children's social care). The expertise within adult social care and health teams in assessing Mother's capacity and vulnerability was not used by children's social workers despite it being known that a high level of support was being (or had been) offered by these services.

[2] Floating support is support within the community deigned to maintain the capacity of the parent to live independently in their own accommodation.

Agencies' response to emerging concerns about Child I (age 7 -12 months)

4.18 When Child I was six and half months old (April 2007) children's social care received a referral from the supported housing project as Mother was low in mood and was saying that she could not cope with him. This coincided with Mother receiving an adult caution from the police for an offence which took place in the presence of Child I, followed by concerns about Mother's mental health. At this point information was passed to the health visitor by the community health nurse that Mother was not taking her medication. The significance of this information exchange was that failure to take the medication could result in low mood, fatigue, difficulty with memory and concentration and could have exacerbated the effects of Mother's learning disability. At no time throughout the period under review did any professional assess the impact of failure to take medication on Mother's capacity to parent. Indeed, at the point of Child M's death, there was a prevailing view that health visitors and social care did not know that Mother had not been taking this on a regular basis.

4.19 The case was inappropriately allocated to a student social worker and the only feasible explanation for this is that there were workload pressures within the team at that time. However, there is no documentary evidence that the team manager alerted senior managers to the fact that work could not be allocated to qualified social workers and instead a student was inappropriately used to plug gaps in the service. This would have been an overwhelming case for an inexperienced worker as there were wide ranging concerns about Mother, both in her role as a parent and in her own right.

4.20 It is therefore perhaps unsurprising that assessments and plans at this point were inadequate, with little analysis of the potential risk to Child I, despite the supported housing project alerting the social worker on several occasions to concerns about Mother's mental health and ability to care for her baby. Even when the student social worker visited with a qualified worker and witnessed Child I becoming ill after ingesting cigarette butts and there was further first hand evidence of rough handling and poor parenting, no protective action was taken. The only recorded action at this time by children's social care was a referral to "stay and play" sessions at the family centre.

4.21 It was, however, recognised by the intake team that Mother needed longer term support and two months after the referral from supported housing Child I was transferred to the long term social work team.

4.22 The absence of effective multi agency working is noticeable during this period with the health visitor noting concerns about the delay in starting the core assessment by children's social care, but not challenging this, despite this being an agreed action in a safeguarding supervision session[3]. The individual management review author believes that failure to challenge at this time may have been a result of Mother subsequently moving address and a change in health visitor.

4.23 The other negative impact on information sharing across professionals was Child I's Child in Need status and Mother's refusal to give social workers permission to share

[3] Safeguarding supervision is a type of supervision used within health organisations, delivered by a safeguarding specialist and provides a forum for discussion and oversight of work with children where there are safeguarding concerns.

information with others. This appears to have been accepted rather than being considered as part of a wider assessment of Mother's capacity to work together with professionals to improve her care of Child I.

4.24 At the end of June 2007, Mother and Child I moved out of supported housing into independent accommodation with floating support provided by the supported housing project. It is unclear why this decision was made although Mother recalls asking to move out as she found the accommodation noisy. Prior to the birth of Child I, a previous risk assessment by adult social care had identified that Mother should not live alone, yet she was deemed to be safe to live alone with a small baby.

4.25 Mother's case was closed by adult social care in August 2007 although they continued to fund an agency family support worker. Following a Child in Need meeting attended by the long term social worker, senior social worker, the health visitor and Mother a decision was made also to close the case to children's social care in September 2007. It is likely that this decision was based on the fact that a number of support services were available to Mother, including a family support worker, a play worker (as Mother had moved to a Sure Start area) and floating support from the housing project. The opportunity to understand the accumulating signs of risk to Child I despite the presence of support from a number of agencies was lost at this point.

4.26 Mother remembers being unhappy at the closure of her case by children's social care and going to the office to ask for social work help. She recalls the response as being that she should be able to manage on her own.

4.27 *Summary - agencies' response to emerging concerns about Child I (age 7 - 12 months)*

Despite evidence that Mother was not coping, was not providing Child I with appropriate safe care, and the best efforts of the supported housing worker in bringing this to the attention of the student social worker, the focus on work within children's social care remained firmly on this as a case of a child in need. Mother was seen as a parent needing support and the interaction between her learning disability and significant trauma as a child/young person, as well as accumulating evidence about her struggles to cope with parenting, were not understood in terms of potential risk to Child I.

Although significant support was provided, this was un-coordinated and it seems that others in the network felt powerless to challenge children's social care's lack of decisive action in response to any concerns that were expressed. A low standard of parenting became accepted as the norm.

Agencies' response to further concerns about the care of Child I and Mother's pregnancy with Child M.

4.28 Within a month of case closure, Mother approached children's social care to say that she could not cope. This is not recorded in the children's social care records but

Mother clearly recalls asking for help and the GP chronology notes her telling the GP that she had "approached social services to have child taken away." Mother asked for admission to a psychiatric unit but the GP advised a referral to the community health team. Whilst the GP was arranging this referral to mental health services, Mother abandoned Child I at the supported housing project. Mother remembers that at this point she was clearly asking for help and records show that she admitted not feeding Child I, hitting him, feeling low and not taking her medication.

4.29 A decision was made by children's social care to ask Maternal Grandmother to care for Child I. She agreed but was clear that she did not want to care for him long term. There was no consideration at this point of Mother's own experience as a child, her relationship with her mother or Maternal Grandmother's capacity to care for Child I. This uncritical acceptance of Maternal Grandmother as an alternative carer set the tone for all future work with the family. The children's social care individual management review notes that:

The threshold to remove and safeguard Child I has been met. The alternative family option is not a safe and secure one for Child I and Maternal Grandmother's motivations and capacity have yet to be properly assessed. An EPO[4] *should have been sought for Child I and he should have been placed with an experienced foster carer to ensure his needs were fully met.*

4.30 The next day Mother was admitted to the Department of Psychiatry via Accident and Emergency after presenting at hospital with symptoms of mental illness. It is notable that she spoke at this time of being happy and supported at the mother and baby unit but unsafe, lonely and suicidal when alone in the flat. Further disclosures made by Mother of maltreatment of Child I, including hitting him on several occasions and denying him food and fluids, were shared with all appropriate professionals by the Accident and Emergency staff prior to Mother's admission to the Department of Psychiatry.

4.31 The Police did not receive notification by children's social care of the disclosures of maltreatment until a week later. This was far too late as any possibility of gathering evidence that may have helped a police enquiry would have been lost. The police were informed that children's social care had begun child protection enquiries[5] and police records note that a joint decision was made with children's social care that a single agency response by children's social care was most appropriate. The reason for this within the police individual management review is that the information given to the police relating to the treatment of Child M was vague, there was no context and the concerns were historic in nature. The police refer to this telephone conversation as a formal strategy discussion[6] as required by child protection procedures but there is no indication that the social worker viewed it in this light, there are no minutes within the children's social care records and other people who

[4] An EPO is an Emergency Protection Order issued by a Court under section 44 of Children Act 1989 in order to ensure the short term safety of a child.
[5] Where a child is suspected to be suffering or likely to suffer significant harm, the Local Authority is required by s47 of the Children Act 1989 to make enquiries to enable it to decide whether it should take any action to safeguard and promote the welfare of the child.
[6] According to guidance in place at that time a strategy discussion should take place whenever a child was suspected of suffering significant hare, This discussion should 'involve LA social care, the police and other bodies as appropriate (eg. Children's centre, school and health). (Working Together to Safeguard Children 2006, para 5.54)

should have been included in the discussion, such as the health visitor, were not spoken to. There is no indication that this situation was challenged by the police who seem to have accepted poor practice.

4.32 The exact reason for the failure to use child protection procedures properly at this point is not clear, although at this time it is known that there were significant service delivery problems within children's social care, with a senior management consultant being brought in during the next year to identify weaknesses.

4.33 An assessment was completed by the social worker whilst Mother was an inpatient in the Department of Psychiatry. According to the children's social care individual management review, this assessment did not meet the requirements of a core assessment[7]. There is no evidence that Child I was seen, or of any input from health professionals into this assessment, which concluded that Child I was thriving in the care of Maternal Grandmother and that Mother did not have the capacity to improve her parenting skills.

4.34 However, the decision of the children's social care senior practitioner was at variance with the findings of the assessment. Their decision was that Child I should return to the care of his mother and that Maternal Grandmother would support this through a "shared care" arrangement. At this time the supported housing outreach worker was withdrawing support as Mother was deemed "too dependent" and spending many hours at the supported housing office. Support from an agency funded by adult social care was arranged instead. The impact of returning Child I to his mother following an inpatient episode at the same time that there was a change in the nature of support does not seem to have been considered by the senior practitioner. There is no evidence that this was discussed with the team manager or that there was any opportunity for the social worker (who had concluded that Mother did not have the capacity to improve her parenting) to challenge the decision.

4.35 In fact, despite the decision by the senior practitioner, there appears to be a lack of clarity within children's social care regarding Mother's living arrangements. Prior to Mother's discharge from the Department of Psychiatry there was information that Mother was associating with a sex offender managed under MAPPA[8]. This resulted in an adult safeguarding strategy meeting. Prior to the strategy meeting Mother was discharged from the Department of Psychiatry to an adult placement carer, with the adult social care learning disability team assessing the possibility of moving her and Child I to another adult placement carer on a permanent basis. This did not happen as Mother became pregnant and wanted to return to her flat. She told this review that this was because she wanted to prepare for the baby and prove that she was able to manage. There is no evidence of a continuing association with the registered sex offender.

[7] A detailed assessment of the child's developmental needs and parents capacity to meet those needs in line with statutory guidance set out in *Framework for the Assessment of Children in Need 2000*.

[8] Multi Agency Public Protection Arrangements which task 'responsible authorities' with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public.

4.36 It is concerning that around this time Child I slipped, almost by default, into a long term living arrangement with Maternal Grandmother who had previously said that she did not wish to care for him long term. A decision was made within children's social care to encourage Maternal Grandmother to apply for a Residence Order[9] without any proper consideration being given to Maternal Grandmother's capacity to parent her grandchild. This is a particularly significant omission, given the information that was available about Mother's own experience as a child.

4.37 The permanent move to Maternal Grandmother resulted in a change of health visitor for Child I. However, Maternal Grandmother was reluctant to engage with health visiting services, a pattern that continued until his death. Child I's notes were not forwarded to the new health visiting team, which would have hampered their focus on his history and needs.

4.38 From January 2008 the focus of work by the health services was on Mother's second pregnancy and it is clear from medical records that Mother was ambivalent about this pregnancy from an early stage. The father of Mother's second child (known in this report as "Father") was someone whom Mother had met in the Department of Psychiatry and who had a significant history of mental health problems, including failing to take medication, and a number of hospital admissions. From this point on there was a disconnection between services to Father as a mental health patient and Father as the parent of a child. Father's GP was unaware that he was about to become a parent and there is no record of this being considered as part of his care plan.

4.39 The GP individual management review comments that again there was minimal background information and that there is no evidence that Mother's involvement with children's social care was shared. However, at booking, the midwife ascertained that there were a number of safeguarding concerns including Father's history of mental health problems, and raised a safeguarding concern form which was forwarded to the safeguarding midwife, children's social care and the liaison health visitor.

4.40 An issue has emerged in the University Hospital Southampton individual management review regarding the positive benefits associated with midwives checking the Mother's accident and emergency records at the point of booking. At this point and again with Mother's later pregnancies information regarding her mental and physical health could have enhanced the midwifery assessment. The legal advice is that a review of Mother's previous care within the Trust would not breach the data protection Act 1998 and a recommendation is therefore made within the hospital individual management review to develop this practice.

4.41 An additional issue is the need to consider the background of the Father at this point as there was an opportunity, following the booking appointment with the midwife, to join up what was known about Mother and Father through liaison with Father's GP. Father's GP was not aware of the pregnancy and at no point were they involved in any subsequent assessments which could have understood more fully the impact of the parental relationship on the unborn child.

[9] A Residence Order is a court order settling the arrangements as to the person with whom a child is to live. The person to whom the order is made shares parental responsibility with the parent(s).

4.42 There was evidence at this point of the potential impact of Mother's learning disability on her ability to take proper care of herself, with a consultant noting that she was not taking her medication and was also having difficulties understanding her clinical/medical issues. The midwife and GP were aware of this information and the Southern Health individual management review notes that this was discussed at a Care Programme Approach (CPA) meeting[10] which would have been attended by adults and children's social care.

4.43 Social work continued to be inappropriately led by adult services, with CPA meetings being used to discuss Mother's ability to care for her unborn child. These meetings did result in appropriate action being taken to understand the support Mother required with, for example, a speech and language assessment identifying that the most useful way to assist Mother in understanding complex information was to "use short clear sentences and easy words and give extra time to process and understand what is being said". The learning disability nurse was also providing additional support to Mother at this time and there had been an occupational therapy assessment which recommended that her care manager needed to find ways to develop mother's confidence in meeting new people.

4.44 Despite work being undertaken to understand Mother's needs there is no evidence that this was used effectively to develop a joined-up approach with children's social care which maintained a focus on the needs of Child I and the unborn baby. Although it was known to all professionals that Mother should not have unsupervised contact with Child I there were indications that this was happening, with Mother taking him to at least one care planning approach meeting. The health visitor was also aware that Child I was cared for by Mother from time to time, yet the whole network seems to have failed to challenge Mother, or each other, about the fact that this was known and allowed to continue. During this period there were staffing problems within children's social care and the case was again inappropriately allocated to a student social worker.

4.45 The issue regarding Child I's legal status whilst placed with Maternal Grandmother from this point became confused. In May 2008, the court granted leave for Maternal Grandmother to apply for a Residence Order and the case was adjourned for a month. The Cafcass individual management review report notes that in June 2008 both parties and the Cafcass duty family court adviser were in court and a Residence Order to Maternal Grandmother in respect of Child I was agreed. However, the court has confirmed that only a *draft* order was prepared as Magistrates required written confirmation that the application was supported by children's social care and the allocated social worker was on holiday. They therefore wrote to the social worker asking for confirmation that children's social care supported the Order and a final hearing date was set for 23rd July 2008. Maternal Grandmother and Cafcass were told that they were excused from attending on that day unless issues were bought to the attention of the court by children's social care. No reply was received from the social worker and due to this failure to reply and an oversight within the court system the case file was not put before the court on the July date. The Residence Order was therefore not made and the court cannot provide any explanation as to why the file was then not reviewed until after the death of Child I.

[10] Meetings designed to plan care for adults in receipt of services.

4.46 From this point, professionals and Maternal Grandmother believed that she had Parental Responsibility for Child I whereas no order had in fact been made and Parental Responsibility remained with Mother. It is clearly highly unsatisfactory that the legal status of a child can be so misunderstood but it should be noted that this situation is unlikely to happen today. Due to changes in court processes in April 2010, Cafcass would have been required to prepare a letter outlining any safeguarding concerns and in this case this would have alerted the court to the background to the application and ensured a greater degree of scrutiny by the court.

4.47 As Mother's pregnancy with Child M progressed, she was admitted to hospital and during the admission there were significant concerns relating to her continuing ambivalence towards this pregnancy and her potential to provide safe care for the unborn baby. At this point she received appropriate psychiatric assessment; the adult social care learning disability social worker noted the need for Mother's support package to be increased and liaised with the social worker from children's social care. It is notable that the health visitor recalls finding the planning for discharge confusing, with a lack of clarity regarding the relative roles of a planning meeting convened by the learning disability team and a professionals' meeting to plan for the birth of the unborn child.

4.48 Mother was discharged from hospital on a Saturday and the hospital notes record that this was agreed by the children's emergency duty team. The team had no authority to make this decision and it seems likely there was a misunderstanding/lack of clarity in the verbal communication between the two teams resulting in the hospital gaining false reassurance about the plan for discharge.

4.49 A professionals' meeting agreed that when the baby was born, Mother and baby should stay with Maternal Grandmother for three months post-birth and the learning disability health services agreed to close the case as Mother's needs were being met by other professionals. There were discussions with the safeguarding midwife who advised community midwives to undertake more frequent post natal visiting as well as liaise with the health visitor. It is, however, important to note that safeguarding midwives can only advise and have no direct line management responsibility for the actions of others.

4.50 Child M was born in August 2008 and as agreed Mother and Child M were discharged to the home of Maternal Grandmother.

4.51

Summary – agencies' response to further concerns about the care of Child I and Mother's pregnancy with Child M.

This period is characterised by muddle and confusion on a number of levels:

- Poor recording within children's social care which resulted in a lack of a clear understanding of Mother's living arrangements.
- Inappropriate allocation to a student social worker.
- Adult social care processes inappropriately driving a children's case.
- Child I moving permanently to live with Maternal Grandmother without a proper assessment of whether this was safe or appropriate.
- There was an assumption that a Residence Order had been made but this

was not the case due to the social worker failing to reply to a query from the court and an oversight within the court system.

- Information known to the GP and midwife about Mother's failure to take medication was not understood as significant information in relation to her parenting capacity.
- Police and social care were not working effectively together, with a failure to use strategy discussions to plan section 47 enquiries in line with procedure.
- A result of this confusion was that the focus on the individual needs of the children was lost.

Agency response to emerging concerns about the care of Child M (birth to 12 months)

4.52 Within a month, it was clear that Mother was staying most of the time with Child M in her own flat. Significant concerns soon emerged about her ability to provide appropriate care for Child M who was observed to be prop fed and in soaking nappies. Additionally, the support worker supplied by adult services was withdrawn due to Mother threatening them when they challenged her about her care of Child M. A note in the file by children's social care senior practitioner commented that they were happy for the case to be overseen by adult services but there is no indication from the adult social care files that this was a joint decision. Since Mother had returned to her own accommodation, a new health visitor was allocated to the family.

4.53 An allegation by Mother of sexually inappropriate behaviour between Father and Child M was discussed between Police and children's social care, and a single agency response by children's social care agreed. This is recognised within the police individual management review as an inappropriate response. The inadequacy of decision making was compounded by an inadequate section 47 enquiry which assumed that because Mother and Father were no longer in a relationship, Child I was safe. This assessment was not revisited when it became known that Father was once more living in Mother's flat.

4.54 Meanwhile, the health visitor became aware that Child I was often in the sole care of his mother and that Maternal Grandmother was refusing all contact with the health visitor in her area. In fact, it was the health visitor for Child M who referred Child I for speech and language therapy after an assessment in Mother's home and Mother who was noted to take him to the first appointment. The significance of Child I's presence was not adequately understood, particularly within the context of increasing concerns about the physical care of Child M. These concerns were noted by both the health visitor and the social worker who carried out a number of joint visits together to the home.

4.55 Mother took Child M to hospital in June 2009 (aged 10 months) concerned that he had tipped cleaning fluid over his legs and hands. Hospital staff were concerned about possible ingestion, although tests did not identify any external signs of either ingestion or contact with a harmful substance. Hospital systems at this point worked well with Accident and Emergency staff accessing previous records, filling in a concern form and alerting the social worker and health visitor. Despite this the social worker did not discuss with their manager or visit for a further two weeks.

4.56 When the social worker and health visitor visited the home, both Child I and M were there along with Maternal Grandmother, and the health visitor records note that Child I had been staying with Mother for the past month. Hygiene and safety concerns were identified, including batteries and cables lying around and a bottle of bleach propping open a door. The social worker said these would be discussed with their manager although there is no evidence that this happened and equally the health visitor did not follow up to find out the outcome of this discussion. The health visitor did, however, take action to provide additional support regarding home safety through a referral to the community nursery nurse.

4.57 A month later in August 2009 the case was closed to children's social care as part of a “closure project”. These projects are described by children's social care as historical features within Southampton and were used to review ‘Children in Need’ cases to identify those that could be safely passed onto other professionals delivering more preventative services.

4.58 Mother’s case had been closed to the adult social care learning disability team a month previously and there were therefore greatly reduced support services available to Mother, who was living on her own with a 12 month old child. The fact that she had previously been assessed as needing consistent support as a vulnerable adult (without a child) appears to have been overlooked.

4.59 Child I’s case had also been closed two months previously as he was understood to be safe in the care of Maternal Grandmother. Little attention seems to have been paid to the evidence that he was frequently in the care of Mother. Since there was no further children's social care involvement with Child I, when he started at nursery they were unaware of any safeguarding issues, and the fact that he was usually taken to nursery by Mother did not cause any concern.

4.60 *Agency response to emerging concerns about the care of Child M (birth to 12 months)*

This was a period where there was a failure to recognise the experience of Child M, increasing evidence of neglect within the home and indications that Mother was aware that she was not coping. The health visitor was aware that Child I was spending significant amounts of time cared for by Mother but the significance of this information was lost.

There was a lack of management oversight within children's social care at key points as well as poor management decisions regarding allowing the case to be led by adult social care and then eventually closed. The fact that closure was part of a “closure project” indicates that practice in this case was influenced by wider stresses within the social care system.

Child protection planning for Child M (age 14 - 20 months) and Mother’s pregnancy with Sibling 1.

4.61 Within a month of Child M’s case being closed by children's social care Mother was

pregnant. By this time there was not only information about Mother's history available to the GP but also accumulating evidence about the difficulties she had in parenting Child I and M. This had not been coded correctly within the GP records and was not included in the referral to the midwife. The fact that Father was registered with a different GP practice resulted in no consideration by primary care of the potential relevance of his mental health history to Mother's pregnancy with his child. Midwives did note Mother and Father's mental health history at time of booking and alerted the safeguarding midwife, but there is no evidence of proactive liaison with children's social care.

4.62 Whereas failure to engage with antenatal care is known to be a significant risk factor in child abuse cases, this was not an issue in this case. Mother regularly attended antenatal appointments, with 22 contacts being recorded with maternity and obstetric services from the point of booking with third child.

4.63 Mother again took Child M to hospital concerned about ingestion of a toxic substance as he had been found in the cot with Sudocrem on his hands and mouth. Although he was found to be medically well, ward staff were concerned that Child M was unkempt as well as this being the third Accident and Emergency visit within six months. A referral was made to the duty social worker within the hospital who also spoke to the health visitor and a plan was agreed for section 47 enquiries and for children's social care to have daily contact. Planning at this stage appears muddled since there was no strategy meeting, despite mention of section 47 enquiries; the role of the hospital social worker in making plans for discharge without discussion with the manager of the allocated social worker (the allocated worker was on leave) is not appropriate. It is unclear whether the plan for daily visiting was relayed to the allocated social worker.

4.64 In November 2009 Mother made an allegation that she had been assaulted by Father, which resulted in his arrest and return to the Department of Psychiatry.

4.65 At the point that Mother made the allegation Police arranged for Child M to be placed with a neighbour overnight. They were, however, very worried about the state of the home and the condition of Child M. They contacted children's social care emergency duty team at 10.20 pm who agreed that Child M should stay with the neighbour overnight and that the situation would be reviewed in the morning. The emergency duty team worker informed the police officer that children's social care were aware of the situation and were planning to remove Child M. It was the view of police officers at this time that there should be no delay in removing Child M from the home and a comprehensive CYPR[11] form was completed and shared with children's social care and relevant health professionals. Despite this effective sharing of information, the police individual management review identified a number of areas where police practice could have been improved, including the fact that no domestic risk assessment took place at this point.

4.66 Following this event Child M spent two weeks with Maternal Grandmother until a "planning meeting" (as recorded in the children's social care and Solent Health records) agreed that he should return home to Mother and there should be a child protection conference. It is unclear what the status of this meeting was as there had

[11] The form used by Hampshire Police to alert other professionals when a child has come to their notice.

still been no formal strategy meeting between police, children's social care and health as would be expected as part of the child protection process. Had such a meeting taken place there could have been a fuller sharing of all available information in order to inform the social work assessment prior to conference.

4.67 A child protection conference was held in November 2009 at which both Child M and the unborn baby were made subjects of child protection plans. There was no midwifery, GP or adult social care attendance at the conference and no evidence that reports were received from these key agencies. Despite Mother not having an allocated social worker within adult social care at this point, the team held important information which should have informed the conference, including their original assessment that Mother was too vulnerable to live independently. The minutes do not show any analysis of the current situation in the light of all known facts including Mother's history with Child I, her medical condition, and capacity and motivation to change. The health visitor noted that the "only" concern was safety within the home and there seems to be a focus on Father as a main risk factor and an optimism that if this relationship ended risks would be significantly reduced. Whilst this may have been the case, the resulting plan was insufficiently robust in identifying what needed to change to keep the children safe, the timescale within which change should take place, how this change would be measured and the consequences of no change occurring. The social worker, the midwife and the health visitor had tasks which included "monitoring" aspects of care with no clarity about what "good" would look like.

4.68 Child I was not considered at this conference as it was assumed that he was safely placed with Maternal Grandmother. Questions about the time Child I spent with Mother and the quality of his overall care (including failed speech and language appointments resulting in the case being closed by that service) were at no point effectively considered. Failed speech and language appointments should have been a cause for concern, but in this case worries about attendance were not passed on by the speech and language therapist as they were unaware of Child I's history. This was because there is no place on the referral form to highlight any safeguarding concerns. Child I was noted to live with Grandmother most of the time but the significance of the fact that he was taken to appointments by Mother was lost, as was the fact that he spent time in front of the TV with Mother.

4.69 After the child protection conference it seems that Mother became reluctant to engage with social workers and during December 2009 and January 2010 most social work visits were failed visits. One visit by a health visitor is referred to in the individual management review and there are no visits recorded in the chronology at the regularity agreed in the child protection plan.

4.70 A core group meeting took place two months after the child protection conference rather than within the ten days which was expected practice. The role of the core group set out in guidance at that time was to work as a multi agency group to develop and implement the child protection plan, and monitor actions and outcomes against the plan making any alterations as circumstances changed[12]. Since the core group meeting was only two days before the review child protection conference it

[12] HM Government (2006) *Working Together to Safeguard Children*. London: TSO Paras 5.110 & 5.112

would not have been possible for the group to fulfil its function effectively in making sure that the plan was reducing the risk of harm to Child M and the unborn baby. The meeting that did take place did note a number of concerns about the care of Child M and that Mother was not taking her regular medication, but it did not address failed visits and professionals' inability to progress the plan.

4.71 Although the review child protection conference agreed that Child M and the unborn child should remain on a child protection plan there is no evidence that the conference chair challenged the lack of progress with the original plan, including the parenting assessment and the implications of this for the safety of Child M and the unborn baby. It is questionable whether the chair should have agreed to the conference going ahead as the social worker was sick and no substitute sent and the only attendees were the health visitor, the agency support worker, a police officer and Mother. The tone of discussion was overwhelmingly positive, based on Mother's self- reporting and the fact that she was noted to be in a relationship with Father no longer.

4.72 One change to the plan was the addition of community childminding[13] for Child M five days a week from 9.00 am – 13.00 pm. (in June 2010 this was extended to 9.00 - 14.30) The child minder was given minimal information about the family and no information at all about the care arrangements for Child I. This is significant as Child I was at times seen by the childminder being cared for by Mother when she dropped Child M off at home. The childminder was unaware of the discussions at the core group meeting (which had taken place the day after child minding started) which had noted that Maternal Grandmother was expecting Mother to look after Child I every day, and that the social worker was to visit and ask for this arrangement to stop.

4.73 The childminder was aware that Child M was subject of a child protection plan and she was diligent in recognising and recording concerns about Mother's parenting. Concerns identified by the childminder between March and August 2010 included Mother frequently not being there when Child M was returned home, a bump and a bruise on Child M's forehead, extremely bad nappy rash and rough handling. The childminder alerted the social worker but did not appear to have any structured support systems or pathways for escalating her concerns when she disagreed with the social worker's comment that Mother would not harm Child M.

4.74 An additional problem with the childminding arrangements was that the procedure for appointing community childminders was that only one month at a time could be contracted. In the case of Child M this meant that there were occasions where the contract was not renewed in time to keep continuity of care. There was a gap of nine days in April 2010 and another of over three weeks in May/June 2010.

4.75 Meanwhile, Mother's third child was due in April 2010. There appears to have been a lack of proper multi agency pre-birth planning with no documented liaison between the health visitor and midwife, no pre-birth assessment being completed and records showing that Mother was not cooperating with parenting assessments at the family centre. In addition, there was an over-reliance on Mother's self-assessment, with the social work file noting that Mother had "assessed herself as being capable" to care

[13] Community childminders are commissioned by Children's Services to provide short term targeted support for vulnerable children.

for Child M and the newborn baby."

4.76

Summary - child protection planning for Child M (age 14 - 20 months) and Mother's pregnancy with Sibling 1.

During this period the risk of significant harm to Child M was recognised, with the case being managed under child protection procedures. However, there was a failure to use these procedures properly with no strategy discussion being used to plan enquiries at the start of the process and confusion about the role of hospital social workers in making plans. There was a failure to use the core group effectively to implement the child protection plan and assess the effectiveness of the plan in keeping Child M safe. In particular, there was no assessment of Mother's motivation to change and the implications of her non-engagement with the social worker.

Even though Mother was known to care for Child I he remained peripheral in professionals' minds. He was not considered at the child protection conference and information about him not being taken to speech and language sessions was not considered in terms of impact on his wellbeing. In fact, speech and language professionals were not appropriately involved in the planning process.

There is a noticeable failure to work effectively with the childminder and value the important information that she was able to provide. In addition, it is clear that the childminder lacked supervision and support systems that would have enabled her to challenge children's social care.

Planning for the unborn baby (who was subject of a child protection plan) lacked focus with lack of communication both within health and across the professional network.

Child protection planning for Child M until his death, and action taken in respect of Sibling 1

4.77 When the baby was born (referred to in this report as Sibling 1) a planning meeting at the hospital agreed an extended inpatient stay and when Mother was discharged home the plan was for Maternal Grandmother to stay with Mother along with Child I and M.

4.78 Sibling 1 was admitted to hospital via Accident and Emergency at the age of two weeks for clinical investigation of vomiting and low weight. She remained in hospital for three days and during this time a discharge plan was agreed, which included children's social care visiting three times a week, the health visitor once a week and the agency support worker organised via adult social care visiting daily Mondays to Fridays.

4.79 Following discharge there are records of increasing concerns expressed by the community midwife. These concerns were relayed to the GP whose notes record that the midwife had difficulty accessing the social worker and felt both children should be taken into care. There is record of a conversation between the midwife and the social worker during which the midwife described the environment as a "picture of neglect".

The next day Mother took Sibling 1 to the GP with medical concerns, and the GP referred to the hospital who checked the electronic records and noted the presence of a child protection plan. The safeguarding team in the hospital was alerted and the admission discussed with the social worker. Sibling 1 was discharged, well, the next day.

4.80 Subsequent social worker visits observed and noted highly critical parenting in respect of Child M; also adult social care noted that Mother was frequently not in when the support worker visited.

4.81 Eleven days after being discharged from hospital, Sibling 1 was taken to Accident and Emergency by Mother with a rash and diarrhoea and vomiting but was discharged home, well. Subsequent gastro-enterology outpatients' appointments in June/July/August did not identify any concerns. She was described as 'well and happy baby, smiling, bright, interactive and handles well'.

4.82 In June 2010 a meeting was held between a senior social worker in children's social care and a locum pupil barrister in the childcare legal team. The legal advice given was that the threshold for commencing legal proceedings had been met and that "a very clear contract of expectations should be drawn up, setting out clear parameters for Mother to meet and ensuring that SCC was not setting mother up to fail" (Legal Services individual management review para 5.2.11).

4.83 The reason for using a pupil barrister at this point was that resources were stretched within the legal team. It is recognised by the individual management review author that it was not appropriate for advice to be given by an unqualified member of staff, although the advice given at the time was sound.

4.84 In July 2010, Mother reported to her social worker that Father had allegedly been sexually abusing Child M. There is no evidence that the social worker discussed this with their line manager or referred to police for a strategy discussion. It appears that Mother was told to contact police herself and did not do so. It is not clear why something so significant was not discussed by the social worker with a manager. The most compelling explanation is that at this time there were severe staffing pressures within the service with a major recruitment drive underway to recruit qualified social workers from America. Information given to this review describes a service in crisis and within this context, the availability of managers (both physically and emotionally) is likely to be limited.

4.85 A review child protection conference took place at the end of July and it was significant that:

- The social worker reported Child I had been left in the care of Mother most days by Maternal Grandmother.
- Mother's allegation about Father earlier that month was not included in the social worker's report.
- A verbal report of the results of the parenting assessment stated that Mother was unlikely to be able to care for her children in the long term even with support.

- The conference was not informed that legal advice had been given about the need to initiate the Public Law Outline (PLO)[14] process and in fact the chair's summary refers to it being "highly likely that legal advice will need to be sought", clearly indicating that the conference had no knowledge of the previous discussions.

4.86 The same day as the child protection conference, Father and his community psychiatric nurse attended a meeting with the children's social worker to discuss supervised access with Child M and Sibling 1. Father was noted to be polite throughout the interview and refuted the previous allegation about sexually inappropriate behaviour with Child M (as described in paragraph 4.53). Father and the community psychiatric nurse left the meeting under the impression that supervised access would be arranged and the child protection conference minutes record that the social worker had asked Mother to agree to contact at the contact centre.

4.87 Following the child protection conference a newly qualified social worker was allocated to the case and immediately identified issues of neglect. However, when the contract of expectations was reviewed during social work supervision in August 2010 the manager concluded that since Mother had signed the contract she was cooperating. Twelve days later Mother told the social worker that she would no longer abide by the contract of expectations. This, combined with continuing serious concerns which were noted during social work visits, did not result in a reassessment within children's social care. It is possible that the newly qualified social worker did not feel able to challenge a manager who appeared to have formed a fixed view about this particular case. There continued to be a discrepancy between supervision notes which focused on supporting Mother to care for the children and social work recordings which document significant concerns about the care that the children were receiving.

4.88 The health visitor did not attend the core group at the beginning of September 2010 but they did do a home visit on same day. The reason for this appears to be that they were fitting in a last visit prior to moving to work in new area. A new health visitor was allocated and within two weeks undertook a joint home visit with the social worker. There had been a verbal handover with the previous health visitor and at the time of the visit they were aware of the child protection plan but they had no time to review notes in detail.

4.89 Meanwhile, Child M had investigations by the ear nose and throat surgeon due to concerns that he had a sweet up his nose. The allocated social worker, health visitor and GP were all kept informed appropriately by the hospital.

4.90 At the end of September 2010 Child M, age two, started nursery. The early years coordinator informed the nursery of parental learning difficulties, domestic violence, and the fact that he was on a child protection plan. The nursery was subsequently invited to and attended core group meetings. No concerns were identified by the nursery who described Child M as a 'normal two year old'.

[14] The Public Law Outline refers to the statutory guidance underpinning care applications which came into force in April 2008. It was designed to ensure that cases were better assessed prior to an application being made and through better preparation speed up the court process.

4.91 At the same time there was a change of community childminder for Child M. Mother recalls a good relationship with this childminder who cared for Child M until his death. However, despite extensive searching of the records it has not been possible to trace the name and address of this childminder and they have not been able to contribute to this review. It is concerning that there are not adequate records of a resource that was being paid for by the local authority.

4.92 In November 2010 there is evidence from the support worker that home conditions were deteriorating and Sibling, 1 aged seven months, was taken to Accident and Emergency by ambulance at 01.09 hrs on a Friday morning, with a history of vomiting and diarrhoea and episodes of unresponsiveness/floppiness. Hospital notes record that ambulance staff advised Accident and Emergency that the home was clean and tidy. Sibling 1 recovered well and the unresponsiveness/floppiness was thought to be secondary to dehydration from vomiting. Accident and Emergency staff checked the child protection plan and ward staff accessed old records regarding Mother's learning disability. No new safeguarding concerns were identified and Sibling 1 was discharged home later on Friday afternoon. The hospital social worker, health visitor and GP were advised of the admission and there is also a record of telephone liaison with the health visitor. There is no reference to whether any discussion took place about arrangements to provide support over the weekend.

4.93 The health visitor visited the home the following Thursday but there is no record of a visit by a social worker until the emergency duty team visited the next Sunday, apparently as a result of a telephone call from the agency support worker who had visited on Saturday and was reporting that Mother was not attending to the children's basic needs and that the house looked like "Armageddon". The emergency duty team social worker did not visit immediately and the children's social care individual management review author has been unable to ascertain why this was the case. By the time they visited the next day they noted that the house was untidy but not dangerous raising the possibility that the support worker had helped Mother to tidy up. From the information based on the file it was a reasonable decision not to take any further action at this time. However, it is not clear what prior information the emergency duty team social worker had about the family when they visited the house and whether they communicated information about their visit to the allocated social worker.

4.94 The allocated social worker did not visit until the next day, which was over a week after the hospital admission, and this sequence of events raises a possibility that there was ineffective liaison between the hospital social worker and the allocated social worker or that the allocated social worker did not see the hospital admission as a significant event requiring a visit. The social worker noted that no "new" concerns were noted.

4.95 The agency support worker was clearly concerned about the family and having called the emergency duty team on Saturday also called adult social care learning disability team on the following Tuesday reporting that Mother's engagement was erratic and that Mother did not know or understand that she needed the support to enable her to look after her children. There is no record that this was shared with the allocated social worker in children's social care.

4.96 The following Saturday there was an anonymous call to the Police alleging that

Mother was drunk in charge of Child M and Sibling 1. When the Police visited, the children were asleep and noted to be “safe and well” although being looked after by a 14 year old. Police contacted children's social care emergency duty team who found an emergency foster placement, however, this was not needed as Maternal Grandmother agreed to have the children for the night. Despite these being children subject of a child protection plan and a record of concerns the previous weekend, no one from the emergency duty team consulted with the duty manager or visited the family in order to make a proper assessment of the potential risks to the children. Police notification forms in respect of a vulnerable adult were completed and sent to relevant organisations.

4.97 There was follow up by children's social care at a statutory visit on the Monday during which Sibling 1 is described as “ashen” and cold with blue fingers. There was no visit by the health visitor following the police report; the only contact was a telephone conversation between the health visitor and Mother on the Wednesday.

4.98 During December 2010, there are clear indications from Mother that she was feeling unable to cope. She told the social worker that she wanted Child M and Sibling 1 removed and on a separate occasion told the health visitor that she found Child M difficult as he reminded her of his father. There is no record of any liaison between the health visitor and social worker regarding these contacts but records show that the social worker visited and persuaded Mother to keep the children. There is no file note indicating that this approach was discussed with a manager.

4.99 The minutes of the core group meeting held just before Christmas 2010 do mention that Mother was struggling with Child M’s behaviour, the episode where she had been drunk and that she had asked for the children to be removed. However, the information from the health visitor and nursery was generally positive and the focus of the meeting was on organising a support plan over Christmas and New Year.

4.100 On the evening of New Year’s Day 2011(a Saturday) Child M was taken to hospital by ambulance with a possible febrile convulsion. Accident and Emergency staff had noted Child M was on a child protection plan and “slightly unkempt and dirty” and there was little interaction between Child M and his mother. A “concern form” was raised for the allocated social worker, and copied to liaison health visitor for action next working day (Tuesday). Ward staff had no concerns but documented their intention to speak to children's social care emergency duty team on the Sunday. There is no evidence that this call was made.

4.101 The diagnosis made by the paediatrician was possible febrile convulsion or meningococcal meningitis and Child M was admitted, treated and discharged home, well, the next evening (a Sunday). Hospital policy is that in general children are better off in their home environment when well, rather than in hospital where they may be exposed to other illnesses, but in this case a child on a child protection plan was discharged on a winter’s evening with no discussion with anyone from children's social care.

4.102 The day after discharge, Child M was again admitted to Accident and Emergency with another possible febrile convulsion. Hospital notes record that both Mother and Maternal Grandmother were present and it is not clear who was caring for either Child I or Sibling 1 at this point. Child M recovered quickly and chicken pox was diagnosed. He was discharged home fit and well with Mother’s agreement at 02.35

am. Accident and Emergency staff again raised a "concern form" for children's social care and for the liaison health visitor, since it was a second attendance in three days. Again, there is no evidence of any direct liaison between hospital staff and social workers from the emergency duty team before discharge.

4.103 In the early hours of 6th January 2011 Child M was taken to Accident and Emergency by ambulance in cardiac arrest and was declared dead at 04.00. He was two years four months old. At this point the Child Death Rapid Response Protocol[15] was activated in order to plan next steps.

4.104 Child I and Sibling 1 were both admitted to hospital at the instigation of hospital staff for paediatric sibling medical assessments. Sibling 1 remained in hospital because of bronchiolitic cough and plateaued weight and discharged the next day.

4.105 *Summary - child protection planning for Child M until his death and action taken in respect of Sibling 1*

During the nine months leading up to his death Child M was subject of a child protection plan yet there is little evidence of any coordinated action to reduce the risk of continuing neglect. This was also a feature of work with Sibling 1. The main practice issues during this period were:

- A failure to act on the legal advice that the threshold for intervention had been met and to advise members of the child protection conference that this was the case.
- An inexperienced social worker identifying concerns and not discussing these with her manager, possibly due to unavailability of the manager or because she felt she would not be heard due to the manager's overly optimistic view of the case.
- A newly allocated health visitor without full knowledge of the background due to not having had time to read all the records.
- A pattern of significant events at the weekend which either resulted in insufficient action by the social care emergency duty team or children being discharged from hospital at a weekend without adequate consideration of the potential impact on Mother's capacity to care for them.

Events following the death of Child M until the death of Child I

4.106 At the point of Child M's death, in accordance with the rapid response protocol, a Detective Inspector from the Child Abuse Investigation Team took charge of the police response and in conjunction with the doctor who had been looking after Child M, examined his body and requested other appropriate examinations to be completed. Both Mother and Maternal Grandmother were interviewed and the children's social care emergency duty team contacted. An initial assessment of the home was carried out that night by a detective sergeant and detective constable in

[15] A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child. *Working Together to Safeguard Children* (2010) Para 7.1

line with the 4lscb rapid response protocol which states that:

When a person under 18 dies unexpectedly in a non hospital setting, the police SIO will consider an immediate visit to the scene of the death by a police investigator to assess the scene and to gather information from the scene to enable an early decision to be made as to whether the death is suspicious or not.

4.107 At 8.40 am the detective inspector examined the home; no obviously suspicious circumstances were identified. It is arguable whether at this point it would have been more appropriate to wait for a joint visit with a health professional who would have been available from 9am. This is explored further in paragraphs 5.50-5.56 below

4.108 On 7th January 2011, the day after Child M's death, in line with child protection procedures, a strategy meeting was convened in order to consider potential risk to other children in the family. This was chaired by a senior practitioner from children's social care who had neither previous experience of chairing such meetings nor previous involvement with the case. It seems that the team manager delegated this task to the senior practitioner without proper consideration being given to the seriousness of the situation or the level of expertise required. The meeting did not have a full picture of the family history since no one attended from children's social care who had worked with Mother or her children. The health visitor did attend the meeting but had not had a chance to fully review the historical records and was only able to contribute information that had been gathered over time from contacts with the family and attending multi agency meetings. She was unaware of the history of problematic relationships between Mother and Maternal Grandmother. The safeguarding nurse from the hospital had gathered information from the GP regarding Mother's failure to collect prescribed medication since 2009. Since it is known that failure to take this medication can exacerbate symptoms of a learning disability and cause tiredness and low mood it is surprising that the minutes note the consultant paediatrician saying that there was no evidence that failing to take the medication affected Mother's ability to care for the children.

4.109 The meeting was informed by the police sergeant of recent allegations that Child M had been left outside the home by a busy road and Mother had been seen to kick his backside and slap his bottom. However, the lack of relevant contextual knowledge within the meeting meant that when the police officer told the meeting that these allegations were not pertinent to Child M's death this was accepted by others without question.

4.110 The decision of the meeting was that the section 47 investigation which had started the previous day could be discontinued as there were no child protection concerns regarding Child M's death.

4.111 Five days after the death of Child M, a review child protection conference was held in respect of Sibling 1. Child I was not considered at conference and the health visitor report was not used as the chair did not feel it appropriate to do so because information about Child M was included in the report. The plan from the conference was to continue with daily visiting from the agency support worker, bi-weekly social worker visits, regular health visitor visits, childminding and a package of support from adult social care.

4.112 On 26th January 2011 a phase two child death rapid response meeting was held. Procedures suggest that this meeting should take place within 5 to 7 days of death; this meeting was therefore considerably out of time and there is no reason given for this in the minutes. The meeting noted that no specific cause of death had been identified. The meeting notes also record that both the health visitor and senior practitioner from children's social care commented that Mother "struggled with Child M's behaviour". This gives the impression that Child M was somehow to blame for Mother's poor parenting and is at odds with descriptions from the nursery which noted no behaviour concerns whilst he was in their care. Although it is recorded that children's social care were looking at long term planning with the legal team there is no information in the minutes which accurately describes the level of maltreatment described in the records. Again, it is recorded that Mother had not collected her medication from the GP surgery for over a year and both social worker and the health visitor were unaware of this. This is at odds with other evidence as failure to take medication was referred to in core group minutes in August 2008 and was also commented on within the parenting assessment which concluded in 2010.

4.113 Following Child M's death attempts were made by the health visiting service to see Child I. Maternal Grandmother, however, did not wish to avail herself of health visitor support saying that she only needed help with housing matters. There is evidence that little consideration was given to the impact of the death on Child I, with the pre school reporting that they were simply told by Mother one morning that "Child I may be out of sorts his brother died". It would have been more appropriate if professionals had given immediate consideration to the impact on Child I and liaised with the pre school at that point.

4.114 Support was offered at this time to Mother from the learning disability nurse who saw Mother at Maternal Grandmother's, undertook a comprehensive assessment and put Mother on a waiting list for work to help her understand her medical condition.

4.115 Sibling 1 was taken to Accident and Emergency on 3rd March 2011 with a shortness of breath and discharged home with antibiotics. She was again taken to Accident and Emergency 5 days later unwell and vomiting, having been seen earlier in the day by the GP. The ambulance crew are recorded as expressing concerns about the home (it is unclear which address this was) and there is no further information about the exact concerns as ambulance records are not kept of conversations with hospital staff and no safeguarding referral was made. Sibling 1 was admitted overnight and Accident and Emergency staff left a message with the safeguarding team in the hospital at 00.26 hrs.

4.116 The next morning the ward staff nurse discussed with the social work senior practitioner on site the hospital staff concerns about the appearance of Sibling 1 and the ambulance crew's concerns about the home. The health safeguarding team further discussed with onsite children's social care, as Sibling 1 was ready for discharge and the allocated social worker off duty. The hospital records note that the onsite hospital social worker and senior practitioner agreed discharge, with allocated social worker follow up. This repeats earlier confusion within hospital records regarding the role that hospital social workers or emergency duty team workers can play in "agreeing discharge". The hospital social worker is clear that this would not have been her remit and she did not "agree", yet a conversation between ward staff

and the social worker has been interpreted as such.

4.117 The evening of the next day, Sibling 1 was taken to taken to the Paediatric Assessment Unit as an emergency by Mother on the advice of the community asthma nurse. She was found to have low blood sugar and recovered well. Ward staff were, however, concerned as she was hungry and thirsty on admission and was in dirty clothing. Mother also seemed low in mood. The ward staff alerted children's social care emergency duty team. It is not clear what the emergency duty team did with this information.

4.118 The next day ward staff alerted the hospital safeguarding team who discussed concerns with the senior practitioner in the Children in Need team and agreed to keep Sibling 1 on the ward for a further day to support mother. This meant that Sibling 1 would be discharged home on a Saturday.

4.119 Sibling 1 was duly discharged into the care of her mother the next day, a Saturday. On the Monday the hospital safeguarding nurse contacted the health visitor to inform her of the discharge and that there were concerns that Mother was not coping. The health family support worker called Mother who said she was low in mood but was going to the GP.

4.120 Following the death of Child M, Mother requested a housing move which was eventually agreed. Support was offered by adult social care but Mother was not present when support workers visited, with Maternal Grandmother requesting that only regular support staff should visit and no replacements sent if the usual staff member was on holiday. There is no evidence of regular children's social care visits as would be expected for a child on a child protection plan where there are significant stressors within the family.

4.121 It is unclear how much regular contact Mother was having with Child I but subsequent Police statements are clear that he was in the sole care of Mother when he was rushed to hospital on 1st April 2011 in cardiac arrest. He died on 4th April 2011.

4.122

Summary - events following the death of Child M until the death of Child I

There are three relevant issues during this period: firstly the response to Child M's death, secondly the adequacy of the help aimed at reducing risk of harm to Sibling 1, who was still on a child protection plan and thirdly consideration of the impact of the death on Child I.

The child death response was limited by the fact that in within Southampton in January 2011 there was no designated paediatrician for child deaths as required by national[16] and local[17] guidance. This meant that there was no one in post with the responsibility for coordinating the multi agency response, including out of hours. The implications of this are explored further in section 5 of this report.

The plan at this time relied on adult social care to provide support and there is

[16] HM Government (2010) *Working Together to Safeguard Children* 7.29
[17] 4lscb (2010) Rapid Response Procedures 7.20

evidence of an appropriate package of help and support being offered. However, there was no evidence of a joined up approach which focused both on the needs of Mother and the care of Sibling 1. The impression from the records is that children's social care “backed off”, probably wishing to be sensitive to Mother’s feelings at this time. The potential for Mother to care safely for Sibling 1 after Child M’s death appears not to have been given adequate consideration at this time. Even though the death was not thought to have been suspicious, at the very least the impact of her child’s death on her mental health and capacity to parent should have been more fully assessed.

Practice following Sibling 1’s admission to hospital repeated the previous pattern of discharge home at a weekend as well as lack of clarity regarding the role of hospital social work staff in making decisions about plans for discharge.

Child I’s needs remained tangential and there is no evidence that proper consideration was given to the impact of his brother’s death on him or the implications of Mother having unsupervised contact.

4.123 Following the death of Child I there was a further Police investigation into the deaths of both children. Mother was arrested on suspicion of murder and a file submitted to the Crown Prosecution Service who recommended “no further action”. This decision was challenged by Hampshire Constabulary and the case was therefore reviewed by an experienced senior crown prosecutor. They took into account the finding-of-fact in the concurrent care proceedings which had decided that on the balance of probabilities the Local Authority had failed to establish that Mother had deliberately suffocated Child I and Child M although she was responsible for significant acts of neglect. In the light of this, as well as thorough review of all the evidence and consideration of existing case law, the decision was made that the prosecution would be unable to prove a criminal case beyond reasonable doubt and there was therefore not a realistic chance of prosecution.

5. THEMATIC ANALYSIS OF PRACTICE ISSUES

5.1 This section of the report focuses on areas of professional practice that have emerged from the case history as being in need of improvement. The analysis aims to explore the link between the practice issues and outcomes in this case as well as why this was the practice at the time. Understanding why events occurred has, however, been hampered in this review by the historic nature of the case and the fact that many staff at all levels of seniority (particularly in children's social care) are no longer in post.

5.2 An analysis of the case history shows that professional actions to protect Child I and Child M from harm were compromised in 11 significant areas of practice:

- Working effectively across children's and adults services to assess the impact of Mother's learning disability on her parenting capacity.
- Quality of assessments.
- Assessments of family carers and confusion regarding the legal status of Child I.
- Working together with early years providers to assess risk of significant harm.
- The use of strategy meetings.
- Using child protection conferences, core groups and child protection plans effectively.
- Assessing risk at point of hospital discharge.
- Working with fathers
- The role of the emergency duty team.
- The effectiveness of child death rapid response processes.
- Staff supervision and management oversight.

Working effectively across children's and adults' services: understanding the impact of Mother's learning disability on her parenting capacity.

5.3 Mother was known to have a learning disability and congenital health issues as well as experiencing significant trauma as a child; a combination of factors which led to an assessment by the Southampton City Council learning disability team that she was at risk living alone. At this point, prior to her pregnancy, there was good joint working across adult and children's services and a residential placement was joint-funded by adult social care and the children's services team responsible fr care leavers.

5.4 Once Mother became pregnant with Child I, it is positive that there was continued involvement by learning disability services provided by both the NHS and Southampton City Council. A wide range of services was provided, including a short term adult family placement for Mother after she had spent a period as an inpatient in the Department of Psychiatry, art therapy and provision of agency support workers. However, roles and responsibilities became confused and children's social care relied on adult services to take overall responsibility for managing the case, rather than the two services planning how to work together. Working effectively together should have led to a clear plan for making sure that there was a focus on Mother's

needs, Mother's capacity to parent and the developmental needs of each child. The fact that this did not happen meant that neither Mother's nor the children's needs were met.

5.5 Knowledge held by one set of professionals should have informed the work of others but too often either the information was not shared or its significance not understood. The information known to the GP, adult social care and the learning disability nurse was not used effectively to plan children's social work and health visiting responses. For example, the GP notes identify that Mother's verbal IQ had been assessed as 12 points lower than her performance IQ, information that is not seen anywhere else in the records and should have informed the way in which information was conveyed to her. The speech and language therapist did note the need to take care in verbal communication but there is no reference to this within child protection plans. Mother told the review that she often felt that she was being told what she had to do and did not understand why she had to do it, possibly a result of lack of consideration being given to the most appropriate ways of communicating with her.

5.6 Within the local authority, information sharing should have been possible through adults' and children's social workers accessing each other's case records. However, although there is a protocol in place to allow this to happen when one worker specifically requests access, current staff interviewed for this review were not aware of the protocol's existence and it is likely that this was also the case during the period of work with this family. Whilst access to records would not have solved all the problems, the fact that sharing is not automatic suggests a culture where a joined-up approach is not the norm. In other local authorities access to records is automatic and consideration of improving information sharing forms the basis of a recommendation within the adult social care individual management review.

5.7 The issue of Mother's failure to take her regular medication is noted at various points in the chronology and was discussed at care programme approach meetings which were attended by adults' and children's health and social care staff. However, this information became lost in the system and was not understood to be significant in relation to her emotional and mental health. Perhaps the GP was the professional best placed to track her use of medication and understand the implications of her failure to take it but they apparently did not understand the significance of information that they held. Not taking the medication would have exacerbated the challenges Mother faced in parenting safety, yet the GP did not raise this as a concern with other professionals, including the health visitor and social worker.

5.8 The lack of effective joint working was most telling in respect of the overall understanding of Mother's capacity to parent. Once Mother became pregnant with Child I, there is evidence of "interacting risk factors" [Brandon et al (2008)][18] that should have worried professionals. This is where the specialist knowledge held within adults' and children's services should have been brought together and understood in terms of risks to the children. Learning disability itself is not indicative of an inability to parent but in Mother's case this was combined with significant trauma as a child,

[18] Brandon, M., Belderson, P., Warren, C., Howe, D., Gardner, R., Dodsworth, J., Black, J. (2008) *Analysing Child Deaths and Serious Injury Through Abuse and Neglect: What Can we Learn*. London DCSF Research report DCSF-RR023.

mental health problems and lack of social support. Research indicates that where learning disabled parents have been abused themselves, have spent time institutionalised or in special education and there is evidence of maternal, emotional or medical disorders, there is a strong likelihood that parenting ability will be diminished (Tymchuk 1992)[19]. There is no evidence in any agency that this knowledge was used to inform thinking at any planning meeting including child protection conferences. Mother's own psychological and emotional needs were not adequately addressed once she became a parent and she told the review that there was no one there just for her who would not judge her.

5.9 Additionally, research shows that where there have been concerns about the capacity of a parent with learning disabilities to care for their child, one of the features that distinguishes children who remained safely with their parent from those who do not is the day-to-day presence of another caring adult such as a partner or relative (Cleaver and Nicholson 2007)[20] . In this case there was an over-reliance on Maternal Grandmother as a day to day support without adequate consideration of the problematic relationship with Mother going back many years.

5.10 Understanding the reasons for the disconnect between the good understanding that adult social care originally had in relation to Mother's vulnerability and the failure to recognise risk in children's social care has been hampered by the fact that some workers involved with the family are no longer working within Southampton. However, the following appear to be relevant and are subject of recommendations.

1. Lack of knowledge by professionals in relation to the combined effect of a learning disability, long term medical condition and trauma in childhood on parenting capacity.
2. Lack of understanding of each other's roles and responsibilities and how to work together where there is a need for a whole family assessment which adequately addresses the potential risks to vulnerable adults and their children.

Quality of assessments

5.11 During the period covered by this review, once a child had been identified as a child in need, it would have been a requirement that an assessment was completed using the national assessment framework[21]. This should have included considering the needs of any unborn children. The importance of this framework was that it prompted a focus on the developmental needs of each child, the parents' capacity to meet the child's needs and the potential influences of family history, current relationships and the current environment on their capacity to provide safe appropriate care for the child. The findings from this assessment should have been regularly updated and used to inform plans for each child.

[19] Tymchuk, AJ. (1992) ;Predicting adequacy of parenting by people with mental retardation' *Child Abuse and Neglect* **16** 165-178
[20] Cleaver, H. and Nicholson, D. (2007) *Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice*. London JKP
[21] Department of Health (2000) *Framework for the Assessment of Children in Need and their Families.* London: The Stationary Office

5.12 Assessments should have utilised information from the multi agency network and completed by a qualified social worker. In this case, there is no evidence that there was sufficient information shared between relevant professionals and the social workers involved with the family did not coordinate an effective multi agency approach to understanding the whole family. This was likely to be partly driven by the case being allocated to either unqualified or inexperienced staff who could not have been expected to have sufficient knowledge and expertise to manage such a complex case.

5.13 There was no assessment before the birth of Child I and if this had been done properly there would have been an understanding of Mother's vulnerabilities right from the start. This assessment would have considered the information that was known to the GP, involved the midwife and thought about the implications of Mother's own childhood relationships on her capacity to care alone for a child. The fact that her history and experience as a child was not considered in any meaningful way meant that the implications of Child I being cared for by Maternal Grandmother were never properly considered.

5.14 Government guidance regarding specific issues to be addressed in relation to pre-birth assessments simply stated that the same procedures and time scales should be followed when there are concerns about the welfare of an unborn child[22]. There was little detailed guidance and in this case nothing appeared to prompt a pre-birth assessment in relation to any of the children. It would have been from this point that the children's fathers could have been considered and where appropriate contributed to the overall understanding of the situation.

5.15 One parenting assessment was commissioned from the family centre; although thorough it did not use a framework specifically designed for learning disabled parents. The literature suggests that successful work with learning disabled parents involves the use of specialist toolkits that match the parents' level of understanding (McGaw and Newman 2005)[23] and a parenting assessment tailored for learning disabled parents should have been used to inform an overall assessment of risk[24].

5.16 The parenting assessment was significant in that it concluded that Mother would not have the capacity to look after her children in the long term. There is no indication that this conclusion informed the overall assessment or plan of work, and from an examination of child protection conference and core group records it seems that its findings were largely ignored.

5.17 The parenting assessment focused on the "parenting capacity" elements of the assessment framework[25] but the findings were not integrated into an overall assessment of both need and risk to each child. Where a separate parenting capacity assessment is commissioned in this way, it should be the job of the social worker to integrate the information with other knowledge of the family from others in

[22] HM Government (2006) *Working Together to Safeguard Children London*: The Stationery Office Para 5.14

[23] McGaw, S and Newman, T. (2005) *What Works for Parents with Learning Disabilities* London_ Barnardos

[24] For example the Parenting Assessment Manual developed by Sue McGaw, See McGaw, S. and Sturmey, P. (1994) *'Assessing Parents with Learning Disabilities: The Parental Skills Model' Child Abuse Review* **3** 36-51

[25] DOH (2000) *Framework for Assessment of Children in Need.* London: The Stationary Office

the network and use this to inform their overall judgement. This did not happen and there is no indication that other professionals challenged the absence of an assessment. It is hard to understand why this was, unless the whole network had developed very low expectations or did not understand exactly what good practice looked like.

5.18 One feature that should have influenced assessments was the clarity with which Mother was saying by her words and actions that she could not cope. On more than one occasion she asked for her child(ren) to be removed and she took Child M to hospital when she had failed to protect him from ingesting harmful substances. There was evidence of deliberate abuse from an early stage and this could have been understood within the context of research available at the time, which indicated that deliberate abuse by parents with learning disabilities is rare but where it does occur it is a very strong predictor of the occurrence of future abuse in the absence of parenting education or support (Tymchuk et al 1990)[26]. Even where supports are in place the chance of recurrence may be high (Gabinet 1983; Jones 1987)[27].

5.19 The child protection conference should have been one place where assessments could be scrutinised and discussed with the family, and gaps challenged. Neither of the two conference chairs was strong enough in identifying this as a significant omission or in questioning the implications of the findings of the parenting assessment. Again it seems that a low standard of practice was accepted as the norm.

5.20 The lack of challenge in relation to the assessment process was most striking within children's social care where no manager ensured that assessments took place and were used to inform decisions. Problems with overall management and supervision were very significant and are specifically addressed elsewhere in the report.

5.21 Due to the passage of time it has been hard to understand the detail of why assessment practice was so poor and why poor practice was not recognised and challenged. In summary, the most likely reasons seem to be:

- Social work staff with insufficient knowledge and experience to carry out the task.
- Lack of understanding across social care, general practice and midwifery regarding the importance of a thorough multi agency pre-birth assessment in situations where a Mother has a high level of vulnerability.
- A tolerance of poor assessment practice within children's social care which extended to a lack of effective challenge by the chairs of the child protection conferences and members of the core group meetings.
- Lack of training and availability of assessment tools specifically designed for parents with a learning disability.

The Southampton Local Safeguarding Children Board will wish to be reassured that these factors are no longer affecting practice.

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[26] Tymchuk, AJ. & Andron, L. (1990 'Mothers with Retardation who do or do not Abuse or Neglect their Children. *Child Abuse and Neglect* **14** 313-323

[27] Gabinet, L (1983) 'Child Abuse Failures Reveal Need for Definition of the Problem' *Child Abuse and Neglect* **7** 395-402 and Jones, D. (1987) 'The Untreatable Family' *Child Abuse and Neglect* **11** 409-420

Assessments of family carers and confusion regarding the legal status of Child I

5.22 The lack of a proper assessment of Maternal Grandmother meant that Child I was placed without any consideration of her parenting capacity or the fact that she had said she did not wish to care for him long term. When it became known that Child I was spending increasing amounts of time with Mother, Maternal Grandmother's capacity and commitment to keeping him safe was not sufficiently questioned. In addition, Maternal Grandmother's lack of engagement with health services, including not taking him to speech and language appointments, was not assessed in relation to the impact on his development.

5.23 One factor that contributed significantly to the lack of scrutiny of Maternal Grandmother's care was the prevailing assumption that a Residence Order had been granted and Child I was therefore safe with her. The failure to make the Order was a result of a Court process at the time that did not require information from Cafcass about any safeguarding issues, although Cafcass were aware that the local authority supported this application. The lack of formal information regarding safeguarding, the failure of the social worker to respond to the letter from the court and administrative failures within the court system resulted in the failure of the Court to make the final Order. The Southampton Local Safeguarding Children Board will need to be reassured that all these factors have now been addressed and in particular that social workers understand the importance of ensuring that the court has all relevant information when a Residence Order application is made.

Working together with early years providers to assess risk of significant harm

5.24 Those providing day to day care for the children in both pre-school and childminding services were those who arguably had the best information about the children. It is noticeable that there is no evidence that they were included as equal partners in the child protection planning process, were given appropriate information that would have helped to understand the whole experience of the child or, most crucially, that they were listened to when they had concerns. This was particularly significant in respect of the first community childminder who told the social worker about serious concerns, but these were not acted upon.

5.25 There is no evidence of effective support systems for the childminder to assist her in escalating her concerns about the children when she remained worried about their safety following lack of action by children's social care. The childminder's link with NCMA (National Childminding Association) did not apparently include active support and intervention with the local authority in situations such as this. There is no evidence of any role within the local authority such as an early years safeguarding advisor, which could have focused on the safety of children in an early years setting.

5.26 The practice of short term contracting for community childminders may have been in place to ensure that this provision was used appropriately in the short term to target specific needs in vulnerable families. However, in this case the inefficient administration of the scheme resulted in gaps in provision that were not planned and

and left a vulnerable child without a vital element of the plan that was designed to protect them. Inefficiencies have been further identified in relation to the failure to find any records identifying the childminder who cared for Child M at the time of his death.

5.27 In respect of Child I, the pre school knew nothing of his background, vulnerability and the potential significance of Mother's involvement with his life. The lack of contact with the pre school was most notable at the lack of information that they were given at the point of Child M's death.

5.28 The focus on the importance of early help for vulnerable families and the role that early years providers could play in providing this was not well developed during the period of this review. This, combined with inefficient systems within the local authority, resulted in a lack of continuity and marginalisation of a key service.

The use of strategy meetings

5.29 Strategy meetings or discussions have been an important part of the child protection process since 1991[28]. Their purpose is to plan next steps where there is cause to suspect that a child is suffering significant harm, and there is an expectation that those involved in the discussions include police, children's social care and relevant others including health professionals. Procedures allow for either a face to face meeting or a telephone discussion depending upon the complexity of the case. However, due to time pressures they may be an understandable tendency to avoid face to face meetings but unless there are effective conference calling facilities this may exclude some key professionals. This is an issue that is not confined to Southampton.

5.30 In this case, there are several occasions where expected procedures were not used in relation to strategy discussions/meetings. There were two ways in which this came about:

1. Police officers thought discussions with social workers were strategy discussions and they were not recorded as such within children's social care.
2. Social workers did not initiate discussions at points where there was clear risk of harm.

In addition, there was no recognition that health professionals should be asked to contribute to the discussions that did take place.

5.31 Lack of, or ineffective, strategy meetings resulted in a lost opportunity to bring together the information known to the police, health professionals and social care, assess the level of risk and plan an appropriate response. They would also have provided another forum where there would have been the opportunity for professionals to challenge each other and recognise the lack of any previous competent assessment of risk.

5.32 It is possible that this came about due to the inexperience of the social workers involved and the lack of effective management oversight which underpins so much of

[28] HM Government (1991) *Working Together under the Children Act 1989* London: HMSO 5.13

the poor practice in this case. Equally, police officers did not challenge the fact that they would not have received any minutes for strategy discussions, or consider the need to ensure that other appropriate professionals were included in the discussion. Again this seems to be a case of low expectations of each other and, in the case of children's social care, a focus on de-escalating concerns.

Using child protection conferences, core groups and child protection plans effectively

5.33 Child protection conferences should be the place where all relevant information can be shared and discussed in order to identify whether a child is at risk of harm and what needs to be done to reduce any identified risk. Core groups are the place where professionals and family come together to develop and monitor the effectiveness of the plan that has been developed to protect the child. When this case eventually entered the child protection conference arena there is little evidence that this had a positive impact on the work being carried out to reduce the risk of harm.

5.34 Conference discussions were not always based on the best possible information. The lack of social work assessment has been commented on above and one conference went ahead with no social worker present. Minutes do not note who submitted reports but indicate that although there was generally information from the health visitor and police officers, there was patchy information from other professionals. Midwives attended core group meetings but were not at either of the conferences where there was a focus on the unborn child. Information from the GP was entirely absent from all meetings and this gap was very significant due to Mother's complex health history. Neither was there specialist input from adult learning disability services until the conference that took place after the death of Child M. Community childminder input was also absent from both conferences and core groups.

5.35 It has been established good practice for many years for parents to be included in child protection conference discussions. Since most children remain with their parents it is important that there is an open and honest discussion about risks and what can be done to reduce the likelihood of harm but this approach is only successful if there is a degree of clarity and honesty about what the concerns are and what needs to change. The conference minutes suggest that in an attempt to be sensitive to Mother's feelings there was an over-emphasis on positives and little clarity about the concerns. No account was taken of the best way to explain the concerns to Mother; who told this review that this did not understand the reasons behind the tasks she was being asked to undertake.

5.36 There were two different conference chairs involved within the timeframe of this review. Neither chair challenged the significant gaps in information or the lack of progress with important aspects of the child protection plan, such as asking for legal advice. The chair of the initial second and third review conferences was an experienced chair who told this review that conferences at that time were hampered by a lack of good information from social workers, and that chairs could only manage and consider the information that was shared at the conference. It is the view of the children's social care individual management review author that there was probably a reluctance to be too demanding of social workers due to the pressure they were

under. In addition, at that time this chair was the only permanent child protection conference chair and was therefore under significant pressure.

5.37 The structure that was being used for child protection plans at that time did not help in focusing on what a safe environment would look like for the child(ren), how this could be achieved and on reviewing progress against expected outcomes. Plans generally focused on tasks to be achieved and included vague references to "monitoring" by health professionals.

5.38 The LSCB will need to be reassured that conference chairs proactively review the information at child protection conferences, challenge and follow up any gaps and focus carefully on whether the child protection plan is making a difference to the safety of the child. In addition, the responsibility of key professionals such as GPs needs to be re-emphasised and their contribution to the conference process evaluated. This is the focus of a recommendation.

Assessing risk at point of hospital discharge

5.39 Although hospital staff were conscientious in recognising and recording concerns about Child M and/or Sibling 1, there was little evidence of a systematic assessment of risk involving hospital and community staff when either Child M or Sibling 1 were discharged from hospital.

5.40 Handwritten concern forms were placed in a tray in the emergency department for collection (Monday to Friday) and action by the onsite social work team and liaison health visitor. They were then distributed to all the appropriate professionals in the community. This system inevitably led to some delay in communicating important information.

5.41 The use of concern forms was backed up by conversations between hospital staff and out-of-hours or hospital based social workers. However, at this point there were misunderstandings about the status of this discussion, with hospital staff believing that social work colleagues had "agreed" the discharge arrangements. Neither of the social work teams involved believes that this was the case and that instead; they had merely been informed that the child was being discharged home. This belief is based on an appropriate view that it is not the role of social workers to agree discharge in this way.

5.42 There were instances where the discharge home took place at night or at weekends. One discharge was on Friday afternoon, one on a Saturday, one on a Sunday, one at 00.26hrs and another at 2.35am. Hospital procedures aim to discharge children home as soon as it is safe to do in order to avoid any hospital based infections and promote recovery. However, in this case, the advisability of discharging a child subject of a child protection plan outside working hours and particularly during the night needs to be questioned. Mother told the review that she recalls getting a taxi home during the night and finding this very stressful. There appears to have been no assessment of the stress that may be placed on a mother who was known to be vulnerable and finding it hard to cope, or the delay in social worker and health visitor visits following weekend discharge.

5.43 The issue of hospital discharge is not subject of a recommendation within the hospital individual management review and there is, therefore, a recommendation within this overview report.

The role of emergency duty team

5.44 Children's social care emergency duty team received specific referrals on two occasions. There is no evidence that they checked the extensive children's social care records in order to help in deciding how to respond and, in fact, failed to take their own record of a visit one weekend into account when there was further referral the following weekend. The children's social care individual management review author has been unable to explain why this was, other than this was custom and practice at the time.

5.45 Custom and practice was also that emergency duty team social workers saw themselves as autonomous workers and have said that they were encouraged not to contact duty managers unless there was an issue on which they were unable to make a judgement. As noted by the children's social care individual management review author:

This meant that decisions that would have routinely received management oversight during office hours did not receive the same level of consideration out of hours (individual management review addendum report).

This is subject of a recommendation within the children's social care individual management review and the Safeguarding Children Board will need to be reassured that emergency duty team services are able to adequately safeguard vulnerable children from harm.

Working with Fathers

5.46 The issue of involving Fathers in assessments and plans has been a feature of a number of serious case reviews across England in recent years. In this case, the father of Child I had no involvement with Mother or his child at any point during the period of this review. However, the father of Child M and Sibling 1 was known to professionals and from time to time was living with Mother. Midwives did note the potential risks associated with Father's mental health problems, but beyond this there was little attempt made to understand the effect of his history, and circumstances on his capacity to parent or the nature of his relationship with Mother.

5.47 The mental health team working with Father only attended the initial child protection conference, sent apologies for the next two conferences and were not invited to the conference held after Child I's death. There is no evidence that information was sought from them in order to inform any ongoing assessments by children's social care. The professionals working with Mother viewed Father as an additional risk, although the exact nature of the risk was not adequately understood due to the lack of proper child protection investigations when allegations were made about his behaviour. He was, from time to time, known to be living with the family (he was for example present when Child M was taken to hospital in June 2009) and there was a focus on encouraging Mother to end any contact with Father. However, the lack of

engagement with Father as the father of the children would have made it difficult to work in any explicit way with Mother to explain the exact nature of the concerns.

5.48 One reason for the marginalisation of Father in this case was that he did not describe himself as part of the family. For example, the Southern Health individual management review noted that:

The Assertive Outreach team working with Father did not view Father to be part of the family and they never viewed Mother and Father as a couple with joint caring responsibilities. This was the clear message that Father gave the team during any discussion about Mother or the children.

5.49 Father's GP surgery also did not understand him to be part of a family unit and the significant information that was known to the GP about Father's mental health history was not shared with professionals who had responsibility for the children. Equally, this was not sought by others and, had it been asked for as part of child protection enquiries, the GP would have been alerted to Father's status as a parent.

The effectiveness of child death rapid response processes

5.50 The role of child death response procedures is relevant to this review in relation to the response to the death of Child M since this was an opportunity to make sure that adequate steps were taken to protect the remaining siblings.

5.51 The 4lscb rapid response procedures are designed to ensure an appropriate balance between:

- The bereaved family's need for sensitive, empathetic care
- The need to identify and preserve anything which might explain why the child has died
- The need to conclude investigations expeditiously so that the child's funeral is not delayed unnecessarily[29]

5.52 Effective implementation of these procedures is particularly vital where there are surviving siblings whose safety may be compromised if there is a slow or insufficiently robust response and in this case there are indications of problems with the way in which rapid response processes were working within the Southampton area. There were immediate discussions in hospital where a medical management overview meeting was held within a few hours of Child M's death, police officers were appropriately involved at this point and made an immediate visit to the home. The further visit to the home the next morning by the Detective Inspector at 8.40 am did not include a health professional, as suggested by the rapid response procedures, which state: the purpose of such a visit is to:

....gather information which may provide immediate insight into the cause of death, information which may later prove significant to the coroner/investigation and to provide support and reassurance to the family in their bereavement process. The SIO will be accompanied by the DP[Designated Paediatrician]/senior health care

[29] 4lscb Rapid Response Procedures September 2010 para 1.2

professional or by an assigned healthcare team who will talk with the parents/carers and assess the scene (paragraph 7.30)

The procedures go on to say:

Should the joint visit be considered inappropriate or professionally not possible in the circumstances, separate visits will be made with the [designated paediatrician] and {senior investigating officer] conferring later to identify all possible factors, from both as medical and police perspective which could have contributed to the child's death. (paragraph 7.31)

There are indications in subsequent meeting minutes that the joint visit did not take place as the police officer did not wish to wait for health staff to be available after nine am and there was no specific provision for a response out of hours. Although there was no designated paediatrician, additional safeguarding nurse specialists had been trained to contribute to the rapid response process during working hours and after nine am there would therefore have been an opportunity for a separate visit to the home by a health professional to take place. There is a need for Southampton Local Safeguarding Children Board to consider adequacy of out of hour's responses in such situations and this is reflected in recommendations made by this review.

5.53 The strategy meeting the next day, which took place under child protection procedures, provided an opportunity to ensure that effective measures were in place to protect the remaining siblings, but this was not chaired at a senior enough level, it did not consider and analyse all known information about the family and failed to consider the needs of Child I.

5.54 Although, the rapid response process requires a second meeting to take place within five to seven days, this review was informed that this is frequently impossible due to the variability in the timing of post mortems, the release of findings and the availability of relevant staff at short notice. A third meeting within the eight to-twelve week timeframe suggested by the procedures was equally impossible in this case since the final post mortem results were not signed until December 2011.

5.55 An additional factor during early 2011 that also affected the application of procedures was the lack of designated paediatrician for child deaths. This role was originally described in Working Together 2006 and was further refined in Working Together 2010 and has an important role to play in both the commissioning and organisation of services as well as coordinating responses in individual cases where a child has died unexpectedly. Within Southampton until June 2013 where a rapid response was required specialist nurses from the safeguarding team in Solent NHS contributed to enquiries and undertook home visits.

5.56 Since a good response to the unexpected death of a child potentially affects the safety of other siblings, the effectiveness of rapid response processes is an issue for the Safeguarding Children Board. Although this case is unusual due to two linked deaths being treated as suspicious, it is unsatisfactory to have a set of procedures that may, in many cases, be impossible to apply and the need for these to be reviewed is the subject of a recommendation within this report.

Staff supervision and management oversight

5.57 One aspect of this case that cuts across all the themes discussed above is the lack of effective management oversight and the fact that no one in a senior position challenged the poor practice and drift in this case.

5.58 Several of the reports submitted for this review identify that within individual agencies staff supervision took place regularly (e.g. health visiting service, adult social care and the supported housing project), or that managers at an appropriate level were involved in decision making (e.g. within the hospital and police). Within children's social care the situation is less acceptable, with evidence of social workers being supervised but an absence of consistent management oversight above the level of senior practitioner. As explored above, in relation to the emergency duty team there is evidence that managers were not consulted even though they were available to the staff on duty.

5.59 The quality of supervision that did take place is commented on within the individual management reviews. Whilst much was found to be positive there are indications that in some areas it could have been improved with more emphasis on a detailed analysis of the safeguarding concerns (for example within children's social care and the health visiting service). Within children's social care, the chronology shows that although supervision took place, social workers did not always take their worries about this family to the meeting possibly because of previous experiences where, when they did so, the senior practitioner response was to downplay the concerns. At one point this may have been an unintended consequence of attempts by senior managers to manage workflow through “closure projects”. This is likely to have influenced social workers’ thinking regarding the likely response from managers should they suggest escalating the case to one requiring child protection intervention. There are comments in the chronology about social workers telling the health visitor that they would discuss the case with their manager and then failing to do so; possibly because they predicted that the response would be focused on case closure.

5.60 The fact that this case was allocated at various times either to unqualified or newly qualified social workers did not prompt a style of supervision which allowed for an exploration of the potentially confusing and overwhelming nature of the case and a focus on potential risks to the children. One factor possibly contributing to this situation was the absence of any effective supervision for the senior practitioners themselves, a lack of involvement of team managers in practice decisions and a culture within the department which encouraged senior practitioners to reduce demands on the service.

5.61 In respect of early years providers, the absence of supervision and support for the childminder is commented on above. There is no specific evidence within the prevention and inclusion individual management review that others involved in providing early years services had the opportunity to reflect on any unanswered

questions about the children as well as their own role within this case. It should however be noted that although the need for adequate supervision opportunities in the early years sector became a requirement[30], this was not the case during the period of this review.

5.62 The picture that emerges is of a situation where although there was evidence of staff supervision, managers across all organisations were not proactive in recognising poor practice and challenging fellow professionals. This was also the case within the child protection conference where, as discussed above, the lack of proper risk assessment and failure to progress the plan was not challenged.

5.63 Reasons for this lack of challenge are not clear but the most likely explanations are:

1. Lack of knowledge on the part of managers about what good practice looked like.
2. Lack of scrutiny of the decision making of front line managers.
3. Accommodating lower standards in recognition of the demands on the child protection services. It is known that children's social care was going through a very difficult period with high staff turnover including at senior management level. There were also significant capacity issues within the health visiting service in 2010. In such situations there can be reluctance to make yet more demands of over-stretched colleagues.

5.64 The LSCB has in place escalation procedures designed to ensure that where there are concerns that a child is not being protected this is brought to the attention of colleagues in the relevant agency. However, in this case the issue was not whether procedures existed, but rather the ability of managers to recognise poor practice outside their own environment, recognition of their responsibility to bring this to the attention of others and a multi agency culture within which constructive challenge is understood to be a fundamental aspect of effective safeguarding. Southampton Local Safeguarding Children Board will need to be assured that this is now the case.

6. CONCLUSIONS

6.1 This was not a case where the potential for the children to be harmed was hidden. Mother was open about the problems she experienced in coping as a parent and on more than one occasion asked for the children to be removed. The physical abuse of Child I and the neglect experienced by Child M and Sibling 1 were obvious, yet did not prompt the necessary action to protect them from further harm.

6.2 It was assumed that Child I was protected through living with Maternal Grandmother, despite no assessment of the advisability of this arrangement and he slipped from the sight of all professionals. The fact that Maternal Grandmother refused health visiting services, the failure of Maternal Grandmother to take him to speech and language appointments and the time he spent in the sole care of Mother was not questioned. Of particular significance is the issue of the Residence Order which all professionals assumed had been made but we now know was never issued by the

[30] Department for Education (2012) *Statutory Framework for the Early years Foundation Stage* London : Department for Education

Court. Child I was therefore residing with an adult who did not have Parental Responsibility for him and without the safeguards that were assumed to be in place. The inexperience of the social worker and their failure to reply to the Court's request for confirmation that the Residence Order was supported by children's social care contributed to this situation, as did inefficiencies within the Court system.

6.3 Both children's social care and community health professionals failed to adequately assess the combined impact of a learning disability, trauma as a child and failure to take medication on Mother's ability to parent. No multi agency pre birth assessments were carried out and the significance of information contained within GP records was not recognised as being relevant to raise with others including children's social care. There was a lost opportunity for midwives to understand the whole picture at the time of all the antenatal bookings as they did not routinely access Mother's other hospital records. Where there was a change of health visitor it is clear that they did not have the time to review all the notes and were unaware of the complexity of the case history. At no point was all relevant information brought together in order to inform assessments and plans.

6.4 Meeting the needs of vulnerable adults and their children is a challenge and can only be achieved through effective joint working across children's and adults services. It requires clear roles and responsibilities and the ability to maintain a focus on the family as whole whilst never losing sight of risks involved to individual family members. In this case this balance was rarely achieved. The case was either being inappropriately driven by adult services or their information was not utilised effectively when planning for the children within the child protection arena. The end result was that the assessments carried out in relation to Mother and/or Father failed to inform an understanding of risk to the children.

6.5 Where a parenting assessment did raise concerns about Mother's ability to parent, this was not taken into account in decision making within children's social care mainly because where social workers did raise concerns with their supervisors, the management message was to minimise the significance of the risks to the children. This seems to have resulted in social workers failing to continue to inform supervisors of all the risks that they were noticing in their day to day work.

6.6 Southampton Children's Services were in some disarray during the period covered by this review with staff shortages, problems with retaining experienced staff and recognition within the senior management team that there were significant challenges in delivering a safe service. Mother experienced this in terms of a lack of opportunity to form a trusting relationship with a social worker and the staffing problems contributed to the case being allocated to staff lacking in the necessary experience and skills. This combined with ineffective supervision and management oversight at all levels of the organisation led to a situation where there was a lack of clear decisive action to protect the children from harm.

6.7 The problems within Children's Services were well known across the City and the evidence points to low expectations about the standard of practice by children's social care and a failure across all agencies to challenge both Children's Services and each other. Where supervision systems were inadequate, such as within child minding services, there was no mechanism to use the support of more senior staff to escalate concerns. Even where individuals had identified risks within their own

safeguarding supervision systems these were not escalated via management systems. Low standards therefore prevailed in relation to a number of areas of practice that were not questioned by anyone within the network. Of particular significance were:

- Strategy meetings that were not always held at key points in time. Where they did occur they did not include all relevant people particularly from health and were not recorded appropriately.
- Planning meetings in relation to the children being led by adult services under procedures designed to focus on the adult's needs
- Child protection conferences that were not always attended by all relevant professionals and did not have all the information needed to make a sound judgement.
- A failure to complete actions required within child protection plans including taking legal advice.
- Failure by children's social care to take action where there was a clear risk of harm.

6.8 Whilst there has been insufficient evidence to prosecute anyone and there was an open verdict at the inquest for both children, it has been determined that both children experienced neglect. It is clear from this review that this experience of neglect would have been preventable had all professionals worked more efficiently and effectively together. Children's social care as lead agency did not fulfil their responsibilities and this was undoubtedly influenced by an organisational context where leadership and management was weak, there were staffing shortages and staff were insufficiently equipped with the knowledge and skills to work with complex cases. However equally, they were not challenged by other professionals who appear to have had low expectations and accommodated to a poor standard of practice.

7. RECOMMENDATIONS

7.1 *No pre birth assessments were carried out and there was therefore a lost opportunity to analyse all the information known across the professional network and consider Mother's capacity to parent.*

Recommendation 1

Southampton Local Safeguarding Children Board should review the use of the 4lscb "maternity services and children's social care joint working protocol to safeguard unborn babies 2011" and ensure that it is being implemented across Southampton.

7.2 *Work with the family as a whole and particularly Mother as a learning disabled parent with complex needs, failed to keep a focus on risk to the children at the same time as providing services to meet the adult's needs.*

Recommendation 2

Southampton Local Safeguarding Children Board should review the approach across the partnership to “Think Family” and ensure:

- There is a holistic approach across adults and children’s services to assessment and service provision where a parent has a learning disability and/or mental health problem.
- It promotes an approach which includes fathers.
- The effectiveness of the protocol on working with adults with a learning disability.
- Adequate knowledge and skills in assessing the parenting capacity of adults with a learning disability.
- Adequate access to records across adults and children’s social care services.

7.3 *Although there were concerns in a number of organisations about the failure to adequately address risks to the children, the escalation processes were not used to bring these concerns to the attention of senior managers in children's social care.*

Recommendation 3

Southampton Local Safeguarding Children Board should promote the use of the escalation procedures as part of the development of a culture where constructive challenge across agency boundaries is understood to be an essential and positive element of safeguarding practice.

7.4 *Strategy meetings were not used in line with procedures*

Recommendation 4

Southampton Local Safeguarding Children Board should evaluate the effectiveness of strategy meetings with particular reference to whether:

- Face to face meetings (rather than telephone discussions) are taking place when required
- All relevant staff are included
- Meetings and/or discussions are recorded in line with procedures.

7.5 *The post of Designated Doctor for child deaths is relatively new within Southampton and in addition, there are indications that some aspects the rapid response procedures cannot be consistently implemented.*

Recommendation 5

Southampton Local Safeguarding Children Board should review the effectiveness of rapid response arrangements in delivering services as set out in the 4lscb protocol particularly where these affect the safety of surviving siblings. The Board should work with the Child Death Overview Panel to develop this service.

7.6 *The child protection conference system did not work well in gathering all relevant information, analysing the level of risk and ensuring that effective plans were implemented.*

Recommendation 6

Southampton Local Safeguarding Children Board should evaluate the current approach to child protection conferences and ensure that conferences include all those who had relevant contact with the family and the provision of reports from all key professionals.

7.7 *Supervision was either absent or ineffective in supporting an analysis of risk.*

Recommendation 7

Southampton Local Safeguarding Children Board should establish a core standard for safeguarding children supervision and seek evidence regarding its implementation. This standard should:

- take account of differing governance arrangements, supervision cultures and organisational structures for the delivery of supervision;
- promote reflection, critical analysis and evidence informed practice
- ensure that all staff have the psychological and emotional support required for effective decision making in safeguarding children
- require regular evaluation of the quality of supervision being provided.

7.8 *The support available to the child minder in escalating concerns was not effective.*

Recommendation 8

Southampton Local Safeguarding Children Board should ask Children's Services to identify a strategic lead for safeguarding for early years services and be assured that there are robust arrangements in place for supporting childminders to escalate concerns if they are dissatisfied with the response they receive from Children's Social Care.

7.9 *There was a lack of clarity regarding the role of emergency duty team or hospital social workers in "agreeing discharge" and there was insufficient consideration given to the implications of discharging a child on a child protection plan from hospital outside normal working hours.*

Recommendation 9

Southampton Local Safeguarding Children Board should seek assurance that Southampton Hospital has adequate systems in place to review discharge plans in the light of all known information and adequately safeguard vulnerable children

discharged outside working hours.

7.10 *There was a misunderstanding regarding the legal status of Child I due to the failure to finalise the draft Residence Order and lack of information before the court regarding the involvement of children's social care. This led to an inappropriate reliance on Maternal Grandmother to exercise Parental Responsibility and keep Child I safe.*

Recommendation 10

Southampton Local Safeguarding Children Board should review current practice in relation to Residence Order applications in order to seek assurance that:

- Any safeguarding concerns are known to the Court
- Social workers are aware of the importance of responding to requests for information from the Court.

APPENDIX A: THE LEAD REVIEWERS AND PANEL MEMBERS

Kevin Harrington chaired the Panel of agency representatives which oversaw and challenged the process of this review. He trained in social work and social administration at the London School of Economics and worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has worked on more than 40 Serious Case Reviews in respect of children and vulnerable adults. He has recently been engaged by the Department for Education to re-draft high profile Serious Case Review reports so that they can be more effectively published. Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council, and has undertaken investigations commissioned by the Local Government Ombudsman. He has served as a magistrate in the criminal courts in East London for 15 years

Jane Wonnacott was the author of this report. She also trained in social work and social administration at the London School of Economics and qualified as a social worker in 1979. She has an MSc in social work practice, the Advanced Award in Social Work and an MPhil as a result of researching the impact of supervision on supervision practice. She has published two books on supervision and co-wrote with Tony Morrison the national training programme for social work supervisors. Since 1994 she has been the author or chair of many serious case reviews and in 2010 completed the accredited Tavistock Clinic and Government Office London nine day training programme for panel chairs and authors. She has also attended the 2012 Department for Education serious case review training programme.

The Panel

Designated Doctor NHS Southampton City CCG

Designated Nurse NHS Southampton City CCG

Detective Chief Inspector, Hampshire Constabulary

Team Manager, NSPCC

Housing Services Manager, Southampton City Council

Service Manager (Intermediate Care), Southampton City Council

Named Professional for Safeguarding Adults, Southampton City Council

Interim Head of Service, Southampton City Council Children's Services

Manager Southampton Local Safeguarding Children Board (in attendance)

Assistant Head of Legal Services Hampshire County Council (in attendance)

Kevin Harrington Lead Reviewer and Panel Chair

Jane Wonnacott Lead reviewer and report author (in attendance)

APPENDIX B

TERMS OF REFERENCE

Child I and Child M

REASON FOR SERIOUS CASE REVIEW

This serious case review report is commissioned by Southampton LSCB in respect of two children known in this review as Child I and Child M. Child M died aged 2½ in January 2011 and along with his sibling was subject of a child protection plan at the time of his death. Child M's half-brother, Child I, died three months later in April 2011 at the age of 4½. He was understood to live with Maternal Grandmother but was in the sole care of Mother at Maternal Grandmother's house at the time of his death.

No charges have been brought in relation to either death, although a finding of fact in subsequent care proceedings did find that both boys had experienced neglect. The inquest into the deaths of Child I and M heavily relied on the finding of fact and resulted in an open verdict for both children.

SCOPE

Period under review

The timescale of the review for individual management review authors is from the date that mother was known to be pregnant with her first child (Child I) i.e January 2006 to the date of Child I's death on 4th April 2011.

Contextual information

Agencies are also asked to summarise relevant background/contextual information/key factors/significant events about family that was ***known or knowable by the agency at the start of the review period***.

This will include any relevant agency knowledge of :

- The family background and childhood of the parents and carers of Child I and M and their siblings

AGENCIES INVOLVED

Hampshire Constabulary

Southampton City Council Children's Social Care

Southampton City Council Prevention & Inclusion (including involvement of Children's Centres and child minders)

University Hospitals Foundation Trust

Solent NHS Trust

Southampton City Council Adult Social Care (learning disability and mental health services)

Southampton City Clinical Commissioning Group / GP

Southampton City Council Housing Services

CAFCASS

South Central Ambulance Service

ANALYSIS ISSUES

Each IMR author is asked to explore not only *what* happened but *why* professionals took the actions they did. Factors that might have influenced practice should be considered including:

- **The nature of the family circumstances** including level of complexity, the nature of the issues presented, the way family members interacted with professionals.
- **Individual staff factors** including knowledge skills and expertise, previous experiences of similar situations, assumptions that may have driven responses, levels of stress and any relevant personal circumstances.
- **Influences on the effectiveness of** inter **professional communication and practice** including the nature of relationships between professionals (within and across agency boundaries), systems and processes in place to support communication and the impact of status and hierarchy on decision making.
- **Organisational and strategic factors** including priorities, resources and quality of guidance
- **Quality of management and team support** including the effectiveness of supervision in promoting reflective practice, team relationships, learning and development opportunities.

The following should be covered within the report but authors should not feel constrained by these topics and should actively explore any issues that emerge as important influences on practice.

a) Was practice child focused e.g. were the children's wishes and feelings ascertained and given appropriate priority? Was consideration given to what it was like to be a child living in the family?

b) Were assessments and investigations carried out and followed up appropriately? *This includes the use or not of CAF, initial and core assessments, medical and health assessments, strategy discussions and criminal investigations and any other assessments that should be provided by each agency*

c) Where formal plans were in place in relation to adults or children in the family were they appropriately focused on outcomes for the children clear in relation to professional roles and responsibilities and revised in the light of new information?

d) Following the death of Child M how effective was the professional network in reviewing the implications of this event for work with Child I and his sister?

e) Did practitioners have and use appropriate knowledge and professional expertise in relation to safeguarding the children in the family?

f) Were communications, within and between agencies, effective in:
   - ensuring that all relevant information was available to support professionals in their respective roles with the family
   - Providing an opportunity for professionals to challenge each other as appropriate?

g) Was practice sensitive to racial, cultural, linguistic and religious identity and any issues of disability?: *include here also cultural issues relating to the family such as the where the family lived, their lifestyle, environmental and social factors*

h) Were managers and supervisors appropriately involved in this case and how did their involvement affect the quality of work being undertaken with the family?

i) Did any resourcing issues affect the way this case was dealt with? If so in what way and why was this?

j) Is there evidence of good practice in the way this case was handled? If so what was this and what factors contributed to enabling such good practice?

INVOLVEMENT OF STAFF

IMR authors should identify and interview any staff that they feel can add value to the review. This should include staff who have left the organisation whose practice may be referred to in the review and who wish to contribute.

It may also be appropriate for the lead reviewers to interview staff but this will be subject of discussion and agreement of the serious case review panel.

INVOLVEMENT OF FAMILY

Child I and M's adult family members have been notified that the review is happening. The lead reviewers will be responsible for meeting with family members who wish to contribute to the review.