



# **BROMLEY SAFEGUARDING CHILDREN BOARD**

## **CHILD E**

### **SERIOUS CASE REVIEW**

**FEBRUARY 2015**

	<b>TABLE OF CONTENTS</b>	<b>PAGE</b>
1.	<b>INTRODUCTION</b>	<b>3</b>
2.	<b>ARRANGEMENTS FOR THE SERIOUS CASE REVIEW</b>	<b>3</b>
3.	<b>METHODOLOGY USED TO DRAW UP THIS REPORT</b>	<b>6</b>
4.	<b>CHRONOLOGY OF KEY EVENTS</b>	<b>6</b>
5.	<b>THE FAMILY</b>	<b>9</b>
6.	<b>THE AGENCIES</b>	<b>10</b>
7.	<b>KEY ISSUES</b>	<b>21</b>
8.	<b>CONCLUSIONS AND LESSONS LEARNED</b>	<b>25</b>
9.	<b>RECOMMENDATIONS FROM THIS SERIOUS CASE REVIEW</b>	<b>26</b>
	<b>9.2 Recommendations to Bromley Safeguarding Children Board</b>	<b>26</b>
	<b>APPENDIX A COMPOSITION OF SCR PANEL</b>	<b>28</b>
	<b>APPENDIX B DETAILS OF THE INDEPENDENT REVIEWER/AUTHOR OF THIS REPORT</b>	<b>29</b>
	<b>APPENDIX C TERMS OF REFERENCE FOR THIS SERIOUS CASE REVIEW</b>	<b>30</b>
	<b>APPENDIX D PRINCIPLES UNDERLYING THIS SERIOUS CASE REVIEW</b>	<b>32</b>
	<b>APPENDIX E SUMMARY OF AGENCIES RECOMMENDATIONS</b>	<b>33</b>
	<b>APPENDIX F REFERENCES</b>	<b>37</b>
	<b>APPENDIX G GLOSSARY</b>	<b>38</b>

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## **1. INTRODUCTION**

- 1.1 This Serious Case Review concerns the tragic death of Child E at the age of 12 weeks in March 2014. At the time of his death, Child E was Looked After (in care) by Bromley Children's Social Care and placed with his twin brother, Child D in the care of his maternal aunt, Ms P. Unknown to professionals, he was staying in a caravan due to Ms P locking herself out of the home address for a few days. In the early hours of 5<sup>th</sup> March 2014, Child E was found on the makeshift bed on the floor of the caravan and was not breathing. Child E had been sleeping with his 2 siblings, a cousin and maternal aunt Ms P.
- 1.2 The Coroner's report has subsequently confirmed in July 2014 that the cause of death was Sudden Unexpected Death in Infancy (SUDI) and decided that there would be no Inquest and no criminal proceedings have been instigated. The SCR Panel agreed to continue with the SCR Process given that it was clear that there was learning for agencies.
- 1.3 Child E was one of twins born to parents on 10<sup>th</sup> December 2013 who also have 3 older children. The family are from an Irish Traveller background and had spent most of their lives moving between and living in a number of different Local Authorities in London and the South East Area of England. There is a very large extended family; mother is one of ten siblings, two deceased, all of whom have families and live in the south east of England.
- 1.4. Both parents and an older sibling Child B were arrested on September 2013 for burglary offences and both parents were remanded to prison. Child B was also arrested with his parents and remanded to Local Authority Foster Carers. The other two siblings - Child A and Child C were placed with maternal aunt - Ms P initially under S. 20 arrangements (voluntary agreement). Bromley Children's Social Care services subsequently initiated care proceedings on all five children.
- 1.5 Both of Child E's parents have criminal convictions and have spent periods of time in prison and both were known to have a history of drug and alcohol abuse.
- 1.6 Following the birth of Child E and Child D, the Local Authority obtained an Interim Care Order (ICO) on 12<sup>th</sup> December 2013 and the babies were placed with Ms P on 19<sup>th</sup> December 2013. They remained with Ms P until the death of Child E in March 2014.

## **2. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW**

- 2.1 This case was referred by the Rapid Response meeting to the Local Safeguarding Children Board in Bromley (BSCB) where Child E was subject to a Bromley ICO. On 27<sup>th</sup> March 2014 the Serious Case Review Committee of the Bromley Safeguarding Children Board (BSCB) met to consider whether the criteria for a serious case review were met.
- 2.2 There is a legal requirement, as defined in statutory Guidance, Working Together to Safeguard Children 2013, to undertake a serious case review when abuse or neglect of a child is known or suspected and
  - either a child has died,

- or a child has been seriously injured and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

- 2.3 At its meeting, the Serious Case Review Committee concluded the criteria for a serious case review were met as Child E was a looked after child who had died and neglect at that point was suspected. The Independent BSCB Chair agreed with their recommendation.
- 2.4 The purpose of a serious case review, as set out in Statutory Guidance, Working Together 2013, is to identify improvements, which are needed, and to consolidate good practice in order to help prevent deaths or serious injury.
- 2.5 BSCB decided to appoint a Serious Case Review Panel to oversee the process and act as the Reference Group. It was chaired by Helen Davies, the Independent Chair of the Bromley Safeguarding Children Board. Its function was to manage and oversee the conduct of the review. The membership of the SCR Panel is set out at Appendix A. The Board appointed an independent reviewer, Alex Walters to lead the review and to write this overview report. Further details are at Appendix B.
- 2.6 In total nine Individual Management Reviews (IMRs) were requested from the following agencies which had substantial contact with child E and his family and there was also a Health Overview Report commissioned by Bromley Clinical Commissioning Group (CCG.)
- The Whittington Hospital that provided ante-natal, labour and post natal care to mother of Child E and Child D
  - Croydon General Practitioners - provision of primary care services to Child E, his siblings and extended family
  - Croydon Health Care Trust - Provider of community services providing health visiting services for Child E and Child D and Croydon University Hospital.
  - Croydon Schools and Learning providing services for Children A, B, C, F and G.
  - Bromley Children's Social Care Services
  - The Metropolitan Police
  - Children and Family Court Advisory and Support Service (CAFCASS)
  - Bromley Legal Services.
  - Bromley Health-Care Provider – provided initial health assessment of Child E and sibling, Child D.
  - A Health Overview Report
- 2.7 In addition, background reports were requested from agencies with less significant or less recent information:
- Holloway Prison (where mother on remand)
  - Lewisham Hospital providing ante-natal services to mother
  - St George's Hospital providing paediatric intensive care services to Child E
  - Bromley Children's Social Care regarding Child E's sibling - Child B
  - Bromley Youth Offending Service – providing services to Child B.
  - Croydon Housing Department providing services to Ms P
  - Croydon Children's Social Care providing services to the family of Ms P
  - Bromley Drug and Alcohol service providing services to Mother.
  - Belmarsh Prison (where father was on remand)

- 2.8 This report was written in anticipation that it will be published. Consequently, the information in the report is limited so as to:
- 1) take reasonable precautions not to disclose the identity of the child or family
  - 2) protect the right to an appropriate degree of privacy of family members
- 2.9 Terms of Reference for this SCR are at Appendix C. Child E was the main subject of the review but the three siblings - Child A and Child C and Child D and the two children – Child F and Child G of maternal aunt Ms P - were included. Child B was not included as he was not in the care of Ms P during this period. Its principal focus was from 3<sup>rd</sup> September 2013 (when both parents were arrested) until 10<sup>th</sup> March 2014 (the day of the Rapid Response meeting). However, all agencies were asked to provide a summary of all significant events and relevant family history outside the specific timescale and to consider any safeguarding issues for Child E's older siblings.
- 2.10 Not all of the IMRs addressed the terms of reference, which is an issue explored in the report. All the authors of the internal reviews were independent of the case management, and conducted interviews with staff involved with Child E and his family.
- 2.11 Following consideration of the combined chronology of events and the Internal Management Reviews, the independent reviewer and the BSCB Business Manager met at a learning event with eleven professionals who had worked with Child E and/or his family. They included Bromley Local Authority social workers, CAFCASS, YOS and staff from the Education Traveller Service and the school attended by child E's siblings in Croydon. This provided a valuable opportunity to gain their perspectives of their work with child E's family and to consider lessons learned.
- 2.12 After the first draft of this report had been compiled, the Independent Reviewer and the BSCB Business Manager met with seven of the IMR authors in order to seek their views on preliminary findings and on recommendations. All of their comments have been included in this Overview Report and the discussion led to some additional recommendations and learning for individual agencies.
- 2.13 All of the practitioners involved earlier in the process were offered a further opportunity to discuss the draft report with the Independent Reviewer and this offer was taken up by two front line social work practitioners. Both social work practitioners felt that the report described the case and the issues from their perspective and no changes were suggested other than a few factual accuracy issues. They both felt that they recognised the learning from this SCR process and that included the learning for BSCB on how to involve practitioners in future SCRs.
- 2.14 Attempts were made throughout the SCR process to involve the family and finally resulted in the Independent Reviewer meeting with both the mother and father in their respective prisons. Neither parent identified any agency actions that might, with hindsight have been helpful to their family or any actions that might have prevented the death of Child E. They acknowledge that this was a tragic death, which has impacted significantly on themselves and their wider extended family, but were both positive that their children were cared for within their wider traveller community.

### **3. METHODOLOGY USED TO DRAW UP THIS REPORT**

3.1 This overview report relies on:

- The agency IMRs and background reports
- Subsequent discussions with the SCR Panel which met on five occasions
- Dialogue with the IMR authors
- Discussion at the learning event in July 2014 with front line practitioners
- Discussion at the follow up meeting in September 2014 with IMR Authors
- Follow up discussion with two social work practitioners
- The views of Child E's parents
- Following permission of the court, the Independent Reviewer read the court bundles in their entirety.

3.2 This report consists of:

- a factual context and chronology
- commentary on the family's input to the SCR
- analysis of the part played by each agency
- closer analysis of key issues arising from the review
- conclusions and recommendations

3.3 The conduct of this review has not been determined by any particular theoretical model. However, the review has been carried out in keeping with the underlying principles of the statutory Guidance, set out in Working Together 2013. These are at Appendix D.

### **4. CHRONOLOGY OF KEY EVENTS**

4.1 This section of the report briefly provides a summary of the family context and key events from August 2013. Further detail is then provided at appropriate points throughout the report.

#### **Chronology**

Bromley Children's Social Care had received two referrals from local police during March 2013 regarding this family. These referrals led to an initial and core assessments being instigated but the case was closed on 24<sup>th</sup> May 2013 following unsuccessful attempts to locate the family in Bromley.

On 26<sup>th</sup> July 2013 the case was re-opened following mother's arrest on drugs and driving offences and the case remained open while the social worker undertook a core assessment.

On 3<sup>rd</sup> September 2013 problems escalated when again both parents were arrested and mother was admitted to Lewisham Hospital having tested positive for cocaine and opiates. Child C was found in the back of the car with parents on their arrest. Local police placed Child C and Child A with her maternal aunt Ms T in Croydon. A number of family's names were given who might have been able to provide care for the children. SW1 began the task of contacting and arranging police checks on those family members.

6<sup>th</sup> September 2013 - scan at Lewisham hospital confirms mother is pregnant with twins (24 weeks).

Father and Child B charged with 46 conspiracies to commit burglary with the intent to steal. Mother charged with driving offences.

Child B remanded to Local Authority care and placed with foster carers as bail conditions stipulated he was not to be placed with a family member. Father and Mother remanded to prison.

16<sup>th</sup> September 2013 - mother's EDD confirmed as 27<sup>th</sup> December 2013. Drug & alcohol abuse may lead to earlier delivery. Mother moved to Holloway Prison.

LBB First Legal Planning Meeting held with decision to institute legal care proceedings. Decision to refer for Family Group Conference (FGC). SW2 to complete court statement by 19<sup>th</sup> September 2013.

Child A and Child C are officially accommodated Under Section 20 of the Children Act 1989.

1<sup>st</sup> October 2013 Child A arrested shoplifting in Croydon and bailed to Ms P address.

1<sup>st</sup> October 2013 Child A and Child C move to Ms P without social care involvement in the decision.

LAC review 1 held on three oldest children – Child A, B and C at Bromley Civic Centre.

9<sup>th</sup> October 2013 - LBB Second Legal Planning Meeting held.

11<sup>th</sup> November 2013 - LBB Third Legal Planning Meeting held. Commissioning request made by Children's Social Care for Independent Social Work assessment of aunt Ms P.

13<sup>th</sup> November 2013 - Fax to GP requesting medical information on Ms P. This request suggests it was the 2nd fax to the surgery in this regard.

29<sup>th</sup> November 2013 - Completed DBS form received from aunt Ms P, signed off and sent to DBS.

4<sup>th</sup> December 2013. Holloway Board held to consider application for mother and baby placement, which was refused.

9<sup>th</sup> December 2013 - Family Group Conference held.

10<sup>th</sup> December 2013 - Child E & Child D born at Whittington Hospital by elective caesarean and transferred to SCBU.

12<sup>th</sup> December 2013 - 1st Court Hearing in the Care Proceedings - Interim Residence Order granted to Ms P in respect of Child A and Child C. Child E and Child D are placed on Interim Care Orders; no order for Child B. Children's Social

Care provided Court Statements and a written Care Plan which recommended an ICO and that Child E and Child D were placed with experienced foster carers whilst family assessments undertaken. The case was deferred until 18<sup>th</sup> December 2013 as this plan was not agreed and further family assessments requested.

13<sup>th</sup> December 2013 - Mother discharged from Whittington Hospital to Holloway Prison.

18<sup>th</sup> December 2013. 2nd Court Hearing agreed to Child E and Child D being placed with Ms P still under an Interim Care Order whilst family assessments undertaken.

19<sup>th</sup> December 2013 Discharge planning meeting at Hospital and Child E and Child D moved to Ms P.

23<sup>rd</sup> December 2013. Statutory LAC visit undertaken by duty SW.

30<sup>th</sup> December 2013. New Birth Visit by Health Visitor.

6<sup>th</sup> January 2014. Statutory LAC visit by duty SW to Child E and Child D.

LAC review of Child E and Child D at home of Ms P.

20<sup>th</sup> January 2014 Child E and Child D noticed at Mother's Court appearance.

24<sup>th</sup> January 2014 Mother discharged from Holloway Prison on bail.

First set of immunisations for Child E and Child D and 8 week check by GP.

17<sup>th</sup> February 2014 Permanency planning meeting held. Decision to seek a family placement or adoption for Child E and his sibling Child D.

18<sup>th</sup> February 2014 Mother in Police custody for breaching bail.

26<sup>th</sup> February 2014 Mother re-arrested for breaching her curfew.

28<sup>th</sup> February 2014 Mother pleads guilty to driving offences and remanded in Holloway Prison until sentencing on 15<sup>th</sup> April 2014.

3<sup>rd</sup> March 2014 Initial health assessment and Adoption Medical undertaken of Child E and Child D.

Meeting at Primary School involving Ms P to support improvement in attendance.

4<sup>th</sup> March 2014 - second set of immunisations for Child E and Child D by GP.

5<sup>th</sup> March 2014 - Child E admitted to hospital in early hours of morning with cardio-respiratory arrest. Child E was transferred to PICU at another hospital but his condition deteriorated and Child E died later that day.

10<sup>th</sup> March 2014 - Rapid Response meeting held and referral to BSCB SCR Sub Committee.

## **5. THE FAMILY'S INVOLVEMENT IN THE SCR PROCESS**

### **Child E's Mother**

- 5.1 Child E's mother was informed of the Serious Case Review process by the Chair of the Serious Case Review Panel and subsequently invited by the Independent Reviewer to contribute to this review. The initial responses were negative however Child E's mother then requested to meet with the Independent Reviewer and this meeting at HMP Send Prison took place on 24<sup>th</sup> October 2014. Mother was supported by a member of a voluntary organisation who provide services in the prison. At this meeting the mother was very clear about a number of concerns, some of which were outside the remit of this SCR. The Independent Reviewer advised the mother to make formal representation of her complaints to the Prison Ombudsman which she was subsequently supported to do. The Mother raised issues about the delay in being informed of the admission of Child E which resulted in her not being able to hold her baby before he died; the response of the prison officers at this visit and the fact that neither parent were allowed to attend Child E's funeral.
- 5.2 As a result of the concerns identified by the mother, the Independent Reviewer wrote to both HMP Holloway and HMP Belmarsh in November 2014 to inform them and allow them the opportunity to respond and also made a further request for information from Children's Social Care in Bromley. Responses were received in late December 2014. It is clear that there are differing recollections of events. In relation to the first concern regarding the time delay, Children's Social Care explain their attempts to contact HMP Holloway and HMP Belmarsh by phone from approximately 2 pm and finally made contact with HMP Holloway about 5 pm. The reality was that it took Children's Social Care time to clarify Child E's condition and the medical level of concern and they then experienced difficulties in contacting the prisons. It is very unfortunate and highly distressing for the mother that Child E had died in this period. HMP Holloway are clear that the prison officers who accompanied the mother to hospital behaved appropriately but were concerned at the large family presence which required them to take protective action. Both HMP Belmarsh and HMP Holloway are clear that the decision not to allow either parent to attend Child E's funeral was due to risk assessments that the risk to prison officers and public safety was too great from the extended family and this decision was supported by the police. The mother is clear that she felt decisions were made as a result of their traveller culture. These issues are beyond the scope of this SCR and need to be raised with the relevant complaint body, which the Independent Reviewer understands is in process.
- 5.3 The mother did however state in the meeting that she was pleased that all the children had been placed initially and now permanently within the wider extended family traveller community. She did not identify any agency actions which might have been helpful to the family or might have prevented the tragic death of Child E.

## **Child E's Father**

- 5.4 Child E's father was informed of the Serious Case Review process by the Chair of the Serious Case Review Panel and subsequently invited by the Independent Reviewer to contribute to this review. The Independent Reviewer met with father at HMP Chelmsford on 24<sup>th</sup> September 2014. At this meeting the father made some helpful points for this review to consider. He was clear that his culture would absolutely expect that if the parents were unable to care for their children that they should be cared for by their extended family. He was therefore very positive about the decision that the court made for Aunt P to care for all four of his children in December 2013. And, stated that he was glad that his children had re-engaged with school. He was very distressed that he had not had contact with Child E before his death and was critical of Children's Social Care for not enabling this to take place. The Independent Reviewer has followed this up and was informed by Children's Social Care that the lack of contact was a) due to the need for Belmarsh Prison to have evidence of birth certificates and babies not being registered until 11<sup>th</sup> February 2014 and b) the limit to numbers of children visiting at any one time and the older children were prioritised and c) their understanding that Ms P would be taking the children to visit their father. Although very distressing for the father, the prison restrictions could not be altered. He was also critical of the decision to remove Child C and Child D from Aunt Ms P's care following the death of Child E but accepted that this was due to the uncertainty regarding the cause of death. He was very positive that all four of his children are placed within the wider extended family. He did not identify any agency actions that might have prevented the tragic death of Child E.

## **Child E's Aunt**

- 5.5 Child E's aunt - Ms P was informed of the Serious Case Review process by the Chair of the Serious Case Review Panel and subsequently the Independent Reviewer attempted to make contact by phone and through the relevant Traveller Liaison service. It was however confirmed that the family were travelling around the UK and did not respond to direct phone contact. The mother gave the Independent Reviewer another mobile phone number at the visit on 24<sup>th</sup> October 2014 for Ms P. A number of voice mail messages were left but no response received.

## **6. THE AGENCIES**

### **6.1 The Metropolitan Police**

- 6.1.1 The IMR and chronology provided by the Metropolitan Police was considerably delayed. This was due to an initial oversight within the police as the IMR request was not passed on to the relevant internal team and then by the volume of work within the SCR team. The Serious Case Review Panel were concerned at the impact of the delay and the Chair made robust representation about the impact of the delay.
- 6.1.2 The IMR was received on 30<sup>th</sup> September 2014 - some 3 months later than the other agency IMRs. The IMR details historical Police conviction information on Mother, Father and Aunt Ms P and describes police involvement during the period of SCR review.

- 6.1.3 There is clear evidence demonstrated in the IMR that the Police responded appropriately to all contacts with the family, recognised the impact on the children, undertook good risk assessments and shared information appropriately with Children's Services using the established Merlin Police notification system and direct contact.
- 6.1.4 The IMR Author identifies that there was good practice demonstrated in terms of a pro-active response to the incident at the bail application hearing for mother in January 2014 when Aunt Ms P was challenged and there were concerns that Child E and Child D were left unattended.
- 6.1.5 Additionally the Independent Reviewer recognised good practice in the evidence of police challenge to Bromley Children's Social Care on the decision to cancel the Initial Child Protection Conference in September 2013.
- 6.1.6 There are no recommendations for the Police Service in the IMR. The Independent Reviewer agrees that this is appropriate. However there is clearly significant concern at the delay in completing the IMR by the Police Service and the impact this has had on the process and timeframe of this SCR process. There is therefore a recommendation in this SCR to the Metropolitan Police to ensure sufficient capacity to respond to IMR requests.

## **6.2 The General Practitioners in Croydon**

- 6.2.1 Ms P had been registered with the GP Practice since 1994 and as a permanent patient since 2002. Her own youngest two children had been registered relatively recently with the same GP Practice and subsequently Child E and his three siblings were registered. The GP Practice had undertaken routine immunisations, developmental assessments and clinical appointments.
- 6.2.2 The IMR clearly identified that the GP Practice had not responded to a request from Bromley Children's Social Care on 12<sup>th</sup> November 2013 requesting urgent information on Ms P and her own children. The response was finally provided 4 months later. The IMR report author identifies the failure in the administrative systems within the GP Practice to respond to requests for information; to cover for sickness absence and the lack of a safeguarding culture in order to "Think Family" and identified staff who had received insufficient safeguarding training.
- 6.2.3 The IMR Author identifies that the impact of not sharing information in a timely manner was that the information about Ms P's medical history was not shared and did not therefore inform assessments of her ability to care for initially two and then four additional children. Ms P had a history of Post-Traumatic Stress Disorder since the sudden death of her husband 13 years previously and dependence on diazepam.
- 6.2.4 The GP Practice received the discharge summary from the Whittington Hospital following the birth of Child E and his sibling but links were not made with their knowledge of Ms P.
- 6.2.5 The IMR Author identifies clear learning for the GP Practice in ensuring the compliance of all GP Practice staff with mandatory training and their role in safeguarding and the need to think family. It recommends that communicating

effectively with Children's Social Care and other professionals involved in the safeguarding process should be undertaken in a meaningful and timely manner. There should be management oversight arrangements including case discussion and the GP Safeguarding Lead having the overview of reports for Children's Social Care and solicitors involved in safeguarding children matters. The Health Overview Author has recognised this vulnerability and makes a recommendation for the CCGs to review safeguarding training and compliance for GP practices. The Independent Reviewer is confident that the IMR has picked up the key learning and that the Croydon CCG responsibility to address the performance management is addressed.

### **6.3 Whittington Hospital**

- 6.3.1 This hospital provided ante-natal, labour and post natal care to mother. The initial IMR did not identify learning but following discussion with the IMR Author by the SCR Panel and Deputy Designated Nurse, recognition of practice, which could be improved, was identified. The hospital first became involved with Child E's mother on 23<sup>th</sup> September 2013 following referral from Holloway Prison. She was at that time on a methadone programme. She was known to have a history of alcohol abuse and depression. Her health was a cause for concern during the latter stages of her pregnancy as she was not eating or sleeping well and was of low mood felt to be due to her recent bereavement of her own mother.
- 6.3.2 Delivery of Child E and Child D was on 10<sup>th</sup> December 2013 by elective caesarean and the twins remained on the ward with mother until 13<sup>th</sup> December 2003 when mother was discharged back to the prison. They were monitored for neonatal abstinence syndrome. Child E and his sibling were then moved to SCBU (Special Care Baby Unit) and later discharged to Ms P on 19<sup>th</sup> December 2013.
- 6.3.3 The circumstances that led to the decision to discharge mother on 13<sup>th</sup> December 2013 were not entirely clear in the IMR. The Children's Social Care and Holloway Prison IMRs describe the social worker receiving voice messages from mother meant for someone else, which requested money and car seats, and there was therefore a perception that there might be an attempt to abscond with Child E and his sibling. There was a discussion between the hospital and the Prison but the decision to discharge mother was made by the hospital with some limited discussion with Children's Social Care who had an Interim Care Order on Child E and his sibling at this point. This was later confirmed to involve contact with the Bromley Out of Hours Service as this decision took place on a Friday evening. This was clearly felt to be a crisis and a potentially risky situation for Child E and Child D and therefore the decision would seem to have been appropriate.
- 6.3.4 Child E and his twin were discharged on 19<sup>th</sup> December 2013 after a discharge meeting involving Ms P, a social worker from Bromley Children's Social Care and a nurse. The discharge summary was sent to the GP in Croydon but not to the Health Visitor, which was a breakdown in communication and did not clearly state that the carer for the twins was Aunt Ms P.
- 6.3.5 These issues have been recognised by the IMR Author and Health Overview Author and a resulting recommendation is for a new recording tool, which is currently being used to improve communication and documentation to track actions taken. In addition there is a further recommendation in relation to training based on the

recognition of the need to ensure increased professional curiosity by midwives. The Independent Reviewer is satisfied that the key learning has been identified.

#### **6.4 Croydon Health Services NHS Trust**

- 6.4.1 This Trust provided health visiting and hospital services to Ms P and the children. The health visiting service first became aware of Child E and his sibling from Bromley Children's Social Care on 20<sup>th</sup> December 2013 with detailed information being provided including the date of the first LAC review on 6<sup>th</sup> January 2014. A new birth visit took place on 30<sup>th</sup> December 2013 and again on 29<sup>th</sup> January 2014 and they were seen at the Health Centre for immunisations and weighing. There were 2 visits to the Emergency Department of the hospital during this time period for Child D which were unremarkable.
- 6.4.2 The IMR describes a universal partnership service being provided which is an enhanced service given the circumstances of the children's legal status and additional vulnerabilities (i.e. being a twin; having spent time in SCBU; mother was drug dependent and they were placed out of Borough). The IMR author felt the new birth visit was within time frame of the relevant health guidance for Looked After children given the Christmas holiday period. But, the Health Overview Author felt this was not the case and the new birth visit should have been prioritised and has made recommendations to the respective CCG/Local Area Team to undertake regular monitoring of timescales for new birth visits. The Independent Reviewer agrees that this will provide useful monitoring.
- 6.4.3 There is an additional shared view that there was no pro-active communication between the Health Visitor and the social worker or vice versa which given the vulnerability of the family situation is surprising and the Health Visitor did not attend the LAC review on 6<sup>th</sup> January 2014 which would have provided a useful information sharing forum. This issue has been subsequently accepted by the IMR Author and incorporated into the recommendations. The Independent Reviewer is satisfied that the key learning has been identified.

#### **6.5 Bromley Healthcare - provider of health services to Looked after Children**

- 6.5.1 This IMR identified that the Initial Health Assessment and the Adoption medical were carried out at the same time and fulfilled statutory requirements. However there was a delay in the LAC Health Team being notified of Child E and Child D becoming looked after which resulted in the Initial health Assessment also being delayed. The Health Overview Report author has identified this as an issue for the Health provider and LA to improve communication channels. The Independent Reviewer is satisfied that the key learning has been identified.

#### **6.6 Health Overview Report**

- 6.6.1 This report was commissioned by Bromley CCG from a designated nurse in another London CCG and although no longer required by guidance provided a very helpful oversight of the health IMRs and identified and confirmed the key issues and areas of learning.
- 6.6.2 This first area identified the delay in the Initial Health Assessment for Child E and Child D which took place 10 weeks after they became looked after and there are

recommendations for the provider, Bromley CCG and the Local Authority to address and improve communication procedures.

- 6.6.3 The second area identified the delay in the new birth visit and the lack of information sharing from the Hospital with the HV. There are recommendations for the CCG/Local Area Team and the provider to improve administrative arrangements and to ensure monitoring is in place.
- 6.6.4 The third area identified the lack of response from the GP practice to the request for information from Bromley Children's Social Care, which was felt to be due to ineffective administrative processes and lack of a safeguarding culture. This has been addressed by additional recommendations to review safeguarding and compliance for GP practices.
- 6.6.5 The Independent Reviewer is satisfied that the key learning has been identified and addressed in these recommendations, which supplemented the recommendations, and learning identified by the IMR Authors.

## **6.7 CAFCASS**

- 6.7.1 CAFCASS became involved with the appointment of the Children's Guardian on 25<sup>th</sup> November 2013 after the LA had applied for an Interim Care Order on Child A, B and C. The Guardian appointed a solicitor for the children. The Guardian undertook all actions required, met with the children and liaised with the relevant professionals. The children's views were clearly set out in all documents and contact arrangements recommended. The IMR Author provides clear evidence that the guardian was culturally aware and sensitive in her practice and responded in a timely and appropriate manner to concerns raised by the viability assessments and the incident in court in January 2014.
- 6.7.2 The IMR Author advises that the Guardian was relatively new in role but with considerable LA experience and had received an appropriate level of induction, training and co-working a case. The Guardian received situational supervision from an enhanced practitioner and had a mentor from within the team in addition to line manager. The IMR identifies a number of areas of good practice around quality of liaison and management arrangements.
- 6.7.3 The learning identified relates to broader issues already identified in IMRs nationally for CAFCASS and include the need to ensure assessments cover all relevant areas and greater scrutiny of the LA oversight. The learning has been shared with the practitioner and her manager and there are no specific recommendations. However the view raised by the SCR Panel was that the Guardian could have challenged the placement with Ms P, which was agreed at court on 18<sup>th</sup> December 2013, as there was no DBS check available. The view from CAFCASS was that this was the least disruptive option for Child E and sibling D and Child A and Child C had already been in placement for 3 months and the care provided by Ms P demonstrated no concerns. However following this discussion, the CAFCASS IMR was amended to recognise the need to check DBS records and this has been included as an additional learning point and has been added to the CAFCASS National Learning Log.
- 6.7.4 The Independent Reviewer is satisfied that the key learning has been identified.

## **6.8 Croydon Education Service**

- 6.8.1 The IMR covers contact with a number of education services in Croydon - School admission; Primary school; Home tuition; Education Welfare and the Traveller Education Service. Croydon Education Welfare Service had been previously involved with Ms P and her family in relation to her two children, Child F and Child G and had issued School Attendance Orders in May 2013 however the education welfare function was then undertaken through the school buying this service from a private provider. It is therefore not known if Bromley Children's Social Care knew the information about Ms P's own historic difficulties in relation to her children attending school. The Independent Reviewer requested further information on the process and criteria used for school attendance orders.
- 6.8.2 The IMR identifies some communication omissions and missed opportunities to share information particularly in relation to safeguarding concerns. The primary school did not refer two incidents to Bromley Children's Social Care – one involved the children not being collected from school. This was on the date of the first care proceedings hearing and another family member failed to collect the children. The second occasion was the day before the death of Child E when the school noticed bruising on Child C's legs. The explanation from Ms P was that this was due to Child C climbing in through a bathroom window as the family were locked out of their flat. This would appear to have been the case given what subsequently became known but the IMR author identifies that there was no action taken by the school. This demonstrates a lack of professional curiosity and there is no evidence that the school confirmed if the situation had been resolved and the impact on Ms P with 6 children for whom she was caring.
- 6.8.3 The IMR Author also identifies that the home tuition service did not notify Children's Social Care when it was believed Child A was missing and not accessing tuition and this did not comply with the Croydon Procedure for safeguarding children missing from home/care.
- 6.8.4 The IMR challenges the fact that the school attendance for all four of the children other than Child C never increased over 50%. Croydon Local Authority have introduced new procedures from April 2014 to include LA investigations when school attendance falls below 80% irrespective of the provider of the education welfare function. This would appear to be an appropriate and robust response to the issue raised in this IMR in relation to the overarching role of the Local authority.
- 6.8.5. The IMR identifies a number of areas of good practice and makes a number of recommendations concerning procedures and reminders to all education staff to contact the MASH (Multi-agency safeguarding hub) helpline for advice on whether to refer issues.
- 6.8.6 The Independent Reviewer is satisfied that the key areas of learning have been identified and the recommendations are robust.

## **6.9 Bromley Children's Social Care**

- 6.9.1 Bromley Children's Social Care became involved in March 2013 but closed the case in May 2013, as they were unable to locate the family. They then became involved again in July 2013 following mother's arrest for drugs and driving offences and a core assessment was commenced.
- 6.9.2 The IMR and chronology detail the significant number of meetings that were held in relation to this family in this short period of four months and all of these meetings and processes met the statutory timeframes. These include two LAC Reviews; three Legal Planning meetings; two Permanency Planning Meetings; a PEP meeting (Personal Education Plan); a Family Group conference; a discharge planning meeting and a complex statutory meeting.
- 6.9.3 The revised IMR following a request for further information and analysis from the SCR Panel and Independent Reviewer however clarifies that there were occasions when statutory timescales were not met:
- i) the decision to accommodate Child A and C should have been made on 3<sup>rd</sup> September 2013 not 16<sup>th</sup> September 2013 – as a result the Care Plan and Placement Plan were out of time.
  - ii) the full stage 2 connected person's assessment was commissioned 10 weeks after placement of Child A and Child C.
  - iii) LAC visits to Child E and Child D did not all meet statutory timeframe.
- 6.9.4 The IMR identifies much positive practice undertaken by SW1 and SW2 and subsequently SW3 and SW4 in engaging with the children and the family in a sensitive manner, the quality of the assessments and the significant amount of liaison and checks undertaken with other agencies and at least five other Local Authorities. The IMR rightly emphasises the complexity of these family arrangements which was exacerbated by many of the family members having similar names and that the level of movement between Local Authority areas meant obtaining a clear chronology and factual information was extremely challenging and time consuming.
- 6.9.5 The IMR does however recognise the impact of where processes/systems did not work effectively or in a timely manner or decisions were with the benefit of hindsight flawed.
- 6.9.6 The first issue relates to the decision not to undertake an Initial Child Protection conference on Child E and Child D which was planned for 25<sup>th</sup> September 2013. This was a decision by the Group Manager in the Quality Assurance function as it was felt that it did not meet the criteria as Child A, B and C were already looked after and a pre-birth conference was not considered necessary. This clearly resulted in a missed opportunity to have a multi-agency focus on planning and assessment for Child E and Child D and may have been the opportunity to share some of the key information. The IMR Author has made a recommendation for the Quality Assurance Team to consider decision making on pre-birth conferences when older children are looked after. This is fully supported by the Independent Reviewer.
- 6.9.7 The second issue relates to the delay and the process for requesting a connected person's assessment of Ms P. The internal processes for commissioning this

assessment were not effective. This resulted in an unnecessary and significant delay in a full assessment of Ms P as a carer for all 4 of the children for whom she was responsible.

- 6.9.8 The Independent Reviewer has identified that the Stage 1 viability/suitability assessment undertaken by SW2 covered much of the content required such as the children's wishes and feelings and information on historical contact with Ms P and her family from Children's Social Care in Croydon. However it did not contain detailed information from Croydon Education Services on the previous involvement with Ms P's own children. It did not contain information on Ms P's medical history as there had been no response from the GP but does state that Ms P stated she wasn't taking any prescribed medication. The information from the police stated there were no concerns about child care but was not a full police record and the DBS was outstanding. The number of aliases used by Ms P and the need to obtain fingerprints had delayed this process.
- 6.9.9 The IMR Author confirms that processes for the commissioning of connected person's assessments were reviewed and revised prior to the initiation of this SCR. There is a recommendation for these to be published as part of the Children's Social Care Procedures Manual. This recommendation is fully supported by the Independent Reviewer.
- 6.9.10 The third issue relates to the delay in undertaking a Family Group Conference. This is within Bromley Children's Social Care procedures as a requirement in initiating care proceedings. It was allocated to a coordinator by 1<sup>st</sup> October 2013 but didn't actually take place until 9<sup>th</sup> December 2013. This may well have been due to difficulties in contacting family members. However, the IMR Author makes a recommendation that the outsourced Family Group Conference service is reviewed to ensure improved timeliness is achieved. This recommendation is fully supported by the Independent Reviewer.
- 6.9.11 The fourth issue relates to the delay in initiating care proceedings. The IMR author provides evidence of the timeframe for the completion of court statements, which were signed off by the Head of Service on 3<sup>rd</sup> October 2013. The 2nd Legal Planning meeting was held on 9<sup>th</sup> October 2013 where it was stated that the intention was to issue proceedings the week beginning 16<sup>th</sup> October 2013. However, at this meeting there was an unconfirmed report raised about the possible risk to professionals from a wider family connection to a serious criminal network and a recommendation that a professionals meeting is held before the start of any proceedings and risk assessments undertaken. This strategy meeting was held on 29<sup>th</sup> October 2013 and no further evidence was found but this caused a delay in issuing the care proceedings by 3 weeks. The impact of this was that although the older children were in placement the planning and assessments of family members for Child E and Child D were not progressed in a timely manner whilst recognising the significant workload that this entailed. The Independent Reviewer recognises that these were unusual circumstances but it is clear that aspects of the care plan should have been progressed during this period and recommends that there should be enhanced scrutiny of the management oversight of cases in care proceedings. This is included in the agency IMR recommendations.
- 6.9.12 The fifth issue relates to the delay in case transfer between the Referral and Assessment Team and the Safeguarding and Care Planning Team. The case

transfer report was completed on 13<sup>th</sup> November 2013 and the case was intended to be transferred to SW5 at an earlier point. However SW5 left the LA suddenly, which required a change of allocated social worker to SW3 (for Child E and D) and SW4 for Child A, B and C. The record shows the case allocated to SW3 on 20<sup>th</sup> November 2013 and to SW4 on 18<sup>th</sup> December 2013. The second Legal Planning meeting on 9<sup>th</sup> October 2013 describes the intention of a joint visit between the social workers to meet the children and family, which then did not take place. The IMR Author makes a recommendation that the transfer protocol between teams is reviewed and additional direction is given to social workers on joint handover visits. It is the view of the Independent Reviewer that there were two issues at this time which are both unusual and difficult to anticipate and which led to the delay in issuing care proceedings for this family. The first was the unexpected departure of the social worker who was identified to take on the case and the second was the potential risk to professionals identified and which needed to be explored. There are no recommendations in relation to this but it is worth considering if the pause in initiating proceedings was necessary whilst additional information and risk was being explored as is addressed above.

Impact on the court decisions:

6.9.13 The impact of this delay was significant in that SW3 and SW4 by their own admission were not well prepared for the court appearance on 12<sup>th</sup> December 2013. The initial statement of SW3 states "the social worker's view is that their needs would not be met if they were to remain with mother in prison as she is unable to prioritise their needs...however as a holding position the LA agree to Child E and Child D remaining with mother whilst the assessment of the wider family is undertaken". The case was deferred until 18<sup>th</sup> December 2013 for family suitability assessments to be completed and for further exploration of a mother and baby placement in prison.

6.9.14 At the court hearing on 18<sup>th</sup> December 2013, the positive suitability assessment on Ms U and Mr V (aunt and uncle) was provided. However police checks provided at court indicated that there was an unknown criminal conviction and concerns about a member of the household. Therefore it was not felt to be an appropriate placement. The choice at that point for the placement of Child E and Child D was for foster care or placement with Ms P as the prison mother and baby placement had not been pursued further as an option. The mother and wider family supported placement with Ms P. and the family's legal representatives pro-actively argued for this. The key issue is that the LA at that point had no evidence that this placement was not appropriate (i.e. that Child E and Child D would not be safe with Ms P). They had no updated information from the GP, School or police/DBS and Child A and C had been in placement since 1<sup>st</sup> October 2013. Consequently following a great deal of debate, checks and negotiation, the LA and Guardian agreed with the placement outside of the court although it is clear that there was a high level of concern from the LA at how Ms P could manage caring for 6 children including new born and vulnerable babies. SW3 and SW4 described the pressure they felt under from the family's legal representatives and the constant challenge that they didn't understand and lacked knowledge of traveller culture. It is recognised by the Independent Reviewer that this would have been a particularly challenging court environment with the reality of two 8-day-old baby twins requiring placements in the week before Christmas.

6.9.15 The IMR makes a number of additional recommendations for the service, which address the need to review how some of the administrative work identified in this case could be better managed to reduce the pressure on social work staff. It also recommends a review of the electronic filing system to address the anomalies of recording differing on individual children's files. There is a recommendation around a review of caseloads for social workers to ensure they are not excessive and that they are appropriate to the individual's level of experience and that the pattern of visiting is assessed and proportionate to the level of need above the minimum standard. These are all appropriate recommendations and supported by the Independent Reviewer who is satisfied that the learning has been recognised.

## **6.10 Bromley Legal Services**

6.10.1 The IMR Author makes a clear observation that pre-proceedings planning in relation to assessments of the extended family would have been beneficial in this case. The IMR report expresses concern that the court statements and reports were not served in a timely manner and the instructions from Children's Social Care were not always clear.

6.10.2 The recommendations in the IMR are for improved processes pre-proceedings and the need for clearer planning and instruction for Children's Social Care. Following discussion at the SCR Panel, it has been agreed that Children's Social Care and Legal Services will look at developing a joint action plan in response to their shared recommendations to ensure that future care proceedings processes are clear and evidenced.

## **6.11 Holloway Prison**

6.11.1 The Briefing report confirms the involvement between Holloway Prison and the support provided to mother as she was clearly identified as vulnerable and their liaison with other agencies.

6.11.2 The key issue in relation to the learning is the request by mother for a mother and baby placement and the process that was followed by Holloway/Islington Children's Social Care. Mother applied on 11<sup>th</sup> October 2013 and reports were requested from internal probation, medical reports, Personal Officer report, Security report and mandatory drug testing (MDT). Bromley Children's services were contacted on 31<sup>st</sup> October 2013 and a request made for an assessment for suitability to the unit prior to the Prison Board meeting on 4<sup>th</sup> December 2013.

6.11.3 Social worker 2 responded on 1<sup>st</sup> November 2013 and explained the case was transferred to another social worker - SW5 and forwarded the e-mail. On 13<sup>th</sup> November 2013 a reminder e-mail was sent and on 25<sup>th</sup> November 2013, SW3 wrote confirming she was now the allocated social worker and wrote again on 3<sup>rd</sup> December 2013 to say that the LA Care plan was to seek an Interim Care Order on Child E and his sibling and for them to be placed with either the extended family following assessment or with foster carers.

6.11.4 The Prison Board met on 4<sup>th</sup> December 2013 - the medical and probation and MDT reports were not available. The reasons why the LA was intending to seek Interim Care Orders on Child E and Child D was shared. The outcome was that the Board could not recommend a place on a mother and baby unit as the LA was issuing

care proceedings. However, mother was advised that if the LA application was unsuccessful then she could re-apply. The Serious Case Review Panel were unclear whether it was policy for the offer to be refused if there were current care proceedings. The Independent Reviewer had further detailed conversation with the link social worker for Holloway prison and reviewed the policy document issued by NOMS (National Offender Management Service). It does state that if the child/other children in the family are subject to care proceedings then this is likely to be a reason for refusal but that if the position changes, then there can be a re-application from the mother.

- 6.11.5 The second key issue is the discharge of mother on 13<sup>th</sup> December 2013 following the birth of Child E and Child D. The Holloway briefing is clear that following the information shared by the social worker there was a risk that Child E and Child D might be taken and arranged for additional staff to attend the hospital and for mother to be removed to another ward. It is then stated that the hospital decided to discharge mother who was initially reluctant to leave but was eventually persuaded to leave. There was some concern that Bromley Children's Social Care had not been involved, but subsequent information confirmed that Bromley Out of Hours Service were informed and that this decision, given the potential risk, was appropriate.
- 6.11.6 Following the initial court hearing on 12<sup>th</sup> December 2013, SW 3 e-mailed the Islington social worker to request a place on the Mother and Baby unit as the LA plan for foster care had been unsuccessful in court and the Court had asked the LA to request a place on the mother and baby unit whilst assessment was undertaken of family members. The response by Islington on behalf of Holloway was to request an additional updated report outlining the request and identifying how any potential risks could be mitigated on the unit. This report was never received as the decision was made at court on 18<sup>th</sup> December 2013 to place children with Ms P. This was a briefing report and no learning identified which is appropriate in the view of the Independent Reviewer.

## **6.12 Croydon Children's Social Care**

- 6.12.1 The report from Croydon Children's Social Care identifies their first involvement with the family in 2008. Further referrals were received in 2009 and 2010 identifying that the children were out of school and concern was expressed about a number of risk factors - parental substance and alcohol abuse; mental health, housing and children not attending school. The parents refused to engage and the case was closed, as the Section 47 threshold was not felt to be met. A further referral was made in July 2010 but by that point the family had left Croydon. Croydon LA made referrals to two other Las where there were possible connections. It is acknowledged by Croydon Children's Social Care that with hindsight there should have been a more proactive response by Croydon LA to the concerns raised.
- 6.12.2 It appears that the family had further contact with two other London Boroughs Children's Social Care but the cases were closed following referrals, however, the risk to the children from the parental lifestyle was apparent.
- 6.12.3 The Serious Case Review Panel discussed the issue of the impact of families moving between Local Authorities and the challenges for any LA undertaking an assessment of need/risk. The need for a collective responsibility across LAs to be

exercised where there are concerns, which cannot be addressed formally as the family moves on was discussed and a proposal that this Serious Case Review should make recommendations to the pan London Safeguarding Children Board to commission further work on developing a collective response to sharing information on children within families who move frequently. Of course this is not just restricted to traveller families but all families whose continued movement causes difficulties. This is therefore a separate recommendation by the Independent Reviewer.

## **7. KEY ISSUES**

### **7.1 Ethnicity and Culture**

- 7.1.1 The children in this family were part of the Irish travelling community and were brought up as practising Catholics. The numbers of Gypsies and Travellers in the UK are unknown and they are not a homogeneous group. The term “traveller” or “gypsy” can refer to Gypsies, Irish Travellers, Scottish Travellers, Roma and others. The 2011 Census for the first time allowed people the opportunity to declare their ethnicity as Gypsies or Travellers and some 58,000 did so. That is likely to reflect significant under-reporting. A support group for these communities, Friends Families and Travellers (FFT) reports that, by combining direct counts of caravans, school records and other recording, there are government estimates of 300,000. Whatever the numbers, Romany Gypsies and Irish Travellers are recognised as ethnic groups and as such fall within the remit of the Race Relations Act and the Human Rights Act.
- 7.1.2 This ethnic group is believed to be the most deprived group in Britain in relation to health and education outcomes and there is substantial body of research to support this. They are also a group that experiences widespread discrimination. In one study, profiling the nature of prejudice in England, Gypsies and Travellers were highlighted as the minority group about which people felt least positive. Media reports about Gypsies and Travellers have often reinforced a lack of understanding and the existence of negative stereotypes. Many of their negative experiences remain unreported and invisible. Consequently, feelings of injustice and persecution are understandable. In this context therefore, professionals involved with Child E and the family needed particular experience and understanding of the culture when working with the Traveller community. This is to ensure that cultural expectations around education, gender roles and lifestyle are fully explored in relation to the children’s placement and the necessity of professionals to be aware of the familial and religious context that emphasised the indissolubility of marriage, and the role of women within that system and the awareness that for some travellers “education at secondary level can be seen as a threat to their culture” with the fear that a traveller child could lose their identity, and expectation that girls and boys should socialise separately.
- 7.1.3 All the children, except Child C, in the care of Ms P have shared with both teachers and professionals that they do not want to go to school nor understand why they have to. It is recorded that Child A had not had any formal education since the age of 11. There is however much evidence to show that the children’s needs were sensitively considered by professionals, for example Child A received education from a tutor rather than attending the pupil referral unit, and this was more culturally appropriate.

- 7.1.4 It was also explicit that the family was very opposed to any of the children being placed in foster care. There is recognition that foster carers are not usually recruited from traveller families, and it can be difficult to ensure a traveller child's cultural needs are met and hard for a traveller child who has been in foster care to be re-assimilated into the traveller community.
- 7.1.5 The Health Overview Review Author felt that issues of ethnicity and culture were not evident in all assessments by health professionals. It is the view of the Independent Reviewer, that overall all professionals involved with the family were culturally aware of the traveller community and sensitive to the impact of this on the children. There was recognition that school attendance was not promoted within traveller families and that there was an extremely high expectation that traveller families would care for the children within their community. The fact that Ms P came forward to care for such a large number of children was seen as less remarkable in this community, where there would have been a strong expectation that she should do so.
- 7.1.6 The Children's Social Care IMR and the meeting with the professionals implies that the Court had an absolute view that Child E and Child D should be placed within the extended family of travellers. The Legal services IMR makes the point that recent case law has reinforced the guidance of the Children Act 1989 that children should be placed within the family if at all possible. The court would therefore wish to be provided with the assessments of family to enable placements to be made in the best interests of children. The difficulty in this case was that these assessments had not been concluded partly because of the issues identified already around delay and partly because there were a large number to be undertaken. This resulted in a placement within the extended family with Ms P which was strongly felt by professionals not to be in the best interests of Child E and Child D given their level of vulnerability and that Ms P was already caring for 4 other children as a single parent.

## **7.2 Communication**

There are a number of examples identified through the SCR of poor multi-agency communication and information sharing which is summarised below:

- 7.2.1 The Whittington Hospital held a safeguarding discharge meeting on 19<sup>th</sup> December 2013 but did not send any notification to Croydon Health Visitors of discharge.
- 7.2.2 The Whittington Hospital did send a discharge summary to the Croydon GP but it was not clear that the foster carer was Ms P as the name was missing from summary.
- 7.2.3 Croydon GP – request made for family information on Ms P on 11<sup>th</sup> November 2013 by Bromley Children's Social Care but no response was received until March 2014. The impact was that this information was not available to inform the assessment and decision to place with Ms P on 18<sup>th</sup> December 2013.
- 7.2.4 Bromley Children's Services notifies Croydon Health Visitor of the placement of Child E and child D but there was no pro-active communication from the Health Visitor following the new birth visit or from the social worker and the Health Visitor did not attend LAC review on 6<sup>th</sup> January 2014.

- 7.2.5 Croydon Education Services had background information on Ms P and had issued a School Attendance Order on Child F and Child G but this info was not known/shared with Bromley CSC or not considered as part of the assessment.
- 7.2.6 Ongoing difficulties for Bromley CSC to contact prisons where parents were placed as well as challenges of following up information requests from a large number of different LA and agencies.
- 7.2.7 Croydon Education (School) did not refer two incidents to Bromley CSC - one when children not collected on 12<sup>th</sup> December 2012 and Ms P not contactable and the second when bruising noted on Child C legs on 4<sup>th</sup> March 2014 and account of having to climb through window as locked out. This was the day that Child E dies that evening. There was a third concern regarding the front door to Ms P house being unlocked on 6<sup>th</sup> December 2013 which was known to SW3 who was no longer involved in the case.

### **7.3 Timeliness of assessments**

- 7.3.1 New birth visit by HV delayed to Child E and Child D.
- 7.3.2 Delay in Initial Health Assessment for Child E and Child D.
- 7.3.3 Delay in process for connected person's assessment by Bromley Children's Social Care on Ms P – the impact was insufficient information on Ms P to inform court in decision making on placement with Ms P.
- 7.3.4 Not all social work visits to Child E and Child D met statutory timeframes.

### **7.4 Care Planning**

- 7.4.1 The decision not to hold pre-birth Initial Child Protection Conference in hindsight was flawed as would have provided multi-agency forum for decision-making.
- 7.4.2 The Case transfer process was ineffective and led to hiatus in care planning for Child E and Child D. There was no joint handover visits.
- 7.4.3 The delay in issuing care proceedings. Impact of perceived threat posed by this family and wider family network contributed to a 3 week delay whilst a professional's risk management meeting planned and held on 29<sup>th</sup> October 2013.
- 7.4.4 The delay in holding the Family Group conference contributed to delay in family assessments being undertaken in a timely way.
- 7.4.5 Mother's pregnancy with Child E and Child D was known in September 2013 and plan for twins to be born by caesarean also known in advance of 10<sup>th</sup> December 2013 delivery. Family members had been put forward but none of the viability assessments had been undertaken to enable clear planning by Children's Social Care.

## **7.5 Organisational issues**

- 7.5.1 Children's Social Care - The delay in case transfer between teams in Children's Social Care which was exacerbated as Child E and D were due to transfer to a Senior Practitioner in SCPT (Safeguarding and Court Proceedings Team) who then left the employment of the LA.
- 7.5.2 CSC/Bromley Healthcare - the delay between the two organisations communication resulted in the initial health assessment being delayed.
- 7.5.3 Croydon GP - The system within the GP practice for responding to requests for information was ineffective and the GP did not respond to request in a timely way.

## **7.6 Additional issues identified by the Independent Reviewer**

- 7.6.1 Emerging low-level concern about the care of the children with Ms P appears not to have been recognised/shared/discussed between Social Workers, Guardian or Independent Social Worker (involved to conclude the assessment of Ms P). This included an assessment of home safety and Ms P's behaviour at mother's bail hearing. In addition, the reality that none of the 4 children were actually regularly attending school. However it is likely these concerns would have been recognised and shared as the placement continued.
- 7.6.2 Information sharing between Local Authorities. It is clear that this family was known to a number of different Local Authorities primarily within the London area over a period of years but no LA had been successful in responding to the concerns raised about the children including non-school attendance and the impact of the parents' lifestyle on their children. Although it is understandable, on an organisational level it doesn't make sense for a continued start again approach with families who continually are moving between Local Authorities. This issue is contained in a recommendation for BSCB.
- 7.6.3 NHS England, London were using a new format /template for IMRs which was intended to combine the Root Cause Analysis approach with the SCR approach. The general view including that of the Independent Reviewer was the reports were not user friendly and did not lend themselves to addressing the SCR TOR (Terms of Reference). There is therefore a recommendation for the BSCB on this issue.

## **7.7 The Children's Voices**

- 7.7.1 Overall there is evidence from all the IMRs that Child A, Child B and Child C were encouraged and able to share their views on their placements and plans being developed for them in relation to contact with their family and siblings and their education. Care was taken by professionals to engage sensitively and develop relationships with the children. Children's Social Care IMR identifies evidence of excellent engagement with Child A despite high levels of mistrust but recognises that the older children were often spoken to in very stressful situations with multiple relatives nearby, and there is limited evidence of any direct work tools used to understand their wishes for the future or their previous experience of safeguarding risks although this was carried out with Child B.

- 7.7.2 Child E and Child D were new born babies. The IMRs describe how their wishes and feelings were measured by their attachment to their main carers and evidence of that interaction which was for the most part overwhelmingly positive. There is evidence of concerns that Ms P and Child A appeared to be assuming lead responsibility for Child E or Child D respectively and the impact and appropriateness of that was raised. The practical sleeping arrangements in the family home were actively monitored and the children's weight and development monitored appropriately. There was some concern that Child E and Child D suffered with severe nappy rash, which may have been missed by professionals, but there is no current evidence to support this. The Coroner's report describes nappy rash but the adoption medical on 3<sup>rd</sup> March 2014 states that there was no nappy rash on either Child E or Child D.
- 7.7.3 Observations were clearly recorded by Children's Social Care of the contact arrangements and the impact on Child E and Child D including practical advice and support.

## **7.8 Effective professional practice**

- 7.8.1 There were some good examples of effective professional practice identified by all agencies. All professionals appear to have been very aware of the cultural issues within this family and were sensitive and thoughtful in their approach and there is evidence of persistent engagement with the family in challenging circumstances.
- 7.8.2 Contact arrangements, although logistically challenging, were maintained for all the children with each other and mother - (other than Child C with mother) and were well supported.
- 7.8.3 Child A, Child B and Child C did engage in education. Although this may not have been at a level that professionals would have wished, it was clearly a positive improvement. The level of support provided was high in terms of free bus passes, uniform etc.
- 7.8.4 Child A, Child C, Child E and Child D were placed and maintained within their extended family traveller community.
- 7.8.5 Child B was felt to be very positively responding to his placement with foster carers and engaging well with education.
- 7.8.6 There were excellent assessments and court statements undertaken by social workers informed by clear analysis of issues and risks and informed by research.

## **8. CONCLUSIONS AND LESSONS LEARNED**

- 8.1 The death of Child E was found by the Coroner to have been a SUDI (sudden unexpected death in infancy) and it is not felt that it was caused by neglect but there was a modifiable factor of co-sleeping. However none of the professionals were aware that Ms P and the children had been sleeping in the caravan for at least two nights and that the sleeping arrangements were chaotic. The cause of death was confirmed 4 months into the process of the SCR and the SCR Panel debated as to whether the SCR should continue. However the overwhelming view was that the

process should continue as an SCR and it should identify the lessons learned and be formally published.

- 8.2 It is important to state that none of the practice issues identified in this Serious Case Review contributed to the tragic death of Child E. However undertaking this Serious Case Review process has clearly highlighted learning for all agencies and areas of practice which could be improved. Most of these areas of practice have been identified by the agencies themselves and some have already been addressed.
- 8.3 The Review has also recognised the systemic challenge to the wider system of how to respond to a community, who are mobile and where there is no opportunity for sustained engagement by professionals and seeks to make a recommendation to begin to address this issue.
- 8.4 A key issue for this SCR was the decision to place these babies with Ms P and the impact of culture on this decision. It is the view of the Independent reviewer that the court was following statutory guidance and case law to place children within their extended family wherever possible. The Local Authority for the reasons outlined previously in this report did not have sufficient evidence to dissuade the court from this decision. It has however been suggested by the IMR Authors that it may be useful for the Court to receive this Serious Case Review and consider the learning identified, with which the Independent Reviewer agrees and this is therefore a recommendation to BSCB.

## **9. RECOMMENDATIONS FROM THIS SERIOUS CASE REVIEW**

Each of the agencies who contributed IMRs for this process, the Health Overview Report and the individual practitioners have all identified a number of areas of good practice and areas of learning and improvement. Agencies have not waited for the completion of this review in order to address issues arising from this case. The Independent Reviewer accepts and endorses all of the recommendations made by agencies. These are attached as Appendix E. Therefore the following recommendations are made for the Bromley Safeguarding Children Board.

### **Recommendations to Bromley Safeguarding Children Board.**

- 9.1 **Bromley Safeguarding Children Board to disseminate the learning from this Serious Case Review to all staff and partner agencies.**
- 9.2 **Bromley Safeguarding Children Board to recommend to Croydon Safeguarding Children Board that individual agency action plans developed through this SCR process for Croydon agencies are discussed and robustly monitored.**
- 9.3 **Bromley Safeguarding Children Board to ensure there is robust governance and monitoring of the individual agency and BSCB Action Plans that can evidence the impact of improvements to practice.**
- 9.4 **Bromley Safeguarding Children Board to share the learning from this Serious Case Review with the London Safeguarding Board and request that work is commissioned to consider how London LAs can develop a collective and**

**holistic response in order to safeguard the children of families that move between Local Authorities.**

- 9.5 Bromley Safeguarding Children Board to request NHS England – London review the format for Root Cause Analysis Reports used for completing the IMRs, which did not fully lend itself to the SCR process. BSCB to feed back the outcome to the London Safeguarding Board.**
- 9.6 Bromley Safeguarding Children Board are provided with the Joint Children’s Social Care and Legal Services Action plan developed in response to this SCR and assures itself that processes for Looked After Children in care proceedings are being reviewed and improved.**
- 9.7 Bromley Safeguarding Children Board and Croydon Safeguarding Children Board to consider if all the public health information on co-sleeping needs to be revisited and requires further promotion.**
- 9.8 Bromley Safeguarding Children Board to share this Serious Case Review and the learning it identifies with the local Family Court.**
- 9.9 Bromley Safeguarding Children Board to request that the Metropolitan Police monitor their response to IMR requests and meeting SCR timeframes to ensure full compliance.**

## **APPENDIX A: COMPOSITION OF SCR PANEL**

- Helen Davies, Independent Panel Chair
- Deputy Designated Nurse, NHS Bromley Clinical Commissioning Group
- Assistant Director, Safeguarding and Social Care, London Borough of Bromley (LBB)
- Assistant Director, Legal services LBB
- Designated Paediatrician, Bromley Clinical Commissioning Group
- Consultant in Public Health Medicine, LBB
- Business Manager, Bromley SCB
- Lead Officer for Education Safeguarding, LBB
- Detective Chief Inspector CAIT, Metropolitan Police
- Senior Service Manager, CAFCASS

In attendance:

- Alex Walters, Independent Reviewer

## **APPENDIX B:       DETAILS OF THE INDEPENDENT REVIEWER/AUTHOR OF THIS REPORT**

Alex Walters is a qualified social worker with 32 years' experience in children's services and currently works independently as a consultant for improvement work across children's services. Alex has been a children's services adviser for the DfE and was also part of the Children's Improvement Board team working with LAs in need of improvement for their safeguarding and adoption performance. Before these national roles she had a range of management roles in local authorities, including 6 years as Assistant Director. She has been the Independent Chair of two Safeguarding Boards since 2011 and has overseen the publication of eleven SCRs.

## **APPENDIX C: TERMS OF REFERENCE FOR THIS SERIOUS CASE REVIEW**

### **Methodology**

The agencies identified in Section 9 are required to prepare:

1. A chronology of the agency's contact with the children and family using the BSCB chronology template.
2. An analytical Individual agency Management Review (IMR) report covering:
  - a) A narrative of the agency involvement;
  - b) An analysis of the involvement identifying any areas of good practice as well as lessons to be learned;
  - c) Recommendations which are drawn from the lessons to be learned by the agency.
3. An action plan addressing any learning arising which has been agreed by a senior manager.

All authors of IMRs will be independent of the case and have had no direct or managerial involvement with the family.

The other agencies set out in Section 9 will be required to submit a Briefing Report.

A combined agency chronology will be produced.

Professionals involved with the family will be invited to a learning event after the IMRs have been submitted. A further meeting for professionals will be held after the first draft of the Overview Report has been completed.

The Independent Reviewer will lead the review and produce an Overview report suitable for publication. The BSCB serious case review committee will act as a reference group and will be responsible for developing an action plan in response to any recommendations.

### **Scope of SCR**

The SCR will consider the following issues in relation to the case:

- Did agencies communicate effectively and work together to safeguard and promote the child's welfare?
- Were there any cross border issues, and if so, how were they addressed?
- What assessments were completed, and were they timely and of adequate quality?
- Were the decisions and actions that followed assessments appropriate?
- Was the level and extent of agency engagement and intervention with the child and family appropriate?
- Were the children's views and wishes sought and taken into account in assessments and planning?

- Was information known by any agency about mental health issues and substance misuse for any of the 3 adults, or concerns about neglect? If so, was appropriate consideration given to how these impacted on parenting capacity?
- Was race, religion, language, culture, ethnicity or disability a factor in this case and was it considered fully and acted upon?
- Were any safeguarding issues identified in respect of the children identified in Section 7 and acted upon appropriately and in a timely way by all agencies?
- Were there any organisational or resource factors which may have impacted on practice in this case?
- Were appropriate management/clinical oversight (supervision) arrangements in place for professionals making judgments in this case?

## **APPENDIX D: PRINCIPLES UNDERLYING THIS SERIOUS CASE REVIEW**

The conduct of this review has not been determined by any particular theoretical model. It has been carried out in keeping with the underlying principles, set out in the statutory Guidance, Working Together to Safeguard Children 2013:

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

## **APPENDIX E: SCR CHILD E - SUMMARY OF AGENCIES RECOMMENDATIONS**

### **Bromley Healthcare**

1. The GP to complete the proforma in the PCHR for the 6-8 week review to ensure this is accessible for the LAC Medical rather than depending on a carers verbal report.
2. Referring Social Worker to ensure that Forms PH and Forms M and B are provided for the assessment.

### **Whittington Hospital**

1. Staff training on documentation.
2. A discharge planning checklist.
3. Name stamps for all staff.

### **Croydon GP Services**

1. Develop a robust system for child protection and safeguarding which processes the flow of information appropriately, gives consideration to the safeguarding lead GP having an overview of reports and includes the need to ensure that when these are requested by social care and/or solicitors, they are completed to an appropriate standard and submitted in a timely fashion.
2. All staff to access safeguarding children training at the appropriate level in order to increase awareness, understanding and how they can be better engage in multi-agency processes to safeguard children and young people.
3. All staff to access safeguarding adult training at the appropriate level.
4. Arrangement for management oversight for cases of concern within the practice to be developed.
5. Implementation of the Case Reflection Model with a specific focus on this case in the first instance.
6. Improve systems of communication with partners including Health Visitors and the CCG safeguarding team in order to share and discuss cases of concern.

### **Croydon Health Services NHS Trust**

1. The IMR author would recommend that the Looked After Children Policy Statement and Guidance for Croydon Health Services 2012 needs to be reviewed and updated particularly in relation to the role and responsibilities of health professionals who are involved with Children Looked After.
2. Information related to parental responsibility, consent and birth registration to be more explicit and included in Safeguarding Children and Looked After Children training.

3. Staff need to be reminded of their responsibilities to ask about the relationship of the adult who attends clinics and appointments with children to the child.

### **Lewisham and Greenwich NHS Trust**

There is no recommendation to come out of the review of the expectant mothers stay in Lewisham Hospital.

### **Health Overview Report**

Bromley CCG endorses all recommendations proposed by provider organisations. In addition the following recommendations are made:

1. Compliance with timescales for new birth visits and Initial health assessments (IHA's) should be monitored quarterly by the relevant CCG.
2. Bromley CCG to ensure provider organisations comply with IHA timescales. The % of IHA's completed within 28 days of coming into care is a useful health indicator demonstrating positive health outcomes through early identification of health needs.
3. All providers to assure Bromley CCG that their safeguarding/ LAC procedures have been strengthened to explicitly set out who information should be shared with and by whom.
4. All providers to assure Bromley CCG that assessment of equality and diversity issues is included in their Safeguarding Children and LAC Health Guidelines and evaluated through clinical audit.
5. Bromley CCG to undertake a review of the arrangements for Looked After Children against the statutory guidance to ensure that systems for promoting and meeting health needs are in place.
6. Bromley CCG/Croydon CCG/ NHS England to review safeguarding training and compliance for GP practices.

### **CAFCASS**

1. Where kinship care is considered for the children, the children's guardian should ensure that a full DBS check has been undertaken. If the children have already been placed, then the guardian should ensure that the LA obtain this as a matter of urgency.

### **Metropolitan Police**

This report makes no recommendations.

### **Bromley Children's Social Care Services**

1. The transfer protocol between teams is reviewed and additional direction is given to social workers on joint handover visits to families.

2. Recording protocols revised to ensure relevant recordings are copied across all siblings, CSC should look at updating case recording system to one that supports 'family' files.
3. Child Protection Service reviews decision making on Pre-Birth Conferences where older children are already looked after.
4. Caseloads in SCP teams are reviewed to ensure workers have agreed to allocation of new cases and no workers are subject to excessive workloads of multiple Court Proceedings and /or number of infants under 2 years old and that caseload is linked to capability.
5. CSC to review supervision tools and care plans to;
  - always have columns to identify dates for completion of tasks
  - Clearly name responsible officer for actions.
  - ensure space for reflection is identified.
6. Process for completion of 'Connected Persons' Assessment are written up and published on procedures manual.
7. Timing of visits by Social Workers is always assessed in supervision to ensure high risk situations have necessarily greater visiting patterns than the minimum prescribed standard.
8. All open cases have completed and up to date plans, and where necessary, Working Together Agreements with family members.
9. The initial period of work covers the Social Workers undertaking an enormous variety of tasks some of which might have been more appropriately dealt with by unqualified staff:
  - Arranging prison visits
  - Arranging to read files elsewhere
  - Contact arrangements.
10. Review the process for the outsourced FGC service, with a view to accelerating the timing of first family meetings to ensure outcomes can be actioned more quickly and match more clearly Court expectations.
11. Review use of our wider resources in Education, health and housing to ensure that in such complex cases we reduce the workload on the Social Workers themselves.
12. Legal officers provided a written note to all Legal planning meetings with clarity deadlines for court action.
13. All staff to be reminded of the importance of key statutory dates for:
  - CIN assessments and visits
  - CP assessments and visits
  - LAC assessments and visits
  - Fostering assessments and visits.
14. Completed minutes to be promptly added to case files and circulated to participants.

15. All agencies to be reminded of escalation processes where timely information is not received.

### **Bromley Legal Services**

1. There should be a review of the arrangements for transferring cases from the Referral Service to Safeguarding Service.
2. Procedures should be put in place to ensure more effective pre-proceedings planning.
3. Statement, care plans, reports, Court orders and other important correspondence should be uploaded to Carefirst.
4. There needs to be compliance with Court orders and directions.

### **Croydon Education Services**

1. If children are placed in care when their parents are arrested or imprisoned, both the carers and schools should be signposted to resources such as I-HOP, funded by the Department of Education by the relevant Virtual School or Social Care to ensure the needs of the children are considered and planned for. This should also be included in the care plans and PEPs.
2. If carers own children have attendance issues or especially SAO, a multi-agency plan including the view of the school may assist in developing a strengthened and robust support system to ensure school attendance. The carers could be requested to sign an agreement that if the school attendance falls below a certain agreed level, that their suitability as carers may be reviewed and they may face court fines or prosecution, according to locally agreed EWS procedures, rather than relying on verbal assurances to professionals that they will bring the children to school.
3. The Croydon Procedure for Safeguarding Children missing from Care and Home should be revised with regard to Keeping Children Safe in Education Guidance and school duties regarding missing children procedures, taking into account revised local police procedures and categories of missing. The new guidance to then be circulated to all Croydon Schools and the Virtual School.
4. Schools should be regularly reminded to contact the MASH helpline to discuss any concerns of abuse/neglect if they are unsure if they should refer or not. The MASH updates to schools and the DSL training and DSL Forums delivered by Croydon CFL.
5. Croydon schools to be reminded annually via the School Bulletin of the procedures when children are not collected from school and to notify the Virtual School and Social Care if applicable.
6. When Local Authorities place children in care, including kinship care or issue ICO, an assessment of the suitability of the accommodation and a visit to the property should be undertaken jointly with a relevant housing representative. Any security or access and egress issues should be included in the assessment and repaired as a matter of urgency if children may be at risk. Any professionals, including education who visit the home should be reminded of the responsibility to follow up any such concerns if noted during a visit.

## **APPENDIX F: REFERENCES**

This report has been generally informed by the following publications:

- Working Together to Safeguard Children (Department for Education 2013)
- A Study of Recommendations Arising from Serious Case Reviews 2009 to 2010 by Marion Brandon et al (Department for Education 2011)
- New Learning from Serious Case Reviews: a 2 year report from 2009 to 2011 by Marion Brandon et al (Department for Education 2013)
- First Annual Report-National Panel of independent experts on Serious Case Reviews (Department for Education, 2014)

## **APPENDIX G: GLOSSARY**

BSCB	Bromley Safeguarding Children Board
CAFCASS	Children and Family Court Advisory and Support Service
CCG	Clinical Commissioning Group
DBS	Disclosure and Barring Service
EDD	Expected Date of Delivery
ICO	Interim Care Order
IMR	Individual Management Review
SCR	Serious Case Review
LAC	Looked After Child(ren) i.e. in the care of the local authority
LBB	London Borough of Bromley
PICU	Paediatric Intensive Care Unit
SCBU	Special Care Baby Unit.
TOR	Terms of Reference
YOS	Youth Offending Service