Windsor and Maidenhead
LOCAL SAFEGUARDING CHILDREN BOARD

Serious Case Review
Redacted Overview Report

Services provided for EY and OY and members of their families during the period 1 July 2008 – 18 March 2011

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CONTENTS

This report has been anonymised and redacted to ensure that personal information about family members that is not already in the public domain is not included. The report was written before it was known that the father of OY was not the father of EY. He remains referred to as the father in the report as this was what professionals believed at the time.

1 ARRANGEMENTS FOR CONDUCTING THE SERIOUS CASE REVIEW

Introduction

1.1 This report was prepared for Windsor and Maidenhead Local Safeguarding Children Board (LSCB) in order to fulfil the requirements of Chapter 8 of the *Working Together* guidance.[1] The guidance sets out the arrangements for the local interagency review of cases which have given rise to serious concerns about the safeguarding of children and where there may be important lessons for the local network of agencies with child protection responsibilities. The purpose of this report is to highlight significant findings of the review with the objective of improving local child protection practice.

1.2 The detailed current arrangements for review of such serious cases by LSCBs in Berkshire are in the Berkshire Local Safeguarding Board Procedures. [2] These reflect national guidance and the SCR has sought to comply fully with the latest statutory guidance. The terms of reference of this Serious Case Review (SCR) were agreed in April 2011 in line with the statutory guidance published on 1 April 2010. The Terms of Reference were updated on 23 May 2011 to take account of additional information about the case and to ensure that the SCR covered all of the areas in which there was potential learning.

1.3 This document is the LSCB overview report on the SCR. It summarises and complements the findings of the individual management reviews conducted by the agencies that were directly involved. The guidance under which the SCR conducted its work provides for the SCR overview report to be published in full.

1.4 The review concerns two children: EY was aged 11 months when he died on 20 March 2011 and his older brother OY was aged 23 months. The children lived with their mother in Windsor and Maidenhead. Their father lived at a separate address in the

[1] HM Government, *Working Together to Safeguard Children – 2010.*.
[2] http://berks.proceduresonline.com/chapters/p_ser_case_rev.html

borough as did the mother's parents who had had some contact with local services. On the morning of 18 March 2011 EY was taken to hospital by ambulance. He had suffered a very serious head injury. This caused his death two days later.

1.5 At the initial post-mortem examination EY was also found to have suffered fractures of different ages to his leg and lower arm. He had sustained numerous rib factures, some of the fractures occurring at the site of previous fractures. He had large and visible bruising on his face and forehead and bruises on the trunk. At this point little is known about the circumstances of the death, which are the subject of a continuing police investigation. The post-mortem report indicates that the cause of death was the result of a '*significant head injury'*, which is '*virtually impossible to explain other than as the result of non-accidental injury'.* The healed fractures are said to have occurred at least two weeks before the death of EY. No opinion has been given as to the impact that these injuries might have had on EY's health in the period prior to his death or as to whether the injuries (other than the bruising to the face and head) might have been noticeable. However during this period professionals and members of the public noticed visible bruising to EY's head. Section 4.3 of this report evaluates in detail the reports of these injuries and the response of professionals. It evaluates the action taken in response to these injuries and the potential for professionals to have taken steps which might have led to action to protect EY.

1.6 The putative father and the maternal grandparents were offered the opportunity to contribute to this report but did not take up this offer.

The scope, focus and terms of reference of the Serious Case Review bearing in mind the circumstances of the death of the EY and the involvement of agencies

1.7 *Working Together* states that the LSCB in the area where the child lived should conduct a SCR when a child has died and '*abuse or neglect is known or suspected to be a factor in the death'.* The circumstances fit this criterion. Windsor and Maidenhead LSCB therefore decided to conduct a SCR. No other LSCB is involved in the SCR. All of the agencies involved are either located in the borough or health trusts which normally provide a service to children and families in the borough and are members of Windsor and Maidenhead LSCB.

1.9 In reaching the decision the LSCB noted the following background information which may have affected professional practice and decision making in the case and which would require attention in the review:

- a number of agencies and professionals with child protection responsibilities had been involved
- EY had been looked after by the local authority until the age of seven months although the case was closed by the local authority three months before he died
- EY's parents had initially indicated that they wished him to be adopted
- a number of professionals had noticed bruising and scratches to EY in the weeks before his death

EY's older sibling OY had not been looked after. Neither of the children had been the subject of a child protection plan at any point.

1.10 The recommendation to hold the SCR was made at the SCR group meeting on 31 March 2011. The independent chair of the LSCB Donald McPhail made the decision to undertake the SCR on the same day. Work began at that point to agree the scope and terms of reference of the review. Following early meetings, formal notifications of the review and the methodology for its conduct were sent to all Windsor and Maidenhead LSCB member agencies. Through a review of agency records the LSCB determined who

should contribute individual management reviews IMRs. A full list of the agencies involved in the review is set out in section 1.15 below.

1.11 The *Working Together* guidance makes the LSCB responsible for determining the scope and terms of reference for the SCR taking into account the circumstances of the particular case. Consideration was given to this within the SCR panel and there was also consultation with participating agencies. The general terms of reference for the SCR adhere to the objectives for SCRs set out in the *Working Together to Safeguard Children 2010:*

- to draw together a full picture of the services provided
- to establish whether there are lessons to be learned from a case about the way in which local professionals and agencies work together to safeguard children
- to identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result, and hence improve interagency working and better safeguard children

1.12 The terms of reference agreed for this review are set out in full in a separate document. Key sections highlighting the focus of the review are reproduced as Appendix 1 to this document. The Terms of Reference address issues identified in *Working Together to Safeguard Children 2010* as being of general relevance and also issues specific to the case history. The terms of reference were followed by the authors of individual management reviews and the independent author of this overview report which provides a chronological account of agency involvement with the family and then focuses on the following questions and themes which are evaluated in detail in Section 4:

- historical information (prior to 1 July 2008) on the family members about factors that may have impacted on the parenting capacity of the mother or the father
- the quality of assessment of circumstance relating to the children and their family
- factors that helped or hindered the engagement with the family

- how well agencies identified and responded to children's injuries and other indicators of harm
- the extent of, and professional understanding of, the support from the extended family
- the advice that was given and the services offered to the parents concerning adoption issues
- risk factors in the family known to agencies during the period under review
- whether staff and managers dealing with the family had the requisite skills, knowledge and experience to respond to the circumstances presented by the family
- whether sufficient attention was given to issues relating the reunification [3] of EY and his mother following the period when he was in foster care

The findings in relation to the terms of reference are addressed throughout section 4 of this report.

1.13 The overview report also makes recommendations on changes that need to be made to implement the lessons of the SCR. These take account of the recommendations contained in individual management reviews and developments in services that have occurred since the events in question took place. The SCR either makes recommendations on matters that are not already part of the work programme of individual agencies and the LSCB, or in some matters it makes recommendations to strengthen work that is already taking place.

Critical periods of agency involvement covered by the SCR

1.14 The scope of the SCR covered a period of two and a half years, beginning in July 2008. However as the mother had no antenatal care in relation to her first pregnancy and no contact with agencies with child protection responsibilities prior to the birth of OY the period covered by the SCR effectively begins with the birth

[3] Strictly speaking EY was not reunited with his mother. He was placed in foster care immediately after his birth. This term will be used as shorthand because much of the research on this issue is relevant to the circumstances of the case. However it is very important to recognise that EY's mother had never looked after him until she assumed responsibility for his care at the age of seven months.

of OY in April 2009. Agencies were asked to scrutinise any earlier information in their records. If significant information had been identified the SCR panel agreed that it would modify the Terms of Reference accordingly. No significant background information has been identified.

Agencies involved by LSCB area

1.15 The following agencies and contracted professionals provided services to the children and to other family members within the period covered by the review and have provided individual management reviews.

- Berkshire East Community Health Services (which provided the health visiting service[4])
- General practice (covering the services provided by four GP practices)
- Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- Royal Borough of Windsor and Maidenhead Council
  - Safeguarding Services [5] (which provides local authority children's social care services)
  - Services for Families (which provides and commissions children's centre services and other family services)

1.16 A number of other agencies had very limited involvement in the case history and were therefore either asked to provide chronologies, background information and reports or to contribute via additional discussions with SCR panel members:

- South Central Ambulance Service
- Combined Legal Services (hosted by Reading Borough Council)
- limited information was also obtained from the mother's school records. This is referred to in section 3 of the report.
- no faith, voluntary or community groups were identified as having been involved.

[4] Berkshire East Community Health Services (BECHS) merged with Berkshire Healthcare Trust (BHFT) during the course of this review. References to BECHS and BHFT should be treated as synonymous in all documents related to this review.

[5] This service is referred to as 'children's social care' in the body of the report

1.17 The *Working Together* guidance stipulates that a health overview report should be prepared on behalf of the commissioning Primary Care Trust (now NHS clusters). Their purpose is to provide an overview of health provision and to identify the key findings from the SCR which have implications for NHS commissioning. The Designated Nurse for Safeguarding for NHS Berkshire prepared this report. The findings of the health overview have contributed to the findings of this SCR overview report.

Availability of records

1.18 With the exception of two sets of records all of the relevant health and medical records were accessed for the SCR. The records not located were 1) the father's paper GP records (the father's current electronic record and summary were available) and 2) some postnatal midwifery notes on the children's mother. Although the inability to locate records is always a concern, neither are likely to contain information which would significantly alter the findings of the SCR. OY did not have health visiting records during the period under review and EY did not have health visiting records from July 2010 onwards. This is because they were assigned to core (universal) health visiting services which meant that the only records created were the Personal Child Health Record (PCHR) which is often referred to as the parent held record). As a result a number of contacts with health visitors over the children (usually phone calls) were identified as having been recorded in the health visitor's work diary. This is discussed in section 4.11 of the review.

1.19 All of the other relevant agency records were available for the review. There are some significant gaps in the records. These and some discrepancies between records are highlighted either in the narrative or in the evaluation in this report.

Appointment of the SCR panel, the SCR panel chair and the appointment and role of the independent overview report author

1.20 A full list of the roles and job titles of SCR panel members is contained in Appendix 2 of this report. SCR panel members are senior managers in member agencies or designated professionals with substantial experience of safeguarding children.

1.21 The SCR panel was chaired by Donald McPhail, who is also the Independent Chair of Windsor and Maidenhead LSCB. This arrangement is consistent with the statutory guidance. He is not employed by any of the agencies involved in the review. He has substantial experience and expertise in child protection services.

1.22 The SCR overview report was prepared by Keith Ibbetson. He has no relationship of any kind with any of the agencies involved in the review or to anyone involved in the case or the SCR. He has not previously worked for Windsor and Maidenhead LSCB. He is an experienced author of SCRs and chair of SCR panels. The independent author has not been a decision making member of the panel but has taken the following roles:

- to attend meetings of the SCR panel and provide professional advice as required
- to review the agency management reviews and to seek out and evaluate along with the SCR panel additional relevant material to corroborate or develop the findings made by agencies
- to assist the panel in improving the quality of the agency management reviews
- to prepare the overview report on behalf of the panel and finalise it following panel discussion
- to prepare the executive summary on behalf of the LSCB

1.23 Since the decision to hold the review the SCR panel has met on seven occasions in order to:

- make decisions on the conduct of the review
- manage the review so as to ensure that it complied with the statutory guidance
- consider progress in the production of agency management reviews and chronologies

- receive and consider an initial draft of this overview report and of the health overview report
- to decide when and how it would be best to engage members of the family in the review
- to consider and agree recommendations
- to consider a draft action plan
- to agree the overview report, the recommendations and action plan and to agree the executive summary for recommendation to the LSCB

Quality of individual management reviews and steps taken to improve their quality

1.24 The SCR panel and the overview report writer have scrutinised the quality of the IMRs to ensure that they provide a full and objective evaluation of the work of each agency. The quality of the individual reviews has largely been good and some are considered to be of a very high quality. They have all made an important contribution to the findings of the SCR. All of the review writers were asked to clarify points of detail in their reports. The SCR asked for a small number of the reviews to be amended and resubmitted because they did not adequately cover areas that were considered essential. There has been a high level of cooperation in that process and support from all of the participating agencies.

1.25 A full list of the individual reviews provided, dates of submission and dates of resubmission of versions is included as appendices to this report which also contain further comment on their quality and contribution to the review.

Parallel processes that have impacted on the conduct of the SCR

1.26 Thames Valley Police is conducting the criminal investigation into EY's death. The SCR panel and the overview author have received updates on the progress of police enquiries. The enquiries have been protracted because of the need to obtain the report of a complex post-mortem examination which in turn relies on information from a number of medical specialists. At the time of

writing the future direction of the criminal investigation is the subject of discussions with the Crown Prosecution Service, which is to be expected given the circumstances of the death.

1.27 The senior investigating police officer has provided the independent overview report author with more detailed progress reports on the range of information that has become available during the criminal investigation. Whilst the focus of the SCR is the provision of services to EY and his family, this has allowed the SCR panel and the independent overview report author to feel confident that the review can take account of any additional significant information that may not have been known to agencies before the death of EY. It also allows the SCR to anticipate any further issues of potential public concern that might emerge during the criminal trial.

Agreed extensions to the normal timescale for completion of the SCR

1.28 Chapter 8 of *Working Together* (April 2010) makes the Chair of the LSCB responsible for determining what action to take when the SCR panel considers that it is necessary to exceed the six month timescale laid down in the statutory guidance for the completion of SCRs. [6] At its meeting in August 2011 the SCR panel discussed the timescale that would be required for the completion of the SCR. In particular it had become apparent that the post-mortem enquiry had identified that in addition to the injury that caused EY's death there had been injuries of different ages. The panel agreed that it would be essential to know as much as possible about the nature of these injuries and the time band within which they were believed to have occurred in order for the SCR to evaluate the professional practice in the case history fully.

1.29 The SCR panel has been mindful of the need for member agencies to take action in the meanwhile in order to learn lessons and to implement recommendations while the review continued. The

[6] Section 8.23 – 8.24

progress made in the implementation of recommendations is reflected in the agency action plans linked to the SCR.

Involvement of family members

1.30 The mother and father of OY and EY were informed in writing that the SCR had been initiated. The SCR panel has discussed in detail whether it would be possible to involve family members in the review in order to include their perspective on the services that were provided. Following discussion with Thames Valley Police the consensus view of panel members and the overview report author is that given the specific circumstances of the case it would not be possible to do this without the risk of prejudicing the criminal investigations and any potential criminal trial. This is because in this case there is a significant overlap between the evidence that may be relevant to criminal proceedings and the areas which are of interest to the SCR (such as the observation of injuries to EY by professionals and discussions with their mother about them).

1.31 This position will be kept under active review and it is hoped that after criminal proceedings are completed there will be an opportunity to discuss the case with involved family members. The LSCB has been asked to adopt this report on the basis that it is a full report of the lessons from the SCR at this point and in the recognition that additional information may supplement the findings at a later date.

The papers constituting the SCR and arrangements for publication

1.32 The SCR consists of the following reports and documents:

- the overview report
- the combined chronology of agency contacts
- the individual management reviews (and background reports from agencies with very limited involvement)
- the integrated multi-agency action plan
- the draft executive summary

1.33 A draft executive summary has been prepared for submission with the SCR papers to Ofsted. The content of the final version of the executive summary and LSCB action plan will be finalised for

publication after evaluation by Ofsted. The LSCB wishes to be as transparent as possible about the findings of the SCR in order that the public and other professionals may have as full an understanding as possible about the case history and about the decisions and actions of public bodies and the courts. After evaluation by Ofsted and the completion of all parallel processes [7] the LSCB will therefore give further detailed consideration to the publication of additional material taking into account the current circumstances of the family, the amount and nature of the information that is already in the public domain, any advice from central government, the views of the father of OY and other family members who know the surviving child and any further information that emerges from criminal proceedings.

[7] In addition to the criminal investigation there are also care proceedings in relation to the surviving sibling

2 DETAILS OF FAMILY MEMBERS

2.1 This information is presented in the following way:

- details of members of the family who had contact with services during the period under review
- a Genogram of the children's extended family. This includes all family members listed in agency records, though not all had contact with agencies
- a separate Genogram shows the family composition as presented by the mother to the Children's Centre[8]

Details of family members

Name	Family role, relationship and living arrangement in March 2011	M/F	Ethnicity and religion	Age at March 2011
Child OY	Subject of SCR – living with the mother in Windsor and Maidenhead	M	White UK	23 months
Child EY	Subject of SCR – living with the mother in Windsor and Maidenhead Died 20 March 2011	M	White UK	11 months
Mother	Mother of children – living in family home in Windsor and Maidenhead	F	White UK Family members stated that they were non-practising Christians	**(Redacted)**
Father	Father of children – living elsewhere in Windsor and Maidenhead	M		**(Redacted)**
Maternal grand mother	Living elsewhere in Windsor and Maidenhead. Extent of contact and involvement with the children at the time of the deaths was not known in detail	F		**(Redacted)**
Maternal grand father	Living elsewhere in Windsor and Maidenhead. Extent of contact and involvement with the children at the time of the deaths was not known in detail	M		**(Redacted)**

Full Genogram of family members based on local authority records.

(Redacted)

The mother told the Children's Centre that EY was called CK and that he was the child of her cousin and that she was his unpaid childminder. She never named the cousin.

(Redacted)

In July 2010 the mother told her GP that she only had one child, though her precise meaning is open to interpretation.

3 NARRATIVE OF EVENTS

A note on terminology – denied and concealed pregnancy

3.1 Agency records, chronologies and management reviews have used the terms 'concealed' pregnancy and 'denial of pregnancy'. There is relatively little research dealing with this issue. However one paper which has been seen by SCR panel members distinguishes between the concepts of 1) 'denial of pregnancy' in which the woman has no apparent awareness of the pregnancy for most or all of the pregnancy and 2) concealed pregnancy in which women know that they are pregnant and actively conceal the pregnancy. [9] There are a number of different explanations proposed as to why both phenomena occur.

3.2 The accounts given by the mother in this case are set out in the following paragraphs as they occurred in the case history. She claimed that she was not aware at all of her first pregnancy (with OY) until she went into labour. Using the terminology proposed by Friedman et al this pregnancy would be categorised as an example of 'pervasive denial' which occurs '*when not only the emotional significance but the very existence of the pregnancy is kept from awareness'*. In some cases, weight gain, lack of periods and other bodily changes may not be present or may be misconstrued and '*even labour pains may be misinterpreted'.* [10] However the account given by the father to a midwife shortly after the birth of OY indicates that he thought that the mother might be pregnant at three months and suggested that she should have a pregnancy test. She in turn admitted that she had a feeling '*and hoped that it would go away'*. This suggests a concealed pregnancy. The second episode would be categorised as a 'concealed' pregnancy (though the mother claims that she did not know about it until a week before the birth).

[9] Friedman, Henegan and Rosenthal, (2007) 'Characteristics of women who deny or conceal pregnancy' *Psychosomatics,* 48.2 March – April 2007
[10] Ibid (page 117)

3.3 In relation to this case history it is not clear whether this is a useful distinction. This is not because it may not be valid but because any categorisation relies on the woman concerned remembering and giving an honest account of her knowledge and feelings. The mother in this case misled professionals and friends on many occasions and so her accounts cannot be relied on. There has not yet been any opportunity to test the mother's account given, either in court or in a thorough psychiatric evaluation. The father gave accounts of his knowledge of the pregnancies immediately after the birth of EY but then, with the exception of discussions with his GP, he was never subsequently asked about the details of what exactly had happened.

3.4 In the following narrative the SCR refers to the pregnancies as being 'concealed'. This is because this is the term most widely used by professionals and the one that was used most widely in the case records, not because it is accepted that the pregnancies fit the categorisation used by Friedman et al. At this point it is not possible to say how much knowledge the mother had of her two pregnancies and if there was a difference between the two. The report will also emphasise the practical consequences of both 'denial' or 'concealment' and the risks that this gave rise to for the infants concerned such as the lack of any antenatal care and delivery without nursing or medical attention.

3.5 It is also important that attention is not focused exclusively on denial and concealment solely in the antenatal period. The narrative which follows also shows that the mother continued to conceal the existence of EY from other members of her family for almost seven months; she denied his existence to herself for long periods when she did not visit him and by her own admission did not think about him. On one occasion she denied his existence to her GP and she went to great lengths to conceal his existence from the staff and other service users at the children's centre.

3.6 Section 4.3 will however refer to the Friedman paper further, particularly the recommendations that it makes about the

management of the pregnancy and psychiatric and child welfare concerns when such a pregnancy is discovered or disclosed.

Background history relevant to the review:

3.7 Agency records contain very little information about the lives of mother and the father prior to the period under review. This is for two reasons: Firstly, neither parent had any significant contact with agencies. Secondly, during the period under review very little background information about the parents or their family circumstances was obtained because no detailed assessment of family circumstances was undertaken. The reasons for this are described in more detail in section 4.3 below.

3.8 Basic details of family members' ages and backgrounds are set out in section 2 above. Prior to 2008 the mother attended her GP infrequently and had no significant health problems. At the age of eight she had difficulty reading and there were concerns that she might have dyslexia. There is no evidence of any further action involving health professionals over this. The mother attended mainstream primary and secondary school and at one point her school identified her as being listed as having special educational needs. These were at stage 1, the lowest level, indicating that the school would take action to meet her needs within its local resources. No further information is available about this. When she was eight years old the mother was noted by her GP to be '*slow to follow instructions'*. The mother left school in 2004 after her GCSEs. She had been entered for 13 exams but obtained no passes at grade A-C. There is no indication at all that she had a learning difficulty. She was reported to be working as a receptionist when OY was born. No previous work history was obtained. She gave this job up but the records do not state exactly when.

3.9 Given the father's age there are no school records available. He has no criminal convictions or record of other contact with the police. He was never asked about his background and the only

background information about him is from his GP records. He attended his GP infrequently for treatment of minor ailments. (**Redacted)** His handwritten records have not been obtained and may contain further information but there is no indication that it is of any relevance. **(Redacted)**The mother and father worked together prior to the birth of OY. Some months later the father told his GP that he had changed jobs.

Agency contact during the period of review covered by the chronology

Events prior to the birth of EY

3.10 OY was born at the home of his father. His mother had received no antenatal care and (according to the account his father gave to his GP) the mother gave birth to OY in bed while the father was asleep. OY was born at 40 weeks gestation and weighed 3.63 kg. The mother had a low iron level there were no other medical complications. The father and maternal grandparents visited the hospital after having been contacted by a midwife. It is not clear if the midwife did this on her own initiative or with the agreement of the mother. The family were noted to be undecided about who should care for the baby. The mother was noted to be 'dazed'. Midwives referred the baby to the social care emergency duty team because there had been no antenatal care.

3.11 The mother wanted to return to her own home on discharge. This is understood to mean her parents' home, rather than the father's. The mother was told that social care '*may visit today'* (at the hospital) but no visit was made as the local authority decided to undertake the initial assessment of the family at home. The social care referral indicated that the parents were considering relinquishing the baby for adoption. During the night of 14 – 15 April midwives cared for OY while the mother received a blood transfusion.

3.12 On 16 April the mother and OY were discharged to the maternal grandparents' home. The discharge letter sent to the GP identified that the mother had not booked antenatal care and had been

'*unaware'* of the pregnancy. A midwife made a home visit on 17 April (day 4). It was noted that the mother was shocked at the pregnancy but there is no further comment on the circumstances of the birth or the attitude of other family members. A further midwifery visit was made the following day and then on day 10 (24 April).

3.13 On 20 April 2009 a social worker SW1 made a visit and saw OY with his parents. It is not clear where this visit took place. The maternal grandparents were not seen. The father stated that he felt trapped and depressed, but that he would offer support. The father stated that (as far as he was concerned) the couple had not intended to be in a relationship. The mother said that she had suspected that she was pregnant a week before the birth, but did not tell anyone or do anything about it. The plan noted was that a core assessment would be undertaken and that the mother would care for OY with the help of '*a lot'* of family members. There is no record to say exactly what this would mean in practice. The social worker checked with the mother's GP who had no significant information as there had been no antenatal contacts and no significant previous health history.

3.14 The same day the father saw his GP. This was a different GP to the other family members and there was never subsequently any contact between this surgery and other agencies. The father told his GP that he had been traumatised by the birth of OY. **(Redacted)** This led to a referral to the Community Mental Health Team (CMHT) as there were no appointments available at the GP counsellor. The CMHT refused the referral on the grounds that the father did not have severe or enduring mental health problems. The father never subsequently had contact with the counsellor.

3.15 On 24 April 2009 the midwife discharged OY to the care of GP and health visitor. It is not clear what information was shared at this point (paragraph 28 in hospital IMR). The new birth visit was carried out by the health visitor (HV1) on 28 April. Standard health checks were made and OY was assessed as requiring a core

health visiting service (i.e. the mother would be left to make contact with the child health clinic and health visitor as she saw fit and standard developmental checks would be carried out). As a result no health visiting record was opened and information about OY's health was recorded on his PCHR. There is no indication in the health visitor's electronic record that the mother had concealed or denied the pregnancy, although the hospital birth notification states this. There is no indication in the records as to who was present at the visit and it appears to have focused exclusively on routine child health matters which is surprising and concerning given the lack of antenatal care and the circumstances of OY's birth. This is discussed in the individual management review and in section 4.3 below.

3.16 On 6 May 2009 OY was seen at the child health clinic. He was noted to have made good weight gain and was now on the 75th centile.

3.17 On 13 May 2009 the social care initial assessment concluded that the mother was able to meet the needs of OY with family support. The assessment had been based on one visit to the family, a phone call from the GP and one phone discussion with a midwife. The social worker refers to a discussion with the health visitor but it was not recorded by either professional. The health visitor clearly had no concerns as she had allocated OY to a core service. [11] There is a reference to a further planned visit with the health visitor to identify any further need for support but there is no record that a joint home visit took place. The social worker recorded making a further visit on 4 June 2009 when the mother and OY were seen. The mother reported that the father was '*recovering from his shock'* and her family were supportive. The case was closed. The social worker was not aware of the father's

[11] At this point as OY had been allocated to a core health visiting service there were no separate health visiting records created and the health visitor would have had no record on which to note this enquiry. The position has changed since the introduction into the health trust of the RIO electronic recording system. All children have a RIO record, in addition to their PCHR.

reaction and **(Redacted)** feelings and relied on mother to provide information about him. There had been no detailed discussion about the reasons for the concealed pregnancy, despite the lack of antenatal care and the very unusual circumstances.

3.18 The view of the manager was that the circumstances of OY did not meet the threshold for continued social care involvement under Section 17 of the Children Act 1989 (i.e. that he was not potentially a child in need). On 25 June a manager decided that due to workload considerations the normal closing summary and letters to other agencies to inform them that there would be no further involvement would not be written.

3.19 On 20 May the mother took OY to the health clinic. His weight was now on the 90th centile (compared to 50th centile at birth). When the health visitor (HV1) made a home visit on 2 June to carry out the 6-8 week postnatal review OY was now noted to be on the 98th centile. That day the mother was screened using the Edinburgh Postnatal Depression (EPND) Tool, [12] which is reproduced as Appendix 6 of this report. She scored 0 (out of a possible 30). There was no comment on how valid a score of zero might be. The implications of this are discussed at section 4.3.19 below.

3.20 The mother next took OY to the health clinic on 24 June 2009. At that point OY's weight was recorded as being on the 99.6th centile. OY was weighed on four more occasions before the end of September and each time recorded as being above the 99.6th centile. Put in lay terms this meant that in a statistically normal sample of 250 male infants OY would have been the largest or close to the largest. OY received his first and second immunisations routinely during May and June 2009. Other than the immunisations it is not certain how much direct contact OY had with health professionals during this time because at the clinics he attended parents would 'self weigh' their babies and only

[12] Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, *150*, 782-786.

speak to a member of the health visiting team if they had concerns. If there were discussions, no concern was recorded on his records about this very fast weight gain.

3.21 In September 2009 the mother started to take OY to health and other sessions at a local children's centre. The registration form gave a Maidenhead address. The mother was quite open with staff that she had not known that she had been pregnant with OY until she went into labour. It was not part of the role of the two members of staff at the centre to assess the parents and so this was not discussed in any further detail. It is not clear if the fact of the concealed pregnancy was seen as being significant. Mother and child attended 'Family Fit' sessions which were attended throughout the remainder of 2009 and then healthy eating sessions until March 2010. Regular attendance at health clinics throughout this period recorded OY's weight as being consistently above the 99.6th centile.

3.22 The first occasion on which it was recorded that the mother was given advice on diet was at the health clinic on 27 January 2010. OY was not walking at that point and it was hoped that OY would not gain so much weight when he started to move around independently. On 8 February 2010 he was seen by a health visitor (HV2) for his 9-12 month developmental assessment. OY was noted to be up to date with his developmental milestones and immunisations. His mother agreed to continue to bring him to clinic to be weighed and he was noted to be attending the Children's Centre. This was a continuation of the plan that had been in place since August 2009 which had so far had no impact on his unusually quick weight gain.

3.23 On 29 March 2010 the mother and OY made their final appearance at the Children's Centre prior to the birth of EY. There was no recording of any indication that she was pregnant. On 6 April and 22 April 2010 she took OY to the GP and again her pregnancy was not noticed.

Significant events between the birth of EY (23 April 2010) and his return to the care of his mother (19 November 2010)

3.24 The mother had moved to her own flat in November 2009. Confirmation of the details of the move was provided to the SCR by Thames Valley Police and had been established after the death of EY. Other agencies knew that the mother and OY had moved but the records gave no details of the date of the move or any specific reasons for it.

3.25 Like his brother EY was born at home. He was larger than his brother weighing 4.26 kg (75th centile). The mother and OY were brought to hospital by ambulance.

3.26 The circumstances of this birth were different to the birth of OY. The father subsequently told his GP that he had suspected that the mother was pregnant, but that she had denied this. She stated that she had thought she might be pregnant a week before the delivery, but that she took no action. This history was not obtained at the time but when the father spoke to his GP later and during the course of the mother's adoption counselling.

3.27 The initial referral to children's social care from Wexham Park Hospital indicated that the mother wished to relinquish her baby for adoption. The mother had given birth 'at home' assisted by the father and she was believed to have been unaware that she was pregnant. The parents were noted to be in a state of shock. They stayed in a separate room from the baby at the hospital.

3.28 Social care identified the case as one that had been open to the service a year earlier following the birth of OY. A social worker (SW2) and a senior social worker (SW4) saw the mother in hospital with the baby and arranged to accommodate the baby under Section 20 (Children Act 1989). The mother was discharged the same day and EY was discharged to a foster carer in Maidenhead. EY was not named at this point.

3.29 The same day (23 April 2010) the foster carer took the baby to register at her GP (a different GP surgery to the ones used by other family members). She was unable to register the baby as

she could give no first name for him. This is not an unusual circumstance and often babies are seen by the mother's GP before their births are formally registered. The receptionist alerted the health visitor linked to the practice (HV4) to the baby's existence and she started to make enquiries. EY was subsequently allocated to the caseload of this health visitor in a different team and town to the one dealing with the mother and OY.

3.30 No further significant events are noted until 26 April 2010 when a postnatal midwifery visit was made to EY at the foster carers' home. A further visit was made on day 5, but the electronic record holds no significant information about this.

3.31 On 26 April the foster carers' support social worker (from the fostering team) phoned her to say that the mother and father might want contact that day. This did not happen and it is not clear what discussion had led to this possible request.

3.32 On 28 April a placement planning meeting was held. This is a requirement for every looked after child. It was attended by the social worker (SW2) from the Referral and Assessment Service, the senior social worker (SW4) the fostering social worker, the foster carer, and the mother and father. This was the first contact between the parents and EY since the birth. Neither parent wished to hold him and his father found it very difficult to be in the same room as the baby. The fostering social worker noted that the mother was 'emotionally detached', though she was noted to act warmly towards OY.

3.33 The key decisions of the meeting were 1) to make arrangements for routine delivery of health services 2) to support contact with the parents and 3) to start adoption counselling to help the parents reach an informed decision regarding the long term plans for EY. Subsequently the mother received a number of counselling sessions. There were no separate discussions with the father. He was always clear in his view that the baby should be adopted.

3.34 It was also noted that an initial assessment would be undertaken in relation to OY by the Referral and Assessment Team. This was completed shortly afterwards and written up and signed off on 20 May 2010. It noted that there were no concerns about the capacity of the mother and father to care for OY, though it is not clear what steps were taken to reach this conclusion. OY was noted to be meeting his developmental milestones. At the end of the assessment no letters were sent to health agencies informing them of the reasons for social care involvement or the outcome of the initial assessment. The reasons for this are not stated. No core assessment was undertaken at this point, despite the highly unusual family circumstances. The needs of OY were not assessed in the context of the complex circumstances surrounding the birth of his brother and the decision that needed to be reached over his future. This is discussed further in section 4.3 below.

3.35 On 29 April 2010 a midwife carried out a postnatal visit to the mother. This was carried out by a midwife in a different team to the one who had visited EY in the foster home. These were treated as discrete tasks and the two never spoke to one another about the unusual circumstances of the birth. Neither midwife accessed the notes relating to the circumstances of the birth of OY. As there are only the briefest of notes relating to the birth of EY it is not clear whether either of these midwives was aware that there had been a previous pregnancy with no antenatal care.

3.36 The postnatal visit was six days after the birth and it is not clear why there was a delay. It is not stated explicitly in the records where this visit took place (i.e. whether it was at the father's home or the mother's own accommodation). There were no medical complications. However the mother requested that 'her home phone number' should be deleted from the hospital records. The specific reasons were not recorded though it seems most likely that following the first birth the maternal grandparents' home number was on the hospital records relating to the mother

and she wished it to be removed so that they could not accidently be made aware of the birth of EY.

3.37 On 30 April 2010 the social worker (SW2) visited the mother, the father and OY. When seen alone the mother admitted suspecting that she was pregnant but concealing it from the father and that she had *'wanted the situation to go away'*. She said that she had been relieved to get *'back to normality'* over the last weekend. The father was not seen alone.

3.38 On 4 May 2010 the final midwifery visit was made to the mother (day 11). The mother had no identified health problems and was discharged from midwifery care. The health visitor for the mother (HV5) was sent a discharge summary from the hospital stating 'baby for adoption' as a handwritten comment.

3.39 On 11 May 2010 there was liaison between the Looked after Children (LAC) health team and social care to obtain consent for health treatment of EY, should it be required. This was a basic procedure. Otherwise both of the children were seen in their own way as having routine health needs at this point. EY was a healthy child who was likely to be relinquished by his mother for adoption. OY was understood to be well cared for by his parents. There was no contact between the health professionals dealing with the two children at this point.

3.40 On 11 May 2010 the social worker (SW2) made a visit to the mother and father. The mother said that she intended to name EY and register the birth (which she did on 1 June 2010). At that point the maternal grandparents did not know about the birth of EY. The social worker stated that the local authority would be seeking legal advice about the need to consult extended family members about EY's future. The father was hostile to this. Mother said she understood why this needed to happen and was '*thinking of telling them herself*'. Father said that if mother did keep the baby it would completely change his relationship with OY. The social worker recorded that she challenged the father about this

statement because she felt that the father was putting the mother under a lot of additional pressure.

3.41 From this time social care staff developed the perception that the father was bullying the mother. Linked to this was the perception that the mother might want to look after EY if left to come to her own view without pressure from the father. With hindsight it is clear that this was an oversimplification of the situation and that as a result the social care staff involved paid less attention to other factors relating to the mother. This is discussed in section 4.3 below.

3.42 The social worker found the mother still difficult to engage in conversation though she stated that she was worried about looking after two young children. Both parents were invited to attend EY's looked after review meeting. The father said that he would not as he was worried that he would become emotionally attached to the baby, but the mother said that she intended to attend the looked after review meeting where she would have contact with EY. The mother did not attend the looked after review, though she did visit EY later on the same day.

3.43 On 17 May the father phoned the social work team manager and complained about the proposed plans to involve members of the mother's extended family. He was told that EY had the right to have his needs considered by the extended family. The local authority had not taken legal advice on this issue at this point. Discussions about informing the extended family continued until November 2010.

3.44 On 12 May the health visitor (HV4) made the new birth visit to the foster home. EY's weight was on 91st centile and he was allocated to core health visiting. The health visitor was aware of the social circumstances. She made no contact with the mother's health visitor.

3.45 On 13 May 2010 the hospital discharge summary was sent to the mother's GP. It contained no reference to the lack of antenatal

care or the circumstances of the birth. However it would have been clear from the mother's GP notes that she had again received no antenatal care. The mother was invited to the GP for a postnatal check up.

3.46 On 17 May 2010 the father attended his GP surgery. He spoke of '*stress'* after the delivery of his second son one year after the birth of the first. The record states that he had helped deliver the second baby during the night. He stated that he knew that the mother was pregnant but that she denied it when he asked her. He wanted the baby adopted and did not want her parents to know about the pregnancy. He was advised to tell her parents but was not keen. He stated that he was awaiting a social services meeting. He did not consult the surgery again about it until 19 November 2010, the day that EY left foster care. **(Redacted)**

3.47 The first statutory looked after review on EY took place on 20 May 2010 at the foster home. EY's mother did not attend, although she came to the foster carers' home after the meeting and saw EY. This was said to have followed a chance meeting with the foster mother the same day. This was the first time she had seen him since his medical on 28 April and only the second time since his birth. The decisions of the meeting were to treat EY as a baby who had been relinquished for adoption, a pre-adoption medical was to be booked and adoption counselling was to be arranged.

3.48 There is some uncertainty as to the understanding that the social worker had at this point. The decisions of the meeting recorded in the chronology refer to plans to proceed as if EY were to be relinquished for adoption. This was four weeks after the birth. At this time there had been no indication that the mother had any ambivalence about relinquishing EY. However the management review refers to 'parallel planning', noting the possibility that the mother would wish to resume the care of EY. This seems to be based on the behaviour of the mother when she visited the foster home after the meeting when she agreed that she was going to register EY's birth and name him. She held EY for some time and

took away pictures taken by the foster carers. She agreed to book another contact session having been encouraged by the foster mother that she could visit whenever she wanted. The foster mother invited the mother to take the baby out and established that she was happy to change and feed him if she did so.

3.49 On 21 May the LAC health team had contact with the foster carers' GP asking for EY's medical records. The medical information gathering was focused on EY and it was not the role of the team to make contact with the mother's GP.

3.50 On 24 May the mother's health visitor (HV5) (who knew the mother and OY) attempted a home visit to the mother but she was not in. The management review states that this was not repeated. However on 26 May the social worker recorded that she had been told by the health visitor (HV5) that the mother had given an indication that she was thinking about caring for EY at home. So far as can be established this was the first firm indication in the records that the mother might want to care for EY.

3.51 On 1 June 2010 the mother had contact with EY at the foster home. No further details of this are recorded. The following day she attended the looked after child initial health assessment and saw EY again. This was undertaken by a paediatrician and attended by the social worker (SW2), the mother and both children. Mother brought the children to the health centre. Mother indicated that she felt under pressure from the father to give EY up and it was recorded that '*he could be quite domineering*'. She had not told him that she had recently had contact with EY. The social worker spoke to the mother about a possible referral to the Freedom Programme. This is a programme for women who have suffered domestic violence, though there was no suggestion that the mother had ever been a victim of domestic violence. The social worker thought it could help her become more assertive and confident. The mother indicated that she might be interested though she never asked about it again.

3.52 This social worker had no further involvement. On 3 June 2010 the case was transferred to a new social worker (SW5) in the looked after children's team. There was no transfer summary because for a looked after child the case plan was summarised in the decisions of the looked after review meeting. Subsequently the key issue in the case was believed to be whether or not the mother wished to resume the care of EY. The issue of the mother's action in concealing the pregnancies was only mentioned in social care notes in one of the adoption counselling discussions.

3.53 On 8 June the mother cancelled a scheduled visit to EY at the foster home. She said she was disappointed that she had not seen him, though the reasons for her cancelling were not noted. The new social worker (SW5) visited EY that day as did a member of the health visiting team. There were no health concerns about EY at this point or at any stage while he was in foster care.

3.54 The same day the mother registered herself and OY at a different GP practice (in Windsor). OY's records were received at the practice on 30 September (3 months later) and summarised. The mother's records did not arrive until 15 April 2011 (after the death) after having been chased by the practice. The reasons for this substantial delay are not clear. The transfer of medical records when patients transfer from one surgery to another is discussed in section 4.6 of this report. The mother's reasons for changing GP practice at this point are not clear. As her own notes were never sent to the surgery staff there were unaware of her previous medical history, including the nature of her pregnancies.

3.55 On 10 June 2010 the mother had contact with EY at the foster home. She had two more visits the following week (13 and 17 June) and then two further visits on 24 and 29 June. There are no detailed notes describing what happened at the visits made in June. This was the only time in the period in which EY was looked after that the mother made any significant number of visits. The visits followed no regular patterns and there is no explanation of this. After June a number of planned contact visits were cancelled

and the mother did not attend the next statutory review on 21 July 2010. The next recorded contact between mother and EY was on 4 September 2010 (after a gap of 68 days).

3.56 On 10 June a solicitor in the legal department sent an email asking the social worker to make contact. It is not clear why this contact was initiated at this point. There appears to have been earlier contact not entered in either agency record. The social worker's response (recorded in legal but not in social care) was that the mother was to receive adoption counselling and that she might be wavering about EY being adopted. This accurately reflected the understanding that the social worker had at this point. The first entry in social care records in relation to legal service involvement is after the next statutory review on 21 July.

3.57 On 25 June the mother had her first adoption counselling session. She had had contact with EY four times in the previous 15 days. She was noted to be ambivalent about the future care of EY.

3.58 The next social work visit to the mother was made on 1 July. The mother stated that she would 'eventually' like to take EY home. Her reasons for not wanting to do so straight away were not established. The social worker indicated that she would need to demonstrate this by increasing her contact with EY.

3.59 The second adoption counselling visit was made to the mother on 2 July. She was said to be demonstrating her 'continuing ambivalence' towards EY being adopted. The notes reflect the counsellor's perception that the mother's concealment of her pregnancy was indicative of her tendency to disassociate from issues that make her anxious. She had a tendency to pretend that nothing would happen in the hope that her problems would go away.

3.60 On 7 July EY's (HV4) and health practitioner (HP1) made a home visit to EY at the foster home. It was noted that the mother had not taken him for his first immunisations as she had apparently undertaken to do. The social worker (SW5) made a statutory visit

the following day. It was not recorded whether the social worker was informed about the delayed immunisations.

3.61 On 9 July the mother cancelled the adoption counselling appointment. On 14 July it was noted that the mother had once again failed to take EY for his first immunisation. She subsequently provided a consent letter.

3.62 On 9 July the mother attended her GP and was given a contraceptive implant. During the consultation she stated that she had only one child. What she meant by this and why she said it are not clear. The mother had no further consultations in this practice.

3.63 On 19 July the foster carers' supervising social worker (SW3) discussed progress with the foster mother. She reported that the mother had not visited for 'three weeks'. The same day EY's social worker recorded that she had indicated to a solicitor in legal services that the mother did not want EY to be adopted and wished to care for him. This was said to be the reason that the mother had cancelled the last adoption counselling session, though this had not been noted at the time. The legal chronology states that the mother had said that she did not want EY to be adopted but records that she had not said that she wanted to care for him.

3.64 The second looked after review was held at the foster home on 21 July. The review was attended by the foster mother, the social worker, the health visitor for EY (HV4) and an independent reviewing officer (UR). Neither parent attended. The health visitor noted that the mother had not had contact for four weeks. She recorded that she voiced her concerns at the review about a number of aspects of the case history: the concealed pregnancy, the fact that EY had been born at home and rejected or denied before the birth, the lack of contact, the delay in naming the baby and the delay in consenting for immunisations. This was the only point in the case history in which any professional identified and

articulated such concerns. As the review focused on EY it is not clear whether it was recognised that the mother had also denied or concealed her first pregnancy. The looked after review noted that legal advice was now being sought as to how to progress the adoption.

3.65 The child's health visitor (HV4) was sufficiently concerned to discuss this with the mother's health visitor (HV5) who assured her that she was '*fully aware of the situation'* and would be following up the mother to offer postnatal depression and health screening. This was noted to be the last entry in EY's health visiting record and the health visitor had no further involvement in the arrangements for EY being cared for by his mother. The health visitor did not receive minutes of the looked after review and she was not notified by the local authority when EY was discharged to his mother's care in November 2010.

3.66 The individual management review of social care services states that this meeting '*was unable to confirm a definitive plan for permanency, owing to (the mother's) continuing ambivalence regarding adoption'.* The record of the meeting states clearly that the main decision of the meeting was to '*secure an adoption placement for EY'* and to '*refer EY to the fostering and adoption service for family finding and arrange a permanency planning meeting to identify permanency planning tasks.* The social worker was asked to inform CAFCASS of the parent's request for an adoption. At the same time the social worker was to '*commence twin track planning'.* It is not clear if this is a reference to consultation with members of the extended family in order to see of they wished to be involved or a further reference to the mother's ambivalence about the adoption decision.

3.67 After the review the social worker made contact with the mother, indicating that the local authority was unable to agree a care plan as she had not been clear about her agreement to adoption. She did not take the other actions agreed at the meeting. The mother asked for further time to discuss this with the adoption counsellor.

The social worker also had contact with the legal department. The social worker provided information about the background to the case and was advised on the procedure in relation to relinquishing a baby and the adoption process. Legal notes state that the social worker was advised that as the mother was changing her mind about the process a clear time-frame should be set in relation to any proposed rehabilitation home, so as to avoid any further delay. If mother failed to work towards the return of EY and there were continued concerns about her ambivalence about his adoption it would be important to consider proceedings to obtain a Placement Order (this is an order authorising a local authority to place a child for adoption where there is no parental consent, or where consent should be dispensed with). The social worker was of the view that the maternal grandparents would be supportive and might wish to care for EY (even though they did not at that time know about his existence).

3.68 This discussion is recorded in the social care records and dated 23 July, but the content is different i.e. that EY's extended family would need to be informed and consulted and that counselling should be continued with the mother so that she has every chance of making a decision that reflected her genuine wishes. The need for a timescale linked to the need to avoid delay for EY was noted but no specific timescale was ever agreed between the social worker and her supervisor or discussed with the mother. Notwithstanding the decisions of the LAC review meeting no action was taken at this point to find a family for EY because of the mother's continued uncertainty.

3.69 The mother attended the third adoption counselling session the following day (22 July 2010). It was noted that the mother was still very confused. She said that when she was not with EY she could cut off from thinking about him and she did not feel pressure to make a decision. She expressed anxiety about coping with two children and what family support she would get. The counsellor suggested another meeting with the social worker and father to

discuss what support would be in place. At this point the position was essentially the same as it had been when the case had been transferred to the team at the beginning of June. The drift in activity on the part of the local authority is discussed in section 4.4 below.

3.70 HV5 made a home visit to the mother on 27 July 2010. This visit clashed with an adoption counselling visit so it was rearranged after a brief discussion with the mother. She explained that EY had been the result of a concealed pregnancy and that he was in foster care awaiting adoption. The health visitor noted that the mother seemed not to understand how the adoption process would proceed. The counsellor noted that the mother remained unable to reach a decision and continued to be worried about how she would cope with two young children.

3.71 The counsellor confirmed that court proceedings may be considered to secure EY's future. This would have meant seeking an application for a Placement Order under the Adoption and Children Act 2002. The mother spoke about going on holiday with her parents during August and indicated that she would not be thinking about EY during this time. The worker noted that the mother appeared not to realize the impact on delays for EY, and failed to internalise discussions following visits. At this point the mother had had no contacts in the previous four weeks and she was proposing to go away for the next four weeks.

3.72 It is not clear if this information about the mother's attitude and plans was made known to the social worker responsible for EY or her manager. There are no recordings to this effect. The worker undertaking the adoption counselling, EY's social worker and her manager may not have read the two sets of notes which were held on two different electronic records, but they did have discussions about the case as they were sitting in the same office.

3.73 On 30 July the mother was phoned by the social worker who had had to cancel a planned visit due to sickness. The mother

indicated that she wanted to give up EY for adoption. On 2 August the team manager of the Child in Need Team confirmed in the electronic records that a letter had been sent to the mother outlining the departmental expectations regarding the re-unification or adoption of EY. Although there are references to this letter in the records no copy of it was saved as part of the local authority records. [13] It cannot be certain what the letter said about the timeline and the options open to the mother or whether it mentioned the need to contact the grandparents. The mother sent a text message the same day to EY's social worker confirming that she wanted to proceed with the adoption.

3.74 In contrast on 6 August the mother told her health visitor (HV5) that she felt 'detached'. She wanted EY back when she saw him, but did not otherwise think about him. The health visitor encouraged her to visit the local children's centre to make more young friends. She also carried out the Edinburgh Postnatal Depression Scale (EPDS – See Appendix 6) screening, recording a score of 12 (which is within normal limits). There was a full assessment of OY who at this point was aged 15 months and said to be developing well. He was not weighed.

3.75 The social worker's next actions are not easy to follow from the records available. It appears that no further social work action was taken until 10 August (when there was contact with legal services and the foster mother). Legal department records state that on 10 August 2010 the social worker was asked for an update on the case. The social worker told legal services that counselling was continuing. The following day the social worker informed the legal department that the mother had decided to relinquish EY for adoption. There is no note of these discussions with legal in social care records. On 12 August the legal department advised the social worker of the protocol and procedures in relation to the

[13] Extensive but unsuccessful efforts have been made to find any version of this significant letter. The most likely explanation is that it was typed and sent but not saved properly on the electronic recording system. However staff recollect discussions about sending the letter and the mother's text message would appear to be a response to it

decision to relinquish a baby. A date was needed for the adoption panel and CAFCASS needed to be informed of the circumstances (the CAFCASS role would be to obtain consent from the mother). The social worker updated the foster mother about these developments on 13 August 2010 stating that mother wished to commence the adoption process, though she gave no indication as to what action would be taken.

3.76 On 17 August the legal advisor asked whether EY had been booked into the Adoption Panel and gave advice about the foster carers taking him on holiday abroad. There is no parallel recording about this in social care. On 20 August the social worker told legal services that there had been no contact between the mother and EY since 21 July 2010. (This was in fact the date of the last review but the mother had not attended it, her last recorded contact had been three weeks before then). It was stated that the adoption counsellor was to offer further counselling sessions when the mother returned from her holiday. As the adoption had been agreed the counselling would have continued with a focus on the impact of the decision on the mother herself and to make sure the decision was final.

3.77 There is no record of the social worker taking any action to progress the adoption throughout August. According to the management review there was no supervision session during this period (because of leave and training commitments) and it was not until September that work was begun in relation to the proposed adoption. The management review states that this included the social worker beginning work on a Child Permanency Report, booking an adoption medical for November 2010 and an Adoption Panel for December 2010. There is no indication as to discussions taking place about the legal advice about contacting the maternal grandparents.

3.78 If the local authority had done this (in order to progress the proposed adoption) it would have opened up the possibility that they would have sought to become actively involved and possibly

offered to care for EY. Implementing the legal advice in relation to this was potentially complex. In the event no progress was made in relation to contact with the maternal grandparents until November 2010.

3.79 At this point it appears that the focus of attention in the local authority was on the difficulty that the mother had had (and perhaps continued to have) in deciding about whether to relinquish EY for adoption and on the difficulty that she was having in telling her parents that she had a second child. The legal advice that had been given was that the focus of attention should be on what was in EY's best interests and the adverse effect that further delay would be likely to have on him. The question of whether the maternal grandparents needed to be involved was one which needed to be actively addressed by the local authority from the perspective of what it believed was in EY's best interests. The difficulty that this posed for the mother needed to be taken into account, but it should have been a relatively minor consideration. This is discussed further in section 4.4 below).

3.80 On 4 September the mother had contact with EY at the foster home, the first recorded contact since 29 June 2010 (almost 10 weeks previously). A further visit was made on 11 September. There was no further contact visit until November by which time the mother had decided that she wished to look after EY.

3.81 On 10 September legal services sought an update from the social worker. This was provided on 14 September following the visit to the family home that day. Again the discussion with legal was not recorded on the social care files. The allocated social worker (SW5) and the social worker who had been undertaking adoption counselling saw the mother and the father. The purpose was to discuss the local authority's intention to disclose the proposed adoption to the extended family. The local authority repeated the view that the manager had explained to the father some weeks before (i.e. that the mother's family would be told). This was based on an interpretation of the legal advice given, though it was

not stated why the local authority had decided that it would be better for EY to disclose his existence to the grandparents (against the wishes of the father and in the face of the mother's failure to do so).

3.82 The father stated that he felt that it was unfair to tell the family because it would be a trauma for them. He spoke of the difficulties he had had since the birth of EY. He was noted to have dominated the discussion and putting the mother under considerable pressure. The social workers and the mother spoke of the support that the maternal grandparents had already given the family over OY.

3.83 It is clear that at this point the discussion about contacting the family (which the local authority had decided was necessary in order to progress the adoption) had reopened the discussion about the agreement to the adoption. The mother had made a clear statement about this at the beginning of August and had then gone away on holiday. There was clearly an assumption on the part of everyone involved that if the mother's family knew about EY they would offer to care for him or persuade the mother to do so with their help.

3.84 The outcome of the meeting reported to the legal service was that the mother wanted to proceed with adoption, the extended family would be contacted and that the father was opposed to this and said he would be seeking legal advice.

3.85 On 16 September the mother re-registered at the children's centre after a five month break. She may have attended sessions earlier in the month but this was the first time her attendance was recorded. [14] Mother attended with OY and did not mention having had a second child in between. The mother registered at the children's centre as a single parent with one child living at a Windsor address. The centre worker and the centre coordinator were not aware of the birth of EY or of any involvement of

[14] Given the nature of the service that not recording an individual attendance would not be unusual

agencies in between. Mother attended a variety of sessions with OY and then with EY until shortly before the death of EY. She began a parenting programme run at the centre in March 2011.

3.86 On 21 September 2010 the adoption counsellor made a further home visit. The mother said that she had not yet informed her parents of the birth of EY but intended to do it 'next weekend'. She said that if her mother offered her support she said she might change her mind

3.87 On 27 September the social worker provided an update to the legal department. She stated that the mother would be telling her parents about EY and that she would do so if the mother had failed to. No timescale was placed on this.

3.88 On 28 September the social worker (SW5) made a statutory visit to EY. He was noted to be developing appropriately and was observed laughing and smiling and he was able to hold the balloon and other toys. He was able to sit up supporting his weight. His carer had begun weaning him; he had a good appetite and was easy to feed. EY was reported to be sociable and happy during meal times. He was sociable in public and sought out social interaction. This is an account of a happy child, developing normally and benefitting from good physical and emotional care. There was a minor concern about his 'tongue tie' which was said to be very mild.

3.89 The social care records contain an email setting out the advice given by the legal service on 1 October 2010. It states that *'the best course of action is for the social worker to write to the mother stating the social worker's intention to visit the grandparents to discuss permanency plans'.* This part of the advice is entirely consistent with the legal advice given in July 2010 after the looked after review. However the email continues that '*this action should only be taken if this is assessed to be in EY's best interests and if mum is in agreement with the approach'.* This strongly suggests that the mother needed to consent to any

approach to her family. It is very likely that the emphasis placed on securing the mother's agreement in this email contributed to the further drift in the case. The SCR believes that the second aspect of this legal advice did not properly reflect the case law or the interests of EY. This is discussed further at section 4.4.18 below.

3.90 On 12 October 2010 a further adoption counselling visit was made. The mother confirmed that she wanted to proceed with adoption, even if her parents were to offer support. However, the mother had still not yet informed her parents of EY's birth. The mother discussed preferences that could assist in matching EY to prospective adoptive carers. Again it is not clear at this point whether there had been liaison between the two social workers involved.

3.91 EY's social worker did set a date to visit the maternal grandparents (18 October) but the mother postponed this on the morning saying that her parents were on holiday. The social worker replied setting a definite date and seeking the return of adoption medical forms which had been delayed with the mother. On 2 November the mother tried again to delay the meeting on the grounds that her parents were away again. The social worker called at their home on 4 November and left a compliment slip. They were clearly not away and phoned immediately to ask why the social worker had made contact. The next day following a further discussion with the mother, the social worker informed the grandparents over the phone about the birth of EY and that he was in care. The grandparents blamed the father. The social worker agreed to visit in a week. It is not clear why she delayed her visit by a week. During this period the family took control of the situation.

3.92 On 8 November the mother sent texts to the social worker stating as follows:

- she wished to have contact with EY the next day

- her parents had agreed to support her if she wished to bring EY home
- her heart was also saying that she wished to bring him home and she was relieved that her parents knew what was happening.

At this point the mother had had no contact with EY for nearly two months.

3.93 On 9 November the mother visited EY and after this she phoned the social worker and told her she wanted to take EY home. She said that her parents had told her that they would give her financial and practical support. The following day the foster mother advised her support worker that she had no reservations about this. This is discussed in section 4.3 below. The social worker emailed an update to the legal service on 10 November. This was the last contact with legal advisors.

3.94 EY was taken to the health clinic on 12 November. He weighed 8.72kg (just below the 75th centile).

3.95 On 12 November a planning meeting was held at the foster carers' home to plan for the discharge of EY to his mother's care for the first time. This was attended by a manager, the social worker (SW5), the senior social worker, the adoption counsellor, the mother and the maternal grandparents. There are no details of the arrangements made in the local authority records. The social worker informed the mother's health visitor (HV5) the next day by phone but did not consult with the health visitor (HV4) who had attended the looked after children review and raised concerns about the mother's potential capacity to care for EY at the review in July. It is impossible to know what she would have said had she been asked. However none of her concerns had been addressed in the intervening four months, EY had grown up considerably and the mother had had even less contact than during the period preceding the looked after review.

3.96 Between 12 and 19 November (when the handover took place) the mother visited on a number of occasions. It is not recorded how long these visits lasted or what took place in any detail. There is no record of the social worker observing the contact sessions, though she spoke to the foster mother. None of the qualified social care staff who had been involved in the meeting visited the foster home during this time. The adoption counsellor spoke to the mother on 16 November on the phone. She said things were going well, although OY had been a little jealous of EY. The foster mother was positive overall but she made a number of observations which she felt were concerning which she reported on the phone to the social worker on 18 November. Twice she noted that the mother kept EY on her lap facing away from her; mother made little eye contact; she did not know how to respond when OY was jealous of the attention that she was giving EY and she was not very effective at stopping OY from scratching EY. The foster mother believed that the mother might need advice on 'bonding'. The social worker recorded these comments but it is not clear if she understood the reasons for the foster mother's concerns or if she discussed them with her supervisor.

3.97 The foster carer's observations were very similar to some made later by staff at the Children's Centre.

3.98 So far as can be established the social worker did not see the mother and child together or speak directly to the mother between the planning meeting on 12 November and 24 November (four days after she resumed the care of EY). During this transitional period there is no record of contact with the father or his attitude. Discussions with the maternal grandparents had triggered the mother's decision to care for EY. They attended the planning meeting that agreed to the placement of EY with his mother, but there is no indication any professional had further contact with them. Their actual role in supporting the care of either child was never established.

3.99 The mother's health visitor (HV5) visited her ahead of the return of EY. She made no detailed notes except that she advised about playgroups and reminded the mother of the support available from the health visiting team. When interviewed for the SCR she stated that the mother had talked about her visits to EY at his foster placement, she appeared relaxed and happy and she reported that she had no concerns about EY coming home.

3.100 The local authority did not seek legal advice about the position of EY at this point. If it had done so it is clear that the local authority would have been advised that there were no grounds to seek to prevent the mother from taking over the care of EY. He had not suffered significant harm as he had been looked after in foster care since his birth. There was no evidence – based on the care that had been provided to OY by the mother and her family – that EY would be likely to suffer serious harm in the future. However there were good reasons to be concerned about aspects of the history, particularly the fact that the mother had concealed two pregnancies and the very limited contact that she had chosen to have with EY when he was in care. There was no question at this point of preventing the mother from taking EY home. Attention should have been focused on the sort of intervention required in order to monitor how the mother was able to care for EY, how the changed circumstances impacted on her care for OY and what sort of provision was needed to best support her in caring for both children.

3.101 These factors were not identified as significant and EY was placed with his mother after a brief period of contact visits with no plan for further intervention and no arrangement for coordinating the input of the professionals involved. As a result each of the agencies and professionals involved was left to make individual decisions about how to respond to the family. Other professionals who became involved (such as GPs who knew little or nothing about the children) responded to events with little or no

knowledge of the children and their history. This is discussed in detail in section 4.3 and 4.6 below.

Significant events between the mother assuming responsibility for the care of EY (19 November 2010) and 15 December when professionals first observed injuries to EY

3.102 On 19 November the mother took over the care of EY. The same day the father visited a locum GP and spoke again about his feelings **(Redacted)**, first triggered by the birth of OY. He said that he had wanted to give up the boy for adoption but that his 'parents in law' were not happy about this and wanted to look after their grandson. **(Redacted)**

3.103 The records of this consultation are confusing because they create the impression that there was only one child (OY) aged 18 months. The reasons for this are not clear but there is no reason to think that this was significant as the father had always previously been clear about the details of both of the children. The GP did not discuss this with any other professional.

3.104 The family health visitor (HV5) made a home visit on 23 November. She saw both parents and both children. She offered information about local services and advice on the support available from the health visiting service. A core health visiting service was offered. The notes from the health visitor who had known EY in foster care were never requested. The father was said to be 'very engaged' in discussions. None of the potentially complex aspects of the situation were identified or discussed. There was no exploration of the mother's long standing ambiguity about caring for EY and the sudden change of mind. There were huge gaps in the knowledge that the health visitor had about the relationship that the parents had with EY, for example the father's hostility to EY being cared for by the mother and the very large gaps in contact between the mother and EY while he was in care. The local authority had not provided this information and the health visitor had not sought information from the local authority

or from EY's previous health visitor in order to carry out a proper assessment.

3.105 Taking over the care of a child at the age of seven months is a challenging task in any circumstances and in this case there were additional complicating factors which needed to be explored and understood. The circumstances at the time of this contact merited a full individual, family and environmental assessment at least on a par with a normal health visitor's new birth visit. This did not happen and this is discussed further in section 4.3 below.

3.106 On 24 November the social worker visited the mother and children. The social care management review reports that there was evidence of positive parenting and attachment observed by social worker, though the only example given is that the mother encouraged OY to be gentle with his brother and not to hit him. The mother said that she was following the same routine as the foster carers and that this was working well. The mother stated that the father had visited every day to help. He was said to be making caring for EY easier by caring for OY. The mother said that she had introduced EY to her parents and would be introducing him to her friends 'that evening'. She felt that she did not need help from any voluntary services and now did not feel concerned about coping. The social worker assessed all aspects of the care provided and family circumstances as being positive. She never subsequently spoke to the grandparents to find out what role they were playing.

3.107 The social worker and her managers did not perceive this as being a potentially complex situation in which they should insist on there being a need for continuing involvement to monitor the children and coordinate the provision of services to the family.

3.108 On 30 November EY was taken to the child health clinic. His weight was 8.90kgs just below the 75th centile. This showed continued growth since his attendance on 12 November.

3.109 1 December 2010 is the likely first date of EY's attendance at the children's centre. EY was added to the register when he started to attend regularly in January 2011, but it would not be unusual for a mother to bring a child to a few sessions without registering him. The mother did not register EY's details and told staff at the centre that he was the child of a cousin whom she was looking after. She maintained this deception – which she also told other parents at the centre - until EY's last attendance shortly before his death.

3.110 This was also the date when the mother registered EY at her GP. His records were received two months later. They had not been reviewed and no summary had been added to the electronic record at the time of his death. The GPs at this surgery were not aware that he had been looked after for the first seven months of his life and that his mother had only just started to look after him. [15] The practice did not have his mother's records from his previous GP until after the death of EY. The health visitor (HV5) was aware of this history but she did not tell the GP when they later discussed concerns about EY.

3.111 On 14 December 2010 the LAC health team was informed by the health trust's systems section that EY had returned home. This suggests an automatic notification from the information system of the local authority to the health trust. The local authority had informed the health visitor for the mother and OY (HV5) directly. She did not request the health records from HV4 who in turn did not know that EY had been placed with his mother.

3.112 On 15 December the social worker made a visit to the mother and children. EY was seen asleep and had scratches on his face which his mother said had been caused by OY. The social worker discussed routines and coping strategies with the mother who said that she was coping well. She gave the mother photos of EY taken by the foster carers. The records do not indicate that the social

[15] There were however some references to this in EY's personal child health record and these are described and discussed in detail in section 1.18 and at several other points in the report. They were not obvious and a number of health professionals did not notice them

worker asked any more about how the scratches had been caused and she did not query the explanation. This was a concerning presentation which might have been an indication of poor parenting or abuse. This was the last social work visit before the case was closed on 22 December 2010. The social worker never saw the father or members of the maternal family with EY after he moved to his mother's. No evidence was ever obtained (other than the mother's general comments) to establish exactly what role the father and the maternal grandparents were playing.

3.113 There was no detailed account of the supervisory discussions that supported the decision to close the case at this point. The author of the social care management review was asked to address this specifically with the manager involved who has cited the following factors which he believed justified it at the time:

- the father and the mother's extended family were seen as involved and supportive
- the mother was understood to have cared effectively for OY
- there were no known history or neglect or abuse or any obvious risk factor such as mental illness or domestic violence in the family
- it was perceived as being a 'good outcome' for EY to be united with his mother and family in what was viewed as a stable family setting
- there was a perception that the history of OY was 'repeating itself'

3.114 Section 4 of this report evaluates these judgements and the extent to which evidence which did not support them was not given sufficient weight. The social work supervisor also believed that there were no significant risks in the mother taking over the care of EY because he had been an easy infant to look after. The fact that he had been an easy infant for foster carers to look after did not of course mean that he would be an easy child for his mother to look after. This assessment underestimated the specific significance or 'meaning' that EY may have had for his mother.

This is a recognised factor in many cases in which children are killed or seriously injured. [16] This is discussed further in section 4.4 below.

3.115 EY was taken to a 'stay and play' session at the Children's Centre on 5 January 2011. The children's centre has two members of staff (a worker and the centre coordinator). References to 'staff meetings' in the remainder of this report refer to minuted weekly discussions between the two. That day staff observed scratches on EY's face. They were not viewed as being significant and records were only made retrospectively when a second set of marks was noticed on 2 February 2011. Staff remember the mother saying that the injuries had been caused by EY's older sister. The exact location of the scratches was not recorded. This presentation appears to be similar to the one which the social worker had seen on her visit on 15 December 2010 and should have been viewed as concerning in a child of this age. [17]

3.116 On 12 January 2011 EY attended the children's centre again. The scratches had faded. The mother now said that she was caring for EY 3 days per week as an unpaid child minder. The information was not recorded at the time, though later centre staff took advice about this.

3.117 On 19 January the mother's GP saw EY with his brother and mother to undertake the 9 – 12 month developmental assessment. This would normally have been undertaken by the health visitor, but it was the practice of this experienced GP to offer this service. He was unaware that EY had been 'looked after' as he had not received a notification from the looked after health team or the social worker and the mother did not tell him. The surgery had not at that time received EY's medical record from his previous GP which contains many references to his looked after

[16] P Reder, S Duncan and M Gray, (1993) *Beyond Blame – Child Abuse Tragedies Revisited,* Routledge.

[17] The social worker only saw EY asleep. The children's centre workers believed that the child they were seeing was a member of another family.

status. [18] The GP did have access to the Personal Child Health Record (PCHR) which contains two indications that EY had been looked after. The first is a reference to his foster carer in one of the health records completed by his health visitor. The PCHR also contained a copy of the form giving parental consent to medical treatment for a looked after child (which would have been folded in a separate section at the back of the small ring binder which holds the record). This was not part of the PCHR which the GP would normally refer to. The earlier health visitor entries also make a number of references to actions that would be taken by EY's 'carer' rather than his mother or parent which at best give a slight clue that he was not living with his mother. The nature of this record and the fact that this significant information was not obviously visible is discussed further in sections 4.6 and 4.11 below.

3.118 The GP noted that EY had three scratches on the right hand side of his head and a bruise behind his right ear (recorded as 2x1 cm). He also had fading bruises on his right forehead and right cheek (measured as 2x7mm) and vertical scratches on his nose. No bruises were noted on his torso, his testes were both down and his napkin area was noted to be healthy. EY's height was measured as 46cm (75th centile) and his weight was measured as being 9kg (on the 50th centile). This was noted to have '*fallen in centile position slightly'*. The GP could tell this from the part of the PCHR that he accessed and he plotted the current weight on the height and weight chart (See Appendix 7). The notes confirm that the GP accepted that the bruises and scratches had been caused by EY's brother (who was present in the surgery) as he recorded '*2 year old brother-spiteful*' (although OY was not yet age two at that point). The records note his intention to refer the family to the health visitor for follow up, which he did.

[18] These arrived shortly after this consultation but had not been reviewed and summarised onto the patient electronic record by the surgery at the time of EY's death.

3.119 Two days later the GP phoned the health visitor (HV5) and discussed his findings. The GP record shows that '*Health visitor (named) is aware and will visit next week.*' The GP confirmed his view that OY had caused the bruising and scratches. There is no record of what HV5 said apart from that she would visit.

3.120 The scratches seen by the social worker in December 2010 and the children's centre staff in January 2011 were unusual presentations in a baby of this age. The bruising observed by EY's GP was the first clear indication of possible physical abuse seen by professionals. They occurred 10 weeks before his admission to hospital with serious injuries.

3.121 The health visitor's (HV5) notes (which are written up in her work diary) state that she received the phone call on her mobile phone while out making visits on 24 January 2011. There is a discrepancy in the dates but the content of the GP and health visitor recordings is consistent. She noted that the GP had observed bruises on EY's 'face and head' during a developmental check. The health visitor's perception was that she was being asked to visit to advise on sibling rivalry, not to visit to check on the bruises. There is nothing in the GP's notes to suggest that he thought anything more was needed or that he asked for anything else to be done.

3.122 The health visitor (HV5) knew a significant amount about the family history at this point, including the fact that EY had been in foster care from birth to the age of seven months. However she did not explain this to the GP. Although she took the call on her mobile phone while away from her base and she had no access to records the health visitor did identify the particular child that was being discussed and recalled his circumstances. Her recollection is that she would have assumed that the GP already knew this because he would have had access to the medical records.

3.123 The health visitor (HV5) made the requested home visit on 26 January 2011 (seven days after the GP consultation). EY was seen

sleeping in his cot during the visit. No details of the bruises were recorded because the health visitor did not believe that it was her task to evaluate the bruises. The mother reported that there were no problems and that she had a lot of support from her family and the father. It was planned that the mother would attend the child health clinic and that she would contact the health visitor if she required further support or advice. The health visitor discussed the problem of 'sibling rivalry' and gave what is described as 'standard advice' to the mother. The health visitor recorded in the PCHR that she had discussed EY's 'excellent weight gain'. It is not clear why the health visitor recorded this remark or what it referred to. EY was not weighed as he was asleep and there was no facility to do so on this home visit. This is now described as being a 'recording error' which the practitioner involved has been unable to explain.

3.124 This may be significant because – even if it was recorded in error – another health visitor who saw the PCHR might have taken it at face value and been less concerned about the subsequent failure of EY to gain weight at the expected rate. EY was not in fact gaining weight. Five days previously he had been weighed at the GPs and his weight was static (representing a fall in percentile terms, though not yet one that on its own would be considered worrying). The height and weight chart is reproduced as Appendix VII

3.125 On 2 February the children's centre worker observed bruises on EY. She did not record a detailed description of these bruises (colour, size or location) and so it is not possible to be certain if these were the same bruises that the GP had first observed on 19 January or new injuries (or a combination of both). This was the second clear indication of possible physical abuse to EY seen by professionals, six weeks before his admission to hospital with serious injuries. This was the second potentially concerning presentation at the children's centre.

3.126 The appearance of these bruises prompted the worker to make a note of the scratches observed on 5 January 2011. The mother

was attending the centre with both of her children. She gave a false name for EY and continued to mislead staff about her relationship with the child. Once again she was asked to register EY and again she did not complete the registration form. Although no record was kept, at around this time children's centre staff sought advice about the legality of the arrangement (i.e. a woman who was not a registered child minder looking after the child of a cousin for three days per week). The (correct) advice given was that it was not illegal so long as no payment was being made. This advice was not recorded. At around this time the parents of another child attending the centre reported concerns about the same bruises. These were backed up by a number of observations of the mother's behaviour and emotional responses to EY but were not acted on by centre staff.

3.127 On 7 February 2011 the children's centre coordinator referred the mother to attend a parenting course due to be held at the centre in March. The centre coordinator said her reason for referring the mother was to positively influence the mother's parenting skills and to improve her childminding skills. No concerns were expressed about the parenting of OY. The underlying reason for the referral was not disclosed to the parenting team members running the course and no information was provided to the parenting team about the scratches and bruises.

3.128 On 9 February 2011 the mother attended a 'stay and play' session. This was a busy session, with 12 adults and 15 children marked as attending. On arrival, EY was left in his pushchair with the hood up facing the wall. During the session the centre worker went to look at him and observed that he was awake and had two bruises on his face ('one on the side and one on his forehead'). At least one of these bruises must have been a new injury as only one bruise had been observed the previous week. He was observed to be happy when interacting with other adults. On the assumption that these were not the same bruises that had been seen a week earlier, these were the third indications of possible

physical abuse seen by professionals, and the third concerning presentation at the children's centre. The mother was again asked for her completed registration form and claimed that she had forgotten to fill it in. She was asked to bring it the next week. The centre staff discussed the injuries after the session and the centre worker completed an incident record. This was not part of an individual record because the children attending the centre did not have individual records or case files. It was an individual sheet of paper (akin to the sort of form that might be used to report an accident). These forms were filed in broadly chronological order so it was difficult to easily draw together a history of all the incidents relating to an individual child. This is discussed further in section 4.9 dealing with the training of the staff working at the centre.

3.129 On 14 February 2011 EY was raised as a concern at the weekly team meeting between the centre worker and the coordinator. The agreed action was '*awaiting registration form, the mother has it at home and will bring on Wednesday to Stay and Play'*. There was no specific action recorded in relation to the bruises.

3.130 On 14 February 2011 EY's former foster mother had a chance meeting with the mother and EY. The foster carer made no notes of the encounter at the time but at her interview for the SCR she said that EY seemed quiet and subdued and that he had '*lost his sparkle'* and that she wondered how the mother was coping. She remembers what she described as a 'fading bruise'. This is likely to be the same bruise seen at the children's centre five days before. She phoned the social worker (SW5) about this on 16 February 2011. The social worker made no record of this contact so it is not possible to know exactly what she was told. She later told a colleague (who made a record of the discussion – see paragraph 3.140 below) that she phoned EY's health visitor and left a message on her voicemail passing on the foster carer's concerns and suggesting that the health visitor might visit to see how the mother was coping. There is no record in the health trust of this voicemail and the health visitor does not recall receiving

such a voicemail. It is not possible to state with certainty whether a message was left or not. This may not have been a new incident of abuse (because the bruise may have been seen by the children's centre a few days previously). However the significance is that at this point the foster carer and either one or two further professionals knew about bruises on EY's face.

3.131 On 1 March 2011 the social worker was reminded of this incident by a colleague who had visited the foster carer (for reasons unrelated to EY). The action taken at that point is described in paragraph 3.140 below.

3.132 On 16 February the mother attended 'stay and play' with OY and EY. Both centre staff observed bruises on EY's forehead and cheek. These were the fourth indications of possible physical abuse to EY seen by professionals and the fourth concerning presentation observed by centre staff. The mother was asked about them directly. She became defensive (to the point of walking away and refusing to discuss it) and said that the bruises on the forehead were from EY hitting his head on the floor. During the session staff observed that he seemed to have good control of his head and neck. The mother said that she did not know where the bruise on his cheek came from. EY was fully clothed and no other bruises were observed. The mother again said that the registration form was at home but she had forgotten it. In conversation with other mothers and staff, the mother said that she was going on a skiing holiday and would not be attending 'stay and play' the next week. Staff thought that the excuse about the registration form was '*probably true*.' Another two parents raised concerns about EY's bruises. One remarked on his mother's lack of concern and responsiveness, the other on how his behaviour was unusual for a child of his age. The other parents' comments were not written down, but were recalled in staff interviews for the SCR.

3.133 The same day the centre manager discussed the case of EY in supervision with her manager, though she did not mention the

name of the mother or the child. It is assumed that this occurred after the incident that day at the centre.

3.134 The account that she gave to her manager are not recorded. There are recorded 'shorthand' notes of the action agreed but it is not possible to be certain from the notes what was intended and this is the subject of disagreement. The meeting record reads '*discuss with carer + then (poss) Mother. HV? Find out who… D Off → referral'.* These notes are clearly open to different interpretations. The actions taken are likely to be those listed below on 16 February.

3.135 The children centre incident form states that social care was phoned and gave advice that the registration form needed to be collected and then the parent identified. The parent should be questioned.

3.136 The same day (16 February 2011) an access officer in the duty service made a record of a discussion in a notebook which may relate to these incidents. Access officers are administrative staff, with no social work qualification, who support the referral and assessment service. Responsibilities include answering incoming telephone calls, acting as a triage for requests for information, recording initial contacts and referrals for the duty social worker and manager. The notes do not name a child and they do not state who the conversation was with. They refer to a 10 month old child who had a fading scratches and a new bruise. It does not say where the bruise was located. It gives no indication that there had been a history of bruising and scratches on the child's face. There is no record of any advice given and no record was made on the electronic social care system. According to the social care individual management review this was not recorded as a contact in the social care Integrated Children's System because the access officer considered the telephone call to be a consultation, rather than a referral. The access officer did not discuss the information that she had received with a qualified member of staff. This is discussed in section 4.9.

3.137 On 17 February 2011 children centre staff sought advice from their link health visitor (this was a health visitor who offered support and advice to the centre, but she was not one who had had any involvement with the family). Attempts were made to identify EY from child health administration records. As the name checked was a false name no relevant child was found. The mother's name was not checked because no one at the children's centre had any suspicion that EY was the mother's own child.

3.138 At around this time the children's centre coordinator and her service manager had a follow up conversation. The conversation was not recorded and could have taken place on 17, 18 or 21 February. The centre coordinator agreed that she was confident about following the concerns up. Both parties agree about this, despite their conflicting earlier accounts. This was after the call to the access officer but it is not clear if this preceded or followed the calls to the health visitor and the administrator. The centre coordinator did not mention the case again to her manager, despite the subsequent failure to identify the child, the refusal of the mother to complete a registration form for EY and the further presentations with bruising. The service manager did not ask her again what the outcome of her actions had been. This is discussed in section 4.9.

3.139 There are no further entries in any agency records until 1 March 2011. That day the mother attended the first session of the Triple P parenting programme run at the centre. Both children were left in a crèche. There were no negative or significant observations recorded.

3.140 The same day the supervising social worker for the foster carers visited. The foster mother repeated her account of seeing EY and his mother to this social worker. The fostering social worker (SW3) in turn contacted the previously allocated social worker (SW5). She said that she had called the health visitor (HV5) and left a voicemail message and that she would chase this up as she had

not heard back. She did not try to contact the health visitor again. The social worker (SW3) did record this conversation.

3.141 On 2 March the mother attended a further 'stay and play' session with OY and EY. The centre worker observed two bruises and scratches on EY's face. The mother who had raised concerns about EY's injuries did so again. These were not recorded on an incident form. The incident record states that '*the mother came with her cousin's baby. He was taken out of his car seat and played with and he appeared happy. EY had a bruise on his forehead which was blue; he also had one on his cheek under his eye. He had two small scratches near his eye. I looked at his nails* (unclear words)*…they are fairly long'*. The incident record does not record the exact location of the bruises. They are likely to be new injuries as the bruise on the forehead is noted as dark blue. This was the fifth indication of possible physical abuse of EY and the fifth concerning presentation at the children's centre. It occurred two weeks before EY's admission to hospital with serious injuries. The action recorded was for the staff to '*continue to observe. Gave the mother another registration form for him as said she lost the last ones'*. The centre worker told the centre coordinator about the bruises some time later in the week. The delay in discussion and the continued emphasis on asking the mother to complete the registration form strongly suggests that the staff involved did not consider the bruising on EY's face to be indicative of a risk of child abuse.

3.142 On 8 March the mother attended the second session of the Triple P parenting programme. OY and EY were left in the crèche. Nothing negative was recorded or noted. It is not clear why the staff did not notice the bruises that appear to have been very evident six days before.

3.143 The following day the mother attended a 'stay and play' session with OY. It is not known where EY was. There is no indication that she was asked (though as he was believed to be the child of another woman this would not have been seen as significant).

3.144 On 14 March EY was seen by a GP (GP4) with a cold and cough which his mother said he had had for five days. He was noted to be '*alert, interacting and comfortable'* and otherwise well. Given the reason for the consultation it is likely that very little of EY's body would have been examined.

3.145 On 15 March 2011 the mother attended the third Triple P parenting programme session. OY and EY were left in the crèche where staff observed bruises on EY. The incident record noted that EY had a '*dark blue bruise on the left side of his face close to his eyes. He has a lighter bruise on his forehead'*. The centre worker had a look down the front and back of his vest and could not see any more bruises. No bruises were observed on his legs. The crèche staff were very concerned about his bruises as they were sure that EY was '*very stable sitting up and didn't fall over'*. The action noted was for staff to '*continue to observe him*'. This was the sixth indication of possible physical abuse of EY and the sixth concerning presentation at the children's centre. They were observed two days before he was taken to hospital with serious injuries.

3.146 The following day (16 March 2011) the mother and both children attended 'stay and play' session at the children's centre. Staff recalled in interview that both children seemed poorly and that EY was lethargic. It is not clear whether the bruises were observed again. They may not have been recorded because they had been recorded the day before.

3.147 On 17 March 2011 the mother took EY and his brother to a child health clinic between 1.30pm and 3.00pm. The clinic was being conducted by a health visitor (HV7). The health visitor had no prior knowledge at all of EY, his family or his history. She made brief notes during the clinic in the PCHR and she made a note of EY's name in her work diary because she intended to speak to his allocated health visitor about her observations. EY had been seriously injured before she was able to do this. Section 4.11 of this report will describe in more detail the arrangements for the

clinic and the circumstances in which this health visitor was working that day.

3.148 The most recent recordings on the PCHR had been made by the GP on 19 January and the health visitor (HV5) on 26 January 2011. The history of bruising observed at the children's centre had not been recorded in any health record as the true identity of EY had not been obtained so there could be no consultation with a health professional.

3.149 EY's weight was recorded in his PCHR and plotted on the weight and height chart. It showed that he had gained only 100 grams in weight since his previous clinic attendance on 30 November. The health visitor recorded EY's weight as static and advised his mother to bring him to attend for a weight check in four weeks time. EY's mother stated that he was eating three meals a day and sleeping through the night. EY had dropped two centile bands on the growth chart since he had left foster care, from just below the 75th to between 25th–50th. This was a very noticeable departure from the established growth pattern. Visually it is very striking on the growth chart, shown as Appendix 7, especially since children's weight does not usually deviate outside one of the marked bands. EY's plotted line becomes effectively horizontal. As she did not know that he had been in foster care as a baby this health visitor did not appreciate that the period of static weight coincided entirely with EY's period in his mother's care.

3.150 The health visitor (HV5) observed EY to have bruising to his face. She noted this on the PCHR, but not the details. During her interview conducted for the SCR the health visitor recalled that he had a bruise on his left forehead and a bruise on his left cheek bone. Both were approximately the size of a one – two pence coin and yellow / brown in colour. This was the seventh indication of possible physical abuse of EY. It was recorded in EY's PCHR that his mother reported that the bruising was a result of a fall at a session at the children's centre the previous day. The health visitor states that she directly asked the mother on two separate

occasions how the bruises were caused, suggesting that she was concerned. The mother was adamant that EY had fallen off a toy at the 'stay and play' session the day before. The health visitor asked if EY had shown any signs of excess drowsiness or if he had vomited. The mother stated that he had not and the health visitor advised her to see the GP if EY showed any of these signs. This indicates that she was concerned to establish that there were no concerning after effects indicative of an injury and to warn the mother to watch out for them. This suggests that she was acting on the assumption that the account of the fall was genuine.

3.151 The mother also stated that OY was very jealous of his brother. The health visitor (HV5) recalls advising her not to leave the two children alone together. She suggested the mother enlist more help from her own mother to have EY while the mother spent more time alone with OY. The health visitor recalls that both the mother and the children were appropriately dressed and she remembered that OY spent some time interacting with other children at the clinic. EY was held in his mother's arms (except when being weighed). The health visitor made a note of the mother's name in her diary with the intention of liaising with her health visitor (HV5). Despite the bruising and the very marked fall off in weight gain the health visitor did not seek advice from the named nurse for child protection or from the local authority.

3.152 On the morning of 18 March 2011 EY was taken to hospital by ambulance. Ambulance service records refer to an account of an injury at a 'play park'. It is not certain if this refers to the children's centre or not. EY was quickly identified as having a serious head injury. He died on 20 March 2011 and was found to have suffered a number of other fractures in addition to the fatal head injury. So far no explanation has been provided as to the circumstances in which the head injuries that caused the death and other injuries believed to be of different ages. The mother was subsequently arrested and is suspected of having caused the death of EY.

4 EVALUATION OF THE SERVICES PROVIDED FOR THE CHILDREN

4.1 Introduction

4.1.1 This chapter of the SCR overview report evaluates the effectiveness of the actions taken and the services provided to safeguard the children. It examines the provision made by agencies individually and by the network of child protection professionals as a whole. It has drawn extensively on the individual management reviews and does not repeat all the findings of those reports. As well as drawing on the individual management reviews the overview report has taken full account of discussions in the SCR panel meetings as well as discussions with individual members of the panel and the authors of individual agency reviews. A number of members of staff were asked supplementary questions about their involvement. All of the authorities involved have made relevant documents available to the SCR author and the panel.

4.1.2 The aim of the SCR overview report author has been to prepare a report that represents shared and agreed findings. If at any point there are substantial differences in emphasis and understanding between the author and the SCR panel or between panel members these are made explicit. The evaluation contained in sections 4.2 – 4.12 provides the best account that can currently be given of the effectiveness of the services provided to the children, based on the information available from all agencies at this point. For the reasons explained in section 1 it has not yet been possible to take into account the views of family members.

4.1.3 In this SCR the evaluation in the overview report serves two functions. Its first objective is to evaluate whether the actions and decisions of agencies with child protection responsibilities had any bearing on the death of EY. The SCR has sought to establish whether agencies had any evidence to suspect that the children were at risk of suffering serious harm and whether his death could

have been prevented if agencies had taken different decisions or acted differently. This is the focus of section 4.14 of this report which presents its overall conclusions.

4.1.4 The second function of the SCR is to provide a wider evaluation of the services provided to the children and their family during key episodes in the case history. The objective is to identify whether there are any lessons that can be learnt so as to improve safeguarding services. There may be important lessons for agencies and the LSCB independently of the death of EY.

The structure of the evaluation and the topics considered

4.1.5 This chapter of the SCR overview report addresses all of the matters set out in the specific terms of reference of this review and others that all SCRs are required by *Working Together to Safeguard Children* to address. The evaluation in this chapter is presented as follows:

4.2 Concerns about parenting capacity relating to the family history
4.3 Assessment and decision making
4.4 Implementation of plans
4.5 Focus on the child
4.6 Information sharing
4.7 Factors that impeded engagement with the family
4.8 Policies and procedures
4.9 The skills, knowledge and experience of the staff involved
4.10 The impact of supervision and management
4.11 Organisational matters - the impact of resources, lack of capacity and other organisational issues
4.12 The impact of diversity
4.13 What do we learn from the case?
4.14 Conclusions as to whether there were missed opportunities to protect the children and whether the death of EY could have been prevented

Judgements about shortcomings in practice and good practice

4.1.9 The Working Together guidance requires that the SCR should bring hindsight to bear in evaluating the actions of professionals and public bodies.[19] Self evidently there is value in seeking to look back objectively at a case history, with a fuller knowledge of the events and the actions taken by professionals and knowing the outcome. As well as the insight that comes from hindsight the SCR is aware of the danger of what is termed 'hindsight bias'.[20]

4.1.10 So far as is possible the SCR has therefore sought to avoid this. It is easy to view decisions as being wrong because we now know that they were part of a chain of events that had a tragic outcome. It is harder but much more useful to seek to understand and explain why actions were taken and decisions were made and to consider the influences over professionals arising from the context within which they were working. In this way it may be possible to learn lessons that are relevant to other professionals who find themselves working in similar circumstances.

4.1.11 When evaluating the actions of individual practitioners and managers and groups of professionals and agencies the SCR has taken the following approach:

- judgements about actions and decisions take into account the information that was available to those who took them
- at points it is necessary to evaluate actions and decisions in relation to information that was known to the network of child protection professionals as a whole and would have been available if relevant information had been sought and provided.
- the review has sought to judge the actions of professionals and agencies against established standards of good practice as they were believed to apply at the time when the events in question took place

[19] *Working Together to Safeguard Children 2010,* Chapter 8 describes the evaluation in the overview report as being '*the part of the report where reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events*.

[20] David Woods et al, *Behind Human Error,* Ashgate (2010) second edition; Sidney Dekker, *The Field Guide To Understanding Human Error,* Ashgate (2006)

- the evaluation will seek to distinguish and outline the influence of individual and wider organisational factors in the decisions and actions taken

Understanding why there were shortcomings in professional practice and in the provision made

4.1.12 The SCR has identified a number of missed opportunities to protect EY and his brother. There were also episodes in the case history when the standard of provision that was made fell short of the expectations that agencies have about how their staff operate. Viewed with hindsight it is usually easy to see what should have been done. On the face of it the local child protection procedures set out the steps that should have been taken and there has been much training for local professionals which was directly relevant to the problems that they were confronted with. The SCR has therefore sought to understand why it was that this case proved to be very difficult for staff to deal with *in situ.*

4.1.13 The approach adopted in this evaluation is a 'systemic' one which points up the potential significance of factors relating to the child, the family, the wider professional network and the context within which staff are operating. [21] In the biennial analysis of SCRs covering the period 2003 – 2005 Brandon et al [22] identify some 30 'themes' in the profile of the cases included in their retrospective evaluation. These are organised in relation to three domains: '*child factors and experience', family and environmental factors' and practice / professional / agency factors'*. The evaluation highlights information relating to these factors.

[21] P Reder, S Duncan and M Gray, (1993) *Beyond Blame – Child Abuse Tragedies Revisited,* Routledge. This is not the same thing as a 'systems review'.

[22] Brandon M, Belderson P, Warren C, Howe D, Gardner R, Dodsworth J, and Black J (2007) *Analysing child deaths and serious cases through abuse and neglect: what can we learn*? A biennial analysis of serious case reviews 2003-2005. DfES

4.2 Concerns about parenting capacity relating to the family history

Introduction

4.2.1 This section addresses the following points from the terms of reference:

Identify any historical information (prior to 1 July 2008) on the family members that may have impacted on the parenting capacity of the mother, GY, and father, PO;

Information about family members before July 2008

4.2.2 There was very little information in the agency records about the family lives of the parents in the period before July 2008. The information that there was has been set out in sections 3.1 – 3.4 of the narrative above. None points to any indication of risks associated with the parenting capacity of the father or mother or any significant events in their family history.

4.2.3 Neither the initial assessments undertaken by the local authority nor the new birth assessments carried out by health visitors explored the family background of the parents in any detail, despite the fact that the mother had concealed two pregnancies and given birth to two children in circumstances which might have placed the children at risk. Midwives usually have their best opportunity to identify relevant background family information in the antenatal period, but the mother did not access antenatal care. Midwives did not record any significant background information during postnatal care of either child.

4.2.4 The assessments undertaken in the case history are evaluated in the next section of the report.

4.3 Assessment and decision making

This section deals with the following terms of reference:

- *What were the key relevant points/ opportunities for assessment and decision-making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?*
- *Establish the quality of assessment of circumstances relating to either and both children and their family;*
- *Establish what risk factors in the family were known to agencies during the period under review;*
- *Establish how well agencies identified and responded to children's injuries and other indicators of harm*
- *Did actions accord with the assessments and decision made? Were appropriate services offered /provided, or relevant enquiries made in light of assessments?*
- *Analyse the extent, and professional understanding, of the support from the extended family*

Introduction

4.3.1 This section of the report evaluates two different types of assessment. Firstly it considers the opportunities that were open to professionals to undertake an assessment of need and potential risk in relation to both of the children. This will deal with the following episodes:

- assessments by midwives immediately following the births of the children
- health visiting assessments (the new birth assessments and the opportunity for assessment that existed when EY's mother took responsibility for caring for him at the age of seven months)
- the initial assessments undertaken by the local authority following the birth of OY and again following the birth of EY

4.3.2 Secondly (from paragraphs 4.3.65 onwards) the report evaluates the actions taken by professionals when they were aware of injuries to EY.

4.3.3 Separate consideration is given in section 4.4 to the planning that took place before EY was discharged to the care of his mother in November 2010. This was an opportunity for assessment but none was undertaken.

Key opportunities for assessment. The quality of the assessments undertaken, the decisions made and the services provided as a result

Assessments by midwives

4.3.4 Midwives usually have their best opportunity to identify any relevant history and social or health risk factors during the antenatal period. This takes place through screening (such as asking routine questions about domestic violence) and more general discussion about the kind and level of support that the parents will have. Missed antenatal appointments, high levels of anxiety or depression and unusual responses to routine events such as scans often point to concerns. In this case there was no opportunity for midwives to undertake assessments prior to the birth of the children because the mother concealed the pregnancies and did not book for antenatal care.

4.3.5 After the birth of OY the mother and infant spent three days in hospital and there was routine postnatal follow up in the community. The midwife most involved in the hospital immediately referred OY to social care. It is not clear what sort of assessment of risk or need had taken place because the actual reasons for the referral were not recorded in the hospital notes. The only detailed account of the behaviour of the mother and other family members during her hospital stay is that the father cuddled OY.

4.3.6 Attention during the mother's hospital stay was also focused to a considerable extent on the medical problems that she experienced as a result of the lack of antenatal care. These were not grave, although she required a blood transfusion which prevented her from caring for OY during one night. The individual management review focuses on the role of midwives, but OY and his mother

were also seen by doctors during the stay and before discharge. None identified or recorded any risks or concerns.

4.3.7 The local authority records indicate that the referral was made because the family wished to consider relinquishing OY for adoption and not that there was any immediate concern about his welfare or safety. As a result the local authority decided to undertake the assessment at home. The hospital management review (paragraph 59) finds that '*various assessments were carried out in relation to the new born requirements as recommended by national guidelines'* and that '*the decisions about assessments and interventions carried out appear to have been reached in an informed and professional manner',* but there is little evidence to support this finding because of the lack of records. The midwives involved may have believed that by referring the family to the local authority they had ensured that a full assessment would take place. If so this is the wrong approach to take. Midwives should have been undertaking their own assessment of the history they knew and should have also been expecting to contribute to the wider social care assessment.

4.3.8 Leaving aside completely the question of whether the parents wanted OY to be adopted or not, hospital staff should have recognised that the potential social and psychological risks for the child associated with the concealed pregnancy and the lack of antenatal care pointed to the need for a psychological or psychiatric assessment of the mother and an assessment of the wider family circumstances.

4.3.9 After the discharge of OY and his mother they were seen in the grandparents' home on three occasions by the same midwife. OY had no health problems and the midwife did not identify any concerns about the attitude or behaviour of the mother. When she was contacted by the social worker undertaking the initial assessment on OY she indicated (according to the social work records) that she had no concerns. She either did not believe that the nature of the pregnancy and the lack of antenatal care

presented a risk or she must have believed that the social worker undertaking the assessment would already be taking this into account. The midwife involved should have recognised the unusual nature of the circumstances, recorded this and underlined it in her discussion with the social worker.

4.3.10 At the time of the birth of EY there were fewer opportunities for staff working within the hospital to undertake an assessment. At the time of OY's birth the extended family had been contacted by a midwife. It is not clear if this was what the mother wanted or just the midwife's instinctive response to the situation. In relation to EY the mother and father pre-empted this happening by indicating immediately that they wanted EY to be placed in care and relinquished for adoption. The mother later asked for her home phone number to be deleted from the hospital records and asked not to be phoned there. The reasons for this were never established. There was no opportunity for antenatal assessment or any significant assessment in hospital.

4.3.11 The postnatal care for the mother and child took place in unusual circumstances. The mother was at home and EY was in foster care. The postnatal visits were undertaken by different midwives. There are no postnatal records but it appears that they treated the visits to the mother and to EY as separate and routine tasks. There were no concerns in relation to either the mother's or the child's physical health. There is no evidence that the two midwives spoke to one another and neither referred to the records of the first pregnancy and the birth of OY. It is not even possible to know if either of the midwives realised that this was the second concealed pregnancy. There is no evidence that any consideration was given to making a referral for a psychological assessment of the mother. The discharge note sent to the GP in relation to EY's birth does not mention the circumstances of his birth or the concealed pregnancy.

4.3.12 The individual management review has made recommendations which include the following areas of practice and service provision:

- policy, procedure and practice in relation to concealed pregnancy
- the information pathway between maternity services and community practitioners
- training on the importance of information sharing
- record keeping to support holistic family assessment
- a checklist form to standardise information on postnatal discharge
- better management of referrals to the local authority and other agencies

This covers most of the key responsibilities of the obstetric and midwifery service in relation to safeguarding and interagency working.

Health visitor new birth assessments

4.3.13 The individual management review dealing with the provision by health visitors refers to the Healthy Child Programme. [23] This is reflected in local trust procedures and practice guidelines referred to as '*Fit for the Future, Universal Children's and Young People's Health Services (Health Visiting)*' November 2010'. All of these documents are rooted in the National Service Framework for Children, Young People and Maternity Services first published in 2004. [24] Although there are variations in the terminology used, all of these documents stress the importance of the new birth assessment visit by the health visitor and all of them underline the need for a holistic assessment of the needs of the child and parents at key points in the child's early life.

4.3.14 Despite the highly unusual circumstances of the birth of OY there had been no handover of information from the midwives who had been involved to the health visitor undertaking the new birth

[23] Department of Health (2010) *Healthy Child Programme- Pregnancy and the First Five Years of Life.* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118525.pdf

[24] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089101

home visit. However the new birth notification to the community service noted that the pregnancy had been concealed. The health visitor's (HV1) home visit was undertaken when OY was aged 15 days, which is within the timeframe expected locally. However in contrast to the approach set out in local and national guidance there is no evidence that a holistic assessment of the child and family's needs was undertaken. The records suggest that - despite the very unusual circumstances of the birth and the lack of antenatal care - the visit focused exclusively on routine child health matters, the interaction that the health visitor observed during her visit between the mother and the child and the positive reassurances that the mother gave her about the support that she was receiving from family members. There is no indication in the health visitor's electronic record that the mother had concealed or denied the pregnancy. There is no indication in the records as to who was present at the visit and no indication of the role and response of the father or other family members. The concealed pregnancy was not referred to in the health visiting record. It appears that it was not viewed as being significant because OY was assigned to the core health visiting service and no consideration was given to the potential psychological needs of the mother arising from her behaviour during the pregnancy.

4.3.15 The health overview report is critical of the standard of practice evidenced by this visit and identifies a list of issues which should have been explored. Whereas the national and local guidance emphasises the need for a holistic assessment of needs, this new birth assessment appears to have been conducted more like a triage exercise to identify serious or pressing problems (which this mother did not seem to have). No clear explanation has been provided as to why this happened. It is not clear whether it was a one off example of practice falling short of expectations. There are a number of possible explanations. These might include:

- The nature of the responses from the mother who was able to reassure almost every professional that she came into contact with that – despite the history – everything was 'fine'
- The lack of specific guidance about concealed pregnancy. However regardless of this the lack of antenatal contacts and the nature of the birth should have been sufficient to identify the need for targeted provision
- The workload and capacity of the health visiting service may have been a significant factor. This is discussed in detail in section 4.11 below.
- Personal factors in relation to the health visitor undertaking the assessment

4.3.16 Neither the management review nor the health overview report makes any reference to audit of the standards met in health visiting practice. Given the lack of any clear explanation it is a recommendation of the SCR that the health trust takes steps to establish the quality of new birth assessments in a sample of cases giving particular emphasis to the wider family, social and environmental issues that are highlighted in the national and local guidance. This should include an audit of the quality of information provided by midwifery services from contacts in the perinatal period. The findings and any recommendations arising from this audit should be reported to the LSCB as well as to the trust board and to commissioners of child health services.

4.3.17 The new birth visit in relation to EY was carried out by the health visiting team in the locality of the foster carers. He was identified as being in need of a package of care from the health visitor as a looked after child. The health visitor remained actively involved and made a useful contribution to the one looked after review meeting to which she was invited. There is no indication that the health visitor dealing with the mother and OY was informed about the outcome of the new birth visit to EY by the health visitor who carried it out (or even that she had been informed about the birth of EY). As a result the mother did not have a new birth visit

following the birth of EY and was only visited by her own health visitor three months after the birth of EY. The BECHS management review identifies the concern about this stating that: '*she was entitled to this visit in her own right and was of high need due to the circumstances of EY's birth and his voluntary placement in foster care. The mother and OY were at risk of psychological trauma and a health visiting assessment, of each family member would have been of benefit at this time. The mother did not have her 6–8 week postnatal review on time; there is no explanation why this was carried out late and the new birth visit did not happen'*.

4.3.18 The lack of information sharing between EY's health visitors was a further indication of a narrow task-focused approach to the care being provided, rather than professionals taking a wider perspective about the needs of both of the children and the whole family. Although it was not seen as being the role of the looked after children's health team to inform all of the health professionals involved with the family about the fact that EY had become looked after, it was very well placed to have done so and could have offered a safety net in the event that other information sharing arrangements did not work. The role of the team is considered more widely in section 4.6 which deals with information sharing.

<u>The assessment of postnatal maternal depression</u>

4.3.19 At OY's 6-8 week review (May 2010) the mother's health visitor (HV5) carried out a screening for postnatal depression using the Edinburgh Postnatal Depression Scale (see Appendix 6). The scale includes 10 items giving a maximum score of 30 and a cut off point of about 12 indicating potential risk of depression. The mother scored zero, indicating that she had no symptoms of depression or anxiety whatsoever. Given the concealed pregnancy and the initial conflict over the care of OY this seems very surprising. In the experience of the SCR panel scores of zero are very rarely recorded for the EPDS and scores within the normal

range reflect the many potentially unsettling changes that the postnatal period can bring. Given the history in this case the zero score was particularly surprising and may have been an indication of the mother's continuing denial of difficulties and problems. The health visitor did not consider this possibility.

4.3.20 There are other aspects of the EPDS that might have made it a less than reliable indicator of the mother's state of mind. The design of the EPDS questionnaire makes it extremely easy to 'rig'. It is self reported and self completed; on every item it is obvious what the non-depressed answer is and the scoring system is listed next to the questions.

Health visiting assessment prior to and after discharge of EY to his mother's care

4.3.21 The mother's health visitor (HV5) saw her shortly before and after EY moved to live with her in November 2010. These visits were organised on the basis of information received from EY's health visitor (HV4) and it was sensible of the mother's health visitor to assess how the mother was managing to take on the care of EY.

4.3.22 EY was a lively, sociable and therefore demanding seven month old baby. He was already attached to the carer that he had known since birth. His mother had never looked after him and had not visited him for long periods of time. Taking over his care would be a challenging and complex task for any parent and for his mother it might be particularly difficult given that she had denied his existence and then not wanted to look after him. In these circumstances a visit akin to the type of new birth visit envisaged in the Healthy Child Programme was called for. This did not happen. The visits that took place provided only a superficial assessment based on brief impressions of interaction and the positive account given by the mother. The visits did not establish how little contact the mother had had with EY over the course of his life. The assessment is very similar in nature to the new birth visit undertaken in relation to OY and the initial assessments carried out by the local authority which are described below.

4.3.23 It does not state in procedures or in the Healthy Child Programme that these were circumstances that required a much more comprehensive assessment. Procedures cannot cover every conceivable situation. This should not be necessary. Health visitors' training and in particular their knowledge of child development and attachment should have indicated that a fuller assessment was necessary.

The initial assessments undertaken by the local authority

4.3.24 The management review provided by the social care service recognises that the two initial assessments undertaken by the local authority were missed opportunities to develop an in depth assessment of the needs of the children and the risk factors that existed as a result of the concealed pregnancies. The first initial assessment took place immediately after the birth of OY while he was living at home. The management review states in relation to the first that '*this initial phase of social care assessment and intervention could have benefitted from a more detailed consideration of the nature / implications of the concealment of the pregnancy on the parenting capacity of the family, and a comprehensive understanding of the dynamics within the extended maternal family for the long term support for (the mother and OY).*

4.3.25 The April 2009 initial assessment document makes references to concerns about the mental health of both parents, in particular that the reason for undertaking the assessment was '*the depressive state of both parents'.* This is a much more strongly stated description of the concern in relation to the mother than any other health record contains. The assessment document contains evidence that the father spoke to the social worker about his feelings of shock and depression in similar terms to the discussions that he had had with his GP. The record suggests that the social worker had no direct discussion with the mother about her mental health, but that the father indicated that she was depressed and that she was 'seeing a counsellor' for this. It is very

surprising that this was not followed up with the mother and it was not established whether in fact this counselling was happening.

4.3.26 The social worker who undertook the assessment may have believed that this would be explored further during the core assessment that she recommended. The manager who reviewed the assessment did not agree that there was any further role for social care. She judged that the circumstances did not indicate that OY was a 'child in need'. In theory this was a valid conclusion but the judgement gave insufficient weight to the very unusual circumstances and the numerous unknowns in the history. When the case was closed after the initial assessment a manager agreed that because of resource constraints the social worker did not need to write letters notifying other agencies of the closure (this is discussed as an issue in its own right in section 4.6 below).

4.3.27 The second social care initial assessment took place after the birth of EY but focused exclusively on the care of OY. The social care management review notes that after the birth of EY there should have been a detailed and comprehensive assessment of '*all the children's physical and emotional development needs, parenting capacity (including a detailed assessment of the nature of the parental relationship), and the community and extended family networks'*. (page 34). The initial assessment that was undertaken focused exclusively on OY whereas his needs should not have been viewed in isolation from the impact of the birth of EY and the future plans for EY (which at that time were undecided). Once again the assessment undertaken failed to address the concealed pregnancy and the impact that having a brother (whose existence had at that time not been revealed to other family members) could have on OY.

4.3.28 The pattern of two concealed pregnancies should without doubt have led professionals to be curious about the mother's personality and mental health, even if superficially she was offering good care to OY. A professional consultation with a

psychiatrist or psychologist over this was the absolute minimum that should have been expected at this point, particularly as the mother was undecided about the future care of EY and might wish to resume his care.

4.3.29 In fact there was an aspect of the health and development of OY himself which could have given rise to concern about his wellbeing. He had put on weight extremely quickly, consistently weighing above the 99.6th centile, despite monitoring by health professionals and attendance at a 'Family Fit' and 'Healthy Eating' sessions at the children's centre. The overfeeding and very rapid weight gain of OY could have been an indicator of his mother's dysfunctional parenting and should have been explored. Responsibility for not addressing this in a robust way lay principally with health visitors who were monitoring his weight and children's centre staff who saw him regularly. However it is a concern that a social worker undertaking an initial assessment on a child would not make some comment about this when completing the element of the initial assessment relating to the child's health.

4.3.30 The recommendations in a number of management reviews point to the need for professionals to recognise the importance of concealed pregnancy as a risk factor that should trigger an in depth assessment. Concealed or denied pregnancy is in fact just one example of any number of historic or static risk factors that might point to the need for a more in depth assessment which professionals in all agencies and their supervisors need to be open to.

<u>Why was there no core assessment undertaken while EY was looked after</u>

4.3.31 No core assessment was undertaken during the seven months during which EY was in foster care, despite the fact that his case became more, rather than less, complex as time progressed and the need to gather evidence for possible Placement Order proceedings appeared to be becoming more, rather than less,

likely. No core assessment was undertaken at that point because it was not required by procedures and no one in the local authority recognised that the complexity of the case merited a more thorough analysis. Staff and managers had adopted the view that the case would end positively if EY went to live with his mother as had happened to his brother. This period in EY's life is discussed in more detail in section 4.4.

The assessment of the role of the extended family

4.3.32 At no point was there a proper assessment of the role of the extended family, including the role of the father.

4.3.33 The mother's extended family were seen as being an important source of support for the parents (and particularly the mother) at a number of points in the case history, most critically when the parents decided to take OY home from hospital after his birth and when the mother decided to discharge EY from care. Both of these plans – and the decision of the local authority to close the case in December 2010 – relied on the maternal family giving the mother regular support.

4.3.34 Although the maternal grandparents were seen as being extremely important in the care plans there was minimal professional contact with them. So far as can be established (based on the chronology and the management reviews) this was as follows:

- The maternal family visited the parents in hospital after the birth of OY (its not clear how many times)
- the social worker spoke to the maternal grandmother on the phone after attempting to arrange a meeting with the grandparents in early November 2011
- the maternal grandparents attended the planning meeting at the foster home on 12 November 2011

It is perhaps more telling to set out how they were not involved:

- so far as can be established the maternal grandparents were not seen during either of the social care initial assessments,

though both assessments concluded that their role was positive and important

- they were not seen by the social worker during the rehabilitation assessment (and they did not visit the foster home during this period so far as can be established)
- they were not seen or contacted by the social worker once EY had been returned to his mother
- the details of the parents' siblings are noted in the social care management review Genogram but they did not feature at all in any agency records

4.3.35 In addition the maternal grandparents were never seen by health visitors. Like the social workers they relied entirely on the mother's presentation of her close and supportive family. The BECHS management review documents how the health visitor who carried out the new birth visit to the foster carers' home, *was informed that the maternal grandparents lived close by and were supportive. Their details were not recorded'.* When the mother moved home she '*informed her health visitor (HV5) that her mother was very supportive and helped her with the children; this was recorded within the record on 26/01/11*. *Actual details of the grandparents were not part of the record*'. The management review notes that '*at the last clinic contact,* (before the death of EY) *HV7 established that there was support from the grandparents'*. The final contact with EY before the injuries that caused his death is discussed in detail from paragraph 4.3. onwards and in section 4.11.

4.3.36 These descriptions are typical of the records across health and social care. The mother's descriptions never went beyond the extremely general, and yet so far as we can see they were never challenged and the mother was never asked to describe exactly how they helped or how often they visited. The actual nature of the relationships was never tested. This was particularly significant as it was clear to social care staff in November 2010 that the grandparents were hostile to the father, yet the plan was that they

were working closely with the mother (who was in turn relying on the father) to support her care of EY.

4.3.37 Sometimes professionals' misconceptions about the role of the extended family supported and reinforced one another. The 2009 social work initial assessment of OY records that *'health visitor observation / assessment is that there is positive support to the mother from maternal grandparents'.* As has been shown there was no health visitor observation of the grandparents and the only 'assessment' was the word of the mother.

4.3.38 In reality no professional knew anything concrete about the role that the grandparents really played, except what the mother had told them and the commitments that they made at the planning meeting (which have not been detailed). No one ever explored the paradox that pervades every aspect of the case history. Why was it – if the mother has such close support from her family – that she had been unable to inform them of her two pregnancies? Why was it that she could not bring herself to mention to them that she had a second child for almost seven months? Rather than being a close supportive relationship, this tends to suggest a much more complex relationship.

<u>Assessment of the role of the father</u>

4.3.39 Very similar concerns apply to the role of professionals in relation to the father, though there are some distinct aspects. He was seen more often: at the hospital after the birth of OY in 2009, during the initial assessments and in discussions about proposed adoption of EY. He was seen once briefly by a health visitor (after EY had gone home in November 2010). However the overwhelming majority of references to the father are records of the mother's comments about him. He was taken to have been a support to the mother in relation to the care of OY, but no one tested what this meant in practice.

4.3.40 In relation to EY social care staff formed a view early on that it was largely the result of the father's influence that the mother did

not want to care for EY or at least that she was ambivalent. He was seen and described as 'domineering'. This led to the rather unusual approach of asking the mother whether she wanted to be referred to a domestic violence programme, even though there was no evidence to suggest that she had been a victim of domestic violence. She did not take up the offer. Adherence to the view that pressure from the father was preventing the mother from making a free choice about whether or not she wished to relinquish EY had two adverse effects on the assessments undertaken.

4.3.41 Firstly the father's actual circumstances and views were never properly assessed. No other information was gathered from him or about him. Potentially important information about his response to the births of the two children held by his GP was never obtained. His clear view that the mother could not cope with caring for two children was never tested and explored.

4.3.42 Secondly the adherence of the local authority to the view that it was largely the father's influence that was preventing the mother from caring for EY led it to give insufficient weight to evidence of other factors which should have been assessed. For example the mother had no contact with EY for nearly 10 weeks between June and early September and told social workers that she gave no thought to EY when she was not with him. However domineering the father was, the mother's indifference to EY was not entirely due to him.

4.3.43 It is a long established finding of Serious Case Reviews that men (including fathers) are often marginalised in the assessment of risk.[25] The most recent review of SCR findings adds an additional dimension which clearly applies in this case. Repeating the findings that there was a dearth of information about men and that they were often '*absent from assessment'*, Brandon et al also identify the danger of '*rigid or fixed thinking'* about men '*who were*

[25] For example Brandon et al, (2009), Understanding Serious Case Reviews and their Impact a Biennial Analysis of Serious Case Reviews 2005-07 DCSF

perceived in a polarised way as primarily 'good' men (good dads) or 'bad' men (bad dads)'. Paradoxically in this case history the father was perceived as both 'good' and 'bad' in different ways but the complexity of both aspects was never explored. He was 'good' to the extent that he was believed to help look after the children, though this was never evaluated in detail. He was 'bad' because he was stopping the mother from looking after EY though his 'domineering' behaviour. He had his reasons for thinking that this was not a good idea. Some of them reflected his own needs, he had not planned to be in a relationship and have children, but some of them may have been very sound. These were never explored.

4.3.44 There is a complete contrast to the attitude of the local authority to the influence of the father over the mother and the influence of the grandparents. As soon as her parents knew about the existence of EY they persuaded her very quickly that she should look after him. Considerable concern had been expressed about the need for the mother to be able to make a choice free of the father's influence and considerable time was devoted to counselling her over this. In contrast the local authority had no disquiet whatsoever about the mother's very rapid decision to care for EY, despite the fact that it was clearly heavily influenced by the grandparents and despite the fact that she had earlier said that her parents' attitude would not affect her decision.

4.3.45 The evaluation in the preceding paragraphs has focused on the role of the local authority because it has the lead responsibility for assessment and decision making. However the weaknesses in relation to the engagement of the father apply to all of the agencies involved to different degrees:

- health visitors saw the father only once (November 2010) and otherwise did not enquire about his role or accepted assurances about him
- the children's centre had no contact with the father and there is no evidence that the mother was ever asked about him

- the father's GPs heard repeated stories from him about the impact of fatherhood, but they all concentrated exclusively on his needs as an adult patient and showed no curiosity about the children involved
- the legal advice given does not touch on the role of the father (though his views about adoption were always clear).

4.3.46 The impact of failing to work with the father is distinctive and important in this case history, but the nature of the problem is long established in safeguarding work. Agencies need to understand why it is that despite this being well trodden ground professionals once again ignored or marginalised the father in assessment and decision making.

4.3.47 The BECHS report makes a specific recommendation on the issue. The local authority view is that if there had been a core assessment then the father would have been more fully engaged. Other than this the individual management reviews are not critical about the failure to consider or attempt to work with the father and they make no recommendations. If agencies feel that the approach to working with fathers is a 'one off' departure from normally good practice then they should be asked to demonstrate this to the LSCB. If this is not the case and wider concerns are recognised then the LSCB needs to consider how it can influence agencies to address this issue in a more constructive way and to monitor the way in which agencies do engage with fathers and other carers. The LSCB should do everything it can to ensure that agencies improve the engagement of fathers in assessments and continuing work and the SCR will make a recommendation in relation to this.

<u>Why did no-one attribute sufficient significance to the two denied or concealed pregnancies?</u>

4.3.48 Although many agency records note that both children were born as a result of concealed pregnancies the individual management reviews note that professionals paid very little explicit attention to this, beyond the immediate period after the children's births.

Neither was much paid to the practical consequences of concealment. The BECHS management review spells these out, including the lack of antenatal care and the birth of two children in potentially perilous circumstances (paragraph 5.3.6).

4.3.49 In order to understand as well as possible the professional response it is important to be as clear as possible about the knowledge that professionals had about the concealed pregnancies. In particular it is important to understand which professionals knew about both of the pregnancies. In their study Friedman et al [26] note a prevalence rate for denied or concealed pregnancies of 0.26% (roughly 1 in 400) of live births, indicating that this is a relatively unusual occurrence. They quote another study with a prevalence rate of 1 in 475. Strikingly the Friedman study makes no reference whatsoever to any women having two such pregnancies, though they would not have been able to include pregnancies after their study or women who delivered at another hospital. This strongly suggests that having two concealed pregnancies would be an extremely rare phenomenon and that indications of risk arising from one concealed pregnancy would increase disproportionately if a mother had two such pregnancies.

4.3.50 Midwifery staff dealing with the second concealed pregnancy are unlikely to have known about the first, because they did not consult the mother's records relating to the birth of OY. Little useful information was provided to other health professionals by the midwifery service and discharge letters did not give sufficient emphasis to this information or highlight it in a way that would have ensured that it was likely to be spotted. This is addressed in a recommendation arising from the individual management review.

4.3.51 The GPs dealing with EY after November 2010 did not know that the pregnancy had been concealed though they might have

[26] Op cit (at page 118)

noticed from closely reading all of the documents in the PCHR that EY had been in care.

4.3.52 The health visitor dealing with EY after he had been returned to his mother knew that his pregnancy had been concealed and that he had been looked after by the local authority. However it is not clear that she knew that OY's birth had also been concealed as she had not dealt with him as an infant. He had no separate health visiting record and this information was not recorded in his electronic records.

4.3.53 Children's centre staff knew that the pregnancy with OY had been concealed but did not attribute any particular significance to this. The centre coordinator had had only basic safeguarding training and the children's centre worker had received no single or multi-agency training (this is discussed further in section 4.9).

4.3.54 Local authority records on the two children make it clear that both pregnancies had been concealed pregnancies though no extra significance was attributed to this.

4.3.55 Professionals only drew attention to concerns associated with the nature of the pregnancies at two points in the case history. There was discussion with the mother about her pregnancies in her counselling about adoption. The mother's tendency to deny and 'disassociate' from issues that caused her anxiety and conflict was noted but this important insight was never integrated into the thinking of the local authority in terms of how it might affect the mother's ability to look after EY.

4.3.56 At EY's second looked after review meeting his health visitor stated her concerns about the history of concealed pregnancy and placement in care, the delay in naming EY, delay in obtaining consent for his immunisations and the long periods of time during which the mother had not visited EY. This could have been the starting point of an analysis linking the mother's denial of EY during pregnancy to concerns about her recent attitude and behaviour. A thoughtful assessment would have gone on to ask

questions about the impact of this in the parenting capacity of the mother, perhaps not in general, but in relation to EY specifically. None of the other professionals present appear to have understood or felt that it was necessary to take up this agenda. These static or historical risk factors were never treated as being significant. The health visitor did not receive minutes of the meeting and was not invited to participate in further discussions planning for the discharge of EY from care. She did not pursue this further herself. She may have been put off underlining the importance of this when discussing the case with OY's health visitor because when she spoke to her about EY being discharged from care, her colleague told her that she was '*fully aware'* of the circumstances.

4.3.57 Friedman et al suggest that the failure to appreciate the significance of concealed pregnancy is not unusual. In their study they found that because the professionals dealing with the birth underestimated the level of potential concern '*psychiatry consultations were rarely requested, although infants were frequently discharged to the care of mothers who had denied or concealed their existence'*. As a result service provision was far lower than the researchers had expected. It seemed to be particularly hard for professionals to address this issue with mothers [27] and that as a consequence '*the lack of attention to the phenomenon of pregnancy denial mirrors the silent stance'* of the mother and family (page 121). It is noted that women who have been unaware of their pregnancy or unable to discuss it with their partner or parents are likely to be dazed, confused, defensive or blandly reassuring after the birth (or a combination of these). The same individual psychological, family and environmental factors that led to concealment before birth will often continue to apply. Some women remain in denial even after the birth. Mothers who have concealed their pregnancy are unlikely to seek help voluntarily and are likely to be a difficult client group for

[27] The authors focus exclusively on mothers

professionals to engage. In such cases good supervision of staff will be critical to aid recognition and assist staff in discussing the issue with women.

4.3.58 An additional factor that may have reduced the likelihood of professional recognition in this case history was that no other obvious risk factor was present. Insofar as professionals are used to concealed pregnancy at all they are used to dealing with it where there are other clear risk factors which go some way towards explaining the lack of awareness of symptoms of pregnancy or poor take up of antenatal services: particularly parental drug misuse, domestic abuse, mental illness and learning disability. In recent years professional thinking has been strongly directed to these risk factors, understandably because they are associated with the majority of serious and fatal cases of abuse. Brandon et al show that taken together one or more of the first three of these factors was present in 87% of the cases subject to SCR during 2003-2005 [28] All of these risk factors will usually in their own right trigger further assessment and intervention within which the issue of concealed pregnancy may be discussed.

4.3.59 This case history highlights the potential for serious child abuse in cases which do not have the predisposing risk factors most commonly associated with the highest levels of risk to children. If 87% of fatal and serious cases feature domestic abuse, mental illness or drug misuse, 13% feature none of them and professionals need to continue to be alert to unusual presentations.

4.3.60 Most of the individual management reviews highlight the lack of specific guidance in the local child protection procedures about concealed pregnancy. However 'concealed pregnancy' is currently included as the first on the list of factors that professionals should

[28] See page 81 of Brandon M, Belderson P, Warren C, Howe D, Gardner R, Dodsworth J, and Black J (2007) *Analysing child deaths and serious cases through abuse and neglect: what can we learn*? A biennial analysis of serious case reviews 2003-2005. DfES

be aware of in relation to risks to the unborn baby and 'denial of pregnancy' is included in the list of parental risk factors pointing to the need for referral to social care, along with failure to take up antenatal care. In line with this the children were referred to social care, but the assessment of risk by all agencies was inadequate and only on one occasion did any professional point to the concerning factors in the case.

4.3.61 The case made by the management reviews is that the current documentation does not give more specific guidance on the assessment of risk where there has been a concealed pregnancy. The LSCB should produce additional guidance on this, but it is recommended that it is brief and that equal attention is paid to the need to assist professionals and supervisors to be flexible in their thinking and to develop their capacity to recognise risk when it arises in cases that fall outside of the presentations that child protection professionals have become used to dealing with. In addition to offering additional guidance on the specific issue of concealed pregnancy organisations need to find a way of improving the capacity of professionals to identify more unusual presentations. By their nature it cannot easily be predicted what these will be and it is not possible to write guidance about all of them.

<u>Provision of services as a result of the assessments</u>

4.3.62 The impact on service provision can be easily and briefly stated. Poor assessment led on several occasions to service provision that did not match the needs of the children. The individual management reviews identify these episodes:

- a proper discharge planning meeting, continuing social care involvement and a fuller assessment following the birth of OY would have been beneficial
- additional health visiting provision was merited after the birth of OY and after EY was discharged from care
- EY should have been treated as a child in need at the point when he was discharged from care

4.3.63 The final episode listed was a critical turning point in the case history. A child in need plan would have enabled provision of coordinated support, monitoring of EY's health and development at a level in keeping with his needs and monitoring of his progress through periodic review. It would probably have prevented the mother from deceiving staff at the children's centre as to the identity of the child because there could have been a close working relationship between this children's centre and the local authority. It would also have offered an easy point of contact for all professionals and prevented the confusion that occurred when staff spoke to administrative staff in the referral and assessment team.

4.3.64 The social care management review states that carrying out a child in need assessment and arranging a child in need plan at the point when a child ceases to be looked after were procedural requirements in the local authority in November 2010 and that they are now reflected in statutory guidance. The social worker's manager knew this but believed that there were so many positive features in the case that it was decided that there was no need to comply with the procedure. This was because the potential risks associated with the mother's long period of little contact with EY and the inherent difficulty of taking over the care of a seven month old child who was becoming attached to another carer were not recognised or understood.

<u>The identification of injuries and other indicators of potential harm</u>

4.3.65 This section will deal with the actions and decisions of professionals in the following episodes in the case history:

- GP and Health visitor (January 2011)
- Children's Centre and parenting programme crèche (January – March 2011)
- Social worker and colleague (responding to information provided by foster carer February 2011)
- Access officer (responding to information provided by the children's centre February 2011)

- Health visitor at child health drop in clinic (March 2011)

4.3.66 Descriptions of all of these events are set out in section 3 above. This section will seek to evaluate why professionals responded as they did. This will be considered in the context of the local child protection procedures. The guidance on 'bruising' is reproduced as Appendix 8 to this report. It specified that '*any bruising or other soft tissue injury to a pre-crawling or pre-walking infant or non mobile disabled child'* or '*bruising around the face' …'must be considered as highly suspicious of a non-accidental injury unless there is an adequate explanation provided and experienced medical opinion sought'.* [29] This guidance is discussed further in section 4.8.

4.3.67 According to SCR panel members the need to refer children under the age of one with any bruising on the face for further assessment has been strongly reinforced in all local training, especially for health visitors and GPs.

4.3.68 EY's GP recorded bruising and scratches on EY at his 9-12 month developmental check in January 2011. It is not normal practice for GPs to carry out such assessments but the GP concerned customarily did so as he had an interest in child health. As this examination took place as part of the developmental assessment there was an opportunity for a full examination. [30] The GP noted bruises and scratches on EY's face and to his credit made a very detailed record of them on EY's GP medical records.

4.3.69 It is significant that the GP did not summarise them on the PCHR which was the record that every other health professional who saw EY would have been most likely to access. The only recording that the GP made on the PCHR was to complete the up to date entries on the height and weight chart. These would be routine actions arising from the developmental check.

[29] Berkshire Child Protection Procedures (section 5)
[30] On 14 March 2011 when EY presented at the GP surgery with cold symptoms it would not have been necessary to remove his clothes to examine him

4.3.70 This is significant in relation to subsequent events because had he recorded information about the bruising in the PCHR (whatever he believed to be the cause) it might have made a difference to later contacts of health professionals with EY, particularly to the contact at the health clinic on 17 March the day before EY was admitted to hospital. It is also significant because it indicates that GPs are less likely to complete the chronological entries in the PCHR. This may apply to other doctors and medical professionals as well. It is not clear why this is so but there are a number of obvious possible explanations:

- time constraints make recording duplicate information on two records less likely
- the PCHR may be seen by doctors as a record of height, weight and development which is largely a tool for parents and health visitors rather than acute medical concerns.

It may therefore be viewed by doctors as a secondary and less important place to record information than the GP or hospital medical records that will be seen by colleagues within their own setting.

4.3.71 Given that so many other professionals will see and rely on the PCHR this indicates that all medical professionals who have contact with children may need to change their practice and adopt an approach to recording that takes more account of the needs of other health professionals.

4.3.72 The GP did not challenge the mother's explanation that OY (then 21 months) had caused the bruising and there is no indication in the records or in subsequent discussions with him that he considered the possibility of non accidental injury. He made no further investigation or evaluation into the cause of the bruising. The GP decided to address the sibling rivalry by referring the children to the health visitor for advice. This was an error of judgement and it is clear that within the existing child protection procedures he should have referred EY to children's social care. If he did not feel sufficiently sure about the level of concern he

should at the very minimum have sought the advice of a named professional and referred the child for an urgent paediatric appointment, following up the referral to make sure that the child had attended.

4.3.73 The SCR panel believes that the GP would have been more likely to have been concerned about the bruising and therefore more likely to have acted in a different way if he had known that EY had been looked after for a considerable period by the local authority. He might have viewed this as an indication of potential risk. It would almost certainly have reduced any inhibition about contacting the local authority if the GP had known that social care had already been involved. The GP had received no notification of the local authority's involvement either directly from the local authority or from the health team responsible for looked after children. Both of these issues are addressed further in section 4.6 dealing with the coordination of services and information sharing. The GP also had no access to EY's original medical records which had numerous references to him being looked after. This is also addressed in detail in section 4.6 of this report.

4.3.74 Close examination of the PCHR (which the GP completed) shows that the document itself did contain a number of entries which indicate that EY had been looked after:

- one entry from his previous health visitor is marked '*in foster care'*
- the PCHR contains a form with the letter head 'Windsor and Maidenhead Council' signed by both parents consenting to medical treatment for a looked after child
- there are a number of entries which refer ambiguously to EY's 'carer' (but not foster carer) rather than his parent taking him to appointments

4.3.75 The SCR has scrutinised these entries and discussed the nature and design of the PCHR at some length to understand why it was the GP did not notice them. The entries referring to 'carers' and to EY being 'in foster care' were made in the chronological contact

section of the record that had been completed by health visitors and other health practitioners. This section of the record is separate from the parts of the record that would normally be accessed in order to register the information about the developmental check. The looked after consent form is folded in a perspex pocket at the back of the PCHR ring binder where parents are encouraged to keep appointment letters and other additional information. Important lessons follow from this in relation to the design of the PCHR, the recording of key events and history in it and the scrutiny that health professionals give to the historical information already recorded when they use it. Both sets of entries which gave a clear indication that EY had been looked after could in the opinion of the SCR be easily overlooked by the GP.

4.3.76 A similar argument applies to the health visitor who saw EY on 17 March. She would have had much less opportunity than the GP to notice this significant historical information because of the much more limited time that she had with EY and the difficult context in which she was working. This is discussed further in section 4.11 below.

4.3.77 It would be unrealistic to expect health professionals to read the entire PCHR at every consultation. This would never be practical. It is clear that the design and use of the PCHR needs to be revisited so as to ensure that any significant information which could influence the future assessment of risk is prominently displayed and is much more likely to be seen by health practitioners every time they consult the PCHR. This needs detailed work and consultation with all users of the PCHR in primary care, community health and acute hospital settings. One approach would be to have a sheet containing key information located in the sections of the PCHR which are most commonly accessed that all health practitioners are required to review at each contact. Steps also need to be taken to ensure that all doctors are much more consistent in their practice in adding

significant information to the PCHR as well as to GP, hospital and clinic medical records.

4.3.78 Seeing significant historical information (such as the fact that a child had been in foster care from birth) would still of course require the correct professional interpretation and action, but at least one potential barrier to recognition of a risk factor would be removed by better design and use of records. Section 6 contains a recommendation in relation to this.

4.3.79 EY's weight is recorded in the PCHR in a table and in a traditional height and weight growth chart (See Appendix VII). These parts of the records were seen by the GP who entered the up to date weight on it. This showed that EY had gained only 100 grams (4 ounces) in the seven weeks between 30 November 2010 and 19 January 2011. On the weight chart the line of EY's growth was now close to horizontal, instead of matching the percentile line that it had tracked consistently while he was in foster care). This pointed to a marked decline in EY's rate of growth over the previous two months. This might not have required a referral or further action in its own right but it should have raised the index of suspicion created by the facial bruises in an infant of this age.

4.3.80 The GP involved was very knowledgeable and experienced. As with the poor assessments referred to earlier in this report the SCR has tried to understand why the professionals involved found it difficult to take the action that they probably knew was necessary. Again there may be a number of factors that made it difficult to act in the way that training, procedures and experience indicate is required.

4.3.81 All of the accounts given about the mother (both prior to and post the death of EY) indicate that she was capable of being utterly convincing, even when she was being untruthful. This will have played a part. It is also important to recognise that many staff who are involved in providing universal health services for children find it very difficult to voice suspicions of child abuse. This requires

them to switch from their normal care-giving mind set in which it is assumed that the practitioner and the parent are both operating in the best interests of the child to a mind set based on suspicion of wrong doing. Intellectually it is easy to say that the child is the patient, that child abuse is a significant cause of child health problems and that the interests of the child are paramount. In practical terms it often proves much harder for professionals to be prepared to consider abuse as a possible explanation and to act in the way that they have been trained to act and which they know they should.

4.3.82 The management review of primary care recommends the adoption of a new pathway for dealing with bruising in infancy. The SCR endorses this recommendation. It will be useful to consider how in addition to the pathway underlining the importance of referral to social care in appropriate cases the pathway can ensure that medical practitioners feel able to make an urgent paediatric referral in appropriate cases. This is a useful recommendation but it is important that the pathway and any training and guidance associated with it also address the psychological and interpersonal barriers that can prevent professionals identifying and referring suspicions of child abuse.

4.3.83 After the consultation the GP spoke to the health visitor, told her about the bruises and asked her to advise the mother about sibling rivalry. There is no discrepancy in the records about this and the health visitor did what she was asked. As the BECHS management review puts it, '*the health visitor was not being asked to check any bruising'*. This helps explain her subsequent response but it does not justify it. When she visited she did not ask to see EY (who was said to be asleep) and instead focused her attention on OY. It is impossible to know how the health visitor would have reacted had she herself discovered this bruising on a nine month old, but her training would have told her to be very concerned. As the BECHS management review points out, health visitors are qualified, experienced and highly trained professionals

and with this comes the responsibility to exercise critical judgement not only about children and families but also about the opinions of other professionals. Unlike the GP the health visitor did know that EY had been looked after and she also knew about that the pregnancy had been concealed. She does not appear to have taken the additional risks into account, nor did she inform the GP about them. There is no reliable way of knowing why she did not do so. There is significant learning here about the need for professionals to be able to challenge one another's judgement.

4.3.84 There is no doubt that when she visited EY and OY the health visitor should have asked to see the bruising for herself and made her own judgement. There is no way of knowing what she would have seen. The visit took place a week after the GP consultation and the bruises might have been less marked. However EY was noted to have more bruises five days later when he was seen at the children's centre so more bruising might have been visible.

4.3.85 The presentations of bruising and other potential indicators of abuse at the children's centre are documented in section 3 above. These incidents included:

- direct observation of bruises and scratches
- reports of concerns from staff running a crèche associated with a parenting programme
- reports of concerns from other mothers

4.3.86 The individual management review of family support services describes these contacts, though they are based on limited records because not all key events were properly recorded. Accounts given to the police after the death of EY suggest that the seriousness of the concerns of staff and parents exceeded the information in the records at the time.

4.3.87 The mother deliberately deceived both staff and parents at the children's centre by saying that EY was her cousin's son. Her specific reasons for doing this are not clear. She also consistently said that EY's injuries were caused by the child's four year old

sister or by toppling over. The effect of the deception was to make it very difficult for the staff to identify EY and contact professionals who knew him. It may also have made staff more likely to accept her accounts (since a four year old would be more likely to leave bruise marks on a baby than OY who was a toddler). Most importantly it distracted staff from concerns about the mother's own parenting onto an imaginary family. The deceit sabotaged attempts to identify EY but there remain fundamental concerns about the response of the children's centre staff to the injuries that they and other parents reported. These are comprehensively identified and explained in the family support service individual management review:

- Recording systems used in the centre were not child-centred – they reported a range of incidents that had occurred in the centre in date order making it difficult to form a picture of the number and range of incidents related to any one child and to track the actions taken in response to them
- Indicators of abnormal parental behaviour were recognised as parenting problems and not indicators of possible child abuse
- Although it was highly unusual for other parents to express strong concerns about a parent, these concerns were not treated seriously enough. More weight should have been given to them and they should have been recorded in more detail because these parents had more contact with the mother than the staff did
- Management advice given about the case was not clearly recorded leaving room for ambiguity and there was a lack of persistence in implementing it
- The children's centre staff and coordinator lacked experience and training in dealing with child abuse allegations. This meant that they were too willing to accept the advice given by the access officer from social care, even though they say that they had misgivings about it

- More senior managers had failed to ensure that centre staff adequately understood their roles and responsibilities in relation to child protection. Training for the centre staff and manager on safeguarding was not given sufficient priority
- The evidence suggests that one reason for this was that the children's centre service was being required to pursue too many potentially conflicting policy and service delivery agendas. This is discussed in more detail in section 4.11
- It is not possible to be absolutely certain what information was given to the social care access officer when the centre coordinator spoke to her. Even if she believed that the call was a consultation and not a referral she should definitely have referred a call about a 10 month old baby with bruises to a qualified member of staff and she should have asked for the name and details of the family members involved
- The roles and responsibilities of access officers in the local authority social care service were not understood by family support service staff and so they believed that they were receiving advice from a qualified social worker and not an administrative worker [31]

4.3.88 The reasons for these shortcomings are explored in more detail in the relevant sections of this report.

4.3.89 Twice staff at the children's centre sought external support in identifying EY and responding to the injuries that they had seen. Given the vulnerability of EY and the lack of any concrete information about who he actually was the centre coordinator and her manager should have placed responsibility for dealing with the concerns squarely in the hands of the local authority social care service by insisting on referring the child to a manager in the referral and assessment service. Staff working in such settings

[31] The role of the Access Officer in the referral and assessment team was also unclear to health members of the SCR panel and IMR authors demonstrating that this was not an isolated misunderstanding of the role. It is noted that this was not a new role or service innovation and that the same individual had fulfilled the role for a number of years.

need to have the confidence and structures in place to be able to do this in future. The SCR accepts that the recommendations made in the family support service should if implemented achieve this so long as the service recognises that it has a specific responsibility towards vulnerable children. This issue is explored further in section 4.11.

4.3.90 Section 3. above describes the actions taken by the foster carer and the social worker reporting on her chance meeting with EY and his mother in February 2010. The previously allocated social worker says that she left a voicemail message for the health visitor, but the health visitor made no note of this. If it did contain an account of bruising and she did receive it and took no action this would be very concerning because it would have been a further report of bruising, three weeks after the GP report. Having left the voicemail message the social worker should have followed it up to establish what had been done. She (and her much more experienced colleague in the fostering service) should also have treated this as a proper referral of possible abuse to the authority about EY. The previously allocated social worker was very inexperienced and this is discussed further in section 4.9.

4.3.91 The final opportunity to identify EY as a child who was at risk occurred the day before he was taken to hospital with serious injuries. He was seen in a clinic with bruises which were documented by the health visitor. The health visitor did not know that EY would be seriously injured within hours of this consultation and in evaluating her actions this needs to be set aside from consideration. The health visitor recognised that the bruising was concerning because she says that at two points during the brief consultation she deliberately and pointedly asked the mother how the injuries had occurred and the mother twice gave the same account. Essentially the injuries that she saw were of a similar nature to the ones seen by GP and reported to EY's own health visitor two months before and the ones seen at the children's centre over the previous three months. However the health visitor

did record that EY's failure to gain weight had now persisted for a further two months. This should have raised the index of concern.

4.3.92 The action taken by the health visitor on that day was not in accordance with the local child protection procedures. These clearly state that she should have referred the injuries to the local authority that day or at least consulted the trust's named nurse. It is clear that this was not due to a lack of knowledge or training. The BECHS management review specifically notes that relevant training had been provided to health visiting teams as recently as November 2010 but that the health visitors actions *'did not follow the approach recommended'*.

4.3.93 The health visitor also noted her concerns about the lack of weight gain. EY's weight had been static for three and a half months and had declined from the 75th centile to a point mid way between the 25th and 50th, a clear indicator of his failure to thrive or a serious health problem. She noted her intention in her diary to speak to EY's own health visitor as soon as possible the following day (the clinic was an afternoon one). Taken in isolation this was a very concerning presentation, but not one which required an instant response and the health visitor's decision to note this and discuss it the next day with the allocated health visitor was appropriate. Taken together with the bruising the persistent failure to gain weight should have added to the level of suspicion.

4.3.94 There is no suggestion from BECHS that this health visitor was not competent. In these circumstances it is important to understand the factors that made it difficult for her to act in keeping with her judgement and training. Some of the factors have already been identified:

- the mother once more gave a convincing but (very probably) untrue account of how the bruises had been caused.
- the health visitor did not know that this was part of a persistent pattern of bruising or even that the GP and the allocated health visitor had seen bruises in January. There is no

way of knowing whether she might have reacted differently if she had known this

4.3.95 It is also important to be mindful of the context in which the health visitor saw EY and the other family members. This health visitor had never met EY or his mother before. The contact was not planned and she knew nothing of EY's history other than the facts she had time to obtain from his PCHR. She knew nothing of the nature of the concealed pregnancies. For the same reasons as the GP she did not know that EY had lived in foster care. The SCR has also discussed the arrangements for child health clinics such as the one in which EY was seen that day. In these health visitors see large numbers of children, many of whom will not be previously known to the health visitor or on their allocated caseload. The clinics are busy, because they are popular and there are few of them. Children are often weighed by parents themselves rather than by health staff and often health visitors spend as little as 3-5 minutes with a child. Health visitors have access only to the PCHR. As has been described the PCHR may not contain important information or make it obvious on a quick review. Depending on the venue the health visitor and her colleagues may have no access to electronic records or any other background information or parental history (or no time to access them). Recordings cannot be made on the electronic records and contact with colleagues (in health and other agencies) is limited to mobile phone.

4.3.96 There can be no doubt that this is a very difficult environment in which to offer a service to vulnerable children, not least because it will often not be clear whether the child who is being seen is vulnerable or not. The concerns about the difficulty of practising safely in this setting are discussed further in section 4.11 which deals with capacity and other organisational matters. Some aspects of the analysis apply both to these child health clinics and to the children's centres.

Overall conclusions in relation to assessment of the risks to EY and the injuries known to professionals

4.3.97 Overall conclusions in relation to assessment of the risks to EY and the injuries known to professionals are set out in section 4.14 below.

4.4 Implementation of plans

- *Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?*
  - *Establish what advice was given and what services were offered to the parents concerning adoption*
  - *Evaluate whether there was sufficient focus on the needs of the child EY in relation to actions taken in relation to adoption by the local authority*
  - *Establish whether sufficient attention was given to issues relating the reunification of EY and his mother following the period when he was in foster care.*

Key dates and events

4.4.1 EY was born on 23 April 2010 and immediately accommodated with the agreement of both of his parents. At the placement planning meeting held five days later it was decided that adoption counselling would take place to assist the parents in making an informed decision about EY's future. This was the correct course of action. Counselling of the mother began on 25 June 2010 after a delay caused by internal confusion about the referral between teams. The counselling continued until October 2010 when the mother confirmed that she did not want to care for EY, regardless of any support that was available from her family.

4.4.2 Following a home visit on 11 May 2010 the local authority took the view that the mother was ambivalent about adoption and that the father was pressurising her to give EY up. From this point local authority records show that there was an understanding of the possible need to involve the maternal grandparents. The reasons for doing this were not clearly recorded at the time and legal

advice was later sought to clarify the position. Discussions about informing the grandparents about the birth of EY continued until early November 2010.

4.4.3 The first statutory review took place on 20 May. The parents had been invited but neither attended. However the mother visited the foster carer later that day and started to have contact with EY. The review minutes note that the mother named EY after the review meeting.

4.4.4 The decisions of the review meeting refer to a process of twin track planning whereby work to secure the adoption of EY would proceed alongside counselling of the mother to help her make an informed choice about adoption. The parents were informed that legal advice was being sought to determine whether the local authority needed to inform the mother's parents and that this related to the possibility that members of the extended family might wish to care for EY.

4.4.5 On 3 June 2010 the case was allocated to a new social worker (SW5) in another team. The initial period of allocation coincided with the period in which the mother had most contact with EY. The mother saw EY twice at the end of May and four times in June. Apart from the week before he was discharged to her care in November, this was the only period in which she saw him reasonably often during his seven months in local authority accommodation.

4.4.6 During this period and early July the mother spoke on a number of occasions about how she would like to care for EY, but no definite plan was made in relation to this. She was encouraged to increase her level of contact, but did not do so and she did not attend EY's second LAC review on 21 July. The social worker took legal advice and was advised to set out a timescale for decision making with the mother in order to avoid undue delay for the child.

4.4.7 On 22 July the mother expressed her continuing difficulty in making a decision, though she admitted that when she was not

with EY she did not think about him and saw no need to make a decision rapidly. On 30 July and 2 August the mother indicated (on the phone and in a text message) that she had decided that she definitely wanted to give EY up for adoption. No action was taken in relation to this during August (when the mother was on holiday with her family) and a further adoption counselling session was fixed for September. It was only in September that discussion began about the arrangements for an adoption medical (planned for November) and an adoption panel meeting (in December 2010).

4.4.8 Legal services records show that updates were requested by a solicitor twice during this period (in mid August and mid September). The local authority made a decision in principle on 14 September to tell the maternal grandparents about the birth of EY because his mother had now agreed that she wanted to relinquish him for adoption. The mother confirmed on 12 October that she wanted to proceed with the adoption, even if her family offered support in caring for EY.

4.4.9 The mother continued to delay telling the maternal grandparents. After some delay the social worker forced the issue and informed them on 4 November. It is not clear what discussions took place between the mother and her parents but almost immediately she decided that she wanted to care for EY. This decision was made between the mother and her parents and the social worker played no active role. The social worker made no record of the grandparents' reasons or motivation. EY was placed in his mother's care on 19 November following a planning meeting and a short series of visits to the foster home.

<u>Delays in reaching decisions and taking action in relation to adoption</u>

4.4.10 Based on this summary of the key events it is self evident that there was undue delay in making and implementing decisions and in the provision of services. There are a number of reasons why this happened.

4.4.11 Misunderstanding between two managers led to a delay in the referral for adoption counselling. One manager assumed that a verbal request had been accepted while another had expected an electronic referral for the service. The individual management review of social care services indicates how this will be avoided in future and makes a recommendation in relation to this.

4.4.12 After the allocation of the case to the new team (following the first review) there were a number of periods when there was considerable drift in the case. It is accepted that during June the mother showed signs of ambivalence about whether or not to care for EY. She visited him about once a week. This was more than at any other time but it was hardly an indication of a strong desire to look after him. She signalled a lack of interest in him by ceasing visits at the end of June and then by not attending his looked after review on 21 July. In early August she confirmed her decision to relinquish EY for adoption and went away for a month. No significant action was taken during this period and when the steps in the proposed adoption were pencilled in during September the timescale was protracted. This is attributed to the fact that the social worker was given no supervision between 2 August and 10 September due to leave arrangements. There were a number of periods when after receiving advice or decisions had been reached, the social worker took a long time before acting.

4.4.13 Having achieved some clarity as to the mother's intentions in late July the issue of adoption was briefly re-opened by the adoption counsellor in September. Then the mother confirmed that she definitely wanted EY to be adopted, regardless of her parents' views. There was then a delay of almost two months while the mother overcame her inhibitions about informing her parents.

4.4.14 It is clear that on a number of occasions the local authority allowed its intervention to be unduly influenced by the pace at which the mother felt able to move and did not act at a pace that was consistent with the best interests of EY. The records and the management review strongly suggest that this was largely due to

the inexperience of the social worker. She was not confident about what to do. Arrangements were made for her to receive practical guidance from her supervisor and more experienced colleagues but they did not result in the action required being taken. The poor quality of the supervision and support provided for her is discussed further in the sections dealing with supervision and training (Section 4.10).

4.4.15 The legal advice given in the email of 1 October 2010 (see section 3.89 above) may also have contributed to this drift because it placed undue weight on the need for the mother to agree to her parents being involved and consulted. This advice was at odds with the correct legal position as understood by the SCR which is that the action of the local authority should always be determined by what it judged to be in EY's best interests and that in some circumstances this might require consulting with members of the extended family without the consent of, or even against the wishes of, the mother.

4.4.16 The thinking of the local authority in relation to the role of the grandparents lacked clarity. It should have been clear from an early point that whatever the decision of the mother about adoption, the grandparents needed to be informed about the birth of EY. If he were to be cared for by his mother then the grandparents would know and they would need to be able to support the mother practically and emotionally. If EY was to be adopted careful consideration needed to be given to informing the grandparents, not least so that they could consider whether they or other members of the family could care for EY. The view of the social worker was that the grandparents were potential carers. Even if this were not an option then legally there might also be other important factors which would point to the need to for the grandparents to be involved (for example EY's right to have knowledge of his family, questions of contact etc). In due course an adoption panel would need to determine whether adoption was in EY's best interests. It would need to know that all of these

issues had been explored and that any proposed adoption match had taken these factors into consideration.

4.4.17 Reviewing the case history it is clear that the local authority treated the decision about adoption and the decision to inform the mother's parents as two separate issues: first the mother would decide on adoption and then the grandparents would be told what she had decided. The adoption counselling focused on the mother's views. The contribution of the extended family was viewed as being something that would come later. In practical terms these issues needed to be addressed in parallel because the attitude of the grandparents would inevitably influence the mother's attitude to adoption.

4.4.18 This is exactly what happened. As soon as the extended family knew about EY the mother was persuaded to care for EY.

4.4.19 It would have been unreasonable to expect a newly qualified social worker to have thought through this quite complex issue on her own, especially if this was the first adoption case that she had dealt with. This was a set of problems that her supervisor and the staff in the fostering and adoption service who were advising her should have recognised at a much earlier point. The failure to do so meant that for some months the actions of the local authority were heavily influenced by the pace at which the mother felt she needed to make decisions and not by the timescale that was appropriate for the child.

<u>The action taken by the local authority in relation to adoption, including the advice given to the parents</u>

4.4.20 The preceding paragraphs demonstrate that while the action taken by the local authority complied with the agency procedures there was undue delay in implementing the steps agreed. [32] The legal advice given on 21 July which emphasised the need for a timescale for further action to be fixed with the needs of EY in mind was correct and helpful, but it was not implemented. The legal advice given on 1

[32] CAFCASS (who would have had to take the mother's informed consent to the adoption in a prescribed format) was never contacted at all.

October placed too much emphasis on the need for the mother to agree that her family should be informed. This may have contributed to the drift in the case.

4.4.21 There are some more general concerns. Much of the legal advice given was given in emails, most strikingly the advice given on 1 October. This may have led to it being less well considered than it should have been. Much of the legal advice given was not recorded in the social care files (or it may have been stored in emails which were not attached to the main records). In so far as it can be reconstructed accurately the audit trail of emails suggests that more often than not it was the legal advisor who was taking the initiative and chasing progress. This should not have had to happen. Adoption law as it applied to this case is complex and leaves much to the discretion of the local authority, based on its assessment of the circumstances of the specific case. On many occasions it is unclear whether the social worker fully understood the advice that was given or received clarification from her manager.

4.4.22 Although it is not explicitly stated the evidence strongly suggests that throughout this period the local authority's actions were based on the assumption that the best option would be for the mother to look after EY with the help of her parents and some involvement from the father. The social worker certainly believed that this could happen. The starting point was a legitimate one based on the legal framework and research about outcomes for children. It was initially quite right for the mother to have the time to make a considered choice about adoption. There are sound ethical and legal reasons for this. There are also pragmatic considerations because consent not properly considered might be withdrawn at any point which can delay placement or the making of an adoption order considerably. The local authority had no evidence that OY had not been cared for properly.

4.4.23 Although the starting point of the local authority was correct, the conflict between the delay in making a decision and the best interests of EY had become apparent by the end of June 2010. Evidence about the mother's lack of interest in him and lack of contact throughout July and August accumulated and should have reinforced this. At this

point the focus of the local authority should have shifted to be exclusively concerned with identifying what was in EY's best interests and it should have been more decisive in implementing the plan for adoption that the mother had agreed to. The reasons are not clear but it is apparent from the records that key professionals in the local authority continued to think that the best option for EY would be to be cared for by his mother and wanted her to succeed in being able to do this beyond the time when an objective and dispassionate assessment of the circumstances would have pointed to the need for the local authority to pursue other options. The lack of interest and contact during July – August and the mother's agreement to adoption at the beginning of August should have been decisive. It remains unclear why the local authority did not at that point move ahead decisively with the planning for adoption.

4.4.24 The inexperience of the social worker and the poor quality of the supervision provided to her were clearly significant; the character and personality of the mother may have been important (as they were in relation to the response to the injuries to EY described above). Staff and managers had a sense that this was 'history repeating itself' and that events would follow the same course for EY as they had with OY.

4.4.25 It is also important to recognise that the situation which the local authority was dealing with was not commonplace. It is highly unusual for a healthy newborn baby to be relinquished for adoption in circumstances where the child is not believed to be at risk of harm. Indications are that in the East Berkshire area this might happen once or twice per year and that there are usually specific cultural and religious factors [33] involved, which did not apply in this case.

4.4.26 <u>Was sufficient attention given to the potential difficulty of the reunification of EY with his mother?</u>

4.4.27 The report will use the term reunification although EY had been accommodated since birth and his mother had never cared for him. The understanding of the local authority in November 2010 when the mother stated that she wanted to care for EY was as

[33] For example a mother with a religious objection to the termination of an unwanted pregnancy might have a clear wish to relinquish a healthy infant from a very early point.

follows. He was developing normally and had no special health needs. He was sociable and outgoing and was viewed as being a child whom it would be easy for other carers to look after. It was believed that the mother had been through a similar process in relation to OY, but her doubts about caring for OY had been overcome. If she did not want to look after EY it was in large part because the father had been 'domineering'. EY's mother had successfully looked after OY with the help of the father and grandparents and there was no evidence that he had come to harm. No complexities or risks were recognised.

4.4.28 However there were equally a number of complicating factors that were not recognised as being significant. The mother had denied or concealed two pregnancies. There was no evidence of overt mental health problems, but the two concealed pregnancies may have been evidence of psychological conflicts or problems in family functioning and communication which the mother had not been able to resolve. The mother's indecision over OY had been quickly resolved and she took him home from hospital aged 3 days. Even then the only recorded reason might be considered unusual (she had noted that OY shared a birthday with his grandmother) and the significance of this was not explored. This was very different to the position in relation to EY whom the mother had never cared for and not visited for long periods. Repeated comments gave a strong indication that she often had little interest in him and she had twice said (without there being any evidence of pressure from the father) that she did not want to care for him. It is a challenge for anyone to take on the care of a seven month old baby such as EY who was beginning to form attachments to its main carer and to actively explore the world. This is recognised by the careful way in which adopters and foster carers are selected and supported and in which children are introduced to new carers.

4.4.29 None of this assessment relies on the benefit of hindsight. The differences should have been obvious. Everything that has been

listed in the preceding paragraph could and should have been recognised at the time. All of the knowledge set out above should have been commonplace for experienced social care social workers (such as those in the fostering and adoption service) and the social worker's supervisor.

4.4.30 It was also wrong to equate what had happened with OY and assume that the same would apply to EY. It is important to recognise that every infant has an individual temperament and personality and different children often have a different meaning for their parent or caretaker. An early review of serious case reviews suggested (albeit speculatively) that the meanings which some carers attribute to individual children can lead to them being singled out for abuse, in contrast to siblings who are relatively well cared for. [34] It is not known what specific meaning EY had for his mother. No one asked, but clues might have been obtained by a skilful worker.

4.4.31 The approach that the local authority took followed from the underestimation of the complexity of reunification in this case. It was agreed that EY would move to his mother's after a short number of contacts which were supervised and assessed only by the foster mother. The social worker played a very passive role in this and as far as can be established she did not observe or participate in any of the contact sessions that took place before EY went home. She knew how things were going only through her phone contact with the foster mother. There is no record of contact (even by phone) with the mother until after EY moved home, though this may reflect gaps in recording. The foster carers' supervising social worker had one phone contact with the mother.

4.4.32 The contact sessions gave an indication of concerns, such as the evidence of the mother's difficulties in interacting with EY and managing EY and OY at the same time. Given the very limited

[34] Reder, Duncan and Gray (1993) *Beyond Blame: Child Abuse Tragedies Revisited,* Routledge (pages 52-59 in particular)

contact that she had previously had with EY it is not surprising that the mother had difficulties. The evidence is that these were noted but that their potential significance was not understood. There is no indication of any discussion with the supervisor about the progress of the reunification. There was no supervision session between 2 November and 3 December – though it would be safe to assume that the progress of the case was discussed less formally. It is clear that there should have been a more protracted series of contacts and a fuller assessment of the circumstances, based on a more realistic understanding of the potential difficulties.

4.4.33 There is now an increasing body of research indicating how complex the return of children to their families after a considerable separation can be.[35] In Farmer et al's study of 180 reunifications of looked after children, 47% had broken down within a 2 year period, and a third of those remaining at home were receiving care of a 'poor quality'. Key lessons from the research were that:

- Early and prolonged separation can affect parental bonding
- Success is associated with careful preparation and plan of support and behaviour management, regularly reviewed

In this case some specific negatives could have been identified. The mother had never looked after EY and by denying his pregnancy had missed the opportunity to form an attachment to him in the antenatal period (for example through seeing scans and preparing psychologically and practically for the baby).

4.4.34 Careful thought was needed about the mother's ability to be open and honest with professionals about her feelings in relation to EY. The history of two concealed pregnancies demonstrated that (for

[35] For example Farmer, E., Sturgess, W., and O'Neill, T (2008) '*Reunification of looked-after children with their parents: Patterns, Interventions and Outcomes*", Research Brief for DCSF, October 2008. (University of Bristol), it is recognised that not all of the lessons from research are relevant because EY had not been directly harmed by his mother before separation, however many of the lessons about attachment and separation apply. I am grateful to Sally Trench for bringing this research to my attention

psychological reasons that remain unclear) she was unable to deal with conflict or confide in others when she faced serious difficulties. More reflective discussion between the practitioners and supervisors might have predicted that the mother would be very unlikely to confide in professionals or be open with her family if problems did develop. So far she had coped with her problems by denying them to herself and concealing them from others.

4.4.35 Farmer's study recommends that local authorities consider the value of skilled and purposeful social work to support reunification practice. Such practice was absent in this case and it is recommended that the local authority develop a plan to ensure that all relevant staff are made familiar with relevant research and able to apply it. Other agencies who may be involved in the reunification of vulnerable children should consider how relevant staff can be made aware of the complexity of reunification of looked after children so as to be able to contribute to discussion and decision making.

4.4.36 It is important to note that even if there had been a thorough assessment of risk and needs the local authority would have had no grounds to prevent the mother taking over the care of EY. However careful observation of the transfer of care would have provided a solid basis for deciding if there were any risks and how EY's needs would best be met over the following months. A coordinated child in need plan would have allowed his progress to be monitored and reviewed and would have ensured that there was a single point of contact for all of the agencies who became involved.

4.4.37 Health professionals were not consulted about the plan to move EY to his mother's. EY's existing health visitor was not invited to the planning meeting, though she was told about the decision. There was no coordinated plan to inform all of the relevant health professionals about the discharge of EY from care. Had this happened it would have assisted in the judgements that they later made about EY.

4.4.38 The looked after children health team played no active role at this time and it appears that the team only acted when officially notified of the discharge some weeks later (apparently through its systems / IT section). The team had no role in the discharge, because its role was limited to overseeing the provision of children who are looked after. Given the lessons learnt it would be wise to review the role of this service to consider whether it is possible to expand its brief to include children who are ceasing to be looked after and discharged to friends or family. In this case it would have been extremely valuable if someone had had the responsibility to ensure that all of the relevant health professionals involved with the family were identified, that they all had relevant background information and that they all knew what the plan for the child was going to be. The SCR will recommend that the local authority and health commissioners review the role of the looked after children health team to ensure that suitable health arrangements are made for children who are discharged from care as well as those who become looked after.

<u>The decision of the local authority to close the case</u>

4.4.39 The decision of the local authority to close the case was entirely consistent with the assessments that had gone before it and the underestimation of the likely needs of EY that had marked the end of his period looked after by the local authority.

4.4.40 The social worker made two visits to see EY with his mother and OY after he returned home (on 24 November and 15 December). The observations recorded on both occasions were largely positive. The mother stated that she was following the foster carers' routine and that the father was visiting and being helpful. OY was noted to have attempted to hit EY on the head and the mother prevented this and showed him how to treat EY gently. The mother claimed that her family were being supportive and that she was introducing EY to her friends. No further details were ever obtained of the role of family and friends.

4.4.41 At the second visit EY was noted to have a couple of scratches on his face which were said to have been caused by OY. This explanation was accepted without further enquiry. Although this explanation was consistent with the behaviour that the foster carer had previously observed this was a potentially concerning presentation about which the social worker should have been more curious.

4.4.42 The case was closed on 22 December in the belief that the plan to unite EY with his mother had been successful. The local authority did not notify other agencies that the case had been closed. The lack of communication with other agencies is discussed further in section 4.6 below.

4.5 Focus on the child

- *Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse and neglect, and about what to do if they had concerns about a child's welfare?*
- *When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?*

Observation of the children to identify needs and risks

4.5.1 Given the ages of the children establishing their wishes and feelings through discussion was not possible. Professional practice should therefore focus on accurate and thoughtful observation of the children and discussion with carers in order to identify their needs and the ability of their carers to meet them.

4.5.2 Observations of OY while in the care of his mother and father was largely positive and gave no cause for serious concern. OY put on weight very rapidly and this was monitored by his health visitors. His mother was encouraged to attend fitness and healthy eating sessions at the children's centre which suggest that it was believed that this arose due to lack of knowledge about diet and exercise.

4.5.3 Observation of EY while living in foster care were all very positive, reflecting the very good care that he was receiving and the attachment that he was forming with his foster carers.

Professional understanding of possible indicators of abuse and poor parenting and the action required

4.5.4 Section 4.4 above deals in full with the possible indicators of possible physical abuse and poor parenting noted by health professionals, children's centre staff and the social worker. A number of professionals failed to recognise potential indicators of abuse or to act on them in a way that was in keeping with the vulnerability of EY.

4.5.5 Staff in the children's centre noted their concerns about more subtle signs of emotional abuse and poor attachment (for example the fact that EY was left in his pram with the cover pulled up facing the wall and away from the activities in the centre). However they interpreted these in the light of the mother's statements that EY was her cousin's child. They believed that the mother needed help to be a better child minder, and this is why she was referred to a parenting programme. Because they had been misled they did not realise that this was a sign of possible poor attachment to the mother's own child. They were not to know that the foster carer had noted and reported similar concerns (the mother not making eye contact with EY and keeping him facing away from her).

4.5.6 As well as noticing the bruises on EY the parents of other children who attended the centre raised concerns about the mother's lack of warmth and responsiveness towards him and about him being uncharacteristically quiet. These parents had considerably more contact with EY and his mother outside of the Stay and Play sessions at the centre and so had the opportunity to observe the interaction over a longer period of time and in a number of different settings. It was unusual for other parents to raise such specific concerns about another parent with centre staff. The centre staff appear to have recognised this and that the other parents were breaking a trust with the mother by going behind her back and raising their concerns with professionals. However as has been described in section 4.4 above the action they took in response to their concerns and those of the other parents was too limited.

A final, poignant clue about the mother's lack of interest in EY is contained in the PCHR. The standard booklet has pages on which parents are able to note developmental milestones in relation to movement, fine motor skills, speech, social interaction and attachment of the infant. On most pages the parent has only to add in the age at which their child accomplishes something; one page invites information about the child's

favourite games and nursery rhymes. The record is comprehensively completed by the foster carer, but there is only one entry (referring to EY crawling at 10 months) after his mother took over his care. It is unlikely that any busy professional would have looked at this section in the PCHR, which is clearly intended for parental use. In this case it contained additional subtle evidence of the mother's lack of attachment to EY.

4.6 Information sharing

- *Were there any issues, in communication, information sharing or service delivery, between those responsible for working during normal office hours and others providing out of hours services?*

The transfer of information and records between GP practices

4.6.1 The slow transfer of medical records between GP surgeries and the time taken to summarise them at the receiving GP practice is significant in the case history. The slow transfer of EY's medical records from one GP practice to another may have adversely affected the way in which his GP was able to carry out his safeguarding responsibilities.

4.6.2 The mother registered herself and OY at a new surgery in early June 2010. She had been a patient at the same GP surgery since childhood, though there was little significant information held about her until she had her first child. The new surgery was nearer her home but her reasons for transferring at this time are not clear as she had moved house the previous November. Her reasons were not established at the time and she was acting within the normal parameters of 'patient choice'.

4.6.3 Following the transfer OY's records arrived from the previous practice on 30 September 2010 (over 3 months later) and were summarised. The transfer took longer than is normally expected, though there is no evidence that this had any impact on the outcome of this case.

4.6.4 The mother's records had not arrived at the time of EY's death in March 2011 and were only transferred when they were chased by the practice in April 2011. The reasons for this delay have not been established. As a consequence any GP consultations with her would have taken place without the benefit of notes. Her records would not normally have been consulted when the children were seen so the failure to transfer the notes would not have made a critical difference to treatment or outcomes in this case.

Nevertheless in other cases it might – if for example a parent suffered from a mental illness which was impacting on parenting.

4.6.5 The mother registered EY at the same surgery on 1 December 2010, two weeks after he moved to live with her. The records were received 2 months later and had not been summarised at the time of his death in March 2011. This may have made an important difference to the safety of practice with him because when he was seen with bruising on 19 January 2011 the GP relied entirely on the information in his Personal Child Health Record and he had no other background information. EY's previous medical records contain very clear references to him having been in foster care. [36] If properly summarised this information would have been included in the computer summary of his records which is opened whenever a patient is seen. This might well have influenced the actions of the GP who identified bruises.

4.6.6 In the light of this the SCR has sought to understand in detail what the arrangements are for the transfer and summary of GP records. In Berkshire GP records are transferred from one practice to another through the Thames Valley Primary Care Agency (PCA), responding to patients' changes of GP practice. Patients register at the practice of their choice and the process of record transfer can only begin when the practice receiving the patient asks the PCA to obtain the records. According to the management review of primary care involvement, the process of recalling the records from the previous practice and sending them to the patient's new practice takes approximately 3-8 weeks when there is an internal transfer of notes within Berkshire. Transfer from further afield takes longer. On receipt the practice is required to summarise the

[36] The primary care IMR underlines the full extent of the information that would have been readily available if the records had been transferred within a reasonable timescale summarised: *On review of the GP records EY's records were clearly summarised as 'looked after' as an active problem on the front computer page in the GP records of the first practice he was registered with. There was a copy of the Health Care Plan in the records from the initial health assessment on 2/06/10 done by the Berkshire East Health Team for Looked After Children and Young people. The foster carer was to facilitate attendance for routine immunisations and relevant developmental checks.*

notes within eight weeks from the date of receiving them. Arrangements for summary are the responsibility of individual practices. GP notes are usually reviewed by a member of the surgery team who has nursing or medical secretary background. The purpose is to ensure that significant information is entered onto the computer records of the current practice.

4.6.7 Some practices transfer information electronically via a national system called GP2GP which enables the immediate transfer of computer records. Currently in Berkshire about one third of records are transferred through this system. Both surgeries have to be registered for this access and they must use compatible brands of medical record software. The management review indicates that work is being undertaken by the NHS in Berkshire to increase the participation of Berkshire surgeries in this system.

4.6.8 The gap of 14 weeks between the registration of EY at a new surgery and his death during which his notes had not been summarised was permissible and probably not unusual within the current arrangements. There is no reliable information to indicate how typical it might be but it is clear that the GP author of the individual management review of primary care services did not find it surprising.

4.6.9 The view of the SCR is that this case history demonstrates that current arrangements for GP record transfer are not 'fit for purpose' in relation to the protection of vulnerable children. Most adult patients with complex medical conditions can bring their needs to the attention of their GP or have carers who are motivated to do so. Vulnerable children will not have made the choice to change GP practice and cannot articulate their needs in the same way. Vulnerable young infants cannot ask the new GP to get their records quicker and check for significant history. Many of the parents of vulnerable children will not be motivated to ask for records to be obtained and will not bring relevant information to the attention of the new GP. Some parents will move house and

change GP deliberately in order to avoid continuing contact with services.

4.6.10 The specific concerns in this case need to be put in the wider context of findings from SCRs about the strong association between serious child abuse and families who move frequently. Such families are hugely over represented in cases subject to SCRs. Moving frequently is likely to be in part a symptom of other risk factors (such as unemployment and poor access to housing) but it also exacerbates the other risk factors in a case by disrupting professional knowledge of children and involvement with them. The national review of SCR findings for 2003 – 2005 states that *'the most startling environmental feature was the number of families who were noted in reports to have moved frequently (more than a third of the intensive sample). The need to locate and protect children more robustly in these circumstances was exemplified in many of the cases.'* [37] *(page 47)* The follow up study of SCRs 2005 – 7 noted an even higher representation with '*evidence that almost half of the children and young people (45%) had moved numerous times'* (page 42). [38]

4.6.11 The movement of families and the slow transfer and summary of records may leave children at risk but also means that GPs are left professionally vulnerable because as this case so clearly demonstrates they are working with incomplete information. As well as being in the interests of vulnerable children it is in the direct interests of every GP in the country to take action to resolve these problems and to press for the policies and practices of all relevant departments and services within the NHS to be amended. Action is needed at a number of levels:

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[37] Brandon M, Belderson P, Warren C, Howe D, Gardner R, Dodsworth J, and Black J (2007) Analysing child deaths and serious cases through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005. DfES

[38] Brandon et al, (2009), Understanding Serious Case Reviews and their Impact a Biennial Analysis of Serious Case Reviews 2005-07 DCSF

- a higher standard should be set for the transfer and summary of children's medical records. For the reasons given in the preceding paragraph there are good practical reasons for GP surgeries and the NHS to prioritise the transfer and summary of children's records
- in Berkshire specific targets need to be set for the take up of the GP2GP system and progress needs to be reported regularly to senior managers in the NHS and to the LSCB
- other agencies may need to take action to mitigate the risk that arises in relation to children who have been subject to child protection plans or looked after by the local authority. In such cases the looked after children's health team needs to play a more active role and other professionals need to ensure that they have sent relevant information directly to the new GP

4.6.12 Training and briefing sessions arising from this SCR should emphasise:

- the vulnerability of GPs who do not take steps to improve their systems for transferring and summarising children's records
- the need for other agencies to recognise that they may need to take into account the fact that when families with vulnerable children have recently moved the GP may be working on the basis of partial information [39]

4.6.13 The action that can be taken locally will have little or no impact when children move across health borders and the SCR will make a national recommendation to the Department of Health on this matter so that it can address the problem at a national level.

<u>Other aspects of information sharing between health professionals</u>

4.6.14 The father had a different GP to other family members. Section 3 of this report notes that the father's GPs treated his reaction to the concealed pregnancies and the birth of two children as potential mental health problems in isolation from the wider family

[39] For example social workers need to be mindful of this when undertaking child protection checks or when a child subject to a child protection plan changes GP

context. The GPs did not show any curiosity about the children involved and did not share any information or make any enquiries with the local authority or other health professionals. An honest appraisal of this however is that it would be very unusual for a GP in these circumstances to do so, unless there were very serious immediate concerns. This does represent a missed opportunity to share information which GPs can learn from.

4.6.15 Sections 3 and 4 of this report have noted that the assessments carried out in the midwifery and obstetric services were superficial and that professionals dealing with the second birth did not have access to information about the pregnancy and birth of his older brother from previous births. The individual management review has noted the lack of useful information highlighting risk factors and unusual circumstances contained in discharge summaries to GP and health visitors. It has made recommendations on this which the SCR endorses.

4.6.16 Sections 3 and 4 of the report highlight the lack of communication between health visitors and GPs except on the occasion when the GP asked EY's health visitor to advise the mother on management of sibling rivalry. On this occasion the health visitor failed to tell the GP during their discussion on bruising that EY had been looked after. It is not clear whether she had this information to hand during the discussion, though she must have when she saw the family.

4.6.17 Earlier sections of this report have identified missed opportunities to share information between the two health visitors involved before his discharge from care and after. The details are fully set out in the BECHS management review:

When the previous health visiting team were notified by the LAC health team that EY had moved, the records were not forwarded to the receiving team…. From the perspective of the receiving health visitor *'there was no communication with EY's previous health visitor and his records were not requested; family contact was documented in his mother's record' (paragraph 5.5.7)*

It is clear that both professionals should have recognised the need to transfer the records as a matter of urgency and in a case which had complexities there should have been phone communication. The reasons for this shortcoming in the service have not been identified, but section 4.11 below will examine more general concerns about the lack of capacity in the health visiting services and the impact that this may have had.

Information sharing between agencies

4.6.18 The SCR has identified six occasions on which local authority missed (or delayed) opportunities to notify health professionals of significant developments and to enable health colleagues to become involved in planning and decision making. (1) There was no discharge planning meeting before OY was discharged from hospital. Both hospital staff and social care staff could have taken the initiative to convene such a meeting. The social care management review rightly recognises that '*it would have been more appropriate if at the point of (hospital) discharge, a multi-agency planning meeting had been arranged, which would have afforded a forum that potentially could have explored, or highlighted the need to further examine the implications of a concealed pregnancy*'. This would have required that other professionals were alerted to the significance of the concealed pregnancy and to have recorded and shared their observations in a more systematic way.

4.6.19 (2) The local authority notified the LAC health team that EY was in foster care on 11 May 2011. This was 19 days after EY became looked after. This is discussed further in paragraph 4.6.22 below.

4.6.20 (3) Other agencies were not notified of the outcomes of the initial assessments of OY or the decision of the social care service to close the case. This was said to be because of a lack of capacity in the service at the time. (4) The same occurred in relation to the second initial assessment of OY. (5) Health professionals were not consulted or involved during the process that led to the placement

of EY with his mother. EY's health visitor was not consulted about the likelihood that EY would be moving to live with his mother. EY's new health visitor was told about the plan on 12 November but not involved further in assessment or discussions. There was thus no agreed plan of support and follow up between the two agencies. (6) Following EY's discharge home to his mother the social worker and the family health visitor did not communicate with one another.

4.6.21 Taken individually some of these episodes could be explained by factors (such as the lack of resources). Some are consistent with the overall underestimation by the local authority of the possible complexity of the case. However taken as a whole they form a worrying pattern, bearing in mind that no manager or quality assurance system identified any of these episodes as being a concern. This suggests that some staff and managers may have underestimated the value of consulting colleagues in other agencies and informing other agencies what action the local authority is taking. This is potentially harmful if it leaves other agencies believing that the local authority is still involved in dealing with a case when its involvement has actually ceased. The local authority needs to be satisfied that this is not a more widespread problem.

<u>The role of the looked after children's health team</u>

4.6.22 The agreed East Berkshire Integrated Care Pathway system requires that social care notify the LAC health team within five days that a child becomes looked after. Notification consists of a completed notification form and a signed consent for LAC health care. In this case the LAC health team became aware that EY was in foster care following communication from EY's health visitor (who had discovered it fortuitously at the GP surgery). Official notification was not received until 11 May 2010; 19 days after EY became looked after. This could have resulted in late provision of LAC health services and a late medical assessment. EY's GP was

officially informed of his looked after status by fax on 21 May 2010 (a delay of a further 10 days).

4.6.23 While EY was looked after his health needs were appropriately addressed. The LAC health team were notified that EY was to move to live with his mother and brother on 12 November 2010. On 22 November the team received a further message from social care that the pre-adoption appointment arranged for that day was to be cancelled as the mother was taking EY home. The team only then communicated the plan for EY to live with his mother to the health visitor who had been working with EY on 10 January 2011 by email. She already knew this.

4.6.24 The BECHS management review comments that '*there was evidence of liaison between the health visiting team and social care and the LAC health team and social care'*. The social care review makes no specific mention of communication with the LAC health team. Close examination of the reports and the chronology indicates that while the LAC health team was effective in its responsibilities towards EY whilst he was looked after (for example by arranging and conducting his LAC medical examination) it played only a marginal role when he ceased to be looked after. In relation to his discharge from care the LAC health team played no role in ensuring that all of the health professionals who were to be involved had access to all of the relevant information.

4.6.25 Until now the scope of responsibility of the LAC health team has been limited to the health of children who are looked after. This reflects the exclusive focus of guidance on the health of children who are <u>in care</u> rather than the health and safeguarding of young children <u>who are being discharged from care</u>. For example the extremely extensive NICE guidance [40] on the health of looked after children and the associated self assessment tool do contain references to placement of children on care orders with family (because services and support tend to be poorer than in foster

[40] NICE (2010) *Promoting the Quality of Life of Looked after children and young people,* NICE / SCIE public health guidance No 28

placements) and to children leaving care age 16-18 (mental health support for adolescents, transition to adult services etc). However they do not address the sort of simple, practical issues that were relevant in this case history - such as the need to notify all the health professionals involved when a child is discharged from care and make sure that they know relevant history and are involved in the child in need plan.

4.6.26 It is clear from the findings of this SCR that – taking particular account of the slow movement of records between GPs and the poor communication between health visitors – there would be considerable value in reviewing the remit of the LAC health team so as to consider whether it can take more responsibility for 1) identifying all of the health professionals who need to be notified of the fact that a child is ceasing to be looked after and 2) sharing key information with them. The SCR recognises that broadening the remit of the team might require additional resources or different use of resources. It also recognises that regardless of the remit of the team and the procedures that are in place the successful performance of all tasks will rely on close working with allocated social workers who need to appreciate the importance of there being a coordinated health input to children who return to their families after being looked after.

4.7 Factors that impeded engagement

- *Identify factors that helped or hindered the engagement with the family*

4.7.1 The narrative in section 3 of this report shows that professionals achieved only a very superficial understanding of the lives and history of the individuals with whom they had contact. This has been emphasised in the health overview report but it applies equally to other professionals as well. The result is that – with the exception of the period when EY was in foster care - none of the records of the professionals involved or the interviews with them conducted for the SCR process give any detailed knowledge of the daily lives of EY and OY and the care that they received.

4.7.2 The principal reason for the very superficial engagement of the family with professionals. The social worker undertaking the adoption counselling with the mother did point out to her that she had a tendency to deny or disassociate herself from anything that she found difficult. With this exception the professionals involved did not appreciate that it was necessary to seek a closer or more challenging engagement with the mother and other members of the family. This was because professionals largely underestimated the potential complexity of the circumstances that they were dealing with and the potential concerns. The details of how and why this occurred have been set out to the extent that it is possible to do so at this point in section 3 and section 4.3 (dealing with assessment).

4.7.3 Specific opportunities to understand the tensions and conflicts that surrounded the concealment of two pregnancies and the unexpected births of two infants were missed. The only member of the family who gave a frank account of how the birth of the children had affected him was the father. When he gave accounts to his GPs they were not shared with other professionals involved. When he spoke to social care staff his frankness and the strength of his feelings were interpreted as him bullying the mother who

was much younger than him and perceived as being more vulnerable.

4.7.4 Shortcomings in professional practice occurred within an organisational context which sometimes made it more difficult for professionals to engage with the family. Sections 4.2 – 4.12 of this report sets out the findings of the SCR in relation to these. Rather than repeat these findings (or anticipate them in detail) this section of the report will highlight some of the key findings and point out why they made engagement with the family more difficult.

4.7.5 There was a pervasive belief among social care staff that it would be beneficial to EY to be united with his family and no risks were identified in doing this. This was not challenged from within the service. This has been discussed at length in section 4.4 above. Sections 4.9 and 4.10 deal with the skills and knowledge of staff, their training and supervision. Professionals in other agencies were not concerned with decision making about EY's future in the same way but there are also concerns about the skill and knowledge that they brought to bear.

4.7.6 The lack of capacity in the health visiting service impaired engagement with the mother and opportunities to reflect on the circumstances faced by staff and the history. This is discussed in detail in section 4.11. This section of the report also evaluates in detail the impact of the settings within which some staff operated – with particular reference to the child health clinic and children's centres.

4.7.7 On a number of occasions professionals might have engaged more effectively if they had had access to relevant information that might have influenced their decision making. This is considered in detail in section 4.6 which deals with information sharing.

4.7.8 Contact with family members may shed more light on their attitudes and beliefs. If at a future time there is an opportunity for direct contact with family members there may be scope for more

learning for the SCR. However it is also apparent from the case records and from interviews with some staff that the character, personality and background of the mother played a significant role at key moments in the case history. She maintained a polite but extremely superficial level of engagement with most of the professionals that she encountered. The relatively comfortable economic circumstances of her and the family may have played a part in shaping the response of professionals. This is considered in section 4.12 dealing with 'diversity'.

4.7.9 It must also be recognised that the mother deliberately and persistently deceived other parents at the children's centre and the staff there as to the identity of EY and her relationship with him. The evidence strongly suggests that she repeatedly gave false accounts of the cause of EY's injuries, while at the same time bringing EY to settings where his injuries would be noticed. At this point it is not possible to fully understand what her reasons were for acting as she did or the different factors that may have shaped her behaviour. However it is clear that the mother's compliance with many services disguised poor parenting and a high level of risk to her younger child.

4.8 Policies and procedures

- *Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?*
- *Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?*

Single and multi-agency safeguarding procedures and guidance on the bruising

4.8.1 Local multi-agency child protection procedures contain guidance on how to respond to safeguarding concerns, including bruising. They specify that '*any bruising or other soft tissue injury to a pre-crawling or pre-walking infant or non mobile disabled child'* or '*bruising around the face' …'must be considered as highly suspicious of a non-accidental injury unless there is an adequate explanation provided and experienced medical opinion sought'.* [41] The relevant section of the procedures is included as Appendix 8.

4.8.2 However carefully written and crafted, the wording of procedures can always be improved. However these procedures leave the reader in no doubt as to the particular vulnerability of young infants and the potential significance of bruising. Bruising on the face of a 9 – 11 month old child requires referral to the local authority and detailed evaluation by a doctor with expertise in child protection.

4.8.3 With one exception the individual management reviews confirm that the staff had access to the local interagency child protection procedures and that all of the staff involved had attended multi-agency or professional training which underlined the importance of messages about the significance of bruising in infants. A number of SCR panel members and management review authors were able to confirm details of the training provided, in particular training for

[41] Berkshire Child Protection Procedures (section 5)

health professionals in late 2010. There is no doubt that these messages had been strongly underlined.

4.8.4 The review of provision by family support services indicates that the children's centre child protection policy was inadequate in some respects, for example not indicating what arrangements should be made when the designated professional was absent. However these were not aspects of the procedures that impacted directly on this case. It is more likely that in relation to this service, members of staff had received insufficient training to carry out their responsibilities. This is discussed further in the section on training and organisational issues. The management review of family support services asks the SCR to consider providing more detailed guidance on thresholds for referral to the local authority. The view of the SCR is that this exists in the current multi-agency procedures and that further detail and reinforcement needs to come through training and management advice within the service. Access to multi-agency training would bring greater clarity about the roles and responsibilities of other professionals and referral arrangements.

4.8.5 The case history underlines that however sound procedures are they do not remove the need for individuals to exercise professional judgement. Referring to the existing procedures: what for example is an 'adequate' explanation for a bruise? The most important issues are (1) the way in which that judgement is exercised and (2) the context within which judgement needs to be exercised - an important component of which is the access to advice and additional information that informs the judgement. In relation to EY it was the manner in which professional judgement was exercised which gives cause for concern rather than the wording of the procedures. The case history demonstrates that on a number of occasions professionals were too willing to accept the mother's accounts of how bruises had been caused without remaining sufficiently sceptical and without taking further advice or seeking further information. In one instance a health visitor was

working in a setting which did not make it easy to do this. Whilst some revision or extension of the procedures might be helpful it is their implementation by staff in day to day practice which needs to be the main focus of learning and activity as a result of this SCR.

Professional initiative

4.8.6 Sometimes additional action is required which goes beyond what is written in procedures and cannot be anticipated in detail by written procedures. There is no procedure to say that a 7 month old who has lived in foster care since birth but is now being placed in the care of the mother should have a new birth visit and a full family health assessment akin to the one that a child would normally receive at 15 days. However it should have been within the professional experience and knowledge of the health visitor involved to recognise this. Procedures cannot be written to alert professionals to every conceivable unusual or unexpected circumstance.

The need for additional procedures and guidance

4.8.7 All of the individual management reviews recommend the need for additional multi-agency procedures to be produced dealing with denied or concealed pregnancy. This will assist local professionals by underlining the importance of denied and concealed pregnancy and by setting out minimum steps that are required or need to be considered. In particular the procedures should underline the importance of closer working in such cases between professionals involved in children's services and perinatal mental health services. The SCR endorses these recommendations and suggests that the work to produce brief procedures on this should be undertaken on a multi-agency basis.

4.8.8 The health management reviews indicate that there would be value in developing a more detailed 'pathway' for the management of bruising. The SCR endorses this and wishes to underline that this will be of value so long as it addresses the psychological barriers that may exist which make it more difficult

for GPs and others to recognise abuse and make referrals as well as the managerial and administrative aspects of the problem.

4.8.9 There are wider concerns highlighted by the case history which relate to the difficulty that many professionals had in considering the possibility of child abuse as an explanation for bruising and the ease with which they arrived at and accepted benign explanations for injuries to a child without being more sceptical and without consulting colleagues. These wider concerns need to be addressed through the continuing supervision and training that takes place in individual agencies and the LSCB and they cannot be addressed through specific procedures. The briefings and training undertaken in relation to this SCR need to underline the continual need for scepticism, caution and consultation before arriving at firm judgements. They will underline the need for continuing professional openness to presentations that do not fit the established picture of a 'high risk' case.

4.9 The skills, knowledge and experience of the staff dealing with the family

- *Establish whether staff and managers dealing with the family had the requisite skills, knowledge and experience to respond to the circumstances presented by the family.*

Staff levels of experience and skill, the training and support given to staff

4.9.1 Each of the individual management reviews comments in detail on the skills, knowledge and experience of the staff dealing with the case. The main issues arising from these evaluations are set out in the following paragraph.

Social work staff

4.9.2 The social care management review states that '*social workers and social care managers … were knowledgeable and had undertaken appropriate training about potential indicators of abuse and neglect'.* It goes on to state that the allocated social worker who was involved in the case from May 2010 onwards was newly qualified. It says that she received '*additional training and development opportunities … through a Newly Qualified Social Worker training programme'*. The management review details the content of this programme which seems to be very relevant, though it is not stated how much of this the worker concerned had completed. [42] It is stated that in addition an arrangement was made whereby she was '*supported in developing her knowledge concerning adoption through close liaison with experienced staff involved through the Fostering Adoption and Respite Service'* and it is understood that the relevant staff were easily accessible to offer advice.

4.9.3 In principle this would appear to be an ideal arrangement reflecting the lack of experience of the allocated social worker. In

[42] *Completion of CWDC Induction workbook, training on roles/responsibilities within the departmental structure, planning interventions, chronology, remaining child focussed/hearing the voice of the child, risk assessment and analysis, recording skills, Section 47 investigations, report writing and analysis, challenging skills, managing difficult behaviour, presentation skills, and assessment framework.* The worker concerned had not completed a number of key modules including recording skills (!), presentation skills, s47 investigations, and assessment framework, suggesting that she was allocated this case because it was considered straightforward

practice the evidence of drift in the implementation of plans, the failure to challenge the mother over her delay and the underestimation of the indicators of possible concern (all described in detail in section 4.3 above) strongly suggest that at her stage of professional development this individual worker did not have the skill and knowledge necessary to undertake the work with EY and his family. Perhaps the clearest symptom of this was the tendency to hold back from actively engaging in the case, for example by not visiting the mother and EY together during the period before the rehabilitation, relying only on the comments of the foster carer and not engaging directly with the grandparents to assess their role much more fully.

4.9.4 From the information that is available it is not clear how far this was due to her lack of experience or whether it is more significant that everyone involved in the case in the social care service adopted the basic attitude previously identified that it would be a positive outcome if EY were to be cared for by his mother and that there were no potential risks or complications in allowing this to happen. This points to the failure of her supervisor and other much more experienced colleagues to identify potential difficulties and to challenge the superficial assessments that were produced. Supervision and management involvement is discussed further in section 4.10.

Children's centre staff and managers

4.9.5 The management review of family support services addresses in detail the question of the skills, knowledge and training of the two members of staff involved.

4.9.6 The centre coordinator had been working in adult education and family learning prior to taking up her posts. This involved '*co-ordinating, designing and delivering training for adults to improve their basic skills*'. Nationally and locally this is not unusual in children's centre services because promoting the learning of parents, improving their ability to gain employment and helping

them learn how to support their children's learning and development have been important policy objectives. The management review recognises that in children's centres that do not provide nursery or child care '*the primary relationships … are with parents rather than children*'. It is suggested that although training was provided in early years development the lack of a professional background specifically within children's services may have impaired the capacity of the staff to safeguard EY. For example, this was the first possible child protection matter that the centre co-ordinator had referred to social care in her career. This would be unusual for someone with management responsibility in a children's setting. When she made the referral the manager assumed that she was taking advice from a qualified member of staff and she was surprised that she was not asked for EY's name. However she did not have the confidence to challenge the approach taken or to ask to speak to someone more senior. [43]

4.9.7 These are very specific examples that relate to the referral of concerns to social services. However it seems very likely that the coordinator's lack of experience in managing a setting attended by children contributed to a wider lack of focus on the needs of individual children. Examples include: the repeated failure to insist that the mother provided registration details of EY; the reliance on recording episodes of bruising in date order as 'incidents' alongside incidents about other children and parents, making it difficult to focus on the sequence of events for an individual child; and the lack of training of staff over safeguarding. The centre coordinator has subsequently acknowledged not feeling confident in her role as the designated person for safeguarding. A manager from a background providing services to children is much more likely to have regarded safeguarding training as an absolute priority.

[43] The local authority had also wrongly believed that the role of the Access Officer was widely understood. This is discussed in section 4.11

4.9.8 This is not to suggest that a manager from an adult learning background could not fulfil the responsibilities of a children's centre coordinator in a child centred manner. It indicates that other things being equal he or she would need additional training, support and monitoring to be able to do this. The individual management review recognises that more account needs to be taken of this in relation to the recruitment and training of centre coordinators in future. Because of its location the coordinator in this centre was also disadvantaged by being professionally isolated from others carrying out the same role who may have been able to offer useful peer support.

4.9.9 The children's centre worker had training in early years teaching and had previously worked in a role with families and children with additional needs. However for a number of reasons she had not attended the level one safeguarding training required for her post. This was in part due to a misunderstanding as to which agency was responsible for providing it but it is also stated that the centre coordinator did not give this sufficient priority because the centre worker's predecessor also received no specific safeguarding training. The centre coordinator also failed to ensure that information about basic child protection responsibilities was included in the centre worker's induction training so she had not been made aware of basic documents on safeguarding or the LSCB's policies or how to access them.

4.9.10 The family support service as a whole did not have sufficiently well organised arrangements for ensuring the take up of training The centre worker's lack of training had not been identified in the regular audit of staff training because staff lists were not up to date.

<u>Health professionals</u>

4.9.11 The individual management reviews state that the health professionals involved had the requisite skills, experience and training. The BECHS management review confirms that '*each member of staff involved with family was up to date with their*

safeguarding training'. The GP who examined EY two months before his death was regarded as being highly knowledgeable in relation to child health and all of the other GPs involved had attended relevant training in the recent past.

4.9.12 If key health professionals had relevant skills, knowledge and training then insofar as there are shortcomings in their performance attention must be paid to the wider organisational context within which they were working to establish whether there are factors which may have made it more difficult for them to apply this knowledge and skill in practice. The arrangements for GP record transfer and the reticence of the GP to identify child abuse have been discussed in section 4.6 above. Section 4.11 which deals with organisational and management issues will discuss the likely impact of the long standing under capacity of the health visiting service and the potential impact on the work of health visitors of working in some child health clinics.

4.10 Managements and supervision

- *Were senior managers or other organisations and professionals involved at points in the case where they should have been?*
- *Was there sufficient management accountability for decision making?*

Agencies and services in which there was no management or supervisory input

4.10.1 GPs do not receive supervision, though they are able to consult a named GP or a paediatrician colleague for advice about the safeguarding of children. None of the GPs involved in this case history did so. It would have been relevant for the GP to have sought advice when he identified the bruises on EY in January 2011.

4.10.2 Midwives operate as autonomous professional practitioners and do not receive supervision in the sense that most professionals operating within child protection services would understand it. [44] If they have concerns about safeguarding, midwives should consult the named midwife, but understandably this was not viewed as necessary in this case. In relation to both children appropriate referrals were made to the local authority. However the conduct and recording of midwifery assessments fell short of the standards required.

4.10.3 Health visitors are required to attend supervision over cases causing child protection or welfare concerns at least every four months (or when specific problems occur on cases). This case was never considered complex or concerning enough to be discussed in supervision.

Social care supervision

4.10.4 Records have been provided which show that EY was discussed in ten supervision sessions between the social worker and her manager during the period late May 2010 (when the case was allocated) and late December 2010 (when the case was closed).

[44] They are required to meet a mentor annually for the purpose of professional development and registration

The sessions were usually held three weekly but there were two gaps of approximately six weeks because of the annual leave arrangements of the social worker and her manager (these were from 2 August – 10 September and from 24 September – 3 November). The extended gaps are inappropriate for an inexperienced worker.

4.10.5 The individual management review states that the content of supervision (as recorded) focused exclusively on the practical tasks that needed to be undertaken. It notes that little attention was paid to exploring any potential risks or complexities in the case and that the supervisor did not challenge the positive assessments made by the social worker. Both the social worker and her manager appear to have shared the same set of positive assumptions about the potential for the mother to take on the care of EY.

4.10.6 In addition the review of the chronology and the sequence of decisions and actions by the social worker in section 3 of this report suggests strongly that the supervision was also not effective in ensuring that practical tasks were undertaken within the timescales agreed and required by the case. The evidence strongly suggests that the social worker struggled to understand the tasks that needed to be carried out. It is not clear if she understood the legal advice that she had been given. It also suggests that she lacked the confidence to engage members of the family in the positive and constructive way that was necessary or to challenge the mother's delay in consulting her family. The evidence available strongly suggests that the input of her supervisor failed to recognise and address these problems. No evidence has been provided to indicate that the performance of the supervisor involved is satisfactory across the range of his other tasks so it is not clear if this was an isolated episode.

Family support service supervision and management

4.10.7 The evaluation which follows draws on the findings of the individual management review. This offers a very detailed and thoughtful account of the arrangements for supervision that existed in the family support service. In particular it has sought to understand the nature of the supervision provided within the children's centre and between the centre coordinator and her manager and the impact that this may have had on the capacity of the centre coordinator to pursue the concerns about bruising on EY.

4.10.8 The arrangements for supervision of the children's centre worker are shaped by the nature of the service. The centre had one full time worker and one co-ordinator (working the equivalent of 4 days per week). It is clear that the concerns about EY were regularly discussed between the two members of staff either in weekly 'team meetings' or as they arose. Actions were agreed, at first for the worker to take in discussion with the mother and later for the centre coordinator to take forward to discussion with her supervisor. The incidents of bruising to EY would have been mentioned as part of a wide ranging discussion about all of the centre's activities and arrangements. So far as can be established the centre coordinator had information about all relevant developments and took responsibility for dealing with them. However there were shortcomings in the actions that she took (which are identified in sections 3 and 4.3 of this report) and in the action of her supervisor and her own line manager.

4.10.9 The Children Centres Programme Manager and the Children's Centre Coordinator had experience of managing universal services or parent focused services rather than services which held case responsibility for individual vulnerable children. The management discussions about EY reflect this experience. The Children's Centre Programme Manager was made aware of the concerns about EY in early February (when a pattern of injuries had emerged). She and the coordinator discussed the action that the centre coordinator should take twice during February 2010. Shortcomings in the

notes of her response make it impossible to know exactly what actions were agreed. The Programme Manager was sufficiently concerned to follow up her instructions a few days later, but again she made no detailed notes of the discussion and so it is not clear what further actions were agreed. The management review recognises that this was unsatisfactory and that in future senior managers in the service need to be trained to provide supervision on individual cases which is more akin to the safeguarding supervision that is provided in health or social care

4.10.10 During the period when EY was being discussed action was being taken in the family support service to address the perceived under performance of the centre coordinator. This had begun in August 2010. As a result of this she was given notice in early March that a formal review of her capability as a manager would be undertaken. On 9 March 2010 the centre coordinator resigned, giving two months' notice. The individual management review notes that the relationship between the centre coordinator and her manager deteriorated as a result of the monitoring that was being undertaken. It is suggested that this may have contributed to her failure to have a further discussion about the injuries to EY after 17 February. After the two discussions were held dealing with EY in early February there were no further discussions about EY between the centre coordinator and her manager after 17 February. At a one to one meeting with the coordinator in early March the service manager did not take further steps to find out what had happened in relation to EY. This meeting focused almost exclusively on the overall management of the children's centre service and the transitional arrangements that needed to be made following the coordinator's resignation.

4.10.11 Although the circumstances described are very specific, this analysis is valuable because it demonstrates that it is important for managers who are dealing with poor performance and wider management issues not to lose sight of concerns relating to individual children's cases while dealing with wider matters.

4.10.12 The management review makes a number of specific recommendations in relation to management and supervision which the SCR endorses.

Involvement of senior managers and professionals

4.10.13 The Programme Manager referred to in the preceding paragraphs was the only person more senior than a first line manager to know about the case. The case was not recognised as being one that carried any significant degree of risk and it should have been adequately managed through the normal supervisory and managerial arrangements in agencies.

Other action that may be required under agency management and human resources procedures

4.10.14 It is not the purpose of the SCR to evaluate the competency and conduct of individual staff members and professionals in the case history or to make recommendations in relation to this. However it is consistent with the functions of the LSCB to seek assurance that agencies have taken appropriate action if they believe that there is cause for concern over the competency or conduct of individuals who have been involved. As part of the process of finalising the SCR the LSCB has therefore sought assurance from the employing agencies and commissioning bodies involved that they have taken any action that they consider to be relevant in relation to professional conduct, disciplinary or competency procedures in relation to individual staff and managers and independent practitioners who were involved in the case history.

4.11 Organisational matters - the impact of resources, lack of capacity and other organisational issues

- *Were there organisational difficulties being experienced within or between agencies? Were these due to lack of capacity in one or more organisations?*
- *Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff sickness have an impact on the case?*

Introduction

4.11.1 This section addresses four wider organisational matters that the SCR believes had an impact on the services provided to EY and his family:

- the lack of resources in the health visiting service relative to demand for services
- the arrangements for child health clinics
- aspects of the development of children centre policy
- aspects of the organisational arrangements and capacity in social care.

These are reviewed in turn.

Capacity in the health visiting service

4.11.2 The individual management review prepared by BECHS gives a clear account of the resource constraints affecting health visiting provision. In January 2011 the average caseload of children under the age of five per full time equivalent (FTE) health visitor post in the service responsible for making provision for EY and OY was 669. This figure is said to be typical of the service throughout the period under review by the SCR. This is 67% higher than the agreed government target for health visitor caseloads which is for caseloads of 400 children per FTE health visitor. This was cited by Lord Laming in his review of child protection services and was adopted by government from studies carried out by the Community Practitioners' and Health Visitors' Association. It is therefore to be treated not as an 'ideal' but a level consistent with good professional standards of work. It is clearly a challenging target.

4.11.3 Although there are regional and local variations the statistics for East Berkshire mirror the national picture. As all posts are currently filled in the service this indicates that establishment figures have been set too low and caseload expectations too high. The management review reports that work is currently under way in East Berkshire to revise the establishment and caseload figures. The service has a target to recruit an additional 36 whole time equivalent health visitors which is designed to reduce caseload numbers to approximately 350 children under five years of age (per FTE). It is noted in the management review that at a national level efforts to increase health visitor numbers have not met with success.

4.11.4 It is very likely that in combination with other factors the capacity of the health visiting service had an impact on the quality of provision made in this case. Sections 3 and 4.3 above outline the shortcomings in service provision by health visiting staff. These centre on the poor assessments of need and risk, poor communication of information and the failure to respond appropriately to potential indicators of risk. There can be no doubt at all that while other individual and case specific factors also applied the excessive workload of health visitors will have adversely affected practice. The management review recognises this stating that:

'should the health visiting teams (have) had caseload numbers closer to national recommendations, this would have allowed more time for planned visits to the family, more time for reflection on the case, more time for planning and more time for effective communication between the teams'.

4.11.5 During its discussions the SCR panel has also recognised that high caseloads can have other negative effects on the way in the health visitors are working with families and managing their work. The chronology and management review highlights how many of the most significant communications in the case history were only recorded by health visitors *'in the health visitor's work diary'*

because many calls are received on mobile phones, children had no records or because health visitors did not have the opportunity to record events in the child's records. [45] If health visitors habitually record important information in this way it will significantly increase the likelihood of it not being properly recorded, accessed by colleagues and shared with others appropriately.

4.11.6 The management review of health visiting provision explains that children and families receive a health visiting service drawing on the skills of different members of the health visiting team and attending child health clinics that may be staffed by any one of a number of health visitors. This approach is commonplace and has much to commend it. However the potential for a number of different practitioners to be involved with a family further underlines the need for comprehensive recording that is accessible to all team members. The use of work diaries to record important information is of greater concern given the team approach to service delivery. The SCR will recommend that the trust reviews its expectations of the recording practice of health visitors and gives clear instructions to health visitors as to how they use work diaries for recording, taking full account of the practice of skill mixed team working.

4.11.7 It is striking that the health visitors involved in the case did not believe that their caseloads had negatively impacted on them. The management review reports that:

Each health visitor stated that they were in a position to offer extra input to the family and they were also in a position to provide this extra input within their caseload …. This is why they did not feel that capacity impacted on their evaluation of the service they delivered to the family. (The mother) did not wish to have extra services from the health visiting team; which is her prerogative. They would feel capacity is an issue if they have

[45] Key events include: the home visit made to the mother prior to EY moving to live with his mother; the referral of bruising by the GP and the clinic contact with EY the day before his hospital admission.

assessed a family as requiring extra input, but were not in a position due to staffing levels to offer input to a family. (emphasis in original)

This should give rise to heightened concern because the staff involved have not recognised that basic standards of assessment and information sharing were not met. The lack of provision is attributed to the mother's choice whereas in fact this has no bearing on the poor quality and lack of breadth of the assessments carried out, the failures to share information or the failure to recognise indicators of risk. The individual management review indicates that action is under way to recruit additional health visitors. It gives no indication of timescales, success or lack of it so far or future milestones. The management review makes no recommendation in relation to health visitor recruitment. This may be because the trust is satisfied with the progress that is being made. The issue of health visitor recruitment and standards of practice is of great significance for safeguarding services. In the circumstances the LSCB needs to be satisfied that it understands what the impact of the shortfall of health visitors is on safeguarding services, the steps that the managing trust is taking to mitigate risk and the progress being made in recruitment. A recommendation is made in relation to this.

<u>The trade off between accessibility and safety of services – child health clinics</u>

4.11.8 EY was seen at a child health clinic the day before he was admitted to hospital with the injuries that caused his death. The right course of action would have been for the health visitor to refer the child to local authority social care services because of the bruising that she observed. In seeking to understand why an experienced and knowledgeable practitioner did not do this the SCR has considered the context in which this consultation took place.

4.11.9 The clinic setting is described in the management review as follows:

Every health visitor will take it in turns to work at a clinic on a rota basis. Health visitors may not have had any previous contact with parents attending clinics as parents are able to drop into any clinic across the area; they may or may not be familiar with the family history. With large numbers of families accessing some clinics, the contact time with the health visiting staff may be reduced to 3-5 minutes for face to face contact time. The health visitor may not be privy to the family's history or be familiar with other professionals' concerns because they only have access to the PHCR for information where limited information about the circumstances of a family is recorded.'

4.11.10 Such clinics (a number of which are located in community buildings rather than health centres) have been developed because they are an efficient way of using scarce health visitor time and because they are readily accessible to families. The approach has much to commend it but there is also a danger that it may negatively impact on the service provided to vulnerable children. It is not that such services are not safe, but there are features of the desire to make them as accessible as possible that may have made them less safe. The trade off between accessibility or efficiency and the safety of some aspects of the service is well established in the literature on accident investigation and it would be naïve to think that it might not equally apply in some measure to this form of health provision. [46]

4.11.11 In the circumstances the health trust should investigate how health visitors and other staff working in accessible outreach services can be helped to offer a safer service to vulnerable children and be able to recognise unusual and concerning presentations. Aspects of the design and operation of the clinics, including access to information about families and access to colleagues should be considered and the staff who are involved in running them should be centrally involved in discussions.

[46] David Woods et al, *Behind Human Error,* Ashgate (2010) second edition; Sidney Dekker, *The Field Guide To Understanding Human Error,* Ashgate (2006)

Discussions about the clinics should be linked to discussions about the tools that health staff use at them such as the PCHR.

4.11.12 In addition staff in other agencies working with vulnerable children need to understand better how these clinics operate. For example the practice of parents attending a clinic, weighing their own baby and completing the PCHR (without having contact with a professional) might be the norm for health professionals but is not well understood by many other professionals. Other professionals such as social workers could very easily assume that a child whose PCHR showed that he had been to a child health clinic had been examined by a professional. This might influence their decisions and actions. It is essential that when service innovations in services take place other professionals are kept up to date, even if the service involved does not consider them to be controversial.

4.11.13 Similar concerns apply to the role of the Access Officer in the social care referral and assessment service. Even though this arrangement is reported to be a long standing one neither the children's centre worker nor a number of SCR panel members and authors of management reviews were aware of the roles and responsibilities of the Access Officer in the referral and assessment service. The SCR makes recommendations in relation to both of these issues.

<u>The impact of the scope and pace of children's centre development on the safety of services for vulnerable children</u>

4.11.14 The section of this report on the skills and training of staff and managers has highlighted some shortcomings in the management and oversight of the children's centre attended by EY and his mother. The management review of family support services has identified that the very rapid scale and pace of children's centre development made the service more prone to these weaknesses.

4.11.15 The individual management review identifies that the scope and responsibilities of the manager responsible for children's centres were substantial:

'In addition to overseeing the entire programme (10 children's centres), this role also directly line manages the four RBWM managed centres and until January 2011 was responsible for the capital build programme for new Phase 3 centres. The failure to specifically check and monitor policies and procedures within an RBWM managed centre would indicate that there was insufficient differentiation between the roles of directly line managing some centres and performance managing others. The intense demands of completing the capital build programme [for Children's Centres – KI] *during 2009-11 placed a very high level of demand on the (manager) that made it difficult to thoroughly manage those centres that were already open.*

4.11.16 The safeguarding of vulnerable children attending children's centres and the training of staff and designated professionals was stated by government to be a priority for the centres. However given the scope and pace of the development that has taken place there was always a potential for conflict between the objective of rapidly developing highly accessible services and maintaining a tight focus on the needs of individual vulnerable children. In this context it is easier to understand that in one children's centre the safeguarding of a child was compromised because staff lacked some of the requisite skills and training and the performance management of this centre had not identified those weaknesses.

4.11.17 This is a significant issue because large numbers of children attend children's centres and their focus is increasingly on vulnerable children. The potential tension between developing easily accessible services and safeguarding the most vulnerable children needs to be addressed. The management review makes a series of relevant recommendations on the steps needed to ensure that safeguarding practice improves in children's centres and the LSCB will monitor progress in the implementation of these closely.

Capacity in the social work teams involved with the family

4.11.18 The management review of local authority social care provision indicates that the referral and assessment team was experiencing problems of capacity in early 2009 leading to decision not to notify other agencies about the closure of the case after the initial assessment of OY. The SCR is satisfied through the information provided by Ofsted unannounced inspections of social care (which focus largely on these duty arrangements) that these problems of capacity no longer apply. Both published inspection feedback letters identify improvements in the service since early 2009 and neither identifies priority actions that need to be taken by the authority. [47]

[47] http://www.ofsted.gov.uk/local-authorities/windsor-and-maidenhead

4.12 Diversity

- *Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?*

4.12.1 The potential significance of ethnicity, religion, disability in relation to the case history has been considered carefully in all of the individual management reviews. EY's mother and father and the children were recorded by all agencies as being of White UK origin. There was no record of any disability or any other information pointing to possible social exclusion. With the exception of the children's centre, professionals recorded no information about the economic status of the family, though home visits by all professionals confirmed that the mother and father were economically comfortable.

4.12.2 GP records contain basic information about the ethnicity of the mother and the children. The BECHS and Heatherwood and Wexham Park Hospitals NHS Foundation Trust management reviews comment on the lack of detailed background information about the family in the agencies' records. This should be treated as indicative of the lack of information about the family and the very limited assessments that were carried out, rather than revealing anything specific about the assessment of diversity.

4.12.3 The social care report demonstrates that in relation to the potential adoption of EY the parents were consulted as to their views about the sort of family that they wanted EY to be placed in. They reveal that the parents did not firmly hold or actively practice any religious beliefs and broadly speaking wanted EY to be in a family that bore some resemblance to the mother's family.

4.12.4 The mother and children had most contact with staff at the children's centre. Interviews with staff confirmed that *'the family were not observed to be in any financial distress. The children were observed as "nicely dressed and with age appropriate clothes" and the mother was well presented and paid close attention to her appearance. The mother showed staff*

photographs from her skiing holiday taken in February 2011'. One of the parenting workers described the mother as a '*young, attractive, chatty girl'* who '*perhaps did not need the Children's Centre as much as others and was not necessarily looking for help but more of a social life'*. The father and mother were both in employment at the time of the birth of OY. It is not recorded in any agency record but it has been confirmed since the death of EY that the maternal grandparents have a successful business.

4.12.5 This relative economic wellbeing in comparison to many families who need targeted support services or have a looked after child is likely to have been the most significant aspect of the family's circumstances, so far as their interaction with professionals is concerned. The review of family support services includes the speculative, but perfectly plausible, comment that: *'this financially stable well presented image was a contributory factor in the children's centre's underestimation of the risk factors and vulnerability of the family and made it less likely that staff would be suspicious of the information given'.*

4.12.6 It is very possible that the same sort of factors may have influenced the assessment of the social care staff and the positive views of the foster carer about the prospects for the successful placement of EY with his mother.

4.12.7 The social background of the family was another factor that marked this case out as being unusual because as has been noted above none of the risk factors most commonly associated with child death and serious child abuse were present.

4.13 What do we learn from the case?

- *Are there significant lessons for the way in which organisations work individually and collectively to safeguard children?*

Key lessons for safeguarding practice

4.13.1 There are significant lessons for the way in which organisations work to safeguard and promote the welfare of children. The following areas have been highlighted in this report and the individual management reviews:

- staff in all agencies need to recognise the significance of concealed and denied pregnancy – including in unusual cases such as this where the usual factors associated with concealed pregnancy (learning difficulty, drug misuse and mental illness) are absent. It is highly unusual for a mother to have two concealed pregnancies.
- the circumstances surrounding any concealed or denied pregnancy need to be investigated in detail, including the psychological and psychiatric status of the parents
- the new birth health assessment in relation to OY was very limited and failed to take account of wider family factors that might have impacted on health
- the initial social care assessments of OY were of limited value. The complexity of EY's circumstances merited a core assessment. Although there was no procedure to require this, professional judgement should have identified the case as a complex one which merited a fuller assessment.
- involvement of the father and members of the extended family was very limited in this case. Better engagement would have added to the assessment of risk and need
- professionals should not underestimate the risks associated with the re-unification of a child with parents after a considerable period of separation (or as in this case when a parent has never had responsibility for the child). The developmental needs of the individual child, the meaning for the parents of the individual child and the child's history of

attachment need to be evaluated in detail even when there is no obvious indication of risk.

- professionals in three different settings – the GP practice, the children's centre and a child health clinic – did not comply with the child protection procedures and the training that they had received and did not report suspicious injuries to social care. Professionals need to have the skill and confidence to take the action required to protect children when faced with confident and convincing parents who are denying the harm done to children
- there was a lack of curiosity about scratches on the face of an infant which should have been recognised as an unusual and potentially concerning presentation
- if professionals are not sure that a referral to the local authority is required then they must consider alternatives such as referral for a paediatric opinion or taking advice from a named professional or another more experienced colleague.
- the current system for the transfer of GP records is not fit for purpose as it relates to the needs of vulnerable children. It may place some children at risk and the delays that are commonplace mean that the service offered by GPs may be seriously impaired. Current arrangements make GPs professionally vulnerable
- the coordination of health care for children who are discharged from being looked after needs to be better coordinated and the role of the LAC health team should be reviewed to take this into account. All of the health professionals who will be involved with a child and its family need to be informed about the relevant history and know which other professionals are involved with the child
- some aspects of professional practice were made more difficult by the context in which professionals were required to work with vulnerable children. When services – such as child health clinics and children's centres - are developed with a view to

maximising the accessibility of services to families, agencies need to ensure that staff and managers are trained and supported so that they can continue to meet the needs of vulnerable children who attend them

- newly qualified social work staff dealing with children's cases require a high level of supervision tailored to their individual level of competence, skill and knowledge.

5 Conclusions

This is a summative section that should comment on whether agencies – individually or collectively - could have predicted that EY was at risk of significant harm and whether his death could have been prevented. Is important to base this judgement on what was known (or should have been known) at the time rather than with the benefit of hindsight.

Missed opportunities to identify the risk to EY and protect him

5.1.1 The professionals involved underestimated the complexity of the family circumstances because they did not understand the level of concern that was associated with the mother's denial or concealment of her two pregnancies.

5.1.2 When considering the rehabilitation of EY to his mother the local authority made overly positive assumptions and paid insufficient attention to the negative features of the case history, such as the long periods when EY's mother did not visit him and had little interest in him.

5.1.3 There were no grounds to prevent EY returning to the care of his mother but the complexity of the background and the evidence that the mother had little positive interest in EY indicated the need for careful monitoring of his health and development and the care that he was provided after his placement with his mother. There should have been a coordinated child in need plan linked to a similar plan for his health needs.

5.1.4 Four weeks after he moved to live with his mother professionals noted scratches on EY's face. Four weeks after this, bruises were noted on his face and head. EY's mother usually stated that these had been caused by his older brother or by falls. Some professionals found the explanations convincing but these presentations were highly suspicious. EY's age and circumstances marked him out as being extremely vulnerable. The professionals involved should have responded differently and they should have been reported to the local authority so that child protection enquiries could be undertaken. At the very least professionals

should have taken advice from a member of staff or a professional advisor with expertise in child protection or referred EY for a paediatric assessment. There were two occasions on which health professionals missed opportunities to protect EY and several occasions when he attended a children's centre and both the staff and other mothers identified suspicious bruises.

5.1.5 When the children's centre sought advice from the local authority the centre coordinator spoke to an unqualified member of staff without realising this. She was unhappy with the advice given, but did not challenge it. The systems in place in the local authority for screening calls were not clear to other professionals.

5.1.6 The post-mortem findings show that EY's death was caused by a very serious head injury. He had numerous bruises on his face, head, chest, back and legs when he was brought to hospital very seriously injured. EY had also suffered a number of fractures that predate his death by at least two weeks. It is not possible to date these injuries more precisely so some or all of them may be older than this. However taking only the two week period before he suffered the injuries that caused his death the agency records list the following episodes in which he was examined or bruising was noted or discussed:

- 2 March 2011 – two bruises and scratches observed on EY's face at children's centre
- 14 March 2011 - EY was seen by a GP with a cold and cough. No detailed examination of his body would have taken place but he was noted to be '*alert, interacting and comfortable'* and otherwise well
- 15 March 2011 – crèche workers at the children's centre reported bruises to EY's forehead and cheek. A crèche worker checked his legs, back and chest and found no other bruises
- 16 March 2011 - the mother and both children attended the children's centre. Both children seemed poorly and EY was lethargic. It is not clear whether the bruises were observed

again. They may not have been recorded because they had been recorded the day before.

- 17 March 2011 the mother took EY and his brother to a child health clinic. The health visitor (HV7) examined him briefly and noted two bruises on his cheek and forehead.

5.1.7 None of these incidents was reported to the local authority. If that had happened or EY had been referred for a paediatric assessment the bruises would have been investigated. Given EY's age and vulnerability it is very likely that a full child protection medical examination would have been undertaken. In the circumstances this would very likely have included a skeletal survey (an x-ray of the whole body). This would in turn have very likely identified the older fracture injuries and this is likely to have led to action being taken to protect EY.

5.1.8 The conclusions of the SCR are that 1) over the long term the risks to EY were underestimated 2) when he moved to live with his mother he should have been closely monitored because of the concerns about the circumstances of his birth and his mother's failure to visit him for long periods when he had been looked after 3) in the two weeks before his death professionals missed opportunities to intervene which, if they had been taken, are very likely to have led to the detection of serious injuries and would probably have prevented his death.

6 Recommendations

Overview Report

1. The LSCB should oversee the production of the proposed 'pathway' for the management by health professionals of bruising so as to ensure that it is consistent with sound multi-agency child protection practice.

2. BHFT should establish the quality of new birth assessments in a sample of cases giving particular emphasis to the wider family, social and environmental issues that are highlighted in the national and local guidance.

3. The LSCB should use ensure that agencies improve their engagement with fathers and other male carers in all aspects of child protection work.

4. The LSCB should produce multi-agency guidance on the assessment and management of need and risk where there has been a denied or concealed pregnancy.

5. Health commissioners and provider trusts should review the current design and use of the PCHR.

6. The local authority should ensure that all relevant staff are made familiar with relevant research on reunification and are able to apply it.

7. Health commissioners and provider trusts should ensure that professionals who may be involved in the reunification of vulnerable children are aware of the complexity of reunification of looked after children so as to contribute effectively to discussion and decision making.

8. RBWM, BECHS and NHS should review the role of the looked after children health team to ensure that suitable health arrangements are made for children who are discharged from care as well as those who become or are currently looked after.

9. a) The LSCB should make known the specific concerns about the impact of the slow transfer and summarising of GP records in this case to the Department of Health and ask it to take action to improve the system at a national level.
   b) The current standard for the transfer and summary of GP medical records should be reviewed and a lower target time set should be set.
   c) NHS Berkshire should set challenging targets for electronic transfer of patient notes between GP practices in Berkshire. Progress should be reported regularly to senior managers in the NHS and as appropriate to the LSCB
   d) Training and briefing sessions arising from this SCR should emphasise the impact of this issue on children and the vulnerability of GPs who do not take steps to improve their systems for transferring and summarising children's records.

10. BECHS should give clear guidance to health visitors on the use of work diaries to record information about service users and contacts with other professionals.

11. BECHS should provide a full report of the current capacity of the health visiting service to the LSCB identifying implications for safeguarding and indicating the steps being taken to recruit health visitors and to mitigate the impact of staff shortages.

12. BECHS should publicise the arrangements for its child health clinics to other professionals working with vulnerable children, including the practice of self weighing.

13. RBWM should publicise the role of Access Officer in the social care referral and assessment service to all other professionals working with vulnerable children.

14. BECHS should review the current arrangements for child health clinics in the light of the findings of the SCR.

Health Overview Report - NHS Berkshire

15. Providers of child protection training to staff in the health services across Berkshire must provide assurance to the Local Safeguarding Children Boards and to NHS Berkshire that strategies are developed to evaluate and assess the impact of child protection training.

16. BHFT must review the clinical supervision policy specific to child protection to include the requirement for discussion about children born following concealment of a pregnancy and also children returned to their birth families.

17. Midwifery services should consider the implementation of clinical supervision specific to child protection for midwives.

18. Training is commissioned to support health visitors to undertake fully informed risk assessments which follow with appropriate actions and identified expected outcomes for children.

19. Quality performance indicators to include a range of measures such as audits of standards and outcomes for children must be developed by the PCT for all contracted health services, including GP services, to assure the PCT, as the current commissioners of health services, that robust mechanisms are in place to support health professionals in the identification of families with vulnerable children and risks to the children are rigorously managed.

20. The LAC Team in BHFT undertakes the self assessment tool offered by NICE Public Health Guidance 28 (2010) to benchmark the current health services for looked after children alongside the services offered by Children's Social Care.

Berkshire Healthcare NHS Foundation Trust

21. All key practitioners directly and indirectly involved in the Individual Management Review are debriefed and informed of the review findings.

22. BHFT procedures will mirror updated LSCB pre-birth procedures and include specific information and action to take in the event of a

23. All health visiting teams will be briefed about action take in the event of observed bruising on an infant.

24. A pathway will be developed for specific action to take in the event of an observed injury on a baby, infant or child.

25. Health visiting teams will be briefed on current research and the potential impact concealed pregnancies may have on the welfare of children at the Annual Safeguarding Forum November 2011.

26. Families in which a child has moved home following foster placement will be targeted for extra intervention, including monitoring the child's health and development.

27. Recommendations from this review will be incorporated within practice guidance for health visitors and disseminated to health visiting teams.

28. There will be a review of 'flagging' systems used within the Personal Child Health Record and a review of professional input at 'self-weighing' clinics.

29. A pathway will be developed for the transfer of records between health visiting teams.

30. The revised health visiting documentation will include recommendations from the individual management review

Heatherwood & Wexham Park Hospitals NHS Foundation Trust

31. HWPHFT should review its policy and procedure to incorporate management of concealed pregnancy.

32. HWPHFT should review its current procedures on the information pathway between maternity services and community practitioners to ensure it is fit for purpose. This should include senior managers and practitioners across the service.

33. HWPHFT's Safeguarding children training should emphases the importance of information sharing with other agencies e.g. GPs, Health Visitors, LAC Nurse, Social Care together with good practice examples.

34. HWPHFT's record keeping standard should ensure that information of interaction between child, parent (s) and other family members; is included in the patient record.

35. HWPHFT's should review its process for disseminating information to other agencies.

36. HWPHFT should use a standard checklist form that should be completed following postnatal discharge of clients; and implement a sign off proforma checklist for completion following postnatal discharge of clients.

37. HWPHFT should amend the record keeping standard to ensure that referrals to the local authority and other agencies are noted in the patient record.

Primary Care

38. GPs should organise a formal mental health assessment of any woman who conceals a pregnancy, unless referral to mental health services has already been made.

39. The Designated and Named Professionals should review clinical guidelines for bruising in infancy, and distribute any revision to all primary care practices.

40. All primary care practices should put in place processes to ensure all new patients' records have been received into the practice within three months of registration with the practices.

41. Berkshire Shared Services should improve uptake of electronic transfer of records with Berkshire through GP2GP transfer.

42. Primary care practices should be encouraged to use a generic email account to enable them to share concerns about children and families with health visitors.

Children's Social Care Services, Royal Borough of Windsor & Maidenhead

43. Social Care will compile and disseminate local good practice guidance for the staff, including the provision of training on concealed pregnancy and birth.

44. Social Care Services and partner agencies involved with children who are in-patients in health setting should agree a protocol to ensure that appropriate services are invited/involved in discharge planning arrangements.

45. Social care should ensure that all relevant agencies involved with children who are discharged from the care of the Local Authority should be invited to attend/actively involved in discharge planning arrangements.

46. Social Care to ensure, as per regulations and guidance, that all children who are Looked After by the Local Authority should have a comprehensive Core Assessment.

47. Social Care to ensure that internal referral systems in PARIS Integrated Children's System are fully understood by managers, and implemented in a timely fashion.

48. Social Care teams should ensure that formal letters, as per regulations and guidance, are sent to key agencies informing them when social care involvement is ending.

49. Social Care teams should ensure that, as per regulations and guidance, all children with Looked After status should be considered as a child in need when discharged from care for at least a three month period.

50. Social Care and partner agencies will agree a step-up/step-down protocol concerning the use of the CAF.

51. Social Care Referral and Duty Team to establish written guidance for role of Access Officer, particularly in relation to contact/ referral arrangements.

52. Social Care to ensure that partner agencies are aware at the point of contact that the Access Officer in Referral and Duty Team is not a qualified social worker.

53. Social Care to ensure that all aspects of learning regarding legal advice and contact with extended family members, for children who may be adopted, is incorporated into local policy and practice.

54. Social Care to ensure that case file and supervision recording policy and practice is reviewed to ensure that case file recording is comprehensive and contemporaneous.

55. Protocol between social care and local CAFCASS service concerning notifications for children relinquished for adoption to be established and implemented.

Family Support Service, Royal Borough of Windsor & Maidenhead

56. FSS standards of practice are developed clarifying which injuries in infants should trigger a referral to social care.

57. Children's centres review their record keeping template and processes for incidents/concerns.

58. Clarification is provided for children's centres on what to do if a member of the public raises safeguarding concerns about a child.

59. The Parenting Team review their referral processes for early intervention parenting groups.

60. Mechanisms to ensure greater oversight of children's centres' safeguarding policies are developed.

61. The FSS Safeguarding Policy and Procedures is fully implemented across the whole service.

62. Recruitment and professional support for Children Centre Coordinators in RBWM managed children's centres are reviewed.

63. Training is provided for FSS managers on the role of supervision in safeguarding.

64. Procedures for accessing Level 1 Safeguarding training are clarified and audit processes strengthened.

65. A standardised FSS induction process is implemented and monitored.

ADDITIONAL RECOMMENDATIONS MADE BY THE OVERVIEW REPORT AUTHOR AND THE SERIOUS CASE REVIEW PANEL

	Why is a recommendation required?	Recommendation made to	Intended impact – local or national	Recommendation
1.	The response of professionals to bruising of an infant was inadequate and led to failures to protect EY	LSCB	Berkshire	The LSCB should oversee the production of the proposed 'pathway' for the management by health professionals of bruising so as to ensure that it is consistent with sound multi-agency child protection practice.
2.	The quality of the health visitor new birth assessment was poor in this case. Assessments of the health needs of infants in the context of wider family functioning are a critical opportunity to identify needs and risks to children.	BHFT	East Berkshire	BHFT should establish the quality of new birth assessments in a sample of cases giving particular emphasis to the wider family, social and environmental issues that are highlighted in the national and local guidance.
3.	The father was not engaged fully in the work by staff in any agency. None of the professionals who received information from him showed sufficient curiosity about the needs of his children and the wider family circumstances	LSCB	Windsor and Maidenhead – all agencies	The LSCB should use ensure that agencies improve their engagement with fathers and other male carers in all aspects of child protection work.
4.	The significance of two concealed pregnancies was underestimated. A number of agencies believe that their staff need more guidance	LSCB	Windsor and Maidenhead – all agencies	The LSCB should produce multi-agency guidance on the assessment and management of need and risk where there has been a denied or concealed pregnancy.

	Why is a recommendation required?	Recommendation made to	Intended impact – local or national	Recommendation
5.	The design of the PCHR impaired the easy access to important information about the child's history. Doctors are believed not to make full use of the PCHR	All health agencies	East Berkshire	Health commissioners and provider trusts should review the current design and use of the PCHR.
6.	The risks associated with the 'reunification' of EY were underestimated by the local authority and staff did not apply relevant knowledge of this issue	RBWM	Windsor and Maidenhead	The local authority should ensure that all relevant staff are made familiar with relevant research on reunification and are able to apply it.
7.	There was no multi-agency assessment of the risks of 'reunification'	Health commissioners and provider trusts	Berkshire	Health commissioners and provider trusts should ensure that professionals who may be involved in the reunification of vulnerable children are aware of the complexity of reunification of looked after children so as to contribute effectively to discussion and decision making.
8.	The LAC health team played no effective role in the discharge of EY to the care of his mother as it was not part of the brief of the team to do so.	RBWM and BECHS	Windsor and Maidenhead	RBWM, BECHS and NHS should review the role of the looked after children health team to ensure that suitable health arrangements are made for children who are discharged from care as well as those who become or are currently looked after.
9.	The system for the transfer and summary of GP records impaired the practice in this case and is not fit for purpose in relation to the needs of vulnerable children	Department of Health	National	9 a) The LSCB should make known the specific concerns about the impact of the slow transfer and summarising of GP records in this case to the Department of Health and ask it to take action to improve the system at a national level
		NHS Berkshire	Berkshire	9 b) The current standard for the transfer and summary of GP medical records

	Why is a recommendation required?	Recommendation made to	Intended impact – local or national	Recommendation
				should be reviewed and a lower target time set should be set.
		NHS Berkshire	Berkshire	9 c) NHS Berkshire should set challenging targets for electronic transfer of patient notes between GP practices in Berkshire. Progress should be reported regularly to senior managers in the NHS and as appropriate to the LSCB
		LSCB	Windsor and Maidenhead	9 d) Training and briefing sessions arising from this SCR should emphasise the impact of this issue on children and the vulnerability of GPs who do not take steps to improve their systems for transferring and summarising children's records.
10.	Many important contacts with BECHS staff were only or primarily recorded in their 'work diaries'.	BECHS	East Berkshire	BECHS should give clear guidance to health visitors on the use of work diaries to record information about service users and contacts with other professionals
11.	The issue of health visitor recruitment and standards of practice is of great significance for safeguarding services. In the circumstances the LSCB needs to be satisfied that it understands what the impact of the shortfall of health visitors is on safeguarding services, the steps that the managing trust is taking to mitigate risk and the progress being made in recruitment.	BECHS	East Berkshire	BECHS should provide a full report of the current capacity of the health visiting service to the LSCB identifying implications for safeguarding and indicating the steps being taken to recruit health visitors and to mitigate the impact of staff shortages
12.	The current arrangements for community based child health clinics (including self weighing)	BECHS	East Berkshire	BECHS should publicise the arrangements for its child health clinics to other professionals working with vulnerable

	Why is a recommendation required?	Recommendation made to	Intended impact – local or national	Recommendation
	need to be understood by other professionals working with vulnerable children			children, including the practice of self weighing.
13.	The role of Access Officer in the social care referral and assessment service was poorly understood.	RBWM	Windsor and Maidenhead	RBWM should publicise the role of Access Officer in the social care referral and assessment service to all other professionals working with vulnerable children.
14.	The circumstances in which staff were working in the health clinic in which EY and his family were seen shortly before he was seriously injured were not conducive to the identification and assessment of risk to vulnerable children, particularly when taken in combination with the current design and use of the PCHR.	BECHS	Berkshire	BECHS should review the current arrangements for child health clinics in the light of the findings of the SCR.

Appendix I

Terms of reference of SCR

The full terms of reference of the SCR are set out in a separate document. The focus of the SCR is as follows

The review will address all of the areas required by Working Together to Safeguard Children – 2010. In addition it will focus on the following:

1. Identify any historical information (prior to 1 July 2008) on the family members that may have impacted on the parenting capacity of the mother, GY, and father, PO;
2. Establish the quality of assessment of circumstance relating to either and both children and their family;
3. Identify factors that helped or hindered the engagement with the family;
4. Establish how well agencies identified and responded to children's injuries and other indicators of harm;
5. Analyse the extent of, and professional understanding of, the support from the extended family;
6. Establish what advice was given and what services were offered to the parents concerning adoption issues;
7. Establish what risk factors in the family were known to agencies during the period under review;
8. Establish whether staff and managers dealing with the family had the requisite skills, knowledge and experience to respond to the circumstances presented by the family;
9. Establish whether sufficient attention was given to issues relating the reunification of EY and his mother following the period when he was in foster care.

The review will consider in detail relevant events from 1 July 2008, the perceived start of the pregnancy of the elder child and 18 March 2011 prior to the involvement of emergency service.

The review will consider the circumstances of both children.

Appendix II

SCR PANEL MEMBERSHIP

Agency	Designation
Donald McPhail, Chair	**Chair of LSCB**
NHS Berkshire East	Designated Paediatrician
Royal Borough of Windsor and Maidenhead Council	Head of Services to Children and Young People
Royal Borough of Windsor and Maidenhead Council	Head of Safeguarding and Specialist Services
Thames Valley Police	Detective Chief Inspector
Thames Valley Probation Trust	Senior Probation Officer
BHFT (Community Health Services)	Assistant Director, Children's Services

ATTENDEES AT SOME OR ALL PANEL MEETINGS

Professional advisor to the panel	LSCB Business Manager
Designated Nurse Child Protection, NHS Berkshire.	Health Overview Report Author
Administration	LSCB Secretary

Appendix III

List of documents provided for the SCR

Individual Management Reviews

Berkshire East Community Health Services [49] (which provided the health visiting service)

General Practice (covering the services provided by three GP practices)

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

Royal Borough of Windsor and Maidenhead Council

- Safeguarding Services [48] (which provides local authority children's social care services)
- Services for Families (which provides and commissions Children's Centre services and other family services)

Background reports on agency involvement

- South Central Ambulance Service
- Combined Legal Services (hosted by Reading Borough Council)

[48] This service is referred to as 'children's social care' in the body of the report

[49] Berkshire East Community Health Services (BECHS) merged with Berkshire Healthcare Trust (BHFT) during the course of this review. References to BECHS and BHFT should be treated as synonymous in all documents related to this review.

Appendix IV

	Agency	Evaluation of the contribution made by the individual management reviews (IMR) to the findings of the SCR
1.	Berkshire East Community Health Services	The IMR was prepared by the Named Nurse Team Lead Child Protection for the trust. She was not involved in the case and had no line management responsibility for the services provided for the family. She has considerable experience as a child protection specialist. The report was authorised by the Managing Director Berkshire Healthcare NHS Foundation Trust - Community East. The IMR provides a very detailed account of the involvement of health visitors and the looked after children health team. It makes a thorough appraisal of the strengths and weaknesses of the input of the services concerned. This IMR has enabled the SCR to understand the settings within which health visiting teams are working and the impact that this may have had on their work. The IMR also deals openly with the difficulties posed by the large caseloads of health visitors The recommendations of the IMR follow from the learning. The SCR overview report has made additional recommendations which go beyond those contained in the IMR because it was able to locate the impact of shortcomings in the services provided by health visitors and the LAC team within the wider context of the case history. The IMR makes clear how information was obtained from staff and records. The IMR states that '*each health visitor had managerial presence at the interviews'*. It is not entirely clear what this means, however the SCR author is concerned that this may not be the best way to enable professionals to participate fully and freely in process whose aim it to learn lessons. It is suggested that the trust should review this process in the event that future IMRs are required.
2.	General Practice	The IMR was prepared by the Named Doctor Child Protection Berkshire East PCT-Bracknell locality. The author is also an experienced GP partner. The report is authorised by the Medical Director Berkshire PCTs Cluster. The author was not involved in the case and had no line management responsibility for the services provided for the family. The IMR provides a very detailed account of the contacts that a number of GPs had with the

	Agency	Evaluation of the contribution made by the individual management reviews (IMR) to the findings of the SCR
		children and their parents. In particular there is a detailed account of the contact that the younger child had with his GP in which bruises were identified. This has enabled the SCR to understand the circumstances in which this happened and the judgement that the GP made. It is clearly recognised that the findings of this report and those of the health overview report and the SCR overview report are in parts at odds with one another. The overview reports are clear that this presentation should have been referred to the local authority or at least for an urgent paediatric assessment. The IMR focuses on the perspective and normal working practice of GPs and seeks to understand why it was that the GP acted as he did. It recognises that GPs are much more comfortable making referrals to medical colleagues than to social care about bruised children. This is not what the procedures say should happen, however recognising this is absolutely vital learning for the LSCB. The IMR and the overview reports all make recommendations, complementing one another, which address this issue. The different perspectives contained in the IMR and the overview reports complement one another and enable the SCR as a whole to understand the pressures that some health professionals feel when considering the need to refer children to social care and how this can be addressed in day to day working. This leads to recommendations in all of the reports for work on a 'bruising pathway'. The GP IMR also recognises that delays in transferring and summarising records had an important impact on the case history. It is extremely helpful that this issue as been highlighted. In relation to this the recommendations of the SCR overview report go beyond those made in the IMR, recognising the national context of this problem and the need to make challenging recommendations to the NHS locally and nationally. This is understandable because it is only when an overview of this issue is available from the case history as a whole that its significance in the outcome of the case is apparent.
3.	Heatherwood and Wexham Park Hospitals NHS Foundation Trust	The IMR was prepared by the Lead Named Nurse for Safeguarding Children for the Trust. The Lead Named Nurse had no direct or indirect involvement to the case or line management responsibility for the staff involved, and is thus independent from the case. The IMR is authorised by the Director of Nursing. The IMR provides an account of the brief contact that the trust had with the children and parents. It is hampered by the fact that on in relation to the younger child contact was only

	Agency	Evaluation of the contribution made by the individual management reviews (IMR) to the findings of the SCR
		very brief and no postnatal records could be found. Unusually there were two concealed pregnancies which meant that the mother had no antenatal care. This would normally be the period in which midwives establish information about risk factors. The IMR identifies that staff identified the basic level of concern arising from the concealment of pregnancies and made appropriate referrals to the local authority in relation to both children. Beyond this however midwives played very little role in actively assessing the circumstances in any depth, for example the reasons for the denial or concealment of pregnancy. There were shortcomings in the information shared with other health professionals. These findings are reflected in wide ranging recommendations made by the IMR about recording and the entire information pathway between antenatal services and community health services.
4.	Royal Borough of Windsor and Maidenhead Council Services for Families	The IMR was prepared by the Family Support Manager. The author had had no contact with the family and no direct involvement in this case during the timeframe covered by this review. However she manages a large service area within the local authority which includes the Children's Centre programme and the Parenting Team. She has also had some involvement in human resources procedures in relation to staff who feature in this review. As such the author is not independent of the line management of the case, though she is in a senior position with a degree of distance from the events under review. The SCR Panel and the independent author were aware of this once the first draft of the report had been prepared and aware of the potential for there to be a conflict of interests. However the SCR panel and the independent overview report author are of the view that the report is a frank and insightful one which has not been compromised by the position of the author in the local authority management structure. In the view of the panel and the independent SCR author the report fulfils the requirements of Working Together because it looks '*openly and critically at individual and organisational practice and at the context within which people were working to see whether the case indicates that improvements could and should be made and, if so, to identify how those changes can be brought about' (paragraph 8.34)*. The report has been closely scrutinised both within the SCR process and within the local authority to ensure that it meets the requirements of objectivity.

	Agency	Evaluation of the contribution made by the individual management reviews (IMR) to the findings of the SCR
		The findings of the review have been of great value to the SCR. The review has described and analysed practice and service provision at a detailed and 'micro' level carefully reconstructing through interviews and records the events under consideration. This is a considerable strength because it has enabled the SCR to understand how – in the day to day working of staff in the children's centre – opportunities to refer the child were missed. However it also offers strategic oversight of the way in which the children's centre service has been developed and scope of responsibility of middle managers in the service and the culture of management in the service. There are some particularly valuable insights such as for example how the focus on performance management led to individual cases not being dealt with properly in supervision. The report proposes detailed solutions to the problems identified in the recommendations that are made. It is likely that the detailed working knowledge brought to bear on the analysis has outweighed any disadvantages that arise from being part of the service that is being scrutinised.
5.	Royal Borough of Windsor and Maidenhead Council Safeguarding Services	The IMR was prepared by the Safeguarding Service Manager who is responsible for Quality Assurance, Development, and Planning. The author was not involved in the case and had no line management responsibility for the services provided for the family. The review was authorised by the Head of Safeguarding and Specialist Services. The IMR provides an account of the involvement of the local authority safeguarding service with both of the children and their parents. It identifies the key decisions and actions of the social care staff involved and the underlying rationale for them. Through interviews with staff and review of records the IMR identifies the key belief of local authority staff. This was that it would be a good outcome to the case if the younger child were to be returned to the care of his mother. The IMR identifies how local authority staff did not recognise the many concerning factors in the case history pointing to the mother's lack of interest in her younger child. It demonstrates clearly the need for a child in need plan to support and monitor the child when he was placed in the care of his mother.

Appendix V

Policy and research references

Research and resources referred to

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Unannounced inspection reports on RBWM http://www.ofsted.gov.uk/local-authorities/windsor-and-maidenhead

David Woods et al, *Behind Human Error,* Ashgate (2010) second edition;

Procedures and process governing the conduct of the Serious Case Review

HM Government, Working Together to Safeguard Children – 2010.

Berkshire Child Protection Procedures

http://berks.proceduresonline.com/chapters/p_ser_case_rev.html

Appendix VI

Edinburgh Depression Scale
(or Edinburgh Postnatal Depression Scale)

DATE COMPLETED_____

As you have recently had a baby, we would like to know how you are feeling.

Please CIRCLE the number next to the answer which comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

IN THE PAST 7 DAYS

1. I have been able to laugh and see the funny side of things.	0 As much as I always could. 1 Not quite so much now. 2 Definitely not so much now. 3 Not at all.
2. I have looked forward with enjoyment to things.	0 As much as I ever did. 1 Rather less than I used to. 2 Definitely less than I used to. 3 Hardly at all.
3. I have blamed myself unnecessarily when things went wrong.	3 Yes, most of the time. 2 Yes, some of the time. 1 Not very often. 0 No, never.
4. I have been anxious or worried for no good reason.	0 No not at all. 1 Hardly ever. 2 Yes, sometimes. 3 Yes, very often.
5. I have felt scared or panicky for no very good reason.	3 Yes, quite a lot. 2 Yes, sometimes. 1 No, Not much. 0 No, not at all.

IN THE PAST 7 DAYS

6. Things have been getting on top of me.	3 Yes, most of the time I haven't been able to cope at all. 2 Yes, sometimes I haven't been coping as well as usual. 1 No, most of the time I have coped quite well. 0 No, I have been coping as well as ever.
7. I have been so unhappy that I have had difficulty sleeping.	3 Yes, most of the time. 2 Yes, sometimes. 1 Not very often. 0 No, not at all.
8. I have felt sad or miserable.	3 Yes, most of the time. 2 Yes, quite often. 1 Not very often. 0 No, not at all.
9. I have been so unhappy that I have been crying.	3 Yes, most of the time. 2 Yes, quite often. 1 Only occasionally. 0 No, never.
10. The thought of harming myself has occurred to me.	3 Yes, quite often. 2 Sometimes. 1 Hardly ever. 0 Never.

Scoring and Other Information

Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptom.

Items 3, 5-10 are reverse scored (i.e., 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items. Users may reproduce the scale without further permission providing they respect copyright (which remains with the *British Journal of Psychiatry*) quoting the names of the authors, the title and the source of the paper in all reproduced copies.

The Edinburgh Postnatal Depression Scale (EPDS) has been developed to assist primary care health professionals to detect mothers suffering from postnatal depression; a distressing disorder more prolonged than the "blues" (which occur in the first week after delivery) but less severe than puerperal psychosis.

Previous studies have shown that postnatal depression affects at least 10% of women and that many depressed mothers remain untreated. These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected and it is possible that there are long term effects on the family.

The EPDS was developed at health centres in Livingston and Edinburgh. It consists of ten short statements. The mother underlines which of the four possible responses is closest to how she has been feeling during the past week. Most mothers complete the scale without difficulty in less than 5 minutes.

The validation study showed that mothers who scored above a threshold 12/13 were likely to be suffering from a depressive illness of varying severity. Nevertheless the EPDS score should not override clinical judgement. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week, and in doubtful cases it may be usefully repeated after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

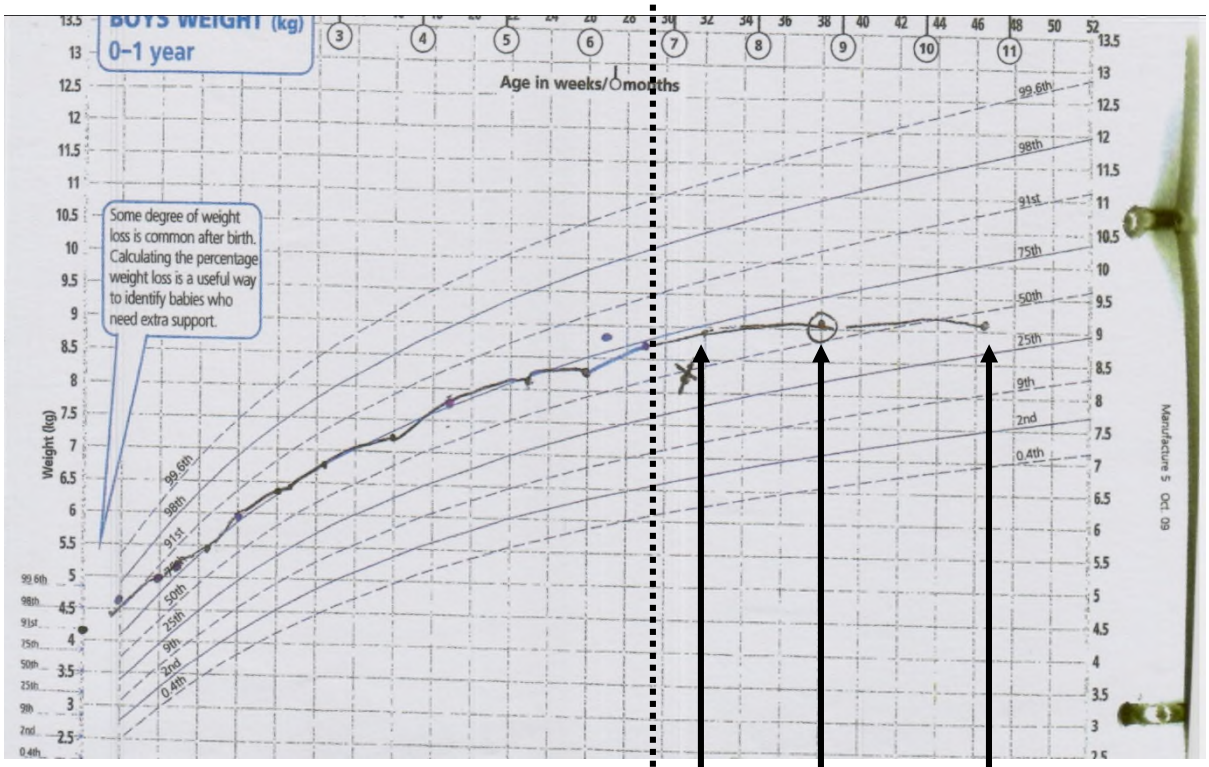
Instructions for users

1. The mother is asked to underline the response which comes closest to how she has been feeling in the previous 7 days.
2. All ten items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
5. The EPDS may be used at 6-8 weeks to screen postnatal women. The child health clinic, postnatal check-up or a home visit may provide suitable opportunities for its completion.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, *150*, 782-786.

Appendix VII

Height and weight chart from Personal Child Health Record of EY



19 November – EY moved to live with mother
All previous weights on 75th centile

30 November 2010 Child health clinic 8.9Kg
Age 32 weeks 75th centile

19 January 2011 GP developmental check 9.0 Kg
Age 38 weeks mid point 50th – 75th centile

17 March 2011 Child health clinic 9.0Kg
Age 47 weeks mid point 25th – 50th centile

It is important to note that this is a substantially enlarged version of part of the original document

Appendix VIII

Berkshire combined safeguarding procedures Section 4.6 on 'bruising' - current at January 2011

Children can have accidental bruising, but the following must be considered as highly suspicious of a non accidental injury unless there is an adequate explanation provided and experienced medical opinion sought:

- Any bruising or other soft tissue injury to a pre-crawling or pre-walking infant or non mobile disabled child
- Bruising in or around the mouth, particularly in small babies which may indicate force feeding
- 2 simultaneous bruised eyes, without bruising to the forehead, (rarely accidental, though a single bruised eye can be accidental or abusive)
- Repeated or multiple bruising on the head or on sites unlikely to be injured accidentally e.g. the back
- The outline of an object used e.g. belt marks, hand prints or a hair brush (a pinch causes small double bruises, a punch or kick causes an irregular bruise with a paler centre, gripping causes ovals from fingertips or lines between fingers)
- Linear pink marks, haemorrhages or pale scars may be caused by ligature, especially at wrists, ankles, neck, male genitalia
- Bruising or tears around, or behind, the earlobe/s indicating injury by pulling or twisting or slapping
- Bruising around the face
- Broken teeth and mouth injuries (a torn frenulum - the flap of tissue in the midline under the upper lip - is highly suspicious in non-mobile children, but frequently occurs accidentally in mobile children)
- Grasp marks on small children
- Bruising on the arms, buttocks and thighs may be an indicator of sexual abuse