Luton Local Safeguarding Children Board

Learning & improving

Serious Case Review report in respect of:

Child E

Independent Lead Reviewer: Kevin Ball, NSPCC Senior Consultant

This report has been commissioned and written on behalf of:

Luton Local Safeguarding Children Board

This report has been anonymised in order to protect the identity of individuals.

1. Introduction

1.1. Statutory guidance[1] states that "*professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others*". Case reviews provide a valuable opportunity to reflect on the quality of services and practice. Guidance also cites Regulation 5 of the Local Safeguarding Children Board Regulations 2006, that a Serious Case Review (SCR) should be undertaken where abuse or neglect is known or suspected and either;

- a child dies; or
- a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

The reason for this case being subject to review

1.2. In January 2014 Child E was found dead in the family home. Following the initial police investigation concerns were raised about the circumstances surrounding the death. An early review of the case showed that Child E had lived, and died, in neglectful conditions prompting concerns about how statutory agencies worked together to safeguard and protect Child E's welfare.

Audience for this review report

1.3. The primary audience for this report is Luton LSCB, local services and professionals. The report may be of interest to the public and a broader professional audience where there may be similarities in findings and where learning and improvement may be considered at a regional or national level.

2. Brief synopsis of the case

Child E: age seven months – English Pakistani	Mother: English
Sibling 1: age four years– English Pakistani	Grandmother: English
Sibling 2: age two years – English Pakistani	Father: Pakistani
Sibling 3: born post Child E's death – English Pakistani	

2.1. At the time of death Child E was a seven month old infant. The household in which Child E lived comprised the mother, maternal grandmother and two older siblings, both of whom were under four years of age. The children's father had no role in caring for the children although it is believed that he may have visited occasionally.

2.2. Child E's mother had received antenatal care for all of her children from local hospital services. Additionally, she and each of the children had been provided with postnatal care from community based services including the GP, although this universal support offer was not always accepted. Both hospital and community based services raised concerns about the neglectful home environment and conditions in which the children were living from around the summer of 2010. Concerns included; a house full of 'clutter', often

[1] This SCR was commissioned under Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, March 2013, HM Government. Subsequently, HM Government issued a revised version in 2015.

dirty due to pet bird droppings, safety hazards around the house, smoke filled due to heavy smoking, cramped living conditions, and bed sharing.

2.3. The local authority Children & Learning Department (Children's Social Care) became aware of the concerns through a referral from the hospital but also discussions with the Health Visiting Service. An agreed plan between agencies (Specialist Family Support service of the Children & Learning Department and the Health Visiting Service) was for the Health Visitor to monitor and work with the family.

2.4. At the birth of each child similar concerns about the conditions of the home environment were raised and yet limited professional input was provided. In part, this was due to the limited engagement by the mother with professionals. Various formal assessment opportunities were either considered or attempted but these had no impact. In turn, improvements to the home conditions were limited and had little positive impact. The mother's capacity to parent and care for three young children was never fully assessed.

2.5. In late 2013 when Child E was 26 weeks old (approximately four weeks prior to death) Child E was noted to be suffering from nappy rash during a scheduled hospital review. Additionally it was noted that Child E's weight gain was erratic; advice was given to the mother about weaning and a feeding regime. These two issues became a focus for the GP and Health Visiting Service to address. Despite very clear professional advice, the nappy rash went untreated by the mother and became more serious. Advice about weaning and feeding was also not followed.

2.6. At around this time, the mother became pregnant; no professional was aware of this. Child E was found dead in the family home in January 2014. A post mortem was conducted and whilst unable to ascertain a definite cause of death it has highlighted a range of contributory factors about the cause of death. These were indicative of a significant failure to thrive.

3. The Serious Case Review process

Methodology for this Serious Case Review

3.1. Throughout, this review has remained mindful of the principles outlined in statutory guidance[2] for conducting reviews. It has endeavoured to examine the case in a manner which is both proportionate whilst balancing the public interest in the outcome. The methodology for this review has therefore comprised of;

- The formation of a Serious Case Review Reference Group in order to contribute to the gathering and analysis of information as well as ensure the smooth and timely completion of the review. Reference Group members were responsible for commissioning and seeking their own respective agency information for submission to the review. Members of this Reference Group were independent of line management responsibility for any member of staff involved in this case thereby ensuring a sufficient level of impartiality. Due to a known potential conflict of interest within one agency under review (Cambridgeshire Community Services: Health Visiting Service) an Independent Consultant

[2] Principles for learning and improvement: a culture of continuous learning and improvement, proportionality, independence, seeking the involvement of professionals, seeking the contribution of children and families, ensuring reports are published, and ensuring sustained improvements, p.66/67, Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, March 2013, HM Government

was commissioned to review the contribution and actions of this agency. This provided a sufficient level of impartiality. This group met six times between June 2014 and April 2015. Membership of this group is shown in Appendix 1;

- The Independent Chair of Luton LSCB appointed Kevin Ball, NSPCC Senior Consultant as the Independent Lead Reviewer for this Serious Case Review. Neither the Independent Lead Reviewer, nor the NSPCC, had any involvement with the subject of this review or members of the family and the professional network;

- The appointment of an Independent Chair of the SCR Reference Group – Keith Ibbetson – to oversee and facilitate the smooth and timely completion of the review process;

- The use of a methodology which adhered to the principles set out in statutory guidance and which aimed to critically examine the episodes of professional contact where there was the greatest value in pursuing learning, understanding what happened and the reasons why individuals and agencies acted as they did;

- Obtaining single agency chronologies of involvement with the child and family[3] (taken from individual agency records) and single agency tabular time-lines[4] (taken from individual agency records, interviews held internally and reflection on the practice that took place) which identify key practice episodes[5];

- Examination of other relevant working documents which informed the review process e.g. policies and procedures (from the range of agencies involved), case evidence and information (from the range of agencies involved), and other pertinent documentation such as other local SCRs, Ofsted reports, research and LSCB documents/reports;

- Individual conversations and interviews (via phone and face to face) with key professionals who were involved in the case, where possible, and interviews with family members (where possible). In order to ensure transparency and fairness[6] professionals interviewed were provided with information about the review purpose and process;

[3] Chronology detailing all contacts with the child and family from 20/07/09 to 17/01/14, including background contextual information

[4] Tabular time-lines: Adapted from a Root Cause Analysis investigative approach devised by the National Patient Safety Agency (NHS), 2011

[5] Key practice episodes: concept drawn from work undertaken by SCIE (Social Care Institute for Excellence) Learning Together model, to describe events *"… that seem to be points at which actions were taken that had a decisive effect on the future course of the case, an effect sometimes positive and sometimes negative*", SCIE, Learning together to safeguard children: developing a multi-agency systems approach for case reviews, Report 19, 2008, p 78, Fish, Munro & Bairstow

[6] Ensuring fairness, 2013, p.13, Improving the quality of Children's Serious Case Reviews through support & training, NSPCC, Sequeli, Action for Children, Department for Education, 2013

- Requesting single agency action plans at the outset of the review as well as at the conclusion of the review process as a way of encouraging continuous learning and improvement[7];

- Being respectful of parallel proceedings taking place alongside this case review, namely a police investigation and associated criminal proceedings but also care proceedings, and working collaboratively with those conducting those proceedings.

Scope of this Serious Case Review

3.2. The scope of the review was intentionally set wide to begin with. This allowed the Independent Reviewer in collaboration with the Reference Group to consider the data presented and examine emerging themes. From this, further refinement of the scope, where useful, was possible. The terms of reference for this review were set as;

1. To initially review events between July 2009 and January 2014 whilst also considering any relevant background contextual information prior to this defined period of time;

2. To review the actions of the agencies that came into contact with Child E and family;

3. To review key practice episodes, within the above timeframe, up to the date of Child E's death;

4. To specifically consider the following issues: the use of the Common Assessment Framework (CAF), the use of the Graded Care Profile, thresholds for intervention, professionals holding information but not seeming to act on it, assessments, service provision, communication across agencies, and the interaction with parents;

5. To seek to involve parents, carers and other family members, in the review, as appropriate;

6. To produce a final report which:

a) Provides a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence,

b) Is written in plain English and in a way that can be easily understood by professionals and the public alike, and,

c) Is suitable for publication without needing to be amended or redacted,

d) Is completed within appropriate timeframes. These were initially set within a six month period (June 2014 – December 2014) however due to the police and criminal investigation this was delayed.

3.3. The review methodology has balanced an investigative approach with a wider understanding about the system in which agencies and professionals were operating. The process has often required certain agencies

[7] New learning from serious case reviews: a two year report for 2009-2011, Marian Brandon, Peter Sidebotham, Sue Bailey, Pippa Belderson, Carol Hawley, Catherine Ellis & Matthew Megson, Centre for Research on the Child and Family in the School of Social Work and Psychology, University of East Anglia/Health Sciences Research Institute, Warwick Medical School, University of Warwick

to undertake a further analysis of specific information following a period of interrogation by the Independent Reviewer and the Reference Group. This approach has encouraged greater local analysis, improved local ownership and accountability and a deeper appreciation of why events occurred as they did.

Involvement of the child, family & carers in this review

3.4. The contribution of family members to this review was desired from the outset. Research[8] has shown there to be added value when this can happen particularly in respect of promoting a child centred review and seeking key information from those closest to the child.

3.5. The mother, grandmother and father were informed of the review at the outset. Due to the Police investigation there was an inevitable delay in seeking the contribution of family members. An agreed and joint strategy was formulated between the Police and Independent Reviewer as to how best secure the participation of family members in the review process. Letters were sent, via Special Delivery, to the three family members. The mother and father made no contact with the Independent Reviewer. The grandmother made contact and expressed an interest in contributing however did not follow this through with action despite subsequent attempts to speak over the phone. On this basis, it has not been possible to secure the family's contribution to the review within the timeframes agreed by the LSCB.

Limitations of this review

3.6. A number of professionals who were involved in this case no longer work for their respective agencies. Whilst these practitioners have not contributed to the review the Independent Reviewer is satisfied that sufficient information has been gathered to understand practice at the time, capture learning and inform improvements.

3.7. As already stated, family members were offered the opportunity to contribute to the review. Regrettably this was not taken up. In turn, this has limited the Reference Group's understanding about how professionals attempted to work with family members.

3.8. The review has identified practice challenges for agencies with the multi-agency understanding of thresholds for intervening when there may be concerns about a child's welfare. Ofsted[9] noted many positives in local safeguarding arrangements in 2012. It is beyond the specific scope of this review to consider, in any depth, changes that may have occurred since this Ofsted finding in 2012. It will be the responsibility of the LSCB to consider the specific findings of this review in the context of its wider understanding of local safeguarding arrangements and thresholds.

[8] A study of family involvement in case reviews: Messages for policy and practice, Morris, K., Brandon, M., Tudor, P., BASPCAN

[9] Ofsted, 2012, Inspection of safeguarding and looked after children services Luton Borough

4. Summary professional contact with Child E (including siblings) & family members

4.1. For ease of reference, Table 1 provides a substantially summarised account of professional contact with Child E's siblings. This information has been extracted from a combined chronology of agency involvement with the family. A similar table for Child E has also been produced. They have been separated as it allows the review to consider patterns of behaviour and engagement by the mother with professional services in respect of each child; this aids analysis and findings.

Table 1: Summary chronology of relevant & key professional contacts with Child E's siblings: Siblings 1 & 2

Key to agencies:
LDUH – Luton & Dunstable University Hospital
CCS – Cambridgeshire Community Services
C&L – Local authority Children & Learning Department
GP – General Practitioner

Sibling	Contact with agency & professional
Sibling 1 (2009)	**LDUH:** Pregnancy booked with the Community Midwife responsible for teenage pregnancies. Mother aged 17 years. No significant history noted. Routine appointments completed at 10, 15, 22, 26, 28, 32, 35, 40 weeks. Within this period Surestart Midwife and Connexions worker visited to discuss support available at local Children's Centre.
Sibling 1 (02/10)	**LDUH:** Sibling 1 born. No concerns noted.
Sibling 1 (03/10)	**LDUH:** Postnatal care provided by Community Midwife from teenage caseload team. There were two occasions of no access during this period of midwife care. Routine discharge to Health Visitor.
Sibling 1 (04/10)	**CCS:** Six week check at GP Practice. First primary immunisations given.
Sibling 1 (09/10)	**CCS:** Second primary immunisations given at GP Practice (overdue).
Sibling 1 (02/11)	**CCS:** One year development check cancelled by mother.
Sibling 1 (05/11)	**CCS:** Third primary immunisations given at GP Practice (overdue).
Pregnancy (06/11)	**LDUH & CCS:** Pregnancy failure noted on file. Safeguarding concerns were raised about the mother (aged 18 years) who had a one year old child, was living in poor housing conditions which were unsuitable for a child or new-born, home cluttered, smoke filled, bird droppings.
Sibling 1 (06/11)	**CCS:** Booster immunisations given at GP Practice.
Siblings 1 & 2 (08/11)	**CCS:** Health visiting service informed of concerns expressed by LDUH. Records indicate that Midwifery would complete Common Assessment Framework (CAF). Records also indicate that three months pass where no action was taken by either CCS or LDUH in respect of the CAF or follow up to concerns.
Sibling 2 (11/11)	**LDUH:** Formal booking at home visit of third pregnancy (Sibling 2). House noted to be smoky and very untidy.
Sibling 2	**LDUH:** Routine antenatal care appointments completed at 16, 20, 24, 28, 29, 32 weeks. During this period the Health Visitor was denied access to the home a number of times

	(including attempts to speak over the phone which were also cut off). The mother declined a visit by the Midwife. Further support was also declined.
Sibling 2 (03/12)	**LDUH:** Mother attended hospital and was seen smacking and shouting at Sibling 1, allowing her to wander; mother also appeared unkempt. Information was shared by LDUH with the Health Visitors.
Sibling 2 (05/12)	**LDUH:** Sibling 2 born (premature).
Sibling 2 (05/12)	**LDUH & CCS:** Separate home visits during the same day – LDUH granted access, CCS denied. Further access denied later in the same month.
Sibling 2 (05/12)	**LDUH & C&L**: Sibling 2 admitted to hospital (at 11 days old) due to poor feeding and weight loss. C&L informed as mother had been difficult to contact, did not appear to interact well with the baby and there were concerns about her care of the baby. Social Worker conducted two home visits, home conditions reported as 'very untidy' (via an independent assessment commissioned by C&L), and the home conditions were perceived to have slightly improve.
Sibling 2 (06/12)	**CCS**: Opportunistic home visit conducted by Health Visitor. Home conditions reported as cluttered but 'fairly clean'. Further advice given and appointment made.
Sibling 2 (06/12)	**CCS:** Health Visitor conducted a new birth visit. Risk assessment completed and discussion about a further assessment being completed.
Sibling 1	**CCS:** Mother encouraged to attend a local Stay and Play group for Sibling 1. Further visits over the next four weeks found the children clean and well-dressed. The home conditions continued to be very cluttered and dirty but with some improvements. Further visits cancelled by mother.
Siblings 1 & 2 (08 – 11/12)	**CCS:** Opportunistic visit by the Health Visitor to home. Home smelt strongly of cigarette smoke, remained very cluttered and dirty, floor covered in rubbish, safety hazards. Home safety assessment completed. Mother planned to register Sibling 1 at local Nursery. Further assessment to be completed. No access when further visits were attempted. Health Visitor 1 contacted C&L to express concerns. Agreed that CCS would continue to monitor. Consideration of using the CAF.
Child E (01/13)	**LDUH:** Pregnancy booking in respect of Child E. Refer to Table 2.
Sibling 1 (09/13)	**Nursery/School:** Sibling 1 begins school.

4.2. Table 2, similarly, provides a substantially summarised account of professional contact with Child E. This information has been extracted from a combined chronology of agency involvement with the child and family.

Table 2: Summary chronology of relevant and key professional contacts during Child E's lifetime

Key to agencies: **LDUH – Luton & Dunstable University Hospital** **CCS – Cambridgeshire Community Services** **C&L – Local authority Children & Learning Department** **GP – General Practitioner**	
Weeks	**Contact with agency & professional**
-20 weeks	**LDUH**: Community Midwife books pregnancy at Aunt's home as the grandmother was not

from birth (01 -02/13)	happy with the pregnancy and did not want the Midwife in her home. Information shared (including information held about previous similar concerns in respect of the two older siblings) with Health Visitor. Mother refused to sign a CAF.
-18 weeks (02/13)	**CCS:** Planned home visit in respect of sibling 2. Home appeared cleaner, strong smell of cigarette smoke, stairs clutter free. Home safety advice given. Further assessment not completed due to perceived improvements. Review in one month.
-11 to -3 weeks from birth (04 – 05/13)	**LDUH:** Mother attended hospital on nine separate occasions over an approximate nine week period. Routine medical advice and treatment provided.
0 (06/13)	**LDUH:** Child E born prematurely at 30 weeks gestation.
Weeks 0 – 8 (06 – 08/13)	**LDUH:** Child E remained in hospital due to prematurity initially receiving high dependency care and then special care. During this time the mother was contacted by CCS to arrange a new birth home visit.
Week 8 (08/13)	**LDUH & CCS:** Child E discharged from hospital and returned to family home. New birth visit conducted by Health Visitor 1. Family assessment completed.
Week 10 (08/13)	**CCS:** Review home visit conducted by Health Visitor. Suggested weighing of Child E to take place by Community Nursery Nurse and two year check for sibling 2.
Week 11 (09/13)	**CCS:** Community Nursery Nurse conducted home visit. Child E weighed. Concerns noted about home conditions; very cluttered, limited space, strong smell of cigarette smoke, unable to manoeuvre adequately. Advice given. Concerns shared with Health Visitor 2.
Week 11 (09/13)	**GP:** 8 week GP check. No significant concerns noted.
Week 14 (09/13)	**LDUH:** Scheduled attendance at Outpatients Department for review by a senior staff grade paediatrician. No concerns noted. Review recommended in 10 weeks (December). Child E and mother also seen by LDUH neonatal physiotherapist. Unable to complete full assessment due to baby being unsettled. Further appointment made.
Week 15 (10/13)	**LDUH:** Mother did not attend follow up appointment with Neonatal Physiotherapist. Letter sent from LDUH to the mother and CCS informing them of this.
Week 15 (10/13)	**CCS and LDUH:** Mother did not attend clinic appointments.
Week 18 (10/13)	**LDUH & GP**: Attendance in Emergency Department for Sibling 2 and then next day by GP for a respiratory tract infection. LDUH prescribe an inhaler. Concerns noted about the quality of parent – child interaction with Sibling 2 and dirty presentation. Information shared with C&L and Health Visitor 2. Request for health promotion advice to be given. Concerns expressed about home conditions and potential impact on Child E due to his prematurity.
Week 18 (10/13)	**CCS:** Home visit. Concerns about sleeping arrangements were raised.
Week 18 (10/13)	**GP:** Mother attends GP surgery for Child E's first set of primary immunisations CCS attempt a home visit; no access.
Week 19 (10/13)	**CCS:** Attempted home visit by Health Visitor 2. Grandmother deceived Health Visitor and Community Nursery Nurse about presence of children in the house. No access. Health Visitor returned for home visit and gained access.
Week 19 (10/13)	**CCS & C&L:** Announced home visit by Health Visitor 2 and Community Nursery Nurse. Depression assessment offered but declined. No concerns noted. Child E not seen – informed by mother he was sleeping. Advice given. C&L contact Health Visitor 2 to discuss concerns expressed by LDUH. Health Visitor advised that any developments would be reported back to the department. It was reported that, although there were issues, the Health Visitor held no concerns for the children.

Week 22 (11/13)	**CCS:** Home visit by Health Visitor 2. Concerns were discussed. Mother still in pyjamas at 11.30am. States she is scared to leave the house due to local gun crime, lacks confidence. Grandmother will not agree to a further assessment being conducted. Discussion about attending local play group. Health Visitor 2 made contact with Nursery/School.
Week 22 (11/13)	**CCS:** Telephone call to mother as she did not attend the Children's Centre as agreed. Further offer of an assessment of the mother's mental health; declined.
Week 25 (12/13)	**LDUH:** Mother attended neonatal physiotherapy appointment with Child E. No concerns noted with baby developing appropriately.
Week 26 (12/13)	**LDUH:** Child E seen in hospital for a Consultant review. Advice given about nappy rash and oral thrush. Mother uncertain about immunisations. GP to prescribe for Candida. Health Visitor 2 to monitor weight as it had dropped a centile. Discussion about weaning onto different formula. Growth on 2nd – 9th centile; mother advised to change milk from specialist formula to Cow & Gate and to start weaning. Plan to review in 3 months. Dietetic follow up not carried out.
Week 29 (12/13)	**CCS:** Health Visitor 2 & Community Nursery Nurse conduct a home visit. Mother did not followed advice about nappy rash.
Week 30 (01/14)	**CCS:** Health Visitor 2 leaves a message for the mother reminding her about the need to collect prescription and treat nappy rash as she had failed to do so.
Week 30 (01/14)	**LDUH:** Ambulance called to home. Child E found dead.

4.3. Prior to all of the above contacts in respect of Siblings 1 and 2 and Child E, evidence submitted to this review indicates that Luton Borough Council Housing Department formally expressed concerns to their tenants about the poor condition of the garden at the family home in 2006 (rubbish and dog faeces in the garden). No further action was taken.

4.4. Additionally, at the outset of this review process being commissioned it was discovered that the mother was pregnant with her fourth child. It is believed that the mother would have known about being pregnant at the time of Child E's death. Agencies were unaware of this pregnancy until the mother booked into antenatal services at 20 weeks.

5. Outcome statements

5.1. The cause of Child E's death is undetermined however the findings of the post mortem indicate a significant failure to thrive, highlighting dehydration and malnutrition as significant contributory factors.

5.2. Child E's mother and grandmother was both found guilty of cruelty to a person under 16 years of age under the Children and Young Persons Act 1933 and guilty of causing or allowing the death of a child under the Domestic Violence, Crime and Victims Act 2004 – and sentenced accordingly.

5.3. Following the death of Child E all of the siblings were removed from the mother's care by Order of the Court. For this to happen, a threshold of significant harm, or the likelihood of significant harm must have been proven. Care proceedings have concluded and the three siblings are now subjects of Special Guardianship Orders and living with members of the extended family. They are all reported to be making positive progress.

6. Review and analysis of single agency contact, including findings

6.1. Information from all the agencies that had contact with Child E and family has been collated as part of this review process. This has allowed a unique opportunity for the Independent Reviewer and the SCR Reference Group to see the entirety of agency involvement. In turn, this has prompted agencies to understand where they can learn about improvements in practice. Findings[10] are presented throughout which are then used to inform a thematic analysis in section 6.

Luton & Dunstable University Hospital (LDUH)

6.2. Submissions to this review reveal that the hospital's first contact was with the mother when she was 17 years old and pregnant with her first child (Sibling 1). During this pregnancy there was nothing of significance noted, with appropriate support being provided by the team responsible for teenage pregnancies. Midwives met with the mother on a number of occasions (see Table 1). Practitioners have described visiting the family home and observing 'stuff' and having concerns about the cigarette smoke (July 2009 to March 2010). Evidence submitted shows that there were appointments missed by the mother when midwives attempted to visit with no access gained but also developmental checks were cancelled by the mother. Primary immunisations were not given as scheduled.

6.3. Finding: Information gathered during this period was not shared by LDUH with other key agencies e.g. the health visiting service or the local authority children's services, as there were no safeguarding concerns identified.

6.4. A failed pregnancy in June 2011 prompted internal communication (via a cause for concern letter) which was then prioritised by the hospital safeguarding team. In turn this prompted the Midwifery Service (LDUH) to share information externally with Cambridgeshire Community Services Health Visiting Service, highlighting cigarette smoking, a cluttered house, and bird droppings from a pet bird. The resultant plan of action was that the Health Visiting Service would make contact with the mother to assess the situation.

6.5. Evidence reveals a similar pattern of engagement by the mother during the second successful pregnancy and subsequent birth of Sibling 2 (this included a short period of Sibling 2 being re-admitted to hospital three days after initial discharge). Similar conditions in the home environment were noted by the Midwifery Service as well as limited parenting skills and poor hygiene when feeding the young infant. On this occasion, this information was shared through an electronic safeguarding alert system with the Health Visiting Service but also the Children & Learning Department (November 2011 to June 2012).

6.6. Finding: At this point information was appropriately shared with other agencies by LDUH given the known history and presenting issues.

6.7. Although we see a similar pattern of engagement by the mother during the pregnancy for Child E, it is evident that this pregnancy appeared more difficult and stressful for her. She attended the hospital on nine separate occasions (April to May 2013). During this pregnancy records indicate that midwives observed and discussed with the mother concerns about the home environment, housing issues, risks of smoking in the

[10] Finding: a judgement or conclusion about a particular aspect of professional practice (positive or negative) where there may be learning.

house with children present (Siblings 1 & 2) and general support needs. The mother refused to consent to a Common Assessment Framework (CAF) being completed.

6.8. Records show that these concerns were also shared with the Health Visiting Service (May 2013). Appropriately (based on research and national learning from serious case reviews[11]), domestic abuse was considered by the hospital given the multiple admissions to hospital during this time, despite there being no explicit evidence it was an issue.

6.9. Finding: This information was appropriately shared internally by LDUH with the Safeguarding Midwife and externally to the Health Visiting Service.

6.10. Following Child E's birth (10 weeks prematurely), positives were noted by maternity staff in as much as staff observed the mother being confident and caring with Child E whilst in hospital, although her visiting was late in the day due to caring for the older siblings. There were no concerns about her interactions with Child E at this time.

6.11. Child E was discharged home seven weeks after birth (August 2013). Review of records show there was a delay by LDUH in informing Cambridgeshire Community Service Health Visiting Service about the birth (CCS received a letter six days after birth and then a notification 13 days after birth). Given that Child E remained in hospital during this period and the care of Child E was noted to be satisfactory, the need to share information immediately was less critical. During this period there were a series of telephone exchanges between staff at the hospital, Health Visitor 2 and the mother. Health Visitor 2 was kept informed of the delays in discharge.

6.12. Finding: The telephone contact between staff on the neonatal intensive care unit in hospital and Health Visitor 2 indicates good practice.

6.13. In September Child E attended hospital for a routine outpatient's appointment, being seen by a Doctor and the neonatal physiotherapist. No significant concerns were noted, particularly regarding weight gain.

6.14. Concerns were raised by LDUH when Sibling 2 was brought to the hospital in October 2013. Sibling 2 was described as dirty and wearing dirty clothing and it was felt that the mother was not coping well with three young children. This resulted in a further electronic safeguarding alert being completed and shared with the Health Visiting Service. Information was shared by Health Visitor 2 to the Safeguarding Nurse for children in the hospital about the maternal grandmother smoking heavily and hoarding. Information was relayed back to hospital staff that the home environment may pose a risk to a premature baby. Information was also shared with local authority Specialist Family Support service. A plan was agreed between LDUH and the Health Visiting Service that a referral would be sent highlighting the need for assessment by the Specialist Family Support service but also support from the Health Visiting Service.

6.15. Finding: This was an appropriate course of action by LDUH; concerning information had been gathered by the hospital about all three children and shared with other agencies. Alerts were raised in June 2012, May and October 2013.

[11] NSPCC Briefing, Domestic abuse: learning from case reviews: What case reviews tell us about domestic abuse, November 2013

6.16. At this point in time the mother, aged 22 years had care of three children all under the age of 3 years 8 months. This would be a significant task for any capable and well-resourced adult, let alone a young single mother in less than advantageous circumstances.

6.17. The final contact LDUH had with Child E, prior to death, concerned a routine series of appointments with the Consultant and the Neonatal Physiotherapy Team (December 2013). No significant concerns were raised by either professional about Child E's weight or appearance. However, Candida nappy rash was noted and the mother was clearly advised to see her GP, obtain medication to treat the condition, and have it reviewed. Child E's weight was to be monitored by the Health Visitor and GP as it had dropped on the centile chart. Advice on weaning and feeding was also given. A letter was written by the Consultant to the GP outlining these findings. This letter was typed the day after the consultation and received by the GP three days later.

6.18. Finding: Independent and expert medical opinions[12] obtained for the purpose of this review have noted that, based on documentary review, there was evidence of Child E failing to consistently gain weight from the point of discharge in August. Although this opinion has been gained with the benefit of hindsight and with all information to hand, the failure to consistently gain weight would have been apparent at the consultation in December. The reason this was not spotted was due to a professional failure to compare individual measurements of growth against an overall trend. This would have revealed a downward trajectory and would have been sufficient to trigger prompt action. An additional contributory factor, of a procedural nature, was that there was an inappropriately wide 12 week gap between two reviews of Child E (particularly given prematurity) where there was an identified weight gain problem.

Finding: It would have been more helpful for LDUH to have issued the medication or at least the prescription to the mother from the hospital at that time in December, rather than transfer the issue of a prescription to the GP practice. This would have ensured the mother had the correct treatment and could begin applying it immediately.

6.19. Of note, at the time of the mother's final visit to the hospital in December 2013 she would have been 10 weeks pregnant. This pregnancy was not however known about by agencies at the time.

6.20. Also of note, throughout the involvement of the hospital with these three pregnancies the children's father was never seen. No information has been submitted to this review to indicate that there was any questioning about the father. Until very recently, the routine asking of information about a prospective father has not been sought. This is changing and the Midwifery Team is currently developing a new booking application which will seek information about fathers e.g. names, date of birth, address, contact arrangements, mental health/drug misuse, other children. It is planned that this will become procedural by the summer of 2015.

6.21. In summary, firstly evidence indicates that LDUH Midwifery Services acted appropriately with information they had gathered in the course of their involvement with the mother and children with the exception of not sharing information with other agencies during the first pregnancy in 2009. Information was gathered and used to inform an assessment of the level of individual vulnerability and potential risk to each

[12] Independent and expert medical opinion gathered from three sources: 1) The former Designated Doctor for Safeguarding Children & Young People, 2) The current Consultant Community Paediatrician and Designated Doctor for Safeguarding, 3) Professor and Consultant Neonatologist appointed for legal proceedings.

of the children; this was achieved in a timely manner. Electronic database systems were used by LDUH to share this information and these appear to have been effective. These findings should be considered in the context of inspection findings made three months following Child E's birth. The inspection by the Care Quality Commission[13] noted that *"… there were enough qualified, skilled and experienced staff to meet people's needs in the main hospital, however in the Maternity Unit staffing levels were not in line with national expectations which meant staff were working under increased pressure …".* Despite these pressures expected policy and procedure were followed. Secondly, two opportunities were missed by medical staff in September and December 2013 to effectively respond to Child E's failure to consistently gain weight.

Cambridgeshire Community Services (CCS Health Visiting Service)

6.22. Cambridgeshire Community Services has submitted a detailed and comprehensive chronology of key practice episodes. It is evident from these submissions that there were a number of opportunities for the community health service to gather information, make assessments and respond.

6.23. CCS first had contact with Sibling 1 at a routine new birth visit. Further developmental checks were cancelled by the mother and there were delays in Sibling 1 receiving primary immunisations due to the mother not attending appointments. No records of these contacts exist on the CCS electronic database which may be due to it not being fully implemented at this time. No concerns about the home conditions at this point in time are therefore logged.

6.24. A further pregnancy in June 2011 prompted liaison between the Midwifery Service (LDUH) and CCS, resulting in a cause for concern letter (June & July 2011**)** being shared. This pregnancy failed but the mother soon became pregnant again prompting a further sharing of information between professionals highlighting cigarette smoking, a cluttered house and bird droppings from a pet bird. The resultant planned action of this sharing of information was that the Health Visiting Service would make contact with the mother. Concerns were shared to the CCS Safeguarding Team[14] via the electronic share mechanism (August 2011). An electronic 'share' is an on-line mechanism where one person can request another to view information; dependent on the content the sharer may, or may not, be seeking advice.

6.25. Finding: The sharing of information about a further pregnancy to the CCS Safeguarding Team was an appropriate course of action given the level of concerns expressed. However, this review has shown that front line practitioners in CCS and members of the Safeguarding Team had differing expectations about how information would be responded to.

6.26. There were a series of exchanges between the Midwifery Service and the Health Visiting Service over a four month period from the point when professionals were alerted to the failed pregnancy (June to October 2011). Records reveal that attempts by the Health Visiting Service to visit or contact the mother were first made from October 2011. Other attempts were made over this period by the Midwifery Service but these either failed or showed that home conditions had not improved. There were also five liaisons between the Midwife and Health Visitors (June to December 2011), indicating a high level of contact beyond that which would routinely be expected during a pregnancy.

[13] Care Quality Commission, Inspection report for Luton & Dunstable Hospital, published October 2013

[14] CCS Safeguarding Team: A team of experienced and specialist practitioners who do not hold a specific caseload or undertake health visiting duties. They provide supervision, support and additional expertise to Health Visitors.

6.27. Finding: As well as seeing an increasing number of risk factors we can also see a developing picture of failure to engage with services and non-compliance by the mother. It is reasonable to conclude that these risk factors could have been identified and considered at the time.

6.28. Evidence submitted also reveals confused practice by the Health Visiting Service during this time period; uncertainty whether a CAF had been completed, two separate Health Visitors making home visits on the same day with no apparent coordination, and liaison with two separate Midwives. It has not been possible to interrogate these episodes further to explore the reasons for the above confusion as the individuals involved are no longer employed by CCS. The review has found that, at this stage, there was no expectation that the Safeguarding Team would take any action in terms of providing advice as the 'share' to the Team was for information only. This Team have reported that there are too many cases shared to make reading of each case sustainable and practicable.

6.29. Finding: Notwithstanding assessment and information sharing by LDUH Midwifery Service, the response by CCS Health Visiting Service around December 2011 was fragmented and lacked coordination.

6.30. A further cause for concern letter was raised (April 2012) by the Midwifery Service to the Health Visiting Service and local authority Children & Learning Department as the mother was observed to be unkempt, had been seen shouting and smacking Sibling 1, and failing to provide appropriate supervision. At this point the mother was pregnant with Sibling 2. The next recorded contact by the Health Visiting Service was in May 2012 at a new-birth visit for Sibling 2.

6.31. Finding: There is no recorded explanation or apparent resolution about actions taken as a result of this cause for concern letter being shared in April 2012, other than an unsuccessful home visit by the Health Visiting Service.

6.32. Of note, information was 'shared' with the CCS Safeguarding Team. As stated earlier, evidence indicates (written submission and interviews) differing expectations about what action might be taken once information is 'shared'. This period of time reveals further situational risks – potential self-neglect by the mother during pregnancy, a failure to respond to Sibling 1's health needs by not attending routine appointments, a failure or inability to appropriately supervise or manage Sibling 1, experiencing stress resulting in shouting and smacking, a disclosure of historical sexual assault by the mother and a refusal of home visits by the mother. These factors clearly indicate an escalation of potential risks to Sibling 1 and the unborn Sibling 2. At this point in time it is possible to see a developing picture where a more robust style of early intervention would have been entirely reasonable in order to promote the children's welfare.

6.33. In May 2012 Sibling 2 was born prematurely at just over 35 weeks. Home visits by the Health Visiting Service were either declined or failed. Sibling 2 was admitted to hospital 11 days after birth due to feeding problems and weight loss. This prompted information to be shared with the local authority Children & Learning Department by LDUH, as there were concerns about the mother's care of the baby whilst in hospital. This will be examined more closely in the section on Children & Learning Department.

6.34. Additionally, two home visits were achieved by Health Visitor 1 during this time – one in which a vulnerability risk assessment[15] was completed. This revealed a number of risk factors which were previously known by the Health Visiting Service. Records reveal that Health Visitor 1 also discussed with the mother the use of the Graded Care Profile assessment framework[16].

6.35. An appropriate plan of intervention and support was initiated during this time period – the use of a risk assessment framework, the suggestion of using a further assessment framework (Graded Care Profile), a suggested plan for a Community Nursery Nurse to visit on a weekly basis, advice being given about issues such as hygiene when feeding, prevention of SIDS[17] , risks associated with smoking and needing to ensure a clean and tidy home environment, and the commissioning by Specialist Family Support of additional support.

6.36. Finding: Using hindsight to our advantage, this review finds that this period of time (May to June 2012) offered a valuable opportunity. As well as managing the immediate and presenting concerns affecting Sibling 1 and 2, ongoing support could have been considered. The opportunity of early and coordinated intervention was not maximised because there was no one single agency taking a lead on overseeing case management; agencies were working in relative isolation of one another. The natural opportunity presented to the Children & Learning Department to take this lead was not taken up because the Health Visiting Service considered that they had a greater role in working with the family and did not see the need for shared management.

6.37. Over the following weeks home conditions fluctuated, sometimes with slight improvements and at other time's conditions falling back. Some compliance was demonstrated by the mother with access to the home achieved, an overdue developmental check being completed for Sibling 1 and developmental checks being completed for Sibling 2.

6.38. The intention of using the Graded Care Profile was never followed through with action because of the perceived improvement in home conditions. Records also reveal that there was no further contact with the family until November 2012 when Health Visitor 1, opportunistically, achieved a successful home visit. Home conditions were observed to have deteriorated with a strong smell of cigarette smoke, dirty carpets with rubbish on the floor, and inappropriate bed sharing arrangements. Additionally, Sibling 2 had only received one set of immunisations and was now behind the recommended schedule of immunisations. Further mention of completing a Graded Care Profile was raised – but again this does not appear to have been followed through because Health Visitor 1 did not gain access to the home. Health Visitor 1 did share information about this deterioration with the Team Lead. The advice given included, completing an internal initial assessment pro-forma to consider seeking additional support to manage the case, but also to contact Specialist Family Support.

6.39. Finding: The response by Health Visitor 1 to share the concerns to the CCS Safeguarding Team was appropriate. The Health Visitor, on the advice of the CCS Safeguarding Team, did contact Specialist Family Support who confirmed that they were not actively involved with the family. The Health Visitor shared the concerns but also detailed a plan of action to be led by the Health Visiting Service. The agreed plan of action

[15] A locally developed assessment tool that is designed to be used in conjunction with the Graded Care Profile as a means of initially identifying a child at risk of neglect through a range of listed factors which are associated with vulnerability

[16] Graded Care Profile, http://lutonlscb.org.uk/graded.html

[17] Sudden infant death syndrome (SIDS): the sudden, unexpected and unexplained death of an apparently well baby

(as above), unless a further formal referral was received, relied on the Health Visiting Service to take the lead with there being no role for Specialist Family Support. This was a missed opportunity.

6.40. In February 2013 the grandmother was seen at an opportunistic home visit by Health Visitor 1. A further home visit took place three days later and home conditions were noted to be similar although less cluttered. The level of smoking remained an issue. The use of the Graded Care Profile was raised again but due to the perceived improvement by the Health Visitor, this was not followed through. This reflects a level of professional optimism[18] in that small changes were deemed acceptable but failed to acknowledge the history and wider concerns for the welfare of the children. Calder (2008[19]) discusses optimism, noting that practitioners often *"… over-estimate the level of progress made, fail to consider the significance of past agency experiences of dealing with the family and make decisions based upon opinion rather than fact …"*. A further appointment was to be made for one month. This did not happen due to Health Visitor 1 going on extended sick leave. The next time the Health Visiting Service made contact with the mother was five and a half months later when the case was transferred to Health Visitor 2. The case was not picked up by the Health Visiting Service during this intervening period.

6.41. Finding: There was an unhelpful level of professional optimism by Health Visitor 1 about the changes and improvements made by this mother. The case (and therefore concerns and risks) was allowed to drift for over five months before being re-allocated to Health Visitor 2.

6.42. When Child E was born, prematurely, the LDUH appropriately referred their concerns to CCS. At this point the current (and newly appointed) Health Visitor 2 considered that the home conditions had improved, with the exception being the level of cigarette smoking. Action about beginning a Graded Care Profile had still not been taken. As stated earlier, Child E was in hospital for seven weeks until discharge. During this period, the review has noted good practice by the hospital in communicating with Health Visitor 2 (until the actual point of discharge).

6.43. Finding: Records highlight good practice by Health Visitor 2 in making contact, or attempting to make contact, with the mother whilst Child E remained in hospital.

6.44. At the time of Child E's birth, Health Visitor 2 had been registered as a Health Visitor for less than a year and was still under guidance from a preceptor[20]. Health Visitor 2 had five child protection cases to manage (cases where children were subject to Child Protection Plans). No other team member had more than six child protection cases at this point in time. This seems to be an excessive number of high risk cases for a recently qualified practitioner.

6.45. From interview, handover arrangements between Health Visitors at this time have been described as less than satisfactory. Health Visitor 2 has described cases being 'swapped' between Health Visitors rather

[18] Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003–2005 Brandon, M., Belderson, P., Warren, C., Howe, D., Gardner, R., Dodsworth, J., Black, J., Research report: DCSF RR023,

[19] Calder, M., 2008, Professional dangerousness: Causes and contemporary features , p 67, in Contemporary risk assessment in safeguarding children, Russell House publishing

[20] Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals, 2010, p 10: Defining preceptorship: *"A foundation period for practitioners at the start of their careers which will help them begin the journey from novice to expert.",* Department of Health, HM Government

than being transferred on a more considered and formalised basis. More experienced practitioners 'swapped' complex cases with less experienced colleagues. One interviewee recounted "*… in other [locality] areas it would have been down to the Team Lead to make the decision about a swap. As a result of it being up to me the swap was sometimes unfair. One case would not be swapped like for like. The people I was swapping with were, generally, more experienced than me … this was a case we swapped because it was a new birth, the previous Health Visitor did not feel she was getting anywhere and it needed a new fresh pair of eyes. I was aware that the mother had declined a CAF …. Although I was told about the issues I suppose I wasn't aware, in my naivety, what I was taking on. Having a completed paper handover form would have helped so that I got the details and likely issues …".*

6.46. Finding: Health Visitor 2 had a very limited amount of experience of dealing with cases where child protection was a feature and appeared to carry a comparative caseload to other, more experienced practitioners. Transfer arrangements between practitioners were not as tightly managed as they could have been which led to cases being inappropriately allocated to less experienced practitioners.

6.47. Visits by the Health Visiting Service were achieved although there were also failed attempts to gain access to the home and see the children. Health Visitor 2 and the Community Nursery Nurse made strenuous efforts to make contact with the mother between June and September 2013 but met continued non-compliance from the mother.

6.48. One Community Nursery Nurse, has described *"… experiencing great difficulty in finding any space to undertake the developmental checks on both Sibling 1 and 2 and finding the environment psychologically claustrophobic … it was difficult to engage with the mother and grandmother regarding the home environment and, in particular, their smoking and healthy eating for the children despite the mother appearing to be attentive …*". The Community Nursery Nurse felt *"… that she could not challenge some of the behaviours she was witnessing i.e. children being given a constant supply of sweets and sugared drinks particularly in the presence of the grandmother … she also felt that any decision to make a child protection referral had to be the responsibility of the Health Visitor".*

6.49. Finding: The Community Nursery Nurse has described differing levels of experience, qualification and perceived status, including being viewed as less 'qualified' within the organisational structure as a barrier to making safeguarding referrals but also challenging the mother over her care.

6.50. In October 2013 the mother attended LDUH with Sibling 2 due to a cough. Staff were however concerned about the quality of the relationship between the mother and the child but also about the grubby appearance of the child. Whilst this prompted a referral to be made to the Children & Learning Department by LDUH the matter was also followed up by the CCS Rapid Response Team (a team that can accept referrals from A&E, Walk in Centre and respond to acute health needs or follow up treatment)**.** Concerns about the quality of the interaction between the mother and Sibling 2, but also the sleeping arrangements for Child E were observed. Further contact and visits were attempted during October 2013 but were either met without success or declined by the mother. One such attempt encountered a level of deceit by the grandmother who stated that the children were not at home, just as Sibling 1 came to the door.

6.51. Health Visitor 2 has reflected on their involvement in this case during the early stages of managing the case *"… I didn't start from where the previous Health Visitor left off – I started from afresh …".* Reflection on this case has also prompted the Health Visitor to consider that *"Since Specialist Family Support had received*

the referral it would have been very helpful for a joint visit. It would have been better if I had made a paper referral to Specialist Family Support with a list of all the activities and with a chronology". This is a useful reflection from a practitioner with limited experience and one that does seem entirely reasonable given the presenting circumstances; it does also however rely on the Health Visitor to use their interpersonal skills and share information in a manner which sufficiently engages and alerts a Social Worker to respond accordingly. This did not happen.

6.52. Finding: The mother and grandmother failed to comply, and attempted to deceive professionals. Attempts by professionals to engage and assist this family were thwarted.

6.53. Finding: Health Visitor 2 has described 'starting again' with this family. Brandon et al (2008, p11)[21] refers to this "… one common way of dealing with the overwhelming information and the feelings of helplessness generated in workers by the families, was to put aside knowledge of the past and focus on the present, adopting what we refer to as the 'start again syndrome'…. The 'start again syndrome' prevents practitioners thinking and acting systematically in cases of long standing neglect".

6.54. A further opportunistic joint visit by Health Visitor 2 and the Community Nursery Nurse took place at the end of October 2013. This further visit was intended to be as a follow up to the referral made to Specialist Family Support. The mother was seen and the children were reported to be present in the house but only Sibling 2 was seen. Child E was not seen and was said to be sleeping and to have a cold. This was a missed opportunity to exercise some professional curiosity[22] and observe whether Child E was safe, view the sleeping arrangements for all children as well as see the condition of the upstairs area of the family home. On reflection, Health Visitor 2 has appreciated that this was a missed opportunity but has described challenges that affected judgement. In particular, these relate to being *"… very conscious I was a male health visitor going into a woman's house and asking if I can see the bedroom …"* to see the infant's sleeping arrangements.

6.55. Finding: The home visit in October 2013 was a missed opportunity to see and check Child E's health, weight and development.

6.56. A number of issues were discussed with the mother including the quality of the attachment to Sibling 2, lack of immunisations, impact of the environment and lack of stimulation on the children's development, attendance at the Stay and Play Group for Sibling 2 and attendance at the clinic/GP for Child E, the mother's mental health and housing. The mother declined the offer to complete a depression assessment (Whooley Depression assessment[23]).

6.57. Following this visit Health Visitor 2 contacted Specialist Family Support to inform them of the findings. It was reported that there were no concerns for the children but that a Graded Care Profile would be

[21] Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003–2005, Brandon, M,. Belderson, P,. Warren, C,. Howe, D,. Gardner, R,. Dodsworth, J,. Black,, J,. Research Report DCSF-RR023, DCSF

[22] For the purpose of this review professional curiosity is defined as the ability to exercise a sufficient level of questioning and challenge in order to fully understand or appreciate a situation or event. The ability to exercise professional curiosity may develop with experience.

[23] NICE, 2007, Antenatal and postnatal mental health: Clinical management and service guidance, now replaced with NICE guidelines [CG192], 2014

undertaken. The Health Visitors views about there being no concerns were further reinforced when he made contact with the Nursery School and was told that there were no concerns about Sibling 1.

6.58. Finding: Health Visitor 2 appropriately made contact with the Nursery/ School but did not use the opportunity to its greatest advantage.

6.59. Finding: The opportunity to discuss the family and share concerns about the level of vulnerability and risk by the Health Visitor with Specialist Family Support was not maximised. The follow up contact by the Health Visitor to Specialist Family Support gave a false assurance about the children's circumstances.

6.60. Health Visitor 2 made arrangements with the mother to meet her away from the home in order to 'gather information' as the practitioner felt the grandmother was an unhelpful influence on the mother during attempts to discuss issues in the family home. This took place and records indicate that a list of concerns was covered in this meeting. The mother declined the use of a CAF and the Graded Care Profile. The mother also described being scared of leaving the home due to local crime.

6.61. Finding: Health Visitor 2 usefully attempted to engage with the mother outside of her usual circumstances, recognising a potentially damaging dynamic between the mother and grandmother.

6.62. In December 2013 Child E attended a routine paediatric outpatient appointment. Child E was found to have mild oral thrush and Candida nappy rash. The mother was advised to make an appointment with the GP for a review, obtain a prescription, as well as seek advice about weaning. The consultation at the hospital also advised that the Health Visitor should monitor Child E's weight as it had dropped a percentile. An unannounced home visit by Health Visitor 2 and Community Nursery Nurse took place three weeks later in January 2014 and found a very smoky house and Child E had not gained sufficient weight. The prescribed medication for nappy rash had not been collected. Weaning arrangements for Child E were also noted to be unsatisfactory. Siblings 1 and 2 were however noted to be clean. Evidence highlights that the mother was asked to present Child E for weighing in 3-4 weeks. The mother's response was *" … this would depend on how she was feeling …".* Child E had serious nappy rash but had also not been transferred onto the appropriate feeding formula. The mother had begun weaning and was using bought jars of baby food. The mother declined advice about using family made foods. A follow up unannounced home visit two days later in January failed. One further telephone contact was attempted but without success. Child E died four weeks later.

6.63. Finding: This review has found that the percentile charts used by the Health Visitor to chart Child E's weight development was the one found in the Red Book (record for individual child health given to all children following discharge from hospital). This records weight/height gain from 32 weeks. Child E was born prematurely and the percentile chart used in the hospital setting was different. Health Visitor 2 adjusted the weight gain from 32 weeks and not 30 weeks. This would have exaggerated Child E's failure to gain weight; there was no analysis and interpretation of Child E's weight and growth data.

6.64. We now know that at this time the mother would have 10 weeks pregnant. This was not known about by agencies at the time and was unlikely to be evident.

6.65. In summary, evidence indicates that the Health Visiting Service was in a prime position to take a lead on gathering information, make an assessment of the children's circumstances and pass this on to the local authority Children & Learning Department requesting a more coordinated and robust approach.

Luton Borough Council: Children & Learning Department

(Comprising of the Specialist Family Support service - which covers social care functions and referral and assessment and Prevention and Early Intervention service - which covers the CAF coordinating function)

6.66. Documentary evidence reveals that their first contact with this family was shortly following the birth of Sibling 2 (June 2012). The LDUH had made a referral as, following a home visit by the Midwifery Service, concerns were expressed about the conditions of the home but also the ability of the mother to care for the baby. This resulted in a visit to the family home via an independent social care provider. This service was initially sent by the Emergency Duty Team (EDT provided by a neighbouring authority – Central Bedfordshire) to complete a welfare check on Sibling 1. The house was found to be clean but with various hazards around the home, and it being 'cluttered'. The family were advised to clean it up. A return visit was completed the following day by the independent social care provider and improvements were noted but the family were assessed as 'struggling'. Based on this assessment, EDT agreed that Sibling 2 could return to the family home from hospital. Central Bedfordshire EDT referred this information to the Luton Referral and Assessment Team of the Specialist Family Support service recommending a follow up the next day. This follow up visit did not happen and no explanation can be provided for this omission. Essentially the brief assessment was a temporary and uncoordinated intervention to a more chronic situation which needed a more coherent and sustained response.

6.67. Finding: The Referral and Assessment Team missed a valuable opportunity to follow up concerns, but also to make further assessments on the family, despite recommendations from EDT and concerns being raised by the independent social care provider. No reason can be provided for this omission. This gave the impression to CCS (and Health Visitor 2) that the concerns were either not at a level that warranted further intervention from the Specialist Family Support service or there was no role for them as part of a multi-agency approach to dealing with the concerns.

6.68. The Specialist Family Support service's second contact with other professionals was approximately four months after Child E's birth (October 2013). This contact arose following a referral to them by the LDUH who expressed concerns about the care and treatment of Sibling 2. This resulted in an appropriate and pro-active exchange of information between the hospital, the Specialist Family Support service and Health Visitor 2 about the care of the children, including the home conditions and parenting issues.

6.69. The Specialist Family Support service made a clear and reasoned decision to not take any further action based on the information they were presented with. The Health Visiting Service was engaged with the family, were visiting regularly and was cognisant of the need to complete further assessments (specifically regarding both mental health and neglect). Progress on these plans was provided by the Health Visiting Service, including information about the mother's failure to follow advice and refusal to participate in assessment work. However, this failure to comply was tempered with the Health Visiting Service detailing that there were no concerns about the children and that a further update would be provided to the Specialist Family Support service if it was deemed necessary. Records indicate that no information about recent historical concerns was shared. On this basis, the Specialist Family Support service did not undertake any further assessment nor gather any additional information, but instead closed the case.

6.70. Finding: This review finds that the Specialist Family Support service considered that they had a clear rationale to close the case. This was based on the fact that another professional (Health Visitor 2) was having

regular contact with the family and there appeared to be a clear plan of action which included the need to return to Specialist Family Support should further assistance be needed. Perhaps crucially, the Health Visitor had expressed no concerns about the children based on the content of the original referral. As there had been no follow up of their involvement in 2012 the Specialist Family Support service's rationale was based on incomplete information.

6.71. Evidence submitted to the review reveals there to be a reoccurring issue of uncertainty, presented in both the LDUH and the CCS submissions about whether a CAF was ever completed. The local authority Prevention and Early Intervention service would routinely take the lead on coordinating a CAF. Evidence submitted to the review reveals that there are no records submitted to Prevention and Early Intervention service to indicate that a CAF was ever completed. This therefore leaves a question about why LDUH and CCS ever thought a CAF had been completed. No explanation can be provided about this.

6.72. In summary, we see attempts to engage the local authority Children & Learning Department through the sharing of information by the LDUH and the Health Visiting Services. The Specialist Family Support service gave reasoned judgements about why they would not become involved in 2013. However, the review has also discovered that the Specialist Family Support service missed an important and valuable opportunity to engage with this family and professionals in 2012.

General Practitioner and Surgery

6.73. A chronology of contact and key episodes with the GP and Surgery has been submitted to this review. Practitioners have described a positive working relationship with the mother, who appeared similarly to any other typical young mother. Appointments were generally kept, there were no particular or remarkable health concerns known about - physical or mental – and there was no known history of domestic abuse, substance misuse or criminality.

6.74. Records indicate a mixed picture of attendance at the nominated Surgery by the mother, with seven attendances to actually see a GP between February 2010 and December 2013. There are also records of the mother seeing an out of hours GP, but also seeing a GP at a local NHS Walk in Centre three times in 2013. Otherwise, documentary evidence reveals a considerable amount of information held by the GP and Surgery that relates to other health professional contact with the mother e.g. health visiting and midwifery. These records are simply an account of what those professionals were doing, or had done, rather than specific contacts with or interventions by the GP.

6.75. It is important to consider the context in which GPs and Surgeries operate in order to appreciate their involvement with children and families. GPs provide a spectrum of care within a local community and deal with a diverse range of problems including those with physical, psychological and social aspects.

6.76. A theme emerges about how information was not used to aid a more rounded understanding about how this mother was living her life and, in turn, how this might have affected her children. This information could have been gathered together in a coherent way, over a period of time. This is highlighted by research[24] (2014) which refers to some of the strengths of GP practice *"… the most cited benefits of recording wider information about the child and maltreatment related concerns in general practice are making children with*

[24] The GP's role in responding to child maltreatment: Time for a rethink? An overview of policy, practice and research, July 2014, pp 18 – 25, NSPCC, Royal College of General Practitioners, UCL and University of Surrey,

concerns 'findable' on the system, building up a cumulative picture of a family where a series of minor concerns might indicate a serious problem and making concerns known to colleagues …". In this case, from chronological records submitted it is possible to see how this cumulative picture could have been formed by the GP reviewing records with a safeguarding mind-set. This did not happen. This could have been strengthened by there being better documentation of possible neglect and correct coding on the GPs electronic database. This would reflect an appreciation that there was a number of low level concerns regarding the home conditions and that these could have been shared. A discussion between the Health Visitor and GP would also have provided similar insights. Again, there is no evidence to indicate that this happened.

6.77. The above points suggest that the GP and GP Surgery could have taken a greater role in prompting a more holistic assessment of the mother and children. Whilst this may be seen as an ideal, the aspiration warrants consideration, particularly given the unique role GPs have within their local community. The author for the GP submission has also reflected on how this may be achieved;

- There should have been greater vigilance about the missed immunisation appointments. This is a wider issue for GP Surgeries.
- There was no specific and direct contact between the Health Visitor and GP or GP Surgery in this case.
- Access by the Surgery to the local database (System One) would have helped information sharing. Information sharing of this nature relies on permissions being given to different users dependent on their role. In this case, permissions were not in place.
- The issue of how GPs respond to young mothers and offering advice about contraception has been raised. This young mother had four pregnancies and gave birth to three children (one resulted in a miscarriage) before the age of 23 years. This undoubtedly placed pressure and stress on the mother to care for three young children as a single parent whilst living in less than favourable conditions. This would be a significant task for anyone. When considered against the local levels of deprivation and limiting life chances it magnifies risk and vulnerability considerably. The GP was well placed to explore this with the mother.

6.78. A proactive safeguarding mind-set would need to be prompted by a trigger event. On this occasion there was no explicit event but rather multiple births in a relatively short period of time. Whilst multiple births, in itself, may not ordinarily be a problem, when combined with information that was held electronically, it may have prompted a wider analysis of family circumstances.

6.79. Finding: This review finds that on the basis of the information immediately available to the GP, given the involvement of other health professionals at the time, there was no evidence or need to consider any additional monitoring or assessment.

School

6.80. Sibling 1 joined the local primary school in the autumn term of 2013. Prior to this Sibling 1 had sporadically attended a Stay and Play Group in the school; this was a drop-in arrangement. Family Workers delivering the sessions have reflected that there was nothing in the presentation of either the child or mother to cause alarm or concern despite Sibling 1 functioning below age expected levels. When Sibling 1 joined Reception class this picture did not alter. The child presented in appropriate uniform, was clean, and

appeared well fed. Sibling 1's attendance was acceptable at 86% (although Sibling 1 was under school age and there is no requirement about school attendance). Absences appeared routine and the school was notified by the mother when they occurred. No notable information was provided on the admission documentation to prompt further enquiry by the School. Early assessment indicated that Sibling 1 made steady progress once in the school and attained age expected levels across a range of areas comparative with other children from similar social and economic backgrounds. There was also nothing in the manner in which the mother communicated with either the child or staff to cause alarm or concern.

6.81. Finding: On the basis of the presentation by both child and mother the School had no evidence or need to consider any additional monitoring, assessment or information gathering in respect of safeguarding concerns.

6.82. The School has however identified a significant learning point in the course of this review[25]. It is general School practice to provide a non-statutory home visit prior to a child starting school. The School had routinely undertaken these visits so as to provide teachers and staff with an opportunity to see children in their own home environment where they are likely to be more comfortable. This also enabled pre-school paperwork to be completed. It is an information gathering and assessment opportunity.

6.83. On this occasion no home visit took place. This was due to extenuating circumstances at the time and all home visits for admissions over the start of the autumn term 2013 being suspended. This decision was taken by the Head Teacher with School Governor support. The extenuating circumstances involved the significant escalation of gun and knife crime in the local neighbourhood around this time period. This led to armed Police being deployed in the neighbourhood for a short period of time. Understandably, this appeared to have a direct impact on the stability of the local area. Residents were fearful and local service providers were encouraged to manage safety in all areas. This corresponds with the mother's report about feeling scared of leaving the family home around early winter time 2013. However, it is important to note that no specific directive was given by the Police that local services should not go about their daily business. The decision to not undertake home visits was taken by the School as a way of them managing potential risks to staff. The local area does have a history of unrest with high crime rates over a number of years.

6.84. This meant that Sibling 1's home environment was not seen, and School staff were unaware of the living conditions. Using hindsight to our advantage, practitioners have reported during the course of this review that, had they been aware of the condition of the home environment, it would have prompted them to share information and involve other agencies. Using experience, they would also have been able to benchmark their findings against other home environments they visit to inform a judgement about whether a threshold had been reached to warrant a referral to the Children & Learning Department.

6.85. Staff members vaguely recollect a phone call made by Health Visitor 2 to the School in November 2013 though not its exact purpose. No record was made of the call because it seemed to be an enquiry about the general welfare of Sibling 1 during which no specific concerns were shared. The School report that they frequently receive multiple general enquiries, not all which would be logged. It is now understood that the call was part of an attempt by Health Visitor 2 to conduct a more holistic assessment of the family in order to

[25] Overview analysis of single agency key practice episodes, Education, Safeguarding in Education Manager, 25/08/14

then report back to the Specialist Family Support service and that he was enquiring about the quality of attachments rather than the wider concerns about neglect.

6.86. Finding: This review finds that the opportunity to form a dialogue with the School in order to inform the assessment was not maximised by Health Visitor 2.

7. Summary of emerging themes

7.1. The analysis of single agency involvement has made a series of findings from evidence submitted. These findings have prompted agencies to review their practice across a number of areas and have informed what they have learnt as a result of this review. Three themes emerge from analysis of key practice episodes, documentation, interviews and findings. These are;

1) Assessment opportunities and the use of assessment tools to understand the child's experience,

2) Thresholds and professional intervention,

3) Organisational arrangements to promote safeguarding practice, comprising of;

- Training
- Supervision
- Caseload management issues

7.2. Section 9 will examine these three themes in an attempt to help us further understand what happened in this case, and importantly, develop our understanding about the underlying reasons that led individuals and organisations to act as they did. Before doing this, valuable information about the local operating context for professionals is provided.

8. Local operating context for statutory agencies

8.1. The findings of this review, and in particular the actions and responses by statutory services, do need to be considered within a wider context. In 2010 Luton was ranked as the 69th (out of 326) most deprived local authority areas. Trend analysis shows a worsening picture when in 2004 it was ranked as 101st and in 2007 it was ranked as 87th. Of significance to this review, is that the family lived in an area where it is ranked as being in the top 10% most deprived areas in the country. This includes the very highest levels of deprivation across a range of fundamental areas which impact on life chances; housing and access to services (including overcrowding, affordability, homelessness and geographical distance to local amenities), crime (including burglary, violent crime, theft and criminal damage), education (considering educational attainment from primary to higher education), employment, health (including illness, disability ratios, measurements of premature death and the rate of adults suffering mood or anxiety disorders), living environment (both indoor and outdoor), income deprivation affecting children, and income deprivation affecting older people[26]. The specific geographical area connected to this review has a high fertility rate, a high rate of low birth

[26] Luton Borough Council, Research and geospatial information, 2010 indices of multiple deprivation, August 2011

weight babies, high incidence of stillbirths compared to England average, high rate of women with post natal depression, and lone parent households with dependent children[27].

8.2. The independent author of the CCS submission to this review has also outlined highly relevant information which describes the operating context for Cambridgeshire Community Services,

"In 2011 the Government published the Call to Action Health Visiting Implementation Plan 2011 – 2015. The purpose of this was to herald a new approach to the development and provision of Health Visiting Services to children and families. Part of this plan was to increase Health Visitor numbers by training more and Cambridgeshire Community Services, as other Trusts, embraced this and actively recruited from its own workforce and externally, student Health Visitors. It is currently on its fourth tranche. However, although the increase in Health Visitors is a positive it has also brought with it a number of risks. Firstly, there is the increased work load on the newly qualified Health Visitors during the students training and supervised practice, secondly, resources to provide clinical supervision and safeguarding supervision to newly qualified Health Visitors do not necessarily increase incrementally, and thirdly, the organisation has a large percentage of its workforce as newly qualified and inexperienced Health Visitors. There is also the issue of retention in that, despite recruiting CCS has found it difficult to retain newly qualified Health Visitors as Luton, and in particular [the specific locality area in this case]*, are seen as a high risk place to work due to the level of complex social issues. There is also a view that those who come forward to train as Health Visitors are not necessarily of the calibre required to deal with the reality of working as a Health Visitor in areas of high need. CCS is aware of these issues and has placed the Health Visitor Service on the CCS Risk Register".*

8.3. Single agency progress reports by CCS submitted to Luton LSCB provide valuable information about the organisational working context in which frontline health practitioners were operating at the time[28]. Of relevance to this review, health visiting capacity, training and the provision of supervision are highlighted as challenges. Evidence submitted to the review indicates that in order to meet targets of increasing frontline health practitioners (and in turn meet local need) there will be a shortfall in practice teachers and mentors for students. This will undoubtedly challenge the current supervisory requirements and the need to support, what is likely to be, a high level of inexperienced practitioners. This indicates a risk, not only to the organisation, but also those practitioners who attempt to operate in less than favourable conditions. In turn, this potentially leaves children at risk. Similar concerns (amongst the positives) were noted by Ofsted[29] in Luton's most recent inspection *"There has been good progress in attracting student health visitors with the aim that once qualified that they will join the understaffed Luton teams. Capacity is stretched with caseloads double that of the required standard."*

8.4. The level of local need and deprivation clearly poses challenges to local statutory services and practitioners. For Cambridgeshire Community Services - a service working closely with children and families in deprived neighbourhoods - these challenges are obviously compounded by capacity and resourcing.

[27] Cambridgeshire Community Services submission to the SCR Reference Group, 25/09/1

[28] Luton LSCB and Cambridgeshire Community Service single agency highlight reports (Aug/Sept 2012, Sept/Oct 2012, 20/04/13 – 31/08/13, 22/05/13 – 31/08/13, 01/12/13 – 28/02/14) and Health Visiting Service: update on progress against the Health Visitor implementation report (not dated)

[29] Ofsted, 2012, Inspection of safeguarding and looked after children services Luton Borough

9. Assessment opportunities & the use of assessment tools to understand the child's experience

9.1. Statutory guidance[30] explicitly refers to keeping the child in focus and ensuring a child centred approach, *"… failings in safeguarding systems are too often the result of losing sight of the needs and views of the children within them, or placing the interests of adults ahead of the needs of children"*. This is supported by research and inquiry[31]. Horwath (2010)[32] describes the assessment process as being a dual activity alongside actions and interventions, but that practitioners should have *"… identified whether the child is at risk of harm … established the developmental needs of the child … have a comprehensive overview of the family's past history and carers patterns of behaviours, information about family strengths and relevant family and environmental factors …"*

9.2. This review has already noted the opportunities for agencies to gather information and undertake assessments in respect of Siblings 1 and 2 and Child E, and where these could have used to greater effect. A number of professionals used, or attempted (or considered) to use formalised risk assessment frameworks but were very limited in their success. These activities occurred in isolation with no collective assessment and synthesis of information.

9.3. The use of such frameworks reduces the need for individual practitioners to make subjective, and what may be perceived as personal judgements. This is especially so where the assessment tool permits the service user to self-assess. For many practitioners, the use of tools and frameworks can make it easier to ask probing and uncomfortable questions particularly when faced with more challenging and complex scenarios. Importantly they promote evidence based interventions which can be child focused and their initiation and/or completion should not prevent intervention (where necessary during the process) or be viewed as the final action. The following tools/frameworks were used or attempted in this case;

9.4. Pre-CAF and CAF: *" … the CAF is designed to be used when someone is worried about how well a child or young person is progressing (e.g. concerns about their health, development, welfare, behaviour, progress in learning or any other aspect of their wellbeing)and/or; a child or young person, or their parent/carer, raises a concern with a practitioner and/or; a child's or young person's needs are unclear, or broader than the current service can address and require additional support …"*[33]. It provides commonality across services and can assist in facilitating early intervention. A Pre-CAF is a tool that helps practitioners identify when a full CAF might be useful and can be used internally rather than as a multi-agency assessment tool.

9.5. A CAF was considered but never used by either LDUH or CCS. LDUH did however share information via another appropriate mechanism (June 2011 and April/May 2013).

9.6. There are a number of references in the documentary evidence submitted to this review which reveal uncertainty or confusion about whether a CAF had been completed, either by the Midwifery Service or by CCS. The fact that there was uncertainty or confusion about this is a significant finding in itself. This

[30] Working together to safeguard children, 2010 & 2013, HM Government

[31] a) The Victoria Climbié Inquiry Report, p 208, HMSO, London & b) Ofsted, Learning lessons from serious case reviews 2009–2010 & c) Ofsted, The voice of the child: learning lessons from serious case reviews, 2011

[32] Horwath, J,. The Child's World, 2nd Edition, The comprehensive guide to assessing children in need, 2010, p 69, Jessica Kingsley

[33] https://www.luton.gov.uk/Health_and_social_care/children_and_family_services/earlyhelp/Pages/CAF

uncertainty, whilst discovered with the benefit of hindsight, could have been relatively easily solved by someone checking (either LDUH Midwifery or CCS Health Visiting Service, or CCS Safeguarding Team), and being curious, with the Specialist Family Support service. This did not happen.

9.7. This review has also highlighted continued confusion about the overall usage of Pre-CAF and CAF, with agency representatives on the Reference Group highlighting confusion and uncertainty about if, how and when these mechanisms are used. This will be an issue for the LSCB to consider.

9.8. This case has also highlighted that if a parent/carer refuses consent for a CAF to be used there is a need for practitioners to understand the implications of this refusal and consider whether their worries or concerns need escalating or dealing with via another route. It certainly indicates a need to closely monitor the child's circumstances rather than simply accepting the parent's wish. The refusal of consent does not eliminate or reduce risks to children; they remain as does the need to respond to them.

9.9. Home conditions did not noticeably improve and any improvements were very minor and temporary. Engagement with professionals remained limited and all the pre-disposing risk factors (young mother, poor housing, limited resources, and three young children) remained. This should have prompted those professionals involved with the family, particularly around May/June 2012 and then again in October 2013, to increase their concern to a higher level of activity and contact i.e. through a Child in Need or child protection assessment route, which should then have prompted a more robust multi-agency response. This potentially reflects professional optimism and a willingness to accept small changes as a sign that risks were reduced or eliminated.

9.10. Graded Care Profile (GCP): *"… a practice tool which gives an objective measure of the quality of care in terms of a parent/carer's commitment. The quality of care, both negative and positive, is measured across 4 different domains of a child or young person needs - physical, safety, love and esteem. The GCP has been developed to quantify care neglect by objectively displaying both the strengths and weaknesses in different grades (1 to 5), to inform judgements by professionals and parents/carers working together about the intervention required and to measure progress"*[34]

9.11. The use of this tool was mentioned by two health practitioners on several occasions, but never applied. Contributing factors to these missed opportunities include:

- practitioners incorrectly believed that consent was needed in order to use it; consent was never given.
- Health Visitor 1 had received formal training on it as a student and it was discussed during one group supervision session that Health Visitor 2 attended, but otherwise Health Visitor 2 had not received any training on how to use it.
- Formal training via the Luton LSCB had been available in January, May, July, September and November 2012 and January, March 2013. No further training was provided during the time of Health Visitor 2's involvement with this family as the training offer had been withdrawn by the LSCB because of the low take up of training by agencies.

9.12. During an interview with Health Visitor 1 about their involvement in this case and their use of assessment frameworks, the following reflections were noted, *"…the Health Visitor view was that [the*

[34] Graded Care Profile, http://lutonlscb.org.uk/graded.html

Graded Care Profile] was a wordy document, called for subjective judgements to be made and required the consent of the parent … the Health Visitor was unsure whether she had built a good relationship with [the mother], wondering whether [the mother] had 'not liked her' but also referred to feeling like she was 'hitting a brick wall' and wondering where she went from here. [the Health Visitor] also appeared uncomfortable about making what were perceived as 'subjective judgement's' as to what was considered 'good enough' seeing this as comparing standards with someone else's". Research into other serious case reviews[35] has found similar discomfort by professionals *"… efforts not to be judgemental becoming a failure to exercise professional judgement …"*. Whilst this reflects a lack of confidence in applying an assessment framework (that is specifically designed to counter these individual barriers), the CCS submission states that this is not an unusual issue for newly qualified or inexperienced professionals and one which should be addressed through supervision.

9.13 Whooley depression assessment: A series of questions designed to identify and assess post natal depression. Clinical guidance[36] recommends that healthcare professionals ask two questions at a woman's first contact with primary care, again at her booking visit, and again post-natally (usually at 4-6 weeks and 3-4 months): 1) During the past month, have you often been bothered by feeling down, depressed, or hopeless? 2) During the past month, have you often been bothered by little interest or pleasure in doing things? A third question should be considered if the woman answers "yes" to either of the initial questions: 3) Is this something you feel you need or want help with?

9.14. This was considered and offered. However because the mother did not indicate that she was feeling depressed in any way after answering the first question it was unnecessary to continue with the remainder of the assessment. Whilst this may be considered a legitimate method for assessing mental health post-natally, it is an adult focused assessment and fails to recognise the wider circumstances in which a child may be living, as well as other pressures the mother may be experiencing. Had the mother's response to this assessment been considered alongside actual evidence of home conditions and the care arrangements for the individual children it may have prompted the Health Visitor to be more curious about how well the mother was coping.

9.15. Vulnerability risk assessment: A locally developed single agency assessment tool that is designed to be used in conjunction with the Graded Care Profile as a means of initially identifying a child at risk of neglect through a range of listed factors which are associated with vulnerability[37]. This is used by CCS.

9.16. This was applied by Health Visitor 1. This review has examined the guidance documents in place for health practitioners for using this tool and finds them confusing and misleading. It refers to needing to understand the Graded Care Profile and seems to complicate the process of analysis. In this case, the findings were never synthesized to have any impact or effective use, nor communicated with other agencies in a manner or style that prompted more robust intervention.

9.17. Home safety assessment: A basic safety assessment of a family home conducted by a Children's Centre worker or a member of the Fire & Rescue Service to identify practical health and safety issues.

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[35] Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C., & Black, J., Understanding Serious Case Reviews and their impact: A biennial analysis of serious case reviews 2005 – 07, p.47, DCSF

[36] NICE, 2007, Antenatal and postnatal mental health: Clinical management and service guidance, now replaced with NICE guidelines [CG192], 2014

[37] Vulnerability risk factors tool: health practitioners guide, 13/09/10 V3

9.18. This was completed in November 2012. Although a potentially useful assessment the findings needed to be incorporated into a wider and more holistic understanding of the children's day to day experiences. This did not happen and there was no joined up assessment and analysis of environmental, child and parenting factors.

Additional assessment activity and considerations:

9.19. Central Bedfordshire Emergency Duty Team (on behalf of Luton Borough Council Children & Learning Department) requested an assessment through an independent provider. Notes and records passed to Luton Children and Learning Department indicate that this was a welfare check visit with some recommended actions. Follow on action by Luton Children and Learning Department was not maximised

9.20. As stated earlier, Health Visitor 2 shared a view about '*starting from afresh'* with the family. This mind-set has to be seen alongside the Specialist Family Support service's failure to follow up an assessment opportunity and the implicit message that this gave to the Health Visitor about how much weight to attach to the concerns. In turn, this impacted on the impetus and style of intervention adopted by Health Visitor 2 to the extent that the Health Visitor felt the case could be managed in isolation.

9.21. Opportunities for assessing the mother's commitment to ensure the children's health needs were not maximised. Firstly, evidence of the mother either missing scheduled appointments/immunisations or declining appointments is apparent. It is unclear from the evidence submitted whether these missed appointments were due to the failure by the mother to recognise the importance of the appointment, forgetfulness, being overwhelmed and disorganised or deliberate non-attendance. This is coupled with a mother (and grandmother) who either attempted to deceive professionals, or who were not prepared to engage with professionals to serve the best interests of the children. Exercising some level of professional curiosity and healthy scepticism about these issues from practitioners at successful visits would have been appropriate. Secondly, the advice given to the mother to treat Candida and nappy rash was not followed through. Weaning advice was also not followed. Health visitor 2 has reflected that, with the benefit of hindsight, a referral to the Specialist Family Support service would have been appropriate in respect of the mother's failure to treat the Candida and nappy rash. Research (2013)[38] about neglect and serious case reviews highlights "… *Professionals tended not to challenge parents' behaviour when medication was given erratically or consider reasons for parents' reduced compliance with advice … Undue professional optimism can mean that the impact of medical neglect and the danger for the child is missed and thus no referral is ever made to children's social care* …".

9.22. On a positive note completing opportunistic home visits seems, on balance, to have been more successful in this case than scheduled appointments. This positive aspect of assessment practice should not be lost and there is valuable learning to transfer from this case to other cases where non-engagement or non-compliance by service users may be a characteristic.

9.23. Given the findings, it follows that there was no 'making sense' of information gathered in a multi-agency context and no coordinated decision making about effective early help. Evidence presented paints a picture of a mother (and grandmother) who engaged with statutory agencies to an absolute minimum and not with a view to promoting the welfare of the children. In this case, no comprehensive or holistic

[38] Neglect and Serious Case Reviews, 2013, p. 12, University of East Anglia & NSPCC

information was gathered or synthesized by any one single agency or range of agencies over a four year period. Fragments of information were gathered but shared in an episodic manner.

9.24. In summary, the review has found that pre-existing mechanisms for professionals to communicate risk which may then prompt assessment were not used. CCS practitioners lacked the confidence or training to appropriately use formal risk assessment tools and the Specialist Family Support service failed to have sufficiently robust commissioning arrangements to effectively use assessment services to the benefit of those children whose welfare was being assessed. Assessment activity lacked a focus on the child's day to day experiences.

10. Threshold and professional intervention

10.1. Two versions of statutory guidance (2010 and 2013)[39] which cover the timeframe for this review provide broadly similar definitions of neglect, serving as a threshold for professionals to determine 'good enough' care arrangements. Key facets of this statutory definition of neglect relate to the persistence of concerns and cover acts of both omission and commission when caring for a child. Research[40] highlights the critical impact of inadequate care during early childhood on later development. Whilst the review may find some sympathy for any parent with limited resources managing three young children, it is apparent that the level of care afforded these children occasionally reached a 'good enough' standard. Three issues emerge;

10.2. Firstly, the care giving context is important. It is evident that the mother lived in an area of high deprivation with limiting life chances. The local community in which Child E and siblings lived created (and continue to do so) daily challenges for those with parenting responsibilities. Neglect as a result of impoverished circumstances is one contributory factor in this case. Horwath (2007)[41] considers this as a challenge for professionals when examining neglect and the care-giving context; that of *"…. distinguishing between low standards of care resulting from deprivation and low standards because of the ability and motivation of the carer …".* This review has found that there was no explicit exploration by professionals with the mother (and grandmother who also had a significant caring role for Child E) which attempted to assess or distinguish between the ability to care for a vulnerable child and the circumstances in which parenting was taking place. The omissions in care by the mother/grandmother, which were predominantly perceived to be linked to housing conditions, were not viewed as serious or serious enough to warrant statutory intervention to protect any one of the children. Health Visitor 2 has recounted *"… the conditions I saw were not unusual in this area. It is not unusual to see clutter, for parents to not keep appointments, for housing conditions to be dirty and for left-over food and dirty nappies to be left lying around …".* This suggests a level of acclimatisation and tolerance by practitioners to information they observe during the course of home visiting. Evidence submitted to this review by the School states *"Practitioners identify the threshold for intervention is high and that when need is consistently high, the principle of 'good enough', is applied in order*

[39] Working Together to safeguard children, 2010, HM Government & Working Together to safeguard children, 2013, HM Government

[40] 1) Neglect: research evidence to inform practice Dr Patricia Moran, Action for Children Consultancy Services, Action for Children, 2009, 2) Early Intervention: The Next Steps: An Independent Report to Her Majesty's Government Graham Allen MP, 2011, HM Government, 3) NSPCC: CORE-INFO: Emotional neglect and emotional abuse in pre-school children, May 2012

[41] Horwath, J., Child neglect: Identification and assessment, 2007, p. 113, Palgrave MacMillan.

to determine if one family presents as more in need than another. Staff note that there is potential for acclimatisation when working with high levels of deprivation on a daily basis".

10.3. Secondly, in this case, we see a worsening picture of neglectful parenting; not one-off incidents or accidents but events which, when looked at as a whole, indicate deteriorating circumstances. These events reflect a persistence of concerns and indicate an emerging chronicity rather than isolated and acute episodes of struggling to care for a child/children. Horwath[42] (2007) considers different categories of neglect which reinforce the findings of this review and the developing chronic picture of neglect. Child E and siblings experienced medical neglect (the failure to protect a child through scheduled immunisations and administering medication when needed e.g. for Candida and nappy rash), nutritional neglect (the failure to follow advice and appropriately feed and wean Child E), physical neglect (the failure the provide a safe, clean and adequate living environment as well as exposing premature infants to a smoke filled house) and a failure to consistently provide adequate supervision and guidance (Sibling 2 whilst at hospital). These features point towards acts of omission by Child E's mother and grandmother.

10.4. Finding: The benchmark or threshold of what constituted 'good enough' care was clouded by a focus on immediate, tangible and observable physical risks to the children. This appeared to mask the difficulties that the mother was experiencing in parenting three young children in less than favourable conditions and failed to adequately assess the impact on the children's overall welfare in a more holistic way. The persistence of risk factors in Child E's life, when considered alongside the experiences of Siblings 1 and 2, were not explicitly or systematically considered and weighted by any professional who came into contact with this family.

10.5. Finally, in order to assist the review understand the failings of the assessment process, but importantly the difficulty for professionals setting an acceptable threshold for intervening, there are a number of contributory factors to consider;

- Information often suggested positive aspects of parenting. There was information presented to professionals which conflicted with the developing picture of neglect. The School note in their submission *"Sibling 1 attended in the appropriate uniform, did not present hungry, or overly smelling of cigarette smoke that was noticeable to staff. At no point did Sibling 1 make any disclosure prior to the death of Child E about … home or familial situation …. Given what information the school directly held, it is unlikely that any concern, and note that none were raised, would have triggered a response. On a front facing basis, Sibling 1 presented no differently to … peers, practitioners note that on the whole Sibling 1 presented better"* [43]. Such conflicting information makes assessment and intervention more challenging for practitioners.

- There was often conflicting information. Based on the original referring issue from LDUH of potential attachment difficulties with Sibling 1 and the mother, Health Visitor 2 contacted the School to make enquiries. He was informed that the School had no concerns about Sibling 1. The Health Visitor did not use this opportunity to convey his wider concerns back to the school to prompt a dialogue about general welfare. This interaction reflects two issues. Firstly, a relatively fixed view of risk by the Health Visitor (also reflected in the view that home visits often did not reveal any immediate risks to the children) rather than seeing the more pervasive and chronic impact of neglectful parenting.

[42] Horwath, J., Child neglect: Identification and assessment, 2007, p. 113, Palgrave MacMillan
[43] Nursery Group & School submission, 25/08/14v2

Secondly a failure to be curious about a possible mismatch in evidence presented by the School with known information held by the Health Visitor. All of these issues may, not unreasonably, be due to limited experience and skill in working with complex dynamics but do affect perceptions around thresholds and intervention.

- CCS have also commented on thresholds but with an additional view about how this affects referrals and access to services *"… fixed perceptions also led to difficulty in challenging and escalating this case into child protection …. However, there was also evidence that the thresholds in health may also have risen and accommodated the social issues present within [the local area]".* One practitioner commented that *" … the circumstances of this family were not unusual … many families living in [this area] present with similar issues …*" and that she was *" … not confident that, had a referral been made to the Referral and Assessment Team, any action would have been taken … based on a recent case that … was not dissimilar to this family …*"

- The Community Nursery Nurse felt *"… any decision to make a child protection referral had to be the responsibility of the Health Visitor …"*[44]. This has been linked to experience, qualification and perceived status within an organisational structure but is clearly a concern.

10.6. Research[45] (2013) highlights threshold dilemmas as a common feature "*Professionals were tolerant of dangerous conditions and poor care …"* and *"… there was a drift and lack of sense of urgency …"* . The findings of this review reflect these dilemmas.

11. Organisational arrangements to promote safeguarding practice

11.1. Statutory guidance (2010 & 2013) respectively state that organisations should have *"… arrangements to ensure that all staff undertake appropriate training to equip them to carry out their responsibilities effectively …"* and *" … creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role …".*

11.2. Three organisational factors had a negative impact on the delivery of services for Child E. Most notably, these relate to the contribution of Cambridgeshire Community Services.

Training

11.3. As previously stated Health Visitor 2 was recently qualified - less than a year – but had attended mandatory training in child protection at levels 1, 2 and 3 based on the Inter-Collegiate guidance[46]. These were courses provided internally by CCS. Review of training records also shows a range of other training courses attended. It is clear from interview that Health Visitor 2 did not feel fully equipped to deal with the complexity of cases held despite having attended training courses. This raises questions for CCS about whether their current training provision adequately equips relatively inexperienced practitioners to deal with the level of need and often complex family situations they will encounter on a day to day basis. It has

[44] Cambridgeshire Community Services submission to the SCR Reference Group, 25/09/14
[45] Neglect and Serious Case Reviews, 2013, p. 12, University of East Anglia & NSPCC
[46] Safeguarding children and young people: roles and competences for health care staff: Intercollegiate document published by the Royal College of Paediatrics and Child Health, September 2010 & Third edition March 2014

also become apparent that there is a potential misunderstanding by Health Visitors in training provision. CCS offer a level 3 training course (which is based on the Inter-Collegiate guidance) and the LSCB also offer a level 3 training course (which is targeted at those in management or designated positions), but which has a different content. The use of the same headline description may have caused some misunderstanding and has the potential to create confusion. This is an area that the LSCB will need to examine.

11.4. The report has already covered when training was provided on the Graded Care Profile (see 9.10) and when it was withdrawn by the LSCB. The ability to understand a particular tool/framework and then apply it in practice is clearly a fundamental requirement for all practitioners who are required to assess child welfare arrangements. A failure to understand and apply the Graded Care Profile has been noted as a contributory factor to the manner in which this case was managed.

Supervision

11.5. Statutory guidance[47] (2010 & 2013) highlights the importance of effective staff support and supervision. Supervision is one mechanism through which organisations can support practitioners to discharge their duties. Owen and Pritchard (1993)[48] state *"Supervision implies overseeing appropriate functioning of the worker …. It also implies guidance, advice, correction, encouragement, teaching and support … The content and the quality of work will be determined by the workers' level of knowledge, their skills, judgement, confidence, stamina and the support and help given to them to do the job effectively and efficiently …"* .

11.6. Two CCS supervision policies were implemented during the time period under review, one in 2010 and then a second in 2012[49]; this was subsequently reviewed in 2014.

11.7. Health Visitors had/have access to three forms of supervision; safeguarding supervision[50], management supervision[51] and clinical supervision[52] . These could all be delivered by different supervisors. Whilst there is an organisational framework that outlines the different forms of supervision this case review has highlighted that it is not obvious to Health Visitors or the Reference Group how advice and support offered by each interact and offer a coherent accountability structure; it is reliant of the individual practitioner to make the links. It is possible that those practitioners moving through the preceptorship framework could also have a fourth person offering support and guidance.

[47] Working Together to safeguard children, 2010, HM Government & Working Together to safeguard children, 2013, HM Government

[48] Good practice in child protection: A manual for professionals, Owen. H, and Pritchard. J, (1993) p.203, Jessica Kingsley

[49] CCS Supervision Policy 2010 & CCS Supervision Policy, 2012

[50] Safeguarding children supervision offers a formal process of professional support and learning for practitioners working with children, young people and their parents/ carers. Safeguarding children supervision is about the 'how' of safeguarding/ child protection practice; it provides a framework for examining and reflecting on a case from different perspectives. It also facilitates the analysis of the risk and protective (resilience) factors involved by enabling discussion of cases of actual or suspected child abuse and those at varying levels of concern from high risk, to cases with very early potential indicators in order to ensure safe practice, Cambridgeshire Community Services, Supervision framework, January 2014

[51] The purpose of management supervision is to provide support and oversee performance, Cambridgeshire Community Services, Supervision framework, January 2014

[52] Clinical supervision provides an opportunity to discuss clinical cases in more detail, provide support and challenge and contributes to professional and personal development, Cambridgeshire Community Services, Supervision framework, January 2014

11.8. The 2010 policy prescribed 1:1 safeguarding supervision with a trained child protection supervisor for experienced practitioners on a three monthly basis and two monthly for newly qualified practitioners. The revised policy in 2012 moved away from 1:1 safeguarding supervision towards group supervision on a three monthly basis; a significant reduction. Additional individual safeguarding supervision would have been available on more complex cases under both the 2010 and the 2012 policies, but this would be at the individual practitioner's request.

11.9. Finding: Records indicate that both Health Visitors 1 and 2 followed policy and procedure in seeking safeguarding supervision at various times.

11.10. In this case, supervision would have been the ideal forum for Health Visitor 1 to discuss issues such as how it felt to make *'subjective judgements'* about parenting, what else to do with the case due to feeling stuck having *'hit a brick wall'*, and the impact of feeling disliked by the mother. Based on the descriptions of these three forms of supervision it is difficult to see which forum would have been most useful to have discussed such a practical but very real dilemma. Evidence submitted to the LSCB following the Review reveals that Health Visitor 1 had individual safeguarding children supervision during this time frame and an electronic record of a session in July 2012 was located. A recommendation of the use of the Graded Care Profile was made and based on interview concrete solutions were discussed. Without more detailed records it is not possible for this review to draw a conclusion about the quality of this session and how useful it was to the individual practitioner. However it does appear to have had limited impact on the effectiveness of Health Visitor 1's approach to the family ".....and that she had achieved little with the family and the case may benefit from a fresh pair of eyes...."[53].

11.11. Records indicate that Health Visitor 2 received clinical supervision five times between January and October 2013, attended five safeguarding supervisions between June 2013 and January 2014 (two of which were individual sessions) and received one management supervision during the timeframe of this review.

11.12. Records show that safeguarding issues were discussed during the group safeguarding supervision sessions e.g. assessment frameworks, working with families where non-compliance was an issue, LSCB neglect procedures. All of the topics that are recorded as being discussed appear highly relevant to the features of this case. Following on from these sessions there appears to be no evidence to suggest that learning from supervision on these particular topics was put into practice.

11.13. Health Visitor 2 appropriately sought 1:1 safeguarding supervision in October 2013. This resulted in a plan of action. Records indicate that attempts were made to follow through this plan, but with limited success due to the non-engagement by the mother.

11.14. Looking at this issue from a wider organisational and systemic perspective, this review has found a number of contributory factors which undoubtedly affected individual practitioners and managers.

- At the time Health Visitor 2 took over responsibility for the case, the safeguarding practice of the Team Leader responsible for providing management supervision to Health Visitor 2 was investigated internally by CCS. Of note, this Team Lead had also provided Health Visitor 2 with support and preceptorship whilst a student. Whilst it may not be appropriate for this review to examine the

[53] Cambridgeshire Community Services submission to the SCR Reference Group, 25/09/1

detail of this internal investigation, it is clear that there must have been legitimate concerns for such a process to be instigated. In the interim, 'care-taker' Team Leads were appointed, which had mixed levels of success.

- The CCS Safeguarding Team (at the time of the review) was resourced with three whole time equivalent posts, provides safeguarding supervision (group and individual) to 93 practitioners, which included 26 practitioners who work with children with additional needs. In addition to this practitioners could/can alert the Safeguarding Team about a case via a 'share'. This can be seen as a way of flagging complex cases that require safeguarding input or additional expertise however due to the high volume of 'shares' this challenges the Team's capacity to respond to every 'share'.

- The review has found that the CCS Safeguarding Team does not have an explicit role in checking and overseeing whether actions discussed as part of a safeguarding supervision session have been followed through. Nor do they have a responsibility for taking action based on information being 'shared' by a practitioner. They provide an advisory function to practitioners on safeguarding matters. Whilst the opportunity to consult or seek advice about a particular case may arise at subsequent supervision sessions, the responsibility for taking action rests with the individual practitioner and then with their respective manager to check.

11.15. Finding: This review finds that given the identified deficits and challenges faced by the Safeguarding Team, the accountability arrangements for individual practitioners when faced with child protection concerns could be strengthened.

11.16. In this case, we see a recently qualified and relatively inexperienced practitioner taking responsibility for reviewing his own child protection practice, having to request 1:1 safeguarding supervision following a period of being managed by a Team Lead whose judgements were called into question. These circumstances highlight a level of personal and organisational vulnerability.

11.17. A revised model of delivering safeguarding children supervision has been implemented in February 2014, maintaining the emphasis on group supervision. The independently authored CCS submission to this review has appropriately challenged the sole use of group supervision in effectively meeting the needs of practitioners, particularly concerning child protection practice. Whilst the opportunity for individual practitioners to access individual safeguarding supervision is available this relies on the individual to know they need some support. This seems inherently risky and, as this case has illustrated, is not reliable and potentially places children at risk.

11.18. Health practitioners from CCS who have contributed to this review have referred to a potential disconnect between the CCS Safeguarding Team and health practitioners. Although practitioners have described the Team as accessible, advice given was often considered to be *"… prescriptive and left some practitioners feeling 'ordered about' … ".* Alongside this, there is a potential tension that, given the Safeguarding Team does not have a responsibility for checking that actions/advice has been followed it places an expectation back on the Team Lead to undertake this check. This creates additional work. This finding has to be considered with the knowledge that the Safeguarding Team is under pressure (both time and resource) which may create particular ways of working as a means of managing demand.

11.19. Whilst this review appreciates the limitations on capacity, workload pressures and financial constraints, it is concerned with wishing to promote effective safeguarding practice – especially given the known local levels of deprivation and the inherent risks this brings for children. Effective safeguarding practice has to be seen and considered in the wider context of support for practitioners to effectively discharge their duties i.e. recruitment of a high quality workforce, training, the overall provision of supervision, and ongoing support. In discussing organisational dangerousness, Calder (2008, p.147)[54] cites Davis (2001) who argues that *" … one of the most significant liaisons that needs to be strengthened in acknowledging, supporting and responding to the inherent emotional currents of the work is the supervisory relationship …".* The need to create fertile conditions in which practice improvements occur cannot be underestimated. This becomes even more critical when, as in this case, CCS has struggled to recruit and retain sufficient numbers of experienced and trained Health Visitors. The local Health Visitor workforce in this area has doubled in the last three years which, whilst providing a greater resource has meant the overall skill mix has lowered due to the relative levels of knowledge and experience. Alongside this, demands on the Safeguarding Team and the need for increased supervision have increased, but without additional resourcing being made available. The findings in this case are reflected by research (2013)[55] about neglect and serious case reviews, notes *"Drift and confusion becomes a systemic problem due to overwhelming workloads, high staff turnover and high vacancy rates …*"

Caseload management

11.20. Of significance is the finding that Health Visitor 2 carried five child protection cases as a newly qualified practitioner whilst still undergoing the preceptor programme. In this instance it has been confirmed that these were cases where children have been formally identified as at risk and who were subject to child protection plans. Although there have been attempts and discussions to quantify Health Visitor caseload size for a number of years[56] nationally there appears to have been no specific guidance to inform the size and profile of case load a Health Visitor should have, particularly in respect of holding cases with child protection issues; local determination is expected. For practitioners in Luton, at around September 2013 caseload sizes decreased from 600 to 455 for those working full time. The target is 243 cases based on an under 5 years population of 17,000 children and 70 whole time equivalent Health Visitors reflecting the level of challenge those delivering health visiting services face.

11.21. Given the problems CCS have experienced with staff recruitment and retention Health Visitors have been given a mixed caseload as an attempt to maintain core service delivery. Such an approach seems reasonable if individual practitioners are capable and appropriately supported (through management support but also training and supervision). However in this case we have also seen local custom and practice developing due to a lack of management oversight with the *'swapping'* of cases between Health Visitors and a mind-set that a *'fresh pair of eyes '* might make a difference. Such a mind-set may have merit[57] but only

[54] Calder, M., Organisational dangerousness: Causes, consequences and correctives, in Contemporary risk assessment in safeguarding children, 2008, Russell House publishing

[55] Neglect and Serious Case Reviews, 2013, University of East Anglia & NSPCC

[56] A) A funding model for Health Visiting: baseline requirements - part 1. Community Practitioner, 2007, 80(11): 18-24 B) A funding model for Health Visiting: impact and implementation - part 2. Community Practitioner 2007: 80(12): 24-31, C) The Protection of Children in England: A Progress Report, The Lord Laming March 2009, p 11

[57] The oversight and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information? Burton, S., National Children's Bureau, November 2009, C4EO

when applied in a systematic and coordinated manner and used alongside effective supervision. In this case, that did not happen; we see that the support system was not as robust as it should have been.

11.22. Recently issued guidance[58] for those delivering health visiting services suggests that practitioners are *"… Not to have sole responsibility for safeguarding families in the first 6 months …"* and refers to shadowing and co-working opportunities in respect of safeguarding cases.

11.23. The size and profile of caseloads is clearly an issue which those with responsibility for delivering health visiting services in the Luton area will need to consider in the future given the operational challenges they face in the recruitment and retention of Health Visitors.

12. Summarised account of review findings

The following section represents a summary of the main findings from this review;

1. Indicators of a mother struggling to cope with parenting three young children in less than favourable conditions were not recognised. In turn this placed all of the children at risk of further neglect and emotional harm,
2. No one single agency took an assertive lead on the management, assessment and intervention of this case, despite opportunities being presented to do so. Although information was shared this did not lead to a coordinated multi-agency response,
3. LDUH shared information appropriately with CCS and the Children & Learning Department having identified concerns at every stage of their involvement,
4. Attempts were made by the Health Visiting Service to engage the mother. These attempts included planned and unannounced home visits plus offers of support and assistance,
5. Assessment frameworks and tools were considered but not implemented by practitioners who had direct contact with this family,
6. Case information was shared by Health Visitors to the CCS Safeguarding Team appropriately as a route for seeking additional support and advice however the review has shown that arrangements were not as robust as they could have been and there were differing expectations by those sharing information and those receiving information about action needed. These differing expectations were caused by local custom and practice evolving over time as a result of an unclear policy but also an overwhelming workload,
7. The overall response by CCS Health Visiting Service was fragmented, lacked coordination and was hampered by inexperienced practitioners who lacked specific child protection experience, and specific training.
8. Crucially, this occurred in a challenging organisational operating climate for CCS Health Visiting Service where resources were stretched, workforce capability was compromised and service delivery was unable to respond to high levels of deprivation at a local level. The requirements of the Call to Action initiative placed the service under pressure to recruit large number of Health Visitors, provide training in order to respond to the Healthy Child Programme plan and offer management support. Additionally, due to organisational restructuring the implementation of different management

[58] A National Preceptorship Framework for Health Visiting: The First 2 Years, 2014, Developed by the Institute of Health Visiting on behalf of Health Education England and the Department of Health

structures meant that oversight and governance of Health Visiting was not as robust as it could have been.

9. Child E's critical needs were not sufficiently recognised at a time when there was an emerging picture of the mother failing to engage with services which occurred alongside Child E failing to gain adequate weight following discharge from hospital. This was coupled with a level of deceit by the mother and grandmother, professional optimism and a failure by the professional network to appreciate the history of the mother's vulnerability.
10. A more robust intervention could have been made which, if the mother and grandmother had cooperated, would have ensured that Child E received adequate care and nutrition. If this cooperation had not been forthcoming, and there had been greater clarity about the level of risk, there would have been evidence to enable the local authority Children & Learning Department to intervene. On that basis, this review concludes that Child E's death was preventable.

13. Lessons learnt from this review

The following section outlines what individual agencies have identified and learnt as a result of conducting this review.

As a result of this review individual agencies have learnt the following;
Luton & Dunstable University Hospital
1. Outpatient staff should inform Doctors and other health professionals of anything out of the ordinary seen when attending to children in the outpatients department, 2. There is a need to continue with information sharing in the event of a pregnancy that does not continue to full term, 3. There is a need to ensure, on discharge, growth charts are known about and understood by all health professionals who may apply them in the community, especially for pre-term infants, 4. There needs to be improved systems that are failsafe for community dietetic follow-up for neonatal discharges.
Cambridgeshire Community Services
1. A high number of inexperienced, newly qualified Health Visitors brings with it an increased risk to the organisation and the service families receive, 2. A high attrition rate brings with it an increased risk to the organisation and the service families receive, 3. The current model of provision of safeguarding supervision may not be suited to the high levels of newly qualified practitioners, 4. The current model of safeguarding supervision may not be suited to the high level of vulnerability within the caseloads,

5. The purpose and expected outcome from the SystemOne 'share' with the Safeguarding Team is not clear to those who refer matters to the Safeguarding Team,

6. Health needs assessments of the child and family are inconsistent across the service. Historical and current health needs and progress are not being robustly assessed. This increases the risk of poor decision making and care planning leading to poorer outcomes for children,

7. The standard of record keeping does not demonstrate a robust assessment, analysis and evaluation process to inform decision making,

8. The current practice around allocation of families coming onto health visitor caseload is not sensitive enough to the complexity of families and the available skills in the team,

9. The current process for transfer of cases between caseloads/colleagues is not as robust as it needs to be,

10. There is a mix of percentile charts in use across agencies and this is a risk when assessing the growth of babies, particularly when pre-term,

11. There is an acceptance of high thresholds and tolerance of risk factors due to the demographics of the resident population,

12. There is a perception that thresholds within Children's Social Care are set too high,

13. The role and accountability of all CCS children's services staff with regard to leadership, professional accountability and safeguarding is not clearly understood,

14. There is a lack of acknowledgement of the roles and responsibilities and collaborative working between health visiting and the responsible professional during the antenatal period.

15. The organisational framework which includes all types of supervision was not robustly implemented or quality assured across children's services. This resulted in weak leadership and role modelling and poor professional practice,

16. Information sharing processes between the Health Visiting Service and maternity/SCBU (Special care baby unit) were not robust.

17. The diversity of clinical experience of new HVs coming into the profession may mean that they do not have the skills and competencies to assess when a child is not thriving or unwell,

18. The leadership capacity required to manage strategic change can cause loss of focus on governance.

Luton Borough Council: Children & Learning Department

1. There is a need to identify the key factors when adults do not engage or comply, and for professionals to be clear about the level of response and action that can be taken in such situations,

2. There is a need to ensure issues of neglect are not seen in isolation, 3. The Graded Care Profile should be completed and repeated in all cases where neglect concerns are present. This should be shared with all agencies.
General Practitioner and Surgery
1. There is a need to follow up missed appointments for immunisations, 2. Health Visitor and GP practice information sharing needs to be through hand over as well as SystemOne, 3. The SystemOne sharing with 0 – 19 team of the GP record should be automatic as opposed to a discretionary opt in.
Nursery Group & School
1. For professionals to be more curious and questioning when receiving query calls in relation to families from other agencies and to record the content of such contacts. 2. To develop formal supervision opportunities for front line case workers which are clearly linked to case files.
All of the above agencies have submitted an Action Plan to the LSCB to address these issues.

14. Recommendations and challenges to Luton LSCB and partners

Individual agencies involved in this case have each submitted an action plan to remedy the deficits and omissions identified in this review. The implementation and progress of these actions will need to be monitored by Luton LSCB. In addition to the action plans submitted, the Independent Reviewer has agreed the following specific recommendations and challenges.

Individual agency recommendations	
Cambridgeshire Community Services:	
1	To review the arrangements for the transfer of cases between practitioners to ensure there is a fair and formal procedure in place, which includes a visible management footprint.
2	To review the role, remit and purpose of the Safeguarding Team. Specifically, this review should include; • Whether the expectations of the Team – by practitioners and Team Leads – match the service provided, and to seek solutions in order to overcome any mismatch discovered, • To review whether the Safeguarding Team has a role in the follow up of actions agreed in supervision sessions with practitioners. • The current levels of resourcing for the team and whether this is sufficient to meet need and demand of practitioners involved in working with vulnerable children and families, • An audit of the arrangements for practitioners to share alerts with the Safeguarding Team and the capacity of the Team to respond. This audit should include an examination of the process of alerting

	the Team as well as the quality of the content referred to see if any improvements can be made, • Whether the Safeguarding Team is adequately trained, resourced and capable of delivering safeguarding supervision to practitioners based on the current policy and model of supervision,
3	To review case recording practices for Health Visitors and managers/supervisors where there are child protection/safeguarding concerns to ensure recording accurately reflects the circumstances and professional activities of the case.
4	To audit the use of chronologies where cases have been transferred to another health practitioner and identify where there are missed/failed appointments and immunisations. This audit activity should also include checking the visibility of management input.
5	To review the practice of allocating child protection cases to newly qualified Health Visitors in their first six months/year of practice.
6	To review the developmental needs of the diverse range of health practitioners in the local area to ensure that supervision arrangements are fit for purpose, especially for newly qualified Health Visitors.
7	To review the use of, and guidance for, the Vulnerability Risk Assessment tool, to ensure it is user friendly.
8	To ensure all health practitioners, at whatever level they may operate within the organisation, feel empowered to act on information or concerns they may have about a child's welfare.
9	To review the supervision policy and ensure it provides clarity about how the different forms of supervision available to health practitioners form a coherent and whole accountability framework.
Luton & Dunstable University Hospital:	
1	Improve the screening arrangements on fathers/males connected to new pregnancy bookings.
2	LDUH, in collaboration with CCS to ensure there is a clear understanding about which percentile charts are being used by health professionals following the discharge of premature babies. Training should be provided to all those professionals who may use these charts to ensure there is absolute clarity about how they should be applied to premature babies once discharged into the community.
3	Parents of children under one year should be given the option of collecting prescriptions from the hospital pharmacy if the medication is not held in the Outpatient Department. This is especially so if there is a chance of a considerable delay in obtaining it from a community pharmacist by the parent.
4	To review the effectiveness of the Outpatient Department policy and procedure for monitoring the weight gain of infants and potential for failure to thrive, particularly those born prematurely.
Luton Children & Learning Department	
1	Luton Children and Learning Department should, in conjunction with Luton LSCB should ensure that documentation on the Early Help Assessment, graded care profile and other assessment frameworks makes clear to professionals how they should address refusal of consent.
Luton LSCB	
1	The LSCB should ensure that professionals working in Luton have access to and can understand and implement a coherent multi-agency strategy for the assessment of neglect which sets clear practice standards about the use of assessment frameworks and tools such as the Graded Care Profile
2	The LSCB should consider how best to ensure that professional acclimatisation to the high levels of poverty and deprivation in Luton does not lead to accommodation to the neglect of children
3	The LSCB should ensure that its multi-agency training programme on neglect deals fully with known vulnerabilities in practice such as professional optimism, disguised/lack of parental compliance, 'start again syndrome' and professional curiosity/healthy scepticism. The Board should set clear

	expectations about mandatory attendance at learning events and hold agencies to account over this.
4	Luton LSCB should ensure that its structures and processes enable it to have an accurate understanding of risks to service provision in member agencies and strategies to address them.
5	Luton LSCB should ensure that professionals working with vulnerable children have a consistent understanding of thresholds for intervention and service provision at all levels of entry, including thresholds and triggers for referring concerns about a child's welfare to the Children and Learning Department.
6	Luton LSCB should in conjunction with Children and Learning Department ensure that documentation on the Early Help Assessment, graded care profile and other assessment frameworks makes clear to professionals how they should address refusal of consent.
7	Luton LSCB should emphasise the importance of weight gain in infants as being a critical indicator of health and development. This may include a) an alert to all relevant professionals to record the infant's weight on a regular, but also opportunistic, basis b) being mindful of weight being recorded by different professionals and held in different locations and the need to cross reference information where there may be faltering growth c) ensuring all relevant professionals can interpret growth charts, particularly for premature infants and d) the need for faltering weight to be closely monitored in line with best practice.

Appendix 1: Membership of SCR Reference Group

Agency name	Reference Group membership	Designation	Agency submission	Author designation	Practitioner interviews conducted
NSPCC	Yes	Independent Reviewer	Overview author	Independent Reviewer	Yes
Luton LSCB	Yes	SCR Independent Chair	No	Not applicable	Not applicable
Luton LSCB	Yes	LSCB Business Manager	No	Not applicable	Not applicable
Luton LSCB	Yes	LSCB Administrator	No	Not applicable	Not applicable
Luton Care Commissioning Group	Yes	Designated Doctor for Luton CCG	Yes	Designated Doctor	Yes
Luton Care Commissioning Group	Yes	Named GP for safeguarding children & adults	Yes	Named GP for safeguarding children & adults	Yes
Luton Care Commissioning Group	Yes	Assistant Director & Designated Nurse	Yes	Designated Doctor and Named GP	Yes
Luton & Dunstable University Hospital	Yes	General Manager Safeguarding Midwife	Yes	General Manager and assisted by Safeguarding Midwife, Safeguarding Nurse, Lead Nurse (NICU)	Yes
Education Services	Yes	Safeguarding in Education Manager	Yes – Primary School A	Safeguarding in Education Manager	Yes
Luton Borough Council Children & Learning Department:	Yes	Interim Safeguarding & Quality Assurance Manager	Yes	Independent Reviewing Officer: Luton Borough Council	Yes
Bedfordshire Police	Yes	Detective Superintendent	Yes – Hertfordshire Police	Review Officer	No
Luton Community Care Services	Yes	Children's Services Manager	Yes	Independent Management Review author	Yes

Appendix 2: Professionals who have been interviewed for this review or who have contributed to the review process

Agency	Designation
Cambridgeshire Community Services	Named Nurse: child protection
	Specialist Nurse: Safeguarding
	Clinical Lead: Health Visiting
	Children's Service Manager: 0 -19 Team
	Health Visitor
	Community Nursery Nurse
	Rapid Response Team
Primary School	Family worker & Designated Safeguarding Lead
	Family worker
	Transition Administrator
	SENCO & Looked after Children Designated Teacher
Luton Borough Council: Children & Learning Department	Social Workers (x2) CAF & Stronger Families Manager: Prevention & Early Intervention
Luton & Dunstable University Hospital	Teenage Caseload Midwives
	Community Midwife
	Safeguarding Nurse
	Safeguarding Midwife
	Community Neonatal Sister
	Nursery Nurse
	Lead Nurse: NICU
	Neonatal Consultant
	Neonatal Physiotherapist
Luton Care Commissioning Group	General Practitioner
Central Bedfordshire Council Emergency Duty Team	Emergency Duty Team Manager