Baby F
Serious Case Review

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EXECUTIVE SUMMARY

Context

On 22.08.14 Baby F, aged 11 months, was found by his mother submerged in the bath, after she left him unsupervised. He was taken to hospital, but died in September 2014. Baby F and his two siblings had been subject to child protection plans under the category of neglect since the end of April 2014.

Baby F's mother pleaded guilty to manslaughter in March 2015 and received a six year custodial sentence.

Summary of Case

Baby F's mother was well known to agencies in Harrow because of historic concerns about the neglect of her children due to her own lifestyle, which involved substance misuse, domestic violence and lack of engagement with services. Her eldest child (Sibling 1) moved to a relative when young and her next two children were the subject of child protection plans between 2010 and 2011. It was understood that these children are half siblings to each other and to Baby F.

The period under review began with the start of her pregnancy with Baby F in early 2013. Prior to the birth the midwifery service did not identify the risks of a vulnerable pregnant woman who had not booked in for antenatal care, did not attend appointments offered and was neglecting her own health needs and in consequence the needs of her unborn baby. Children's social care were unaware of the pregnancy so no pre-birth assessment was undertaken.

Baby F was born early, at a friend's home, delivered by the man understood to be his father. The paramedics thought they could smell alcohol on the mother's breath when they took mother and new born baby to hospital. Baby F remained in hospital (first in Brent and then in Buckinghamshire) until he was 23 days old, before joining his mother and two siblings in a refuge in Buckinghamshire; mother had moved there just before his birth. Despite intentions to hold a pre-discharge meeting at both hospitals baby F was discharged without such a meeting or any social work involvement.

During baby F's first five months of life, from the time he was discharged from hospital, he was seen twice by health visitors and once in a clinic. No social worker saw him or his siblings despite concerns around the circumstances of his birth, mother's current circumstances, the context of the family history and several referrals from members of the public. These referrals mentioned that Baby F's parents were smoking heroin in front of the children, whose health and nutritional needs were being neglected.

Despite initiating a child protection enquiry, Harrow children's social care did not see baby F and siblings or investigate the allegations that were made. This was due to confusion around the children's whereabouts, with Mother claiming to be travelling to different places. There was initially a mistaken assumption that Buckinghamshire would investigate concerns, even though the family had returned to Harrow, or an acceptance that it was not possible to locate the family and that the mother did not want help. This ignored both the fact that this was clearly a Harrow family and the alleged risks to the children that needed to be investigated.

From February 2014 onwards there was a great deal of effort and tenacity displayed by the newly allocated social worker in constant attempts to locate the family and try to see the children. The health visitor at the time also put in a great deal of effort to support the family and ensure the children received the health resources they needed. However, despite this major individual and collaborative effort by the professionals, there was no progress made and the children did not receive the health and dental care they needed. Moreover, there was increasing suspicion that the mother had returned to misusing alcohol and drugs.

Whilst it took too long for the management in children's social care to progress the case firstly to child protection and then to legal intervention, by the end of June the need for such was identified and legal planning meetings were held in July and August 2014, with the mother advised of the imminent use of legal intervention unless she complied with the child protection plan.

A new social worker took over the case in July and initially there appeared to be some improvements made by the mother in response to the warning of legal intervention, but just before August Bank Holiday the social worker learnt from the Bed & Breakfast manager that a man was visiting the family every day, that the mother was borrowing money from the manager and other residents, and was overheard asking for heroin in a telephone conversation. Also Baby F's siblings were rescued by staff after they ran across the road unsupervised, dressed just in nappies.

The next day the management of children's social care took legal advice and agreed that proceedings would be initiated, with an application for an Interim Care Order to be made after the Bank Holiday.

Whilst consideration was given to the immediate removal of the children, a joint home visit by police and social worker that evening did not give grounds for the police to remove the children under Police Powers of Protection[1], as there was no immediate risk: mother did not appear to be under the influence of substances and the children appeared well.

[1] The Police have powers under s. 46 of the Children Act 1989 to protect children. If a police officer believes that a child is at risk of immediate danger and there is insufficient time to seek an Emergency Protection Order, then s/he may exercise powers under this Act to remove the child to suitable accommodation or if the child is

The next day consideration was given to the immediate removal of the children that day through the taking of an Emergency Protection Order[2] by children's social care. However, the understanding of legal advice was that there were insufficient grounds for such emergency action. Instead plans were made to provide support to the family over the Bank Holiday, with two visits daily. Legal intervention was planned to take place on the Tuesday with an application for an Interim Care Order. Tragically, between the support worker's visits on the Saturday, the mother left Baby F unsupervised in the bath and he suffered brain injury which led to his death some weeks later.

Findings and recommendations

1) Systemic weaknesses in ante-natal midwifery services contributed to the failure to identify and refer pre-birth safeguarding concerns to children's social care

The provision of midwifery services demonstrated fundamental flaws in safeguarding practice involving the:

- inability to access historical records of patients who are not 'booked in' for services
- repeated lack of recognition of /or response to the vulnerability of a pregnant woman
- lack of fulfilment of the basic midwifery duty to ensure patients are 'booked' in (especially those who are vulnerable)

Recommendation 1

The LSCB to ask the CCG and the LNWHT to report to the LSCB how midwifery will be able to provide a safe service which:

- provides access to historical patient records for all midwives, regardless of which team is providing the current service and whether or not the patient is 'booked-in'
- ensures that all midwives are able to identify and work with vulnerable patients, recognise safeguarding risks and make child protection referrals when required
- does not apply a DNA policy of withdrawing services following 3 DNAs, without reference to the fact that such behaviour is likely to denote greater need and risk
- provides a safety net which ensures the 'booking in' process is not avoided by staff due to time constraints and which addresses the risk to baby and patient of women who have not

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in hospital or in a place of safety, take steps to keep the child there. A child cannot be kept in police protection for more than 72 hours.

[2] An emergency protection order or EPO is a court order granted under Section 44 of the Children Act 1989 on the grounds that a child will suffer immediate significant harm unless they are removed to council accommodation or moved from where they a current place of safety. Separation is only to be contemplated if immediate separation is essential to secure the child's safety: 'imminent danger' must be established (X Council v B (Emergency Protection Orders){2004}.

made use of antenatal provision

2) *The belief that mother was a 'traveller' together with her effective avoidant behaviour contributed to a lack of effective follow up of concerns; this highlights the vulnerability of children in mobile families and the risk that children can become invisible*

Mother was understood to come from a travelling family, so when she missed appointments but explained she was staying in different places outside of London, practitioners accepted this as part of her culture, without further checking.

There was inadequate consideration given to the need for follow up of concerns (in the case of children's social care) or of checking the children's health and development (in the case of health visitors) when mother claimed to be elsewhere. On one occasion children's social care assumed that another authority would undertake the required assessment (despite having not agreed this with them) and at other times no contact was made with the 'host' authority where Mother claimed to be, even when there was a s.47 (child protection) enquiry in progress.

Even when Mother seemed to be staying in the B&B accommodation provided, she was skilful in avoiding professional contact, despite the tenacity of a social worker spending considerable time in trying to locate her. In such circumstances it is vital that intervention is taken at earlier points in order for practitioners to be able to see the children and assess their needs. Whilst in this case practitioners were threatening to take such action, this took too long. Mother explained to the author that the repeated warnings made to her, without immediate action, reassured her that no action would happen.

Recommendation 2

a. The LSCB to consider how to develop practice so that:
   - children within mobile families do not become 'invisible' and that they receive continuity of health and social care involvement, and when necessary intervention, even when the family moves around
   - practitioners challenge avoidant parental behaviour and do not accept at face value explanations of the family travelling
   - managers recognise the immense time involved in such challenge, but that this is required whenever there are safeguarding concerns
   - no child protection case is ever closed because a parent claims to be living elsewhere, without an agreement by the next local authority to take over enquiries

b. The LSCB to ask children's social care to report on quality assurance processes on the 'front door' of the service; in particular that children's needs within mobile

families are met (including cases not being closed without assurance of them being picked up in other areas) and that decisions for no further action are consistent with the safety of children.

3) The case demonstrated a misunderstanding about the use of Police Powers of Protection instead of an Emergency Protection Order

The senior manager within children's social care identified the risk to the children the need for their urgent removal following the information received from the manager of the B&B. However, subsequent decision making reflected a misunderstanding within children's social care about the use of an Emergency Protection Order as opposed to a reliance on Police Powers of Protection, which should only be used if there is evidence if immediate risk.

This case also demonstrated the need for social workers and managers to take account of legal advice, but when they feel that the risk is too high to leave children within the family whilst an Interim Care Order application is made, an EPO should be progressed and the matter put to the Court for a decision.

Recommendation 3

Children's social care to hold facilitated workshops for managers to explore the differing use of Police Powers of Protection and Emergency Protection Orders. This should also cover the role of lawyers to provide advice as opposed to social work managers in making the decisions

4) There was repeated misunderstanding within children's social care of the function of police welfare checks as opposed to the children's social care responsibility to investigate allegations and concerns

Within children's social care in Harrow there was an assumption that when police visited a home and concluded that the children were safe and well, there was no need for further investigation of referrals. This demonstrated a basic misunderstanding of the police role to establish if the children were at immediate risk of harm at that point in time, as opposed to the role of children's social care to undertake the wider and in depth assessment of the allegations.

Recommendation 4

Children's social care to consider how best to disseminate to staff the distinction between police welfare checks and the role of children's social care, and how to establish if this is successful in changing practice. The LSCB to request a report from children's social care on the implementation and progress of this recommendation.

5) *The repeated lack of investigation by children's social care of the referrals from members of the public may reflect underlying cultural attitudes and suspicions to non professional referrals; such an attitude is a serious weakness in a safe service*

Safeguarding is everybody's responsibility and referrals from members of the public need to be fully investigated. This needs to involve referrers being provided with the opportunity to meet with a social worker so as to provide more detail and evidence of concerns. This has been part of the London child protection procedures since the first edition in 2003.

Recommendation 5

a. The LSCB to consider how best to promote cultural change so that professional practice fully values the involvement of members of the public in safeguarding children - such a cultural shift would see changes in practice which includes routine interviews of members of the public as part of follow up to referrals and assessment practice
b. The LSCB to request agencies include the involvement of members of the public, friends and wider family in audits of response to referrals and of assessment practice - the results of such aspects of the audit to be provided to the LSCB and published as part of the promotion activities of the LSCB

6) *The lack of individual supervision for social workers is likely to impact on cases that require a great deal of reflection and management oversight*

The allocated social workers in this case were part of the 'pods' within the children in need service. Staff within a pod are managed by a pod manager but do not necessarily receive individual supervision as this model of organisation predominantly uses group supervision for staff. Whilst group supervision can be a very helpful tool, it does not address the individual needs for reflection and management decision making that is typically needed in chronic neglect cases, especially in relation to avoiding delay in moving into child protection and legal proceedings.

The social workers within this pod were concerned that their concerns about this case were not being adequately 'heard' by management at the time. It is important that whatever structure is in place, senior managers are assured that systems are in place for practitioners to have their concerns heard and addressed by managers beyond the individual pods.

Recommendation 6

a. Children's social care to review the use [or not] of individual reflective supervision within pods, and report to the LSCB on how the needs for reflective case supervision are met in complex cases, and particularly where there is chronic neglect.
b. Children's social care to provide systems for social workers to be able to articulate concerns about case management or to seek consultation, outside of the individual pods; children's social care to report to the LSCB how this will be accomplished and review its effectiveness

7) There was little indication within midwifery services and children's social care 'front door' of practitioners understanding the need to take account of the family's known history

A common finding in serious case reviews is the lack of practitioner understanding of the need to access and understand previous agency history of the family, in order to evaluate the risk to children. In this case the practice weakness was evident in both midwifery services and the children's social care teams involved between August 2013 and January 2014.

Recommendation 7

The LSCB to consider how to change cultural practice across all agencies so that practitioners routinely access the known agency history of families (including all carers), and that the history is taken into consideration in any responses

8) The father and wider family members were insufficiently involved in the assessments undertaken

In common with findings from other serious case reviews nationally, there was insufficient involvement of the father in the assessments undertaken, although one social worker did initially try to engage him. Most critically the previous history of father was not accessed, although he was known to be the father of another child who had been adopted.

The assessments also did not involve other family members, despite it being known that both paternal grandparents, maternal grandfather, and other members of the extended family were involved in supporting the family.

Recommendation 8

The LSCB to consider how to change professional practice in all agencies, but especially within children's social care, so that all carers and involved family members are routinely involved in assessments of children subject to child protection plans and that their history is accessed as part of the assessment.

9) During the period of this review mother and children were homeless and moved many times, including eight different bed and breakfast placement: the constant moves and type of accommodation provided is likely to be detrimental to the children's welfare

Whilst the reason for the frequent moves are not totally understood and were in part due to Mother's actions and inactions, such constant moves must have been disruptive and distressing for the children.

The use of B&B accommodation for families is recognised as being unsuitable, only to be used when there is no alternative provision available and that the family should not remain there in excess of six weeks. This family were in B&B accommodation for longer than six weeks.

Recommendation 9

a) The LSCB to establish the use of B&B accommodation by Housing for Harrow families, the frequency of moves between B&B per family and the total amount of time families spend in such accommodation before being offered more suitable temporary accommodation such as a flat or house.

b) When the LSCB have this information, consideration to be given if there are systemic problems in the available provision and if further action is needed locally or in collaboration with other London boroughs.

10) There were examples of good practice by individual practitioners, despite an overall service characterised by 'too little, too late'

- The first Harrow health visitor who persevered in trying to see mother and tried to get children's social care in both Buckinghamshire and Harrow to investigate the concerns; had she escalated the failure of both children's social care services to do so, her involvement would have been even more effective
- The team manager of the child in need service for ensuring in February 2014 that the case was allocated and that this time the mother and children must be assessed
- The persistence and tenacity of both allocated social workers after February 2014 enabled the risks to be identified, recognised by management and begin to be addressed
- The persistence of the Ealing health visitor to try to facilitate the health and development needs of the children and her continuing involvement after the children moved out of Ealing
- The escalation of concerns by the Ealing health visitor, leading to the safeguarding advisor communicating concerns to Harrow children's social care
- The willingness of police to do welfare checks in response to referrals from members of the public
- The good communication and partnership working between the two allocated social workers and their colleagues in health and in the police, involving a number of joint visits
- The attempts by staff in the refuge to find mother, identify the whereabouts of the children and maintain the placement whilst trying to facilitate the family's return

This case demonstrated some very good examples of safeguarding being everyone's business, with the last B&B manager and staff involved in trying to help the family, as well as reporting to the social worker the concerns about the children's care and mother's behaviour. This manager also contributed to this serious case review which has enhanced our learning.

Members of the public also tried to contribute to the children's welfare by expressing their concerns at the time to police and children's social care. Such responsibility towards children in our community is to be greatly commended.

What will the LSCB do in response to this?

At the end of each finding in section 6 recommendations have been made for the LSCB. The LSCB has prepared a separate document which describes the actions that are planned to strengthen practice in response to the findings and recommendations of this serious case review.

1 INTRODUCTION

1.1 Initiation of Serious Case Review

1.1.1 On 22.08.14 Baby F, aged 11 months, was found by his mother submerged in the bath, after she left him unsupervised. Baby F was taken to hospital, but died in September 2014. Baby F and his half siblings (hereupon described as siblings) had been subject to child protection plans under the category of neglect since the end of April 2014. Baby F's mother pleaded guilty to manslaughter in March 2015 and received a six year custodial sentence.

1.1.2 The LSCB Chair at the time, Deborah Lightfoot, decided on 04.09.14 that a Serious Case Review should be held in respect of Child F.

1.2 Methodology

1.2.1 Statutory guidance[3] requires SCRs to be conducted in such in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings

1.2.2 Harrow Safeguarding Children Board (referred to as the LSCB) adopted a systems approach for this case to meet the above requirements. The systems principles and data collection process in the Social Care Institute for Excellence Learning Together systems guidance[4] was used in developing this local approach.

Period under review

1.2.3 The period under review is from 01.01.13 to 31.08.14. This covers the pregnancy of mother with Baby F until the tragedy that led to his death. Information that was held by agencies about the family prior to this period was provided in summary form to help understand the historical context of professional interventions.

Learning from review

1.2.4 The LSCB identified particular areas of learning to be considered as part of this serious case review. These are the strengths and weaknesses of the multi-agency safeguarding system with regard to:

- Homeless and mobile families

[3] Working Together to Safeguard Children, 2015 Chapter 4
[4] Learning Together, Fish, Munro & Bairstow SCIE 2008

- Substance misuse by parents
- Barriers to improving practice around neglect (in the context of previous focus by the LSCB on neglect)
- Where can we identify good practice in this case and what aspects of the multi-agency system support such practice?

Process

1.2.5 The process used involved:

- Appointment of two independent lead reviewers, Edi Carmi, to chair the review and Ghislaine Miller, to lead on data collection and to produce the report.
- A review panel of senior managers to oversee the process (see appendix 1 for details)
- The lead reviewers to work collaboratively with the review panel, lead the analysis and write the review report
- Identification of agencies involved with the children in the family and their mother (see appendix 2 for details)
- Collation of a detailed chronology of professional activity
- Obtaining information from other areas where the family had lived or frequently visited: 19 LSCBs were contacted for information, those who confirmed knowledge of the family and contributed to the review were Buckinghamshire County Council and the London Borough of Ealing
- The review was undertaken from a multi-agency perspective from the outset: consequently individual management reviews from agencies were not requested
- Lead reviewers and Panel members' involvement in speaking to practitioners so as to understand what happened and why- the rationale for actions, inactions and decisions
- Direct involvement of practitioners and managers through individual and two group meetings to provide information and participate in the findings; (see appendix 3 for details)
- Consideration of a variety of written records and reports undertaken as part of the ongoing work of practitioners

Timescales and necessary delays

1.2.6 In order to be able to include all relevant staff and family members, the process was delayed until after the criminal proceedings on the advice of the Metropolitan Police Service (MPS).

1.2.7 Subsequent delay also occurred due to change in the authorship of the report in August 2014, when the review chair took over writing the report.

Family participation

1.2.8 Mother participated in the review process, meeting with the lead reviewers following the completion of the criminal process.

1.2.9 Father and grandparents were also invited to participate but did not respond to the requests.

Limitations

1.2.10 Whilst Buckinghamshire contributed a chronology, none of their staff from children's social care or from health met individually with the lead reviewers, due to long term sick leave. Consequently the rationale for their decisions is not understood.

1.2.11 The Harrow children's social care pod unit manager and the first Harrow health visitor had both left Harrow and were not included in the review process. The locum solicitor who provided the legal advice was also not available.

1.2.12 The lack of response by grandparents and Father has limited our learning in this case. Maternal grandfather and paternal grandparents were very involved at times with Mother and the children. The role of Father at the time was never understood or explored; unfortunately this serious case review has not been able to overcome this omission and was unable to access historical data about him as a parent.

1.3 Structure of the report

1.3.1 The report is structured as follows:

- **Section 3** provides the context in which to understand what happened during the period under review:
  - family composition
  - historical information of professional involvement prior to the period under review
- **Section 4** explains what happened from the perspective of those involved at the time, including both professionals and family members
- **Section 5** provides an analysis of the themes emerging from the practice in this case
- **Section 6** provides the overall findings and recommendations
- A **glossary of terms** is provided at the end of the report
- The **three appendices** give the serious case review panel composition; the details of the agencies identified as providing services to the family in the review period and the practitioners who participated in the review process

2 CONTEXT

2.1 Family composition

2.1.1 Baby F lived with his mother, sibling 2 and sibling 3 in Harrow at the time of the incident. They were living in bed and breakfast accommodation.

Term used in report	Relationship to child F	Age in August 2014	Residence in August 2014
Baby F	Subject of the review	11 months	Harrow B&B with mother
Sibling 3	Elder half sibling of child F	Nearly 3 years old	Harrow B&B with mother
Sibling 2	Elder half sibling of child F	4 years old	Harrow B&B with mother
'Mother'	Child F's mother	31	Harrow B&B
'Father'	Understood to be the father of baby F		Not known, but thought to be in Harrow with his parents (paternal grandparents)
Maternal grandmother	Baby F's mother's mother		Harrow - but not with maternal grandfather. She died in December 2013
Maternal grandfather	Baby F's mother's father		Harrow, but not with maternal grandmother
Paternal grandparents	Baby F's 'Father's' parents		Harrow
Sibling 1	Mother's eldest child and baby F's half sibling	11 years old	Has lived with a relative elsewhere in London for most of his life and has no contact with Harrow services during the period under review

2.2 Background culture of maternal family

2.2.1 Mother comes from an Irish travelling family background and was known to local services as a child. She has 7 siblings (4 sisters and 3 brothers). Mother explained to the lead reviewers that her parents settled in Harrow following one of her siblings need for regular specialist health support from a London hospital. However, she explained that her father (maternal grandfather) still has his caravan which he uses.

2.2.2 Mother still identifies herself as a traveller and throughout the period under review she told practitioners she was in various locations in England and Ireland, visiting relatives. It is not clear to what extent these trips were real or used as excuses at times that she wished to avoid contact, or to explain non attendance at appointments.

2.2.3 One of Mother's relatives had previously stayed at the refuge in Buckinghamshire, where mother was in September 2013: this relative also identified herself as a traveller.

2.3 History of family prior to period under review

Maternal history

2.3.1 Mother has an elder son born in 2003. He lives with another relative in another London borough due to concerns about Mother's 'chaotic lifestyle' and ability to parent him.

2.3.2 Maternal grandparents lived at different addresses in Harrow prior to maternal grandmother's death in December 2013. Mother and siblings 2 and 3 lived with paternal grandfather in 2011 and a family group conference[5] was held at that time.

2.3.3 There was knowledge of mother's drug use in previous periods of intervention with Harrow children's social care and also information that a close relative of mother was a known drug user.

2.3.4 Mother describes herself as dyslexic, with difficulty reading and writing due to travelling around and missing school, but has subsequently learned to read.

[5] A family group conference (FGC) is a voluntary process led by family members and assisted by an independent FGC facilitator. The aim is to plan and make decisions for a child who is at risk of harm. At the first part of the meeting, social workers and other professionals set out their concerns and what support could be made available. In the second part of the meeting family members make a plan for the child. The family is supported to carry out the plan, unless it is judged not to be safe

2.3.5 During Mother's pregnancy with sibling 2, there were serious concerns relating to her then partner's violence towards her when she was pregnant. Child protection concerns culminated in a child protection plan for the unborn baby in 2010 on the grounds of neglect. The concerns centred on paternal violence, maternal past disengagement from drug and alcohol services (she used heroin and diazepam), previous post natal depression, lack of engagement with antenatal services and discharging herself prematurely from hospital when recovering from a severe assault and before the outcome of checks on the unborn baby.

2.3.6 The child protection plan continued during the pregnancy with sibling 3, and the unborn baby was also made subject to a plan in August 2011, when there remained concern of violence from sibling 2's father, who was due out of prison. There was also reference to Mother's deliberate self harm.

2.3.7 The children were removed from the child protection plans in January 2012 and became subject to child in need plans[6]. This followed an independent parenting assessment and support provision to reduce the risk of domestic violence and a return to substance misuse, along with educative parenting work and input to promote Mother's mental health.

2.3.8 Mother and children then moved to Brent and Harrow children's social care transferred the case. Following this there were a number of moves as accommodation was provided in different boroughs. At the start of the review period Mother's accommodation was provided through Enfield housing.

Paternal history

2.3.9 The review has found it difficult to obtain information about Father's history, due partly to the lack of practitioners doing so at the time, but also because this is contained in the file of another child (his daughter) who was subsequently adopted and the file therefore closed and not linked to Father. See 4.11 for further discussion about the lack of knowledge about the father.

2.3.10 There were also various comments of his to professionals which suggest he may have other children with different partner/s, but the London Borough of Harrow does not have any information on these.

[6] A child in need plan is drawn up following an assessment which identifies the child as having complex needs and where a coordinated response is needed in order that the child's needs can be met. Children who have been subject to a child protection plan are and who receive child in need services for a further 6 month period after the child protection plan has ended.

3 APPRAISAL OF PROFESSIONAL PRACTICE

3.1 Introduction

3.1.1 Section 3 provides a commentary on professional practice during the period under review.

3.1.2 To understand the rationale for professional practice, what happened is described from the perspective of those involved at the time, professional staff and Mother. The information is derived from agency records at the time, individual interviews and group meetings with those involved in the period under review.

3.1.3 The details of what happened are broken into time periods. The commentary within the shaded boxes at the end of each time period is an appraisal of professional practice in that period. Where such appraisal and explanation reflects a recurrent theme regarding the service provided there is a cross reference to subsequent analysis in section 4.

3.2 Missed opportunities by midwifery to identify risks: April - June 2013

3.2.1 The first time local professionals learn about Mother's pregnancy, with Baby F, is in April 2013, when she was admitted to Northwick Park Hospital Maternity Unit with abdominal pain. She was 18 weeks pregnant and living in a refuge because of alleged domestic violence. She had not received any antenatal care to date, was not 'booked in' despite a history of significant health conditions. These health conditions required ongoing treatment and monitoring and placed Mother and unborn baby at a high health risk. Mother was aware of this having received treatment in a previous pregnancy.

3.2.2 Mother was discharged without being 'booked in' and returned four days later when the results of her blood tests unsurprisingly showed a health risk. Further tests were undertaken but she was still not 'booked in'. Over the next few weeks Mother failed to attend four antenatal appointments; the Acting Community Matron was informed and the case discussed with the Safeguarding Midwife, who advised that home booking be done by the community midwife. The booking administrator was informed, but still no home booking took place.

Comment:

The history of the family was known to the Jade team [7] who were involved in Mother's previous pregnancy. Their records would have shown both the health risk factors for Mother in pregnancy and also the background of her children being subject to child protection plans. The latter knowledge on its own should have resulted in an immediate referral to children's social care for a pre-birth assessment. These notes were never accessed in this pregnancy because Mother was never booked in.

[7] The Jade Team are a specialist group of midwives who support women who are pregnant and have significant and high risk social vulnerability. The team case work directly with a small number of women risk assessed as highest need and provide a consultation service or shared care with community midwives to many others

Mother's self reported account of being in a refuge because of domestic violence, her late attendance and her non attendance at hospital, identified additional risks that were known by midwifery and should have in themselves triggered a referral to children's social care.

The contributory reasons behind such a poor response by midwifery are discussed in section 4.2

3.3 July - August 2013: late pregnancy, homeless, not attending antenatal care and first anonymous call

3.3.1 In this period Mother did not attend ante-natal care and did not answer her telephone. In consequence, a decision was made that she would have to contact her GP and have a new referral if she wanted to be booked at Northwick Park Hospital.

3.3.2 In August, police received an anonymous telephone call expressing concern about siblings 2 and 3 (then aged two and three) being looked after by adults who were drunk. Police attended the address, spoke to Mother, who was not drunk, and saw both children. This was the first of a number of anonymous calls about the children's welfare received by agencies during the review period.

3.3.3 During July and August Mother remained unsettled, requesting assistance from Harrow Housing in July and again at the end of August, on basis that the father of sibling 2, was a perpetrator of domestic violence and had discovered her whereabouts. On both occasions she was referred to a neighbouring London borough who were then providing her with accommodation.

3.3.4 In August Mother was also in contact with Harrow children's social care and a refuge in Buckinghamshire. The latter offered her a place and Harrow children's social care provided funding for a night at a bed and breakfast unit [first B&B in the review period] and transport to a refuge in Buckinghamshire the next day(Friday). The case was then closed by Harrow children's social care.

3.3.5 The mother arrived at the refuge the next day (Friday, 30.08.13) and informed the staff of her pregnancy and due date, which was some three weeks later.

Comment:

At this stage Mother is in the last weeks of her pregnancy and has not been receiving antenatal care, despite concerns for her own health, that of the baby and historical concerns about her parenting. Instead of recognising the risks to Mother and baby and need for referral to children's social care, midwifery decide to terminate service to Mother without a re-referral from the GP.

Given historical knowledge of Mother's parenting skills, and the knowledge of the imminent birth of another child, Harrow children's social care needed to undertake a pre-birth assessment, or ensure that this task was taken on by another authority. Most worrying is the lack of evidence at this stage of any contact with Buckinghamshire, or any checks about arrangements for ante-natal care and the imminent birth of the baby.

3.4 First few days in September 2013: birth of baby F

3.4.1 When staff arrived at the refuge on the Monday, Mother and children were missing. In fact the previous day (Sunday, 01.09.13) at 8.35am Mother was picked up by ambulance from an address in Brent, having given birth to Baby F in the toilet of a friend's home, apparently with Father's help. She had attended a party there the previous evening. Baby F was born at 37 weeks gestation. Paramedics smelt alcohol on Mother's breath and took her and Baby F to Northwick Park Hospital.

3.4.2 Father visited along with maternal grandparents, saying this was his seventh child. The midwives smelt alcohol on his breath. Mother said her other children were with a friend.

3.4.3 The day after the birth Maternity made a referral to the multi-agency safeguarding hub (MASH)[8] in Harrow. MASH advised Midwifery first to make a referral to Brent as Mother was homeless and the hospital was located in Brent and subsequently to Buckinghamshire, when it was learnt that mother had already been discharged when Baby F was two days old and had returned to the refuge. Baby F remained at Northwick Park Hospital in an incubator in the special care baby unit before being transferred to a hospital in Buckinghamshire when six days old as he had contracted pneumonia.

3.4.4 A psychosocial meeting was held (baby F aged 5 days old on 06.09.13) at Northwick Park Hospital, and a decision was made that baby F was not to be discharged until a strategy meeting was held. However, after discussion with a manager it was decided the baby could be transferred once a referral was made to children's social care. A doctor at the hospital first tried to make a referral to Brent children's social care, which was not accepted, and then to Buckinghamshire, appropriately marking this as urgent and requesting confirmation of receipt.

Comment:

The hospital acted appropriately in making referrals to Harrow, Brent and Buckinghamshire children's social care. The named nurse was though not informed of the concern; this could have provided another system to promote the safeguarding of Baby F.

The lack of the initiation of child protection processes at this point was a major omission, given the history and the circumstances of the pregnancy and birth. Harrow MASH should either have initiated this themselves, with a strategy meeting at the hospital prior to baby F being transferred, or ensured that this happened in Buckinghamshire. Instead, Harrow left it to the hospital to liaise with children's social care in Buckinghamshire and made no direct contact at this point to provide a full understanding of the history and the risks to the children, although there was subsequent contact initiated by Buckinghamshire. ***See 4.4 for further discussion.***

[8] MASH The Multi Agency Safeguarding Hub is a team of practitioners from social care, health, education and police who access and consider multiple sources of information relating to a child or family in a timely and proportionate way, to ascertain level of risk following a referral or incident.

3.5 Buckinghamshire Refuge: September - October 2013

3.5.1 Baby F remained in hospital in Buckinghamshire for 17 days, having been transferred there when he was 6 days old. Mother and siblings 2 and 3 were at the refuge and staff there describe Mother as 'quite chaotic' and always needing something 'now'. Involvement with staff was around crisis which effectively prevented any chance to probe her background.

3.5.2 The children tended to run around 'all over the place' and lacked concentration but were happy and not aggressive. The children attended the play room, but only went to the induction session at the nursery. One of the children had 'very bad teeth' so staff made calls to a dentist, but Mother did not follow this through.

3.5.3 When baby F was aged nine days old, Buckinghamshire children's social care manager telephoned Harrow MASH, asking if the case was open and requested information. This was followed later in September with a written request for history. It is not clear what information was provided.

3.5.4 Records indicate that the child protection concerns were understood in Buckinghamshire: health visitor records refer to children's social care consideration for a legal planning meeting and an anticipated discharge planning meeting. Also the refuge were told by the social worker that there was concern about a lack of bonding between mother and baby.

3.5.5 However, the information from Buckinghamshire does not explain the change in plans and lack of discharge planning meeting, before Baby F's discharge from hospital aged 22 days (23.09.13). The health visitor saw Baby F at the refuge the next day, before Mother and her three children left the refuge three days later (Baby F aged 25 days old), saying she was at her brother's home and planned to return.

3.5.6 The workers from the Refuge were concerned as Mother missed the appointment to register baby F's birth and a visit from the Buckinghamshire health visitor. The staff at the Refuge kept in touch with her to keep her place open.

3.5.7 Mother was admitted to Northwick Park Hospital for 6 days in October via ambulance in relation to her ongoing health conditions. She told the staff at the refuge she had pneumonia. Whilst at hospital the whereabouts of her children were unknown, but she absented herself from the ward several times, which was explained by her as being to make arrangements about their care.

3.5.8 When Mother was discharged from hospital she did not make contact with the refuge, or return for her belongings. By the end of the month the refuge had ended her tenancy.

Comment

The original plan in Buckinghamshire for a discharge planning meeting was the appropriate response. The reason for not following this through is not known due to the inability of the Buckinghamshire staff to participate in the review, but does appear to be after a conversation with Harrow MASH.

When Mother disappeared again from the refuge, with three such small children, a referral to children's social care was warranted, given the history and the vulnerability of such young children.

Meanwhile despite the concerns from the past, the lack of antenatal care and the worrying circumstances of baby F's birth, the children had not yet been seen by a social worker and only seen by one professional outside of the hospital (health visitor in Buckinghamshire); this was immediately following his discharge from hospital. Mother missed all other appointments and baby F had not had his 6 week check, which would have been due in mid October.

3.6 Inadequate investigation of anonymous referrals in Harrow: November 2013 - January 2014

3.6.1 This period starts in early November with an anonymous caller on 04.11.14 to both Harrow children's social care and the Metropolitan Police Service (MPS)). The caller alleged parental use of heroin smoked in front of the children who coughed up 'black stuff'. Baby F was reported as suffering with breathing problems and sibling 2 was always falling over; neither were receiving medical attention. The caller also referred to the parents' lifestyle, lack of adequate food for the children, concerns around the circumstances of the birth of Baby F and earlier child protection plans for the siblings.

3.6.2 In response to these concerns the Police immediately attended the address (paternal grandparents in Harrow), saw Baby F sleeping in his cot and appropriate toys and food in the home. Mother was out with the siblings at the time.

3.6.3 The response of Harrow children's social care involved communication with Buckinghamshire children's social care (which established the case was still open, although no social worker had ever seen the family) and the previous Harrow health visitor (Harrow health visitor1) from 2010/2011. A s.47 enquiry[9] was initiated, but the case was closed three days later without any further investigation being undertaken.

3.6.4 Meanwhile Harrow health visitor1 called at paternal grandparents; Father said Mother and children had left and he did not know where they were. When the health visitor reported this to Harrow children's social care she was told the case was closed as the family were living in Buckinghamshire. However, the Buckinghamshire social worker told her that the family were moving to Harrow and case closed there too.

3.6.5 Harrow health visitor1 persevered to try to see baby F, liaising with professionals:

- The Harrow GP told her of the lack of antenatal care and that baby F was not registered with the GP practice
- The Buckinghamshire health visitor said the family's records were sent to the Child Health Department [never received in Harrow, despite internal investigation]
- Harrow health visitor1 liaised with Buckinghamshire and Harrow children's social care: both reported the case was closed and the other area was responsible.

[9] Where there is reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm, the local authority is required under s47 of the Children Act 1989 to make enquiries, to enable it to decide whether it should take any action to safeguard and promote the welfare of the child.

- Harrow health visitor1 spoke with Mother on the 'phone; she said she was at her brother's home in Peterborough, planning to return to Harrow the next week and confirmed that baby F (at that point aged 10 weeks old) had not had his 6 week check or immunisations
- Harrow health visitor1 persevered and contacted the Harrow children's social care team manager1, explained the lack of contact with baby F, mother's plans and that Buckinghamshire had closed the case, but was told that case responsibility was not accepted by Harrow

3.6.6 Harrow health visitor1 managed to see baby F (aged 11 weeks), his siblings and Mother in mid November at the home of a relative: Baby F had a cold, severe nappy rash and looked pale. The assessment of siblings was difficult due to the high level of noise and activity in the room. Harrow health visitor1 concluded that Mother was looking after her children in difficult circumstances, was determined to return to Harrow and could still be at risk of domestic violence by sibling 2's father.

3.6.7 Harrow health visitor1 followed up by checking with Mother she had sought advice at A&E regarding the nappy rash and arranged for Baby F to be registered and have his 6 week check at the GP surgery in late November. Mother instead took him for a 6 week developmental check at Alexandra clinic two weeks later (when he was aged 3 months) and made an appointment for his immunisations, but there is no evidence that the appointment was kept.

3.6.8 Harrow health visitor1 completed a CAF referral to Harrow children's social care, highlighting the history of child protection plans, substance misuse and domestic violence; Baby F's health needs not being met and that the family were homeless, moving on a weekly basis.

3.6.9 Harrow children's social care decided to undertake a Child in Need assessment, as opposed to the earlier s.47 enquiry. The team manager (Harrow team manager2) allocated this to a social worker (Harrow social worker1) in early December. Harrow team manager2 tried to see the family over the next month, but Mother variously reported herself to be in Kent, in Peterborough and in Manchester. She also informed Harrow social worker1 that her own mother (maternal grandmother) had died just before Christmas and that she was not planning to return to Harrow imminently. Following discussion with Harrow team manager2 the case was closed at the end of January 2014, without referral to Manchester, on the basis she was not in Harrow and not wanting social work support.

3.6.10 Harrow health visitor1 had also been speaking to Mother and learnt she was in Manchester and the plan was to transfer the health visiting notes, but there is no evidence that this occurred.

COMMENT

The Harrow children's social care practice during these three months has significant shortcomings. The lack of professional contact with baby F and of further investigation into the concerns identified in the anonymous referral left the children at suspected risk of significant harm .

The initial plan to undertake a s.47 enquiry was correct and its abandonment on the basis of the case being open in Buckinghamshire was wrong - whether or not the family returned to Buckinghamshire, the allegations concerned care of the children in Harrow and was Harrow's responsibility ***(see 4.5 for further discussion about mobile families****).No local authority should close s.47 enquiries without being confident that the concerns are being investigated elsewhere. This did not happen.*

When the case was re-opened, the decision for it to be a child in need assessment and not a s.47 enquiry was flawed given the level of concern, but was based on the lack of supporting evidence from the police welfare check. This is a misunderstanding of the function of such a check which is a limited assessment of immediate risk, as opposed to a multi-agency investigation into chronic neglect ***(see 4.6)****.*

The subsequent closure of the case (without referral to another local authority) was based on Mother's absence from Harrow and her lack of wanting social work support. This ignored the reason for the assessment, which was about child protection concern. It also ignored the potential impact of bereavement and/or post natal depression on Mother's parenting. However, the manager recalls that because Mother often made up stories for avoiding contact, the account of her mother's death was at the time thought to be untrue.

The Harrow health visitor, Harrow health visitor1, is to be commended during this period, as the only pro-active practitioner who did see the children, albeit only once, and liaised with colleagues in Harrow and Buckinghamshire, as well as escalating concerns to the team manager in children's social care in order to get Harrow children's social care to undertake an assessment. However, it seems when Mother then said she was going to be in Manchester for some time, the lack of referral to colleagues there, meant that the children's health and development needs continued not to be addressed.

3.7 Further referrals in Harrow with Mother avoiding professionals: February - March 2014

3.7.1 In the first week in February, a third anonymous referral expressed child protection concerns to police and Harrow children's social care about neglect and the parents using drugs in front of the children at paternal grandmother's home in Harrow. Allegations included children being hit with a spatula, children kept in the back room of the house, in a travel cot, and the room smelling of urine. Baby F was said to be given Calpol© to make him sleep so the parents could take heroin.

3.7.2 The police again undertook a welfare check and found no evidence of substance misuse or lack of food. MASH returned the case to the children's social care child in need team for an assessment and Harrow team manager2 allocated the case to a social worker (Harrow social worker2).

3.7.3 The MASH health practitioner informed Harrow health visitor1 of the concerns and advised a home visit. Harrow health visitor1 called Mother the next day to be told she was moving to Manchester and agreed to provide an address when she got there. Harrow team manager2 made it absolutely clear that the family needed to be found, that Mother had evaded contact by saying she was elsewhere and that other local authorities must be informed should Mother say she was staying elsewhere.

3.7.4 Over the next seven weeks Harrow social worker2 made 11 telephone calls or texts to Mother and 4 unannounced visits to paternal grandparents' home without success in seeing the children. Harrow health visitor1 and social worker2 liaised and both tried to locate Mother.

3.7.5 Mother gave information initially (second week of February) that she was in Manchester with aunt, was planning to stay 2/3 months and would text the address. In the third week of February, information provided by Mother was that she was going / was in Ireland. Also that week another different anonymous referral (from a different source) reported to a (different) social worker that Mother and Father were together, using heroin and crack cocaine, and that Father had previously had a child removed due to his drug use. Also at this point there was information about the substance misuse relating to Mother's close relative.

3.7.6 In the third week of March, Harrow social worker2 found Father and his mother at home on an unannounced visit and was told Mother and children stay at that address when in Harrow and was last there two weeks previously. Mother agreed by telephone conversation that she would attend an appointment with Harrow social worker2 at the end of March, on her return from Ireland.

3.7.7 Harrow social worker2 completed a social work assessment the last week of March recommending child in need plan, or a s.47 enquiry if mother failed to attend the appointment at the end of March.

Comment

These third and fourth anonymous referrals should have triggered a child protection threshold, and the urgent need to see the children. The team manager this time was clear in her instructions about what had to happen, and the social worker was right to point out the need for a child protection response given Mother's continuing evasion of professional contact in the face of the same concerns. By the end of March, baby F was aged 7 months and had been seen by 2 health visitors and one clinic since being discharged from hospital in September 2013. Siblings 2 and 3 similarly were not being seen by professionals, and not attending any pre-school or nursery, other than one attendance in Buckinghamshire in September.

3.8 Child protection process initiated and children become subject to plans: Harrow April 2014

3.8.1 The child protection process was initiated on 03.04.14 in response to Mother not attending the appointment agreed with Harrow social worker2. A strategy discussion with the police agreed a s.47 enquiry as well as an initial child protection conference.

3.8.2 Mother did not respond to texts and telephone calls, so Harrow social worker2 visited paternal grandparents address and saw clear signs of the family's presence. Mother denied this saying (in a 'phone call) she was on her way to London and would come to the office that day. She did not do so. Harrow social worker2 returned to the paternal grandparents' home that day in the late afternoon and saw Mother and three children. This was the first time a social worker had managed to see Baby F and his siblings since the birth of Baby F.

3.8.3 Mother acknowledged living at 8 different addresses since October, because of her travelling culture. She denied being in a relationship with Father or using drugs. Harrow social worker2 discussed sibling 2's speech delay, which Mother queried as autism, and the lack of immunisations since 2012.

3.8.4 A written agreement was signed by Mother including attendance the next day at children's social care and housing, not to use alcohol or drugs, to take children to health appointments, to take telephone calls and give 72 hours notice of travel arrangements.

3.8.5 The next day Mother failed to keep her appointment with Harrow social worker2. An initial child protection conference was arranged for 25.04.14 and Harrow health visitor1 informed of events. Over the next 10 days Mother continued to miss appointments with the social worker and at health clinic, but did take the children to the GP surgery for immunisations and finally saw Harrow health visitor1 at the clinic on 17.04.14. She was in a rush en route to Housing, looked pale and thin, and did not have enough time to complete health assessments of the children. Mother obtained B&B accommodation in Barnet that day (second B&B in review period), having approached the Harrow Emergency Duty Team out of hours.

3.8.6 She subsequently attended Harrow Housing Services on 23.04.14 accompanied by Harrow social worker2 and provided an unspecific address history which included London, Peterborough, Manchester and Northampton, and an application in Watford. The decision was made to house Mother and three children under an interim homeless housing duty in a B&B Ealing (third B&B in review period). Harrow social worker2 visited the next day and the children appeared 'healthy and happy'. Mother complained of mice, bedbugs and a broken washing machine.

3.8.7 The initial child protection conference on 25.04.14 made all 3 children subject to a child protection plan under the category of neglect because of concerns about Mother's lifestyle and avoidance of professionals and parental substance misuse. The children's immunisations were now up to date and baby F (aged nearly eight months) was meeting his developmental milestones. Sibling 3's tooth decay was noted and that he needed a Speech and Language assessment. There were no health / developmental concerns in relation to sibling 2. The conference also learnt that Mother had difficulty reading and had dyslexia.

3.8.8 On the 28.04.14, the police were called to a shop by a member of the public, where sibling 3 (aged 2 years 8 months) had been found, having run off when Mother was visiting a friend. This was reported to children's social care.

3.8.9 The same day health visiting responsibility was transferred to Ealing. The children's records were still in Brent as Harrow had not managed to obtain them. The family had lived there from 2011 to 2013.

Comment

The concerns about the children start to be addressed at this point and the social worker provided the much needed perseverance to see Father as well as Mother and the children. In this instance, with Mother's evasive tactics challenged by a social worker, the children were finally seen and accommodation provided.

It is one of the occasions when professionals did follow through with Mother on the consequences of her non compliance. However, there was no challenge to her regarding her neglect of sibling 1, which enabled him to run away without her noticing on 28.04.14.

The conference child protection plan focused mainly on the many services the children required to meet their health needs (dental and optician appointments, developmental needs (Children's Centre and nursery) and the drug testing of the parents. Contingency measures included earlier core group or legal planning meeting and missing person's alerts should the children disappear again. What was missing was further assessment of both parents and their parenting capacity. Father had not attended the conference despite having agreed to do so.

3.9 Implementation of child protection plan: May - July 2014 (Family in Ealing and then Harrow)

3.9.1 Between the child protection conference convened by Harrow children's social care in April and the first review conference in mid July there was very little progress in terms of the implementation of the child protection plan. Overall Mother did not engage with services, albeit occasionally was seen with the children (often through unannounced visits) but with little follow through by her of the steps required to meet her children's needs as identified in that plan. Contacts with professionals demonstrated a pattern of missing appointments, not answering 'phone calls or messages and being out at visits.

3.9.2 Most critically neither Mother nor Father attended either of the two Core Group meetings held in this period. This is the multi-agency forum to make the plan more specific and monitor its progress, and where explicit parental agreement is sought.

May 2014: family in Bed & Breakfast in Ealing

3.9.3 A new Ealing health visitor (Ealing health visitor2) made a number of appointments and visits in May and saw Mother twice in the first half of the month. Sibling 3 was home the first time and was observed to be eating chocolate despite his tooth decay. On the second occasion all the children were asleep and mother had just woken (afternoon visit).

3.9.4 Mother agreed to a clinic appointment, to register at a local GP, to register the children at a dentist, co-operate with referrals for Speech and Language therapy and Audiology for sibling 3. However, Mother did not attend the health clinic to complete the forms required for the referrals, and did not register with a GP or dentist.

3.9.5 Harrow social worker2 repeatedly tried to contact Mother during May, but she did not answer the telephone or respond to messages. In mid May Harrow social worker2 found only Mother and sibling 3 at home when he visited unannounced: the other children had been left asleep at a friend's. No-one answered the door when Harrow social worker2 visited unannounced on 28.05.14 and 30.05.14. On the latter occasion the caretaker said the family had not been seen for 5 days.

3.9.6 Mother also failed to attend her appointment with Housing on 30.05.14.

June 2014: family in Bed & Breakfast in Ealing

3.9.7 Harrow social worker2 found the family, including Father at the Ealing B&B early on 02.06.14, despite Mother's assertions that the relationship was over. The place was cluttered and dirty, with 5 cigarette lighters lying around in the room. Sibling 3 was noted to have a dirty face and unwashed clothes. Mother claimed that registration with GP, dentist and nursery were all in progress. Father agreed to be assessed, but not immediately.

3.9.8 At a 'pod'[10] supervision in Harrow children's social care the next day, further assessments and actions were decided, such as a parenting course and risk assessment of Father as well as a re-iteration of the actions already being pursued without success.

3.9.9 Mother attended Housing on 03.06.14 with some of the required documents and registered with a GP on 05.06.14. She missed her first appointment at the substance misuse service (RISE) on 09.06.14, saying she had a death in the family: it was noted that she was under the impression she was to undertake a drug test.

[10] A 'pod' in Harrow children in need service provides a framework for supervisory arrangements and management oversight of case work. Weekly case discussions allow managers to provide greater scrutiny and challenge

3.9.10 On 11.06.14 Harrow social worker2 made an unannounced visit to the Ealing B&B. The caretaker told him that Mother left over the weekend with her 'boyfriend'. The social worker then went to Father's parents' house, where there was no reply there and neither of the parents answered their phones.

3.9.11 Harrow social worker 2 found Mother at the Ealing B&B the next morning, with the children. There was an unidentified 'older person' asleep. The social worker advised Mother that the children should not have contact with Father until he had been assessed. There had been no progress in accessing dentist, or addressing the children's health needs. The room was cluttered, and the children's feet dirty. Mother was planning to visit a close relative the next week who was known to be a drug user.

3.9.12 Following this visit the case was discussed within a 'pod' supervision session on 13.06.14 with a decision to start the paperwork for a legal planning meeting.

3.9.13 The second Core Group Meeting was on 19.06.14: Mother failed to attend despite having been reminded of the meeting 2 days earlier by Ealing health visitor2 (when Mother had forgotten an appointment with her). Mother spoke to Harrow social worker2 on the phone several times saying she was on her way, but never arrived.

3.9.14 Ealing health visitor2 reported that she had only been successful in seeing the children on one occasion, and that Mother failed to attend three clinic appointments and one 'home' visit. In consequence there had been no progress made on the actions on the Child Protection Plan. The decision to hold a Legal Planning Meeting was shared. Mother attended the office later that afternoon and was updated on the Core Group Meeting.

3.9.15 When Harrow social worker2 and Ealing health visitor2 did a joint visit to the Ealing B&B the next week, the children had just woken up at lunch time, the room was cluttered with clothing, cigarette butts and lighters. Sibling 2 put a butt in his mouth, pretending to smoke. Mother said sibling 3 was registered with a dentist and waiting for an appointment.

3.9.16 Mother was told to register the children at Nursery by the end of the week. A further appointment was made with Ealing health visitor2 for a weight review at the clinic on 01.07.14 and Mother was reminded of her appointment with Ealing RISE (substance misuse service). She was told that there was grave professional concern for the children's safety.

3.9.17 Ealing health visitor2 accompanied the substance misuse worker to the home on 26.06.14. Mother was encouraged to access a Children's Centre for Baby F, aged nearly 10 months.

First half of July 2014: Plans for legal intervention progress, family move to Harrow and change of social worker

3.9.18 The Mother failed to attend her appointment at Ealing RISE on 30.06.14 and also did not take the children to the clinic for their weight check on 01.07.14. On 03.07.14 the housing officer emailed Harrow social worker2 about Mother's lack of co-operation in attending appointments and providing documentary evidence. She had previously been warned she

would lose her accommodation and the case was then closed due to this lack of co-operation, despite the children being subject to a child protection plan.

3.9.19 Harrow children's social care agreed to house the family and that afternoon another social worker (Harrow social worker3) arranged B&B accommodation in Harrow (fourth B&B placement in the review period).

3.9.20 Harrow social worker 2 had been on sick leave, so the plans for the legal planning meeting had not progressed until the pod manager requested a Legal Planning Meeting on 04.07.14, because of parental alcohol and substance misuse, parental lack of engagement and neglect of the children's needs.

3.9.21 The case was re-allocated to Harrow social worker3 on 07.07.14 because of social worker 2's ill health. The new social worker met the family the next day when Mother attended a housing appointment. A new B&B placement was provided in Hounslow (fifth 5th B&B placement) on 08.07.14. In approving the finance for the B&B the Harrow children's social care service manager expressed concern about what work had been done to date and asked for an update.

3.9.22 A Legal Planning Meeting took place the next day when it was agreed that the threshold for initiating proceedings was met, and that the PLO[11] route would be taken**.**

3.9.23 Harrow social worker2's had written the report for the child protection conference and provided his successor with an email summary of the case. The report cites the difficulties seeing Mother, her lack of registering for services for the children, sibling 3's tooth decay and toothache, Baby F's weight loss, concerns about the children's diet and the overall lack of progress on the protection plan.

3.9.24 Ealing health visitor2 did not provide a report, but attended the conference and reported that the children were up to date with immunisations, but she had been unable to carry out their developmental checks. The two older children were registered with a dentist and had their teeth examined. The referral was made for Speech and language therapy for sibling 3, but the children had not been registered at a nursery.

3.9.25 The decisions of the conference were similar to the previous plan, but with the added recommendation of a further legal planning meeting with a view to initiate care proceedings 'forthwith' and putting a police alert on the current address and the family to be reported officially missing if professionals were unable to access them.

[11] The Public Law Outline [referred to as the PLO], is a revision of the 2003 Judicial Protocol, which was itself an attempt to reduce unwarranted delays in family court cases. The PLO emphasises the importance of strong judicial case management throughout a case; of narrowing the issues in dispute and seeking to resolve these at a much earlier stage; of reducing the amount of written material and oral evidence so that practitioners can focus on the big issues in a case; and of introducing a pre-proceedings gate-keeping regime to ensure local authority cases are better assessed prior to an application to court being made.

Comment

This two and a half month period is the first time that professionals consistently tried to see the children and Mother. Unusually given the past, the family appear to have remained in the locality and with a great deal of perseverance both Harrow social worker2 and Ealing health visitor 1 do manage to see the children, albeit with great effort and somewhat infrequently.

This was a case that understandably caused the social worker great anxiety (as he explained the review process), being unable to make any real progress with the child protection plan.

Despite the fact the children were subject to a child protection plan, Housing ceased to finance their B&B and closed the case without notice to the social worker; this suggested working in isolation, and should have been addressed via co-ordinated activity between housing and children's social care.

There was a slow professional response in terms of implementing the contingency arrangements defined in the protection plan, in particular legal proceedings. The lack of individual supervision sessions for the social worker would have been a major contributory factor to this slow decision making. See 4.8 for discussion of management issues.

3.10 Immediate Harrow case management following review conference: mid July

3.10.1 On 14 July a discussion took place between Harrow social worker3, two 'pod' managers and Harrow team manager2 about whether to initiate proceedings immediately rather than follow the Public Law Outline (PLO) route. They agreed daily visits to the family, a strategy discussion with the police and a further discussion with the Service Manager for a decision to be made.

3.10.2 Harrow social worker3 got no response to his home visit the next day and emailed his concerns to the service manager, Harrow team manager2 and the pod manager. The service manager, Harrow team manager2 and the pod manager met and agreed to ask the B&B to log Mother's whereabouts and her visitors. Through liaison with the caretaker it was anticipated visits would be more successful.

3.10.3 The police child abuse investigation (CAIT) team queried the need for a strategy discussion, and declined a joint investigation and the request for uniformed police to visit after only one failed visit. Harrow team manager2 advised the pod manager that another legal planning meeting be convened and for uniformed police to be called if the social worker remains unsuccessful in seeing the family.

3.10.4 Harrow social worker 3 made a referral to the Harrow substance misuse service, Compass Hidden Harm that day. The co-ordinator came out with him on a joint visit immediately, knowing Mother from an earlier successful period of intervention. The family were home and no concerns were noted about their physical and emotional presentation, nor about the home conditions. Sibling 3 had a bite mark said to be caused by sibling 2. The caretaker reported a man visiting every day, but Mother stated she had no visitors. The Compass co-ordinator planned to undertake an immediate drug test, but Mother refused, denying any drug use.

3.10.5 Also on 15.07.14, the audiologist discharged sibling 3 as a partial booking letter was returned as address was not correct.

3.10.6 On 17.07.14 the family moved to Harrow in their sixth B&B placement. Harrow social worker3 visited Mother, provided the pre proceedings letter and noted positive interaction between her and her children. The second legal planning meeting was held that day and decided to continue follow the pre-proceedings route following the positive visit and to give Mother the opportunity to be able to demonstrate if she had the capacity and motivation to change.

Comment

I*n the week following the review conference, the case was high profile involving three managers within Harrow children's social care after the family was not home when the social worker called. The review recommendation of involving the police if the family weren't home when visited was shown not to be feasible, as the police understandably did not see the need for their involvement on the basis of the family being out when an unannounced visit was undertaken.*

The impact of being homeless and constantly moving was evident with the 6th B&B placement for the family in the period under review, before the health visitor allocated in Hounslow had had the time to visit them.

The Compass co-ordinator demonstrated very good practice by responding instantly to the referral and undertaking an immediate joint visit.

3.11 Mother thought to be engaging better: late July - 10.08.14

3.11.1 Mother was more co-operative once she knew of the initiation of the legal process. She started by attending an appointment at housing and providing requested documents on 21.07.14. However, she deferred drug testing for 11 days, having missed an appointment with the Compass Co-ordinator on 17.07.14, and asked instead to be seen on 28.07.14 (which was not possible for Compass).

3.11.2 A pre-proceedings meeting took place with Mother on 23.07.14. Father was not included in this action. The pod manager felt that Mother engaged in the meeting and a written agreement was signed (albeit this has not been located in the records).

3.11.3 The pod manager drew up an immediate plan of action on 25.07.14 for a Family Group Conference (FGC) referral and nursery placements identified by 30.07.14; a parenting assessment and a hair strand test to be completed by 06.09.14; an updated social work report by 08.08.14 and a review pre-proceedings meeting on 02.09.14. The manager also informed the police of the case going in the right direction following the pre-proceedings meeting. This view was communicated to the service manager and discussed in pod supervision on 04.08.14.

3.11.4 When Harrow social worker3 visited on 28.07.14 he discovered that Mother had dyed her hair, although she denied this. Harrow social worker3 concluded this was to avoid a hair strand test for substance misuse. Mother said that sibling 3 had seen the dentist and was to have 5 teeth removed. Harrow social worker3 checked the position with the dentist on 30.07.14 who confirmed the procedure would be undertaken at hospital.

3.11.5 The new health visitor (Harrow health visitor3) was allocated the family on 30.07.14 and immediately liaised with the social worker, the dental surgery and arranged a visit with Mother the next day.

3.11.6 The family was home for the appointment, with children dressed only in nappies. 11 month old Baby F was lifted from his soiled sheet and his nappy needed changing. The two older siblings kept opening the door, running outside, hitting and biting others, including Baby F.

3.11.7 Mother agreed to attend the clinic on 01.08.14. However, Mother then cancelled the appointment due to baby F having a sickness and diarrhoea bug, but said she wanted to see Harrow health visitor3. She did turn up at the clinic three days later, when Harrow health visitor3 observed the children to be clean and tidy, but was unable to assess the children because they were still poorly.

3.11.8 Mother attended a core group meeting for the first time on 05.08.14, meeting with Harrow social worker 3 and Harrow health visitor 3, leaving her children with maternal grandfather. Plans included progressing a referral for a Paediatric Assessment of both siblings, a speech and language referral for sibling 3 and encouraging Mother to register at the local Children's Centre for playgroup for the children. The same day the local centre confirmed that Mother had requested two free-funded places.

3.11.9 Harrow social worker 3 made a referral to Early Intervention Support[12] (EIS) for Mother on 06.08.14 and discussed this with her on his announced visit the next day. The only concern noted was the smell of smoke in the room. Harrow social worker 3 was positive about mother's recent engagement.

Comment

The Ealing health visitor (Ealing health visitor2) commendably attended Harrow on 29.07.14 for the core group meeting, despite case responsibility having moved first to Hounslow and then to Harrow. Unfortunately she had not been informed the meeting had been postponed. She then telephoned her colleague in Harrow to give her the history. This demonstrated a recognition of the need for continuity in the face of the family's constant moves.

It was positive for the pod manager to take responsibility to identify actions required with dates. There appears to have been a very long time frame allowed for the hair strand test for substance misuse.

[12] Early Intervention Teams provide integrated support to children, young people and families 0-24 (LDD). The key objective of the service is to provide evidence based early intervention, advice, support and direct case work to prevent issues escalating and requiring statutory intervention.

The positive view of Mother's engagement discussed at the pod supervision on 04.08.14 does appear to have some basis. The focus on tasks to be completed is necessary, but does not address the underlying assessments needed of parenting capacity and motivation to change. It is not at all clear how this can be undertaken during home visits with three children, who are all needing a great deal of attention. There appears to be no reference to Father and his current role in the family, although sibling 2 mentions 'daddy' and Mother states this refers to maternal grandfather. The social worker and manager begin to start the process of understanding the family by requesting information from another borough (where Mother had previously lived and where her eldest child (Sibling 1) was living) and asking Mother for family details to progress the FGC.

3.12 Circumstances deteriorate rapidly from 11.08.14

3.12.1 The situation deteriorated from this point, with the family being asked to leave the B&B on 11.08.14, due to Mother smoking and knocking on doors to borrow money. Mother signed an agreement with Harrow social worker 3 about rules when living in a B&B and was moved that day to a seventh B&B placement. This was also in Harrow. 3 days later they were moved to another B&B in Harrow, the eighth placement, with the same complaints about her behaviour emerging.

3.12.2 The Compass co-ordinator arranged an assessment appointment for 26.08.14, when it was planned Mother would attend the office.

3.12.3 On 19.08.14 Harrow health visitor3 visited the B&B, but the family was out. Harrow social worker3 visited the next evening and saw the children. The B&B Manager told the social worker that he believed Mother used drugs being delivered to her by men. He explained that a male knocked on the door aggressively every morning and she let him in. Another male had also been seen in the room. She had borrowed £50 from the B&B manager and asked another member of staff for a small amount of foil. He had overheard her asking for “one B’s” (slang for heroin) when speaking on the telephone. The two older children had ran across the road unsupervised in their nappies and members of staff had to bring them back. The Manager agreed to put his concerns in writing.

3.12.4 Mother appeared pale and dishevelled, but denied having visitors, and explained the children were playing. She provided names and contact details of family members for a family group conference. Harrow social worker3 communicated this information to Compass and managers at children's social care stating his concern that 'Mother's behaviour mirrors past behaviour and feels the children are at risk of significant harm'.

3.12.5 The next day the service manager convened a legal planning meeting in the afternoon attended by the service manager, Harrow team manager 2, Harrow social worker3, Harrow legal advisor and the Compass co-ordinator.

3.12.6 The legal advice was that the threshold had been met for legal proceedings and the meeting considered options 'to manage risks' until an interim care order (ICO)[13] hearing could take place in court after the Bank Holiday. By this time it was out of hours and the decision was to ask police for assistance in a joint visit that evening.

3.12.7 Harrow team manager2 had a telephone strategy discussion with the Police and a joint s47 enquiry with a joint home visit agreed for that evening at the B&B. The Police were told by Harrow team manager2 that legal advice was that the threshold had already been met to issue proceedings.

3.12.8 At 8.30pm that Thursday evening Harrow social worker3 made a home visit with two police CAIT Officers. The room was untidy and an asthma inhaler was found, with foil inside, considered likely to be used for smoking heroin. This was removed for testing, with Mother denying that it was hers. No heroin was found during the police search of the room and the police were clear that the threshold to remove the children under Police Powers of Protection (PPoP)[14] was not met. The social worker knew Mother would not agree to the children being accommodated under s.20 Children Act 1989 and then suggested the family stay with relatives, contacted a family member to discuss this. This proved to be not possible for the relative.

3.12.9 The next day a case discussion took place between a second legal advisor, service manager and Harrow team manager2. The social worker and pod manager were on leave. The decision was taken to proceed with an application for an Interim Care Order (ICO) after the Bank Holiday, as the grounds for an Emergency Protection Order (EPO[15]) were not met. If there were any further concerns over the weekend, an EPO should be sought.

3.12.10 Harrow team manager2 planned to visit Mother with the Compass co-ordinator, but Mother left the B&B before this was accomplished. Arrangements were made for Mother and the children to be visited regularly over the Bank Holiday by a sessional EIS worker, who would also contact the Compass co-ordinator to attend for a drug testing.

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[13] At the start of care proceedings, the council asks the family court to make a temporary court order, called an 'interim care order' or ICO under s.38 of the Children Act 1989. If the court agrees, the council can take the child into care on a temporary basis. This can be for up to 8 weeks at first. After that, it can be renewed every 28 days.

[14] The Police have powers under s. 46 of the Children Act 1989 to protect children. If a police officer believes that a child is at risk of suffering significant harm in a particular situation then s/he may exercise powers under this Act to remove the child to suitable accommodation or if the child is in hospital or in a place of safety, take steps to keep the child there. A child cannot be kept in police protection for more than 72 hours.

[15] An emergency protection order or EPO is a court order granted under Section 44 of the Children Act 1989 on the grounds that a child will suffer significant harm unless they are removed to council accommodation or moved from where they are currently living.

3.12.11 The EIS worker planned to visit the family on the evening of Friday 22.08.14, but the Manager of the B&B told her that Mother and the children were out that evening. She telephoned Harrow team manager2 for advice and agreed to go twice on the Saturday: morning and early evening. The B&B manager was advised to call police if any concerns arose over the week-end.

3.12.12 The EIS worker went to the B&B at about 09:10 on Saturday 23.08.14 and saw the family. There were no evident signs of drug taking. The EIS worker arranged to return about 17:00 when they would go to the park; this would enable her to better assess the children out of the confines of the B&B.

3.12.13 At 16:18 that day an ambulance was called to the B&B where baby F was reported as not breathing. Mother explained to the Fast Response Unit when they arrived that she had left baby F in the bath unattended whilst she got his bottle. When she returned he was in the bath not breathing. Oxygen was administered and CPR commenced, before baby F was transferred to hospital.

3.12.14 PPoP were taken on the siblings that evening and they were placed with foster carers.

Comment

The social worker correctly identified the risk to the children, having received the information from the B&B manager on the evening of 20.08.14 and he recalls emailing his manager immediately, copying in more senior managers.

The lead reviewers have been provided with different understandings of the decision making the next day (21.08.14) and what was anticipated would be the outcome of the joint visit that evening. It was entirely appropriate to consider the available options to intervene that day, as well as the plan to initiate care proceedings after the Bank Holiday. However, the misunderstandings around the use of PPoP are discussed in 4.6

4 THEMATIC ANALYSIS

4.1 Introduction

4.1.1 Section 5 considers professional practice themes that emerged from this case exploring what helps and hinders good safeguarding practice. Section 6 provides the concluding systemic findings and recommendations arising from this analysis.

4.1.2 The LSCB identified particular areas of learning to be considered as part of this serious case review. These are the strengths and weaknesses of the multi-agency safeguarding system with regard to:

- Homeless and mobile families
- Substance misuse by parents
- Barriers to improving practice around neglect (in the context of previous focus by the LSCB on neglect)
- Where can we identify good practice in this case and what aspects of the multi-agency system support such practice?

4.1.3 Discussion of these is included in this analysis.

4.2 Midwifery failure to recognise need for pre-birth safeguarding referral

4.2.1 This was Mother's fourth pregnancy and there was a history of previous risk factors relating to what was defined as her 'chaotic life', substance misuse, domestic violence, post natal depression and self harm and general neglect of her children's needs. This led to siblings 2 and 3 being subject to child protection plans between 2010 and 2012, and sibling 1 living with a family member.

4.2.2 This history should have been well known to maternity services at Northwick Park Hospital as they had been involved during Mother's previous pregnancy, when there was a pre-birth conference and a child protection plan for the unborn baby. Also from the last pregnancy there was knowledge of Mother's serious health conditions which required additional monitoring during pregnancy.

4.2.3 Maternity services repeatedly missed the need for an urgent referral for a pre-birth assessment. This was due to not:

- Accessing Mother's notes (containing her history) as she was not booked-in and
- Identifying her current circumstances (domestic violence, in a refuge, lack of ante-natal care and attendance at appointments, neglect of own health needs) as being a risk, requiring accessing her history and a referral to children's social care

4.2.4 Mother's previous history was on the records of the Jade team, who provided the service on Mother's previous ante-natal care. This is a specialist team for vulnerable Mothers. The Jade team was set up with the philosophy that vulnerable women have individualised care, continuity and ongoing support during and post maternity service involvement. Staff were aware that the Jade team had prior involvement, but did not access the history. Whilst there was an attempt to liaise with the Jade team, with one message left, this was not followed up.

4.2.5 The fact of previous involvement of the Jade team should have triggered the need to access the records. The author is advised that when patients are not 'booked-in' for midwifery services, staff are not able to access their historical records. The lack of routine access to a patient's records is a systemic failing, and should not be dependent on whether the patient has 'booked-in' or if the staff 'booked-her in'.

4.2.6 Moreover, this inability to access the records given the risk factors associated around the two inpatient episodes, poor general health, concerns about non attendance at appointments and domestic violence, should have triggered the need to urgently 'book-in' the Mother for antenatal services, which would have given access to the history. The reasons behind this failure in the basic duty of a midwife, has been attributed by practitioners to the length of time the booking process takes (around an hour). The lack of attendance at appointments contributed to the failure to book Mother in for antenatal services and at one point this was referred to the safeguarding midwife. However there is no evidence of her advice being followed to undertake a home 'booking-in.

4.2.7 A further worrying aspect to the midwifery service was the response when Mother missed a 3rd appointment due to GP advice (she had contact with chicken pox) was to inform Mother to return to the GP if she wanted a referral to Northwick Park Hospital, or attend her nearest hospital. Such a response to hard-to-reach patients has long been recognised as flawed, especially in the Mother's circumstances of needing to be monitored.

4.2.8 There has been discussion within the review whether Mother should or should not have received services from the Jade team. Given her vulnerability, this should have happened in the current configuration of service delivery. However, there is also debate about whether it is helpful to have such a separate team, given the need for **all** midwives to be able to identify and support vulnerable parents, as opposed to seeing this as the remit of a specialist team. This risk has been highlighted in a previous case review undertaken involving this midwifery service and been recognised within the internal subsequent service review:

'The principles of establishing specialist midwifery team to provide expertise in managing and supporting women with particularly complex and challenging child protection concerns is commendable. ..... The difficulty then arises ....., subsequent midwifery colleagues become deskilled in this challenging area of health care, delegation of recognising, responding and

reporting becomes a specialist role when all midwives have a statutory responsibility for safeguarding children'[16]

4.2.9 The major concerns about the failure of midwifery to identify risk, book-in the Mother for services and make a pre-birth referral to children's social care are addressed in the first finding and recommendation in section 6.

4.3 Professional difficulty in dealing with avoidant parents leaves children at risk of significant harm over a long period with their circumstances not being assessed

4.3.1 Mother was considered to have a 'chaotic lifestyle'. This may or may not have been true, but it tended to be accepted easily as an excuse for her not attending appointments. In fact her behaviour was largely predictable when seen over time, not answering her phone or responding to messages and not keeping appointments, even when the children were subject to child protection plans and written agreements.

4.3.2 Mother's apparent mobile lifestyle may or may not have been real, but it acted as a very successful way to avoid professional contact, constantly telling practitioners she was out of Harrow for that week, or for several weeks.

4.3.3 This behaviour of not answering her phone or claiming to be out of the locality was from Mother's perspective an extremely successful way of avoiding professional assessment of the risks to her children, so delaying and hindering the ability of practitioners to be able to obtain information to justify child protection and then legal proceedings. Mother managed to successfully divert the investigation into concerns about her children expressed in anonymous referrals through avoiding contact, and saying she was away. Consequently, despite significant concerns and allegations about the children's welfare, children's social care repeatedly did not assess the children's safety at all (see 5.5), closing the case, without seeing the children.

4.3.4 Once the case was finally allocated for assessment at the beginning of February 2014, following the third anonymous allegation, there was a determination that this time the family needed to be found. The social worker showed great persistence and determination over the next two months, but never managed to see mother or children. Neither did the health visitor. This did appropriately lead to a child protection enquiry and an initial conference, but her avoidant behaviour continued.

4.3.5 The impact of such avoidant behaviour was that before February 2014 Harrow children's social care would close the case, and from February it prevented adequate assessments of the parenting or of the children's health and development so delaying any decision making about the safety of the children.

[16] Review of Maternity Safeguarding Services at Northwest London Maternity Unit (internal report December 2013)

4.3.6 In some instances within health, the lack of attendance at appointments led to the service being withdrawn, as opposed to raising concerns. This happened when Mother did not attend 3 midwifery appointments.

4.4 Repeated inadequate response to referrals by Harrow children's social care between August 2013 to February 2014 suggest threshold may be too high at this point in the system and /or that there are critical flaws in the understanding of responsibilities when families are mobile

4.4.1 Between August and the end of January, Harrow children's social care repeatedly either refused to accept the referral or closed the case without investigation, either on the basis that a police 'welfare' check had been done and not identified concerns, or because the family did not live in Harrow. In all these instances the priority appears to have been 'gatekeeping' by children's social care to prevent access to services as opposed to a focus on the safety of the children.

4.4.2 In August 2013 an anonymous phone call that the children were looked after by adults who were drunk led to police welfare check which established Mother was not drunk *at that point.* No further assessment by children's social care of the possibility that Mother and other unknown adults might be drunk at other times. Given what was known about her earlier parenting, this would not have been out of character.

4.4.3 When just after this, in August 2013, Mother was homeless and eight months pregnant and allegedly escaping threat of domestic violence by sibling 2's father, assistance was provided in terms of B&B accommodation and travel expenses to a refuge in Buckinghamshire. Given the pregnancy, the known family history, as well as the anonymous referral, it should have been clear that Mother was struggling and there needed to be an assessment of the children's needs. Because the refuge was outside of Harrow the case was closed without consideration of the need to refer to Buckinghamshire.

The circumstances of Baby F's birth were referred by Northwick Park Hospital, with references to questions about the possible withdrawal from drugs of Mother and baby (later this concern is discounted). Harrow children's social care did not accept the referrals: initially on the basis that the hospital was located in Brent, so the referral should go there and subsequently as the refuge was in Buckinghamshire. On neither occasion was there any acceptance of responsibility to ensure Mother and children received help by a children's social care which was in possession of the history (see also 4.7 response to referrals from members of the public).Evidence from other agency contributions to the review indicate that Buckinghamshire children's social care originally intended to hold a strategy discussion and pre-discharge meeting prior to Baby F joining his family in the refuge, especially in the light of concerns about Mother's lack of bonding being observed: Baby F was discharged without this.

4.4.4 Further anonymous referrals in November 2013 about parental substance misuse and neglect of the children were not investigated other than police welfare checks (see discussion of these in 5.5 below). Whilst a s.47 was briefly initiated, the case was closed on the totally mistaken insistence that Buckinghamshire would be responsible, even though the family were no longer there.

4.4.5 During these six months when Mother was very pregnant and the first 5 months of baby F's life it is very difficult to understand the lack of any social work assessment or s.47 enquiry in November, given the very high level of risks in this family on the current concerns in the context of Mother's history. The priority appears to have been in for Harrow children's social care to not get involved at all, despite the fact that the family were self evidently a Harrow family, and mother's moves (if they did occur) were temporary and short.

4.4.6 The outcome of the avoidance of involvement in both authorities was that Mother and children, including a new born baby continued to live a nomadic lifestyle without there being any investigation of the considerable concerns that were being reported.

4.5 Homeless and mobile families

Mobility and/or avoidance?

4.5.1 It is well recognized that children can be particularly vulnerable when families move between local authorities, especially because of the lack of continuity of services and changes. For this reason the London Child Protection procedures[17] have, since the initial edition in 2002, included a chapter covering the arrangements between agencies in different authorities, so as to minimize risk to children.

4.5.2 Mother stated she was constantly moving around, going to visit family in Ireland or elsewhere in the UK. It would be difficult to speculate how much of this moving around is because she is a Traveller and how truthful she was about travelling as opposed to saying she was elsewhere so as to avoid professional contact. Her own parents, also Travellers, are now settled in Harrow, but Mother was clear when interviewed for this review, that her life experience has been moving around, which contributed to her lack of consistent education and learning to read.

4.5.3 The impact of her apparent high mobility was that professionals were often unaware of her whereabouts, so could not assess the needs of the family or the risks to the children. Moreover this mobility prevented the children being able to attend Children's Centres and pre-school.

[17] London Child Protection Procedures 2002 edition 1; 2003 edition 2; edition 3 2007; edition 4 2011, edition 5 2015

4.5.4 Even more disturbingly was the impact such reported mobility had on the ability of professionals to undertake assessments, even when there were child protection allegations that needed investigating. The response in Harrow was for children's social care to close the case as opposed to either continue with the investigation or ensure this was being done elsewhere. At one point both Harrow and Buckinghamshire closed the case based on the false assumption that it was open to the other area.

4.5.5 Once the children were subject to child protection plans, the travelling around the UK became less of a feature as opposed to Mother's avoidant behaviour (see 5.2). However, Mother's homelessness, her inability to comply with the requirements to produce evidence for housing and latterly her own behaviour led to constant moves between B&Bs. Some moves were in Harrow but she was also placed in Ealing and in Hounslow. This led to enormous obstacles in providing for the children's health needs as moves between boroughs led to changes of health visitors and the loss of appointments at dentists and audiology (in the case of sibling 3).

Accommodation provided to the family

4.5.6 During the 20 month period under review the family were provided with eight different B&B placements by Harrow Council. They were also known to have had a placement in a refuge in Buckinghamshire. For much of the time it was not known where and in what circumstances the family were staying and what implications this had on the welfare of the children.

4.5.7 The reason for the constant moves was not always apparent, but involved being asked to leave because of the behaviour of mother (asking others for money), mother choosing to give up the accommodation, decision by the housing authority as well caused on one occasion because mother did not produce the written evidence that had been requested - in that case the family were evicted, despite being subject to a child protection plan, and children's social care had to step in with a new B&B.

4.5.8 The use of B&B accommodation is not good practice for families, although in recent years the shortage of properties available has led to an increase in its use, especially in London. Shelter[18] gives the following advice on their web-site:

'The law says that councils should only place families and pregnant women in bed and breakfast hotels when no other accommodation is available. If you are placed in a B&B, this should not be for more than 6 weeks'.

4.5.9 Amelia Gentleman in The Guardian[19] in 2013 points out that the number of families placed in B&B had been increasing over the previous decade and quotes Shelter research:

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[18] http://england.shelter.org.uk/get_advice/homelessness/emergency_accommodation_if_homeless/emergency_housing_from_the_council

[19] http://www.theguardian.com/society/2013/nov/04/homeless-families-b-and-b-highest-decade

'based on interviews with 25 families who were, or had recently been, living in B&Bs, found that most felt unsafe. Almost half said their children had witnessed disturbing incidents, including threats of violence, sexual offences and drug use and dealing....

Most of the families lived in one room, and half said their children were sharing beds with their parents or siblings. Twenty-two said it was very difficult to find a safe place for their children to play, 12 had to share kitchen facilities, and three had no cooking facilities. One family reported sharing a cooker and a fridge with 22 other people.

Two-thirds of the families interviewed said their children had no table to eat on, more than half had to share a bathroom or toilet with strangers, and 10 families shared with seven or more other people...'.

4.5.10 In this case the professional observations all appeared to be around the family having one room. In one place mother complained about vermin in the premises and in another it was observed the children were able to open the door and get out of the room, and were constantly getting out of the room. Additionally, the family were in B&B accommodation well in excess of six weeks.

Impact on practitioners

4.5.11 Mother's high mobility, combined with her active avoidance of professionals and appointments, made this family a real challenge to professionals, who carried the responsibility and duty of care to the three children.

4.5.12 Individual discussions with those involved confirmed that it was very frustrating, stressful and tiring trying to work with Mother and safeguard the children. Many of the professionals involved showed great tenacity, and this is to be applauded. Especially of note here are social workers involved with the family in 2014 and the Ealing health visitor who took on responsibility after the family moved out of Ealing to liaise with her counterparts in Hounslow and Harrow and even to try to attend a core group meeting.

4.6 Role of police welfare checks and of Police Powers of Protection

Welfare checks by police

4.6.1 There was a repeated theme that when police undertook welfare checks in response to concerns, their conclusion that the children were safe and well was misunderstood as there being no basis for the referrals.

4.6.2 To the credit of the police these visits always done promptly and in full liaison with children's social care. They were useful in so far as establishing if there was any immediate risk to the children (at the point of time of the visit). Such a check though provides a snapshot at a moment in time and whilst of immediate use, cannot replace an investigation of the allegations or concerns, as is the responsibility of children's social care.

4.6.3 Within children's social care in Harrow there was an assumption of 'malicious' referrals on the basis that police found no evidence to support the allegation, as opposed to an understanding of the limitations of such police welfare checks.

Police Powers of Protection (PPoP)

4.6.4 On 21.08.14, there was high level concern about the immediate risk of harm to the children and whether action should be taken immediately, prior to the Bank Holiday, to remove the children.

4.6.5 In this decision making a misunderstanding of the role of Police Powers of Protection (PPoP) occurred, along with an apparent misunderstanding of the legal advice provided to the local authority by their legal advisors.

4.6.6 The service manager described in the review process that on hearing of the increased concerns about Mother's suspected use of heroin and lack of adequate supervision of her young children, she immediately convened a legal planning meeting to obtain advice. This meeting was attended by the team manager, social worker and the substance misuse co-ordinator.

4.6.7 Discussions were held about the possibility of removing the children that night, which was what the service manager considered was needed (according to her contribution to the review). Various options were explored, including PPoP, applying for an Emergency Protection Order (EPO), the use of s.20 voluntary agreement (which mother was thought unlikely to agree) and the family staying with a relative. The latter was thought to be risky as Mother could change her mind.

4.6.8 There are different understandings of the legal advice provided that day, but all agree that the view was that the grounds had been met to issue care proceedings and that this would be implemented after the Bank Holiday. The legal advisor to the serious case review panel reports that the grounds for an EPO were not however met, as the concerns were ongoing and the risks had not substantially changed. This is though different to the understanding of the social worker and managers who attended the meeting and considered that the taking of an EPO that day was an option, and the grounds for such action were met.

4.6.9 The service manager explained that the decision agreed at the end of the meeting was for a joint visit by police and social worker that evening, with a request to police for the children to be removed under PPoP. The use of an EPO was decided against due to the fact that by this time it was after office hours (this does not prevent the use of an EPO, but does make it a longer more complex process).

4.6.10 This expectation within children's social care that the police would use PPoP that evening has been reported by both social work and police participants to this review, and caused misunderstanding between those involved at the time about the appropriateness of such an expectation. PPoP can only be used if there is evidence of immediate harm to the children. That was not the case, so it was not an option for the police officers concerned. The lack of removal of the children that night came as a disappointment to the children's social care service manager.

4.6.11 The next day the service manager considered what other options were available to get the children out before the week-end and a further legal planning meeting was held. The understanding of the legal advice provided as explained by those involved that day, was that the grounds for an EPO were weakened because the police had not found evidence the previous evening for a PPoP. The serious case review panel is advised that this would not necessarily be the case, but that the grounds for an EPO were weak as described in 4.6.8 above.

4.6.12 Whatever the advice provided, the decision for legal intervention lies with children's social care and not with legal advisors: if the view was that the risk to the children was too great to leave them over the week-end, this could and arguably should have been put to the Court. The new information provided by the manager of the B&B had changed the evaluation of risk for the social workers.

4.6.13 In conclusion there was a misunderstanding by staff within children's social care of the use of the PPOP as opposed to an EPO. Also if the managers were convinced that the children needed to be out of mother's care, as has been communicated to the lead reviewers, this should have been tried, even if the legal advice was there were insufficient grounds.

4.6.14 This is not the first time that the use of PPoP instead of an EPO has arisen in case reviews in Harrow. In a learning review in 2012, a recommendation was made that *'Police Powers of Protection should only be used in an emergency and not as a replacement for an Emergency Protection Order'.*

4.6.15 In discussion with practitioners as part of this serious case review, police officers confirmed this misunderstanding by children's social care of the police role, which has on occasion caused tension between the two services.

4.7 Response to referrals from members of the public

4.7.1 A feature of this case was the number of 'anonymous' referrals during the period under review, sometimes with the same referral being made to both police and children's social care. Although anonymous in terms of not wanting her/his identity disclosed or on records, it is understood that the identity of two of the referrers was in fact known. The referrals were made in three different time periods and on each occasion the police visited the family home and found no evidence of immediate harm. However, these visits were either not followed up by children's social care (August 2013) or not followed up effectively due to Mother and children not being seen due to Mother's claims she was travelling.

4.7.2 What is also notable in this case was the final trigger to initiate legal proceedings and to consider emergency removal of the children came from information supplied by staff at the bed and breakfast accommodation, as opposed to professional contacts and assessments. Unfortunately baby F died in the week-end prior to the implementation of the resulting plan to initiate care proceedings after the Bank Holiday.

4.7.3 Other than the manager of the bed and breakfast accommodation there is no evidence that the various referrers were offered the opportunity to meet with and fully discuss their concerns with a social worker. In one instance there is evidence from records that because of the lack of any evidence from the police visit, assumptions were made that the referral was 'malicious'.

4.7.4 When the London child protection procedures were first written in 2002[20] the author (also the author of this report) provided the instruction that when members of the public make a referral they should 'be offered the opportunity of an interview'. This has remained part of every edition of the London child protection procedures since that time. The reason for this instruction was partly in recognition of a cultural bias towards professional referrals and wariness of anonymous referrals, but also an appreciation of the limitations of telephone and written communications. These are likely to only form a small part of the information that is available and follow up interviews provide the opportunity to explore and obtain fuller understanding of the basis of concerns and information.

[20] London child protection procedures edition 2002 and edition 2 2003.

4.7.5 Interviews with concerned members of the public will usually provide relevant additional knowledge such as suggestions of alternative sources of evidence, including other individuals who may be able to contribute to any assessment of the concerns, as well as how best to do undertake any resulting investigation. The author though is aware from other case reviews and case audits over the country, that face-to-face interviews of referrals from members of the public do not form part of usual professional practice.

4.7.6 The serious case review process has been able to identify and speak with one of the individuals who tried to make a referral. This has highlighted the inadequacies of the earlier responses, as it is evident that s/he would have been able to have provided further evidence about the children's care and of other concerned individuals who may have been a source of further evidence.

4.7.7 In conclusion our multi-agency safeguarding system relies on an understanding that safeguarding is everybody's responsibility and that means not just social workers, not just professionals, but also members of the community. When that duty is exercised by members of the public, their concerns need to be heard and investigated fully, as these referrals come from those who may (and in this case evidently did) know most about the family's circumstances.

4.8 Management oversight and supervision

4.8.1 The role of both management and critical reflection is especially important in cases of neglect, as a there is a risk of becoming desensitised to the conditions of individual families living in chronic neglect circumstances. Moreover, because of its nature, intervention in neglect cases often involves building up evidence over time, and the need for management oversight to identify when 'enough is enough'. With avoidant parents where it becomes impossible to get information and make assessments, due to lack of direct contact, it is very much a management decision about the need for more assertive intervention.

4.8.2 Working Together 2015 emphasises the important role of critical reflection in supervision:

"No system can fully eliminate risk. Understanding risk involves judgement and balance. To manage risks, social workers and other professionals should make decisions with the best interests of the child in mind, informed by the evidence available and underpinned by knowledge of child development. Critical reflection through supervision should strengthen the analysis in each assessment."[21]

[21] Working Together 2015, DfE, paragraph 46-48

4.8.3 There is evidence that within health, health visitors were discussing this family in their safeguarding supervision and that by July concerns were being raised with Harrow children's social care by the Safeguarding Children Advisor in Ealing Community Services

4.8.4 The allocated Harrow social workers were in the Child in Need team, which is split into 'pods', each with a 'pod' manager, who provided weekly group discussion on cases of concern for all the staff in the 'pod'. However, this case was never discussed in individual supervision with a line manager. This is a major weakness with such a case and this omission will have been a major cause of the delay in moving from child in need to child in need of protection, and the subsequent delay in holding a legal planning meeting and moving into initiating the PLO.

4.8.5 Also in this case, evidence from the practitioners involved at the time indicates that the allocated social workers were themselves extremely worried about the circumstances of these children and felt insufficiently heard and supported about the need for more assertive intervention at an earlier stage. One practitioner spoke of his view at an earlier stage of the need for legal intervention, and his strategy of copying in more senior managers to emails to highlight his concerns. Within children's social care management there is now a view that management at the time had been too 'process' driven, which led to the concerns of practitioners being insufficiently heard.

4.9 Understanding a family's history

4.9.1 The understanding of a family's history with an agency is a fundamental basis for any assessment from deciding how to respond to a referral, to decisions about threshold and types of intervention further along the 'child's journey' with professionals. The rationale for this is, as noted by Munro[22] :

'The best predictor of future behaviour is past behaviour...'.

4.9.2 This is particularly important in cases of chronic neglect, which is typified by improvements and deteriorations in parenting capacity, often in line with the levels of support provided. Brandon et al[23] refers to the 'start again syndrome' in neglect cases when the history is either not known or largely ignored:

'In families where children suffered long term neglect, children's social care often failed to take account of past history and adopted the 'start again syndrome'.

[22] Eileen Munro 'Effective Child Protection' 2nd edition, Sage Publications 2008.ISBN 978-1-4129-4695-7 (pbk)

[23] Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003–2005 Marian Brandon, Pippa Belderson, Catherine Warren, David Howe, Ruth Gardner, Jane Dodsworth, Jane Black (DCSF 2008)

4.9.3 The practice in this case highlights both systemic and practice weaknesses in accessing and understanding the history of the family.

4.9.4 Within midwifery, there appears to be systemic obstacles in accessing the history when women are not 'booked in' for a service as discussed in 4.2 above. However, over and above the systemic problems was evidence of a lack of understanding the importance of accessing the history in the context of knowledge that the Mother had been previously identified vulnerable (received services by the Jade team), reported herself as fleeing domestic violence and had neglected her own health care and consequently that of the unborn baby.

4.9.5 In children's social care the practice between August 2013 and January 2014 took no discernible account of the known history of the family and consequent risks to the children in the light of the current circumstances and repetition of earlier concerns.

4.10 Barriers to improving practice around neglect (in the context of previous focus by the LSCB on neglect)

4.10.1 There have been several previous case reviews in Harrow involving children living in situations of chronic neglect, as well as the LSCB devoting its annual conference in 2013 to the subject. The fact that there continue to be case reviews in Harrow around practice in neglect cases, is not surprising given that neglect continues, both locally and nationally, to be the category of child protection plan used most frequently. In the year 2013/14, the DfE statistics[24] 44.4% of the children who became subject to child protection plans in England were on one for neglect, with 32.8% for emotional abuse, 9.9% for physical abuse, 4.6% for sexual abuse and 9.3% for multiple categories. Within Harrow that year, the DfE statistics demonstrate a similar pattern, with 91 children subject to a child protection plan for neglect, 67 for emotional abuse, 18 for physical abuse and fewer than five children for either sexual abuse or multiple categories.

4.10.2 The practice obstacles for improving practice around neglect are those mentioned in other themes, in particular understanding the history of a family and the role of management and supervision (see 4.8 and 4.9 above).

4.11 Lack of involvement of Father and wider family in attempts to understand and assess the needs of the children

4.11.1 A common finding in serious case reviews nationally is the absence of fathers in professional assessments. Brandon et al [25] refer to this:

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[24] Characteristics of children in need: 2013 to 2014, https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2013-to-2014

[25] Understanding Serious Case Reviews and their Impact A Biennial Analysis of Serious Case Reviews 2005-07, Marian Brandon, Sue Bailey, Pippa Belderson, Ruth Gardner, Peter Sidebotham, Jane Dodsworth, Catherine Warren and Jane Black (DCSF 2009)

***'Fathers and men**: A number of issues emerged including the dearth of information about men in most serious case reviews; failure to take fathers and other men connected to the families into account in assessments; rigid thinking about father figures as all good or all bad; and the perceived threat posed by men to workers' (p.3)*

'There was, yet again, scanty information about men in most reviews, particularly in relation to an understanding about past history. This pattern reflects the wider problem of the lack of information about and lack of engagement with men in child health and welfare more broadly (Haskett et al [26]1996). The information that was available sometimes highlighted the tentative engagement by and with men and fathers...' (p.52).

4.11.2 In this case whilst there were some attempts to involve the father in assessments, meetings and conferences the father did not co-operate. In the absence of father's involvement with professionals an unrealistic expectation was made with the mother that she should not have contact with the father unless he was assessed. This was ineffective and by the time of the initiation of the Public Law Outline had been abandoned.

4.11.3 Even more critically, the risk or not to the children of the father's involvement in their lives remained unknown in part due to a failure to undertake any basic research into his history, which involved another child of his being adopted. He also variously mentioned having other children, to his GP and within the hospital following baby F's birth. This was not known to the social workers and never consequently investigated.

Wider family

4.11.4 Another weakness in this case was the lack of involvement of extended family on both sides in assessments, despite the family staying often with paternal grandparents and the known high historical involvement of maternal grandfather and siblings.

4.11.5 When wider family, and where relevant friends, are involved in assessments it becomes possible to triangulate self reported information. Moreover it provides opportunities to obtain wider information and also provide family and friends with possible ways to express concerns without having to make specific referrals.

[26] Haskett M, Marziano B, Dover E. (1996) Absence of males in maltreatment research: a survey of recent literature. Child Abuse & Neglect, 20:1175-82 quoted in Brandon et al, Understanding Serious Case Reviews and their Impact A Biennial Analysis of Serious Case Reviews 2005-07

4.12 Voice of the child?

4.12.1 There is relatively little understanding by professionals about the wishes or feelings, or the experiences of the children, as there was little actual contact directly with them. When practitioners did manage to see the family, the descriptions are of a mother struggling to manage her three children aged under 5 years. The two siblings appear to be out of control, racing around and escaping, whilst baby F is largely on the bed or by the end of his life crawling. All the children are described usually as being just in a nappy, or vest and nappy, and often also looking dirty at times. Clearly within the surroundings of the visits, in one room, it would have been difficult for practitioners to have engaged any of the children directly on a one-to-one basis.

4.12.2 There are though some glimmers into the experiences of the children, especially in the description provided by practitioners in their interviews as part of this review. The manager of the B&B in August 2014 described baby F as smelling of stale urine and 'poo' when they arrived, that he was full of life and responded to attention, that Mother did not show much affection and left the children unsupervised whilst trying to get money from other residents

4.12.3 Overall the children lived their lives constantly moving around, usually staying in one room all together in somewhat unhygienic conditions. They did not attend any nurseries or pre-schools, so were not having the benefit of consistent relationships with other children and adults in a more formal setting, which would have assisted their development in preparation for school.

4.12.4 Sibling 3 in particular appears to have suffered through lack of his health needs being addressed, which must have left him in discomfort and possible pain. He was suffering with tooth decay and required the extraction of 5 teeth. This was not done during the period under review, despite records referring to him being in pain and the concerted efforts of a health visitor and social worker. There are also concerns about his speech and development, but the planned assessment by the speech and language therapist and paediatrician never occurred due to Mother's neglect.

4.13 Where can we identify good practice in this case?

4.13.1 Overall this case was characterised by 'too little, too late' especially in regard to the lack of midwifery identification of concerns in the antenatal period, children's social care lack of intervention prior to February 2014 and then the slowness in which the case moved to a child protection plan, legal planning meetings and initiation of care proceedings.

4.13.2 However, there were also examples of good practice in this case:

- The first Harrow health visitor who persevered in trying to see mother and tried to get children's social care in both Buckinghamshire and Harrow to investigate the concerns; had she escalated the failure of both children's social care services to do so, her involvement would have been even more effective

- The team manager of the child in need service for ensuring in February 2014 that the case was allocated and that this time the mother and children must be assessed
- The persistence and tenacity of both allocated social workers after February 2014 enabled the risks to be identified, recognised by management and begin to be addressed
- The persistence of the Ealing health visitor to try to facilitate the health and development needs of the children and her continuing involvement after the children moved out of Ealing
- The escalation of concerns by the Ealing health visitor, leading to the safeguarding advisor communicating concerns to Harrow children's social care
- The willingness of police to do welfare checks in response to referrals from members of the public
- The good communication and partnership working between the two allocated social workers and their colleagues in health and in the police, involving a number of joint visits
- The attempts by staff in the refuge to find mother, identify the whereabouts of the children and maintain the placement whilst trying to facilitate the family's return

4.13.3 This case demonstrated some very good examples of safeguarding being everyone's business, with the last B&B manager and staff involved in trying to help the family, as well as reporting to the social worker the concerns about the children's care and mother's behaviour. This manager also contributed to this serious case review which has enhanced our learning.

4.13.4 Members of the public also tried to contribute to the children's welfare by expressing their concerns at the time to police and children's social care. Such responsibility towards children in our community is to be greatly commended.

5 FINDINGS & RECOMMENDATIONS

5.1 Introduction

5.1.1 This section contains the overall findings of this serious case review, with the associated recommendations for the LSCB. The findings relate to what we have learnt about the strengths and weaknesses in multi-agency safeguarding systems through examining what happened to baby F.

5.1.2 The LSCB has prepared a separate document with their responses to these findings and the plans to address the recommendations.

5.2 Findings

1. Systemic weaknesses in ante-natal midwifery services contributed to the failure to identify and refer pre-birth safeguarding concerns to children's social care

5.2.1 The provision of midwifery services demonstrated fundamental flaws in safeguarding practice involving the:

- inability to access historical records of patients who are not 'booked in' for services
- repeated lack of recognition of /or response to the vulnerability of a pregnant woman
- lack of fulfilment of the basic midwifery duty to ensure patients are 'booked' in (especially those who are vulnerable)

Recommendation 1

The LSCB to ask the CCG and the NWLHT to report to the LSCB how midwifery will be able to provide a safe service which:

- provides access to historical patient records for all midwives, regardless of which team is providing the current service and whether or not the patient is 'booked-in'
- ensures that all midwives are able to identify and work with vulnerable patients, recognise safeguarding risks and make child protection referrals when required
- does not apply a DNA policy of withdrawing services following 3 DNAs, without reference to the fact that such behaviour is likely to denote greater need and risk
- provides a safety net which ensures the 'booking in' process is not avoided by staff due to time constraints and which addresses the risk to baby and patient of women who have not made use of antenatal provision

2. The belief that mother was a 'traveller' together with her effective avoidant behaviour contributed to a lack of effective follow up of concerns; this highlights the vulnerability of children in mobile families and the risk that children can become invisible

5.2.2 Mother was understood to come from a travelling family, so when she missed appointments but explained she was staying in different places outside of London, practitioners accepted this as part of her culture, without further checking.

5.2.3 There was inadequate consideration given to the need for follow up of concerns (in the case of children's social care) or of checking the children's health and development (in the case of health visitors) when mother claimed to be elsewhere. On one occasion children's social care assumed that another authority would undertake the required assessment (despite having not agreed this with them) and at other times no contact was made with the 'host' authority where Mother claimed to be, even when there was a s.47 (child protection) enquiry in progress.

5.2.4 Even when Mother seemed to be staying in the B&B accommodation provided, she was skilful in avoiding professional contact, despite the tenacity of a social worker spending considerable time in trying to locate her. In such circumstances it is vital that intervention is taken at earlier points in order for practitioners to be able to see the children and assess their needs. Whilst in this case practitioners were threatening to take such action, this took too long. Mother explained to the author that the repeated warnings made to her, without immediate action, reassured her that no action would happen.

Recommendation 2

a) The LSCB to consider how to develop practice so that:

- children within mobile families do not become 'invisible' and that they receive continuity of health and social care involvement, and when necessary intervention, even when the family moves around
- practitioners challenge avoidant parental behaviour and do not accept at face value explanations of the family travelling
- managers recognise the immense time involved in such challenge, but that this is required whenever there are safeguarding concerns
- no child protection case is ever closed because a parent claims to be living elsewhere, without an agreement by the next local authority to take over enquiries

b) The LSCB to ask children's social care to report on quality assurance processes on the 'front door' of the service; in particular that children's needs within mobile families are met (including cases not being closed without assurance of them being picked up in other areas) and that decisions for no further action are consistent with the safety of children.

3. The case demonstrated a misunderstanding about the use of Police Powers of Protection instead of an Emergency Protection Order

5.2.5 The senior manager within children's social care identified the risk to the children the need for their urgent removal following the information received from the manager of the B&B. However, subsequent decision making reflected a misunderstanding within children's social care about the use of an Emergency Protection Order as opposed to a reliance on Police Powers of Protection, which should only be used if there is evidence if immediate risk.

5.2.6 This case also demonstrated the need for social workers and managers to take account of legal advice, but when they feel that the risk is too high to leave children within the family whilst an Interim Care Order application is made, an EPO should be progressed and the matter put to the Court for a decision.

Recommendation 3

Children's social care to hold facilitated workshops for managers to explore the differing use of Police Powers of Protection and Emergency Protection Orders. This should also cover the role of lawyers to provide advice as opposed to social work managers in making the decisions

4. There was repeated misunderstanding within children's social care of the function of police welfare checks as opposed to the children's social care responsibility to investigate allegations and concerns

5.2.7 Within children's social care in Harrow there was an assumption that when police visited a home and concluded that the children were safe and well, there was no need for further investigation of referrals. This demonstrated a basic misunderstanding of the police role to establish if the children were at immediate risk of harm at that point in time, as opposed to the role of children's social care to undertake the wider and in depth assessment of the allegations.

Recommendation 4

Children's social care to consider how best to disseminate to staff the distinction between police welfare checks and the role of children's social care, and how to establish if this is successful in changing practice. The LSCB to request a report from children's social care on the implementation and progress of this recommendation.

5. The repeated lack of investigation by children's social care of the referrals from members of the public may reflect underlying cultural attitudes and suspicions to non professional referrals; such an attitude is a serious weakness in a safe service

5.2.8 Safeguarding is everybody's responsibility and referrals from members of the public need to be fully investigated. This needs to involve referrers being provided with the opportunity to meet with a social worker so as to provide more detail and evidence of concerns. This has been part of the London child protection procedures since the first edition in 2003.

Recommendation 5

a) The LSCB to consider how best to promote cultural change so that professional practice fully values the involvement of members of the public in safeguarding children - such a cultural shift would see changes in practice which includes routine interviews of members of the public as part of follow up to referrals and assessment practice

b) The LSCB to request agencies include the involvement of members of the public, friends and wider family in audits of response to referrals and of assessment practice - the results of such aspects of the audit to be provided to the LSCB and published as part of the promotion activities of the LSCB

6. The lack of individual supervision for social workers is likely to impact on cases that require a great deal of reflection and management oversight

5.2.9 The allocated social workers in this case were part of the 'pods' within the children in need service. Staff within a pod are managed by a pod manager but do not necessarily receive individual supervision as this model of organisation predominantly uses group supervision for staff. Whilst group supervision can be a very helpful tool, it does not address the individual needs for reflection and management decision making that is typically needed in chronic neglect cases, especially in relation to avoiding delay in moving into child protection and legal proceedings.

5.2.10 The social workers within this pod were concerned that their concerns about this case were not being adequately 'heard' by management at the time. It is important that whatever structure is in place, senior managers are assured that systems are in place for practitioners to have their concerns heard and addressed by managers beyond the individual pods.

Recommendation 6

a) Children's social care to review the use [or not] of individual reflective supervision within pods, and report to the LSCB on how the needs for reflective case supervision are met in complex cases, and particularly where there is chronic neglect.

b) Children's social care to provide systems for social workers to be able to articulate concerns about case management or to seek consultation, outside of the individual pods; children's social care to report to the LSCB how this will be accomplished and review its effectiveness

7. There was little indication within midwifery services and children's social care 'front door' of practitioners understanding the need to take account of the family's known history

5.2.11 A common finding in serious case reviews is the lack of practitioner understanding of the need to access and understand previous agency history of the family, in order to evaluate the risk to children. In this case the practice weakness was evident in both midwifery services and the children's social care teams involved between August 2013 and January 2014.

Recommendation 7:

The LSCB to consider how to change cultural practice across all agencies so that practitioners routinely access the known agency history of families (including all carers), and that the history is taken into consideration in any responses

8. The father and wider family members were insufficiently involved in the assessments undertaken

5.2.12 In common with findings from other serious case reviews nationally, there was insufficient involvement of the father in the assessments undertaken, although one social worker did initially try to engage him. Most critically the previous history of father was not accessed, although he was known to be the father of another child who had been adopted.

5.2.13 The assessments also did not involve other family members, despite it being known that paternal grandparents, maternal grandfather, and other members of the extended family were involved in supporting the family.

Recommendation 8

The LSCB to consider how to change professional practice in all agencies, but especially within children's social care, so that all carers and involved family members are routinely involved in assessments of children subject to child protection plans and that their history is accessed as part of the assessment.

9. During the period of this review mother and children were homeless and moved many times, including eight different bed and breakfast placement: the constant moves and type of accommodation provided is likely to be detrimental to the children's welfare

5.2.14 Whilst the reason for the frequent moves are not totally understood and were in part due to Mother's actions and inactions, such constant moves must have been disruptive and distressing for the children.

5.2.15 The use of B&B accommodation for families is recognised as being unsuitable, only to be used when there is no alternative provision available and that the family should not remain there in excess of six weeks. This family were in B&B accommodation for longer than six weeks.

Recommendation 9

a) The LSCB to establish the use of B&B accommodation by Housing for Harrow families, the frequency of moves between B&B per family and the total amount of time families spend in such accommodation before being offered more suitable temporary accommodation such as a flat or house.

b) When the LSCB have this information, consideration to be given if there are systemic problems in the available provision and if further action is needed locally or in collaboration with other London boroughs.

10. There were examples of good practice by individual practitioners, despite an overall service characterised by 'too little, too late'

- The first Harrow health visitor who persevered in trying to see mother and tried to get children's social care in both Buckinghamshire and Harrow to investigate the concerns; had she escalated the failure of both children's social care services to do so, her involvement would have been even more effective
- The team manager of the child in need service for ensuring in February 2014 that the case was allocated and that this time the mother and children must be assessed
- The persistence and tenacity of both allocated social workers after February 2014 enabled the risks to be identified, recognised by management and begin to be addressed
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- The willingness of police to do welfare checks in response to referrals from members of the public
- The good communication and partnership working between the two allocated social workers and their colleagues in health and in the police, involving a number of joint visits
- The attempts by staff in the refuge to find mother, identify the whereabouts of the children and maintain the placement whilst trying to facilitate the family's return

5.2.16 This case demonstrated some very good examples of safeguarding being everyone's business, with the last B&B manager and staff involved in trying to help the family, as well as reporting to the social worker the concerns about the children's care and mother's behaviour. This manager also contributed to this serious case review which has enhanced our learning.

5.2.17 Members of the public also tried to contribute to the children's welfare by expressing their concerns at the time to police and children's social care. Such responsibility towards children in our community is to be greatly commended.

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GLOSSARY OF TERMS & ABBREVIATIONS

Term used in report	
B&B	Bed and Breakfast accommodation
CAF	Common Assessment Framework
CCG	Clinical Commissioning Group
CIN	Child in Need under s.17 Children Act 1989
DfE	Department for Education
DNA	Did not attend (a pre-booked appointment)
EIS	Early Intervention Service
EPO	An emergency protection order or EPO is a court order granted under Section 44 of the Children Act 1989 on the grounds that a child will suffer significant harm unless they are removed to council accommodation or moved from where they are currently living.
FGC	Family Group Conference
Front Door	
GP	General Practitioner
ICO	Interim Care Order: At the start of care proceedings, the council asks the family court to make a temporary court order, called an 'interim care order' under s.38 of the Children Act 1989. If the court agrees, the council can take the child into care on a temporary basis.
LNWHT	London North West Healthcare Trust
LSCB	Local Safeguarding Children Board
MASH	Multi-agency safeguarding hub
MPS	Metropolitan Police Service
PLO	The Public Law Outline [referred to as the PLO], is a revision of the 2003 Judicial Protocol, which attempts to reduce unwarranted delays in family court cases.
Pod	A framework for supervisory arrangements and management oversight of case work.
PPoP	Police Powers of Protection: Under s. 46 of the Children Act 1989if a police constable believes that a child is at risk of suffering significant harm then he/she may exercise powers under this Act to remove the child to suitable accommodation or if the child is in hospital or in a place of safety, take steps to keep the child there. A child cannot be kept in police protection for more than 72 hours.
RISE	A substance misuse service based in Ealing
s.47	Section 47 of the Children Act 1989, which provides the legal basis for a child protection enquiry
SCR	Serious Case Review

APPENDIX 1: PANEL MEMBERS

The review panel consisted of the following members:

Agency:
Lead Reviewer
HSCB Chair
HSCB Business Manager
Central North West London NHS Foundation Trust
Harrow CCG Designated Nurse
Harrow CCG Designated Doctor
Metropolitan Police
Compass Drug & Alcohol Service
Children's Services, Harrow Council
HB Public Law

APPENDIX 2: AGENCIES CONTRIBUTING TO THE REVIEW

Brent Children's Services
Buckinghamshire Health Care NHS Trust
Central North West London NHS Foundation Trust
Ealing Community Services
GP Surgery, Ealing
Ealing RISE
Enfield Community Services
Enfield Social Care
Harrow Community Services
Harrow Children's Services
Harrow Housing Services
Hounslow & Richmond Community Health Trust
London Ambulance Service
London North West Health Care Trust
Wycombe District Council

APPENDIX 3: PRACTITIONERS WHO CONTRIBUTED

Family Support Worker, Harrow Council
Social Workers x 2, Harrow Council
Team Manager, Harrow Council
MASH Team Manager, Harrow Council
Service Manager, Harrow Council
Health Visitor, Harrow Community Health Services
Lead Midwife, Harrow Community Health Services
Parental Substance Misuse Worker, Compass
Manager, Bed & Breakfast accommodation
Refuge workers x 4, Refuge Centre
Social Care Lawyer, HB Public Law
Safeguarding Midwife, London North West Healthcare NHS Trust
Housing Adviser, Harrow Council
CP Named Nurse, Buckinghamshire Health Care NHS Trust
CP Lead Professional, Buckinghamshire Health Care NHS Trust
Metropolitan Police Officers x 2