



SERIOUS CASE REVIEW

Overview Report in respect of
Baby T

Barry Raynes
Independent Reviewer

Approved by the LSCB September 2013

Anonymised/adapted for publication by Alan Bedford, October 2013

Foreword to the Report by the new LSCB Chair

The report that was approved by the Local Safeguarding Children Board (LSCB) in September 2013, under interim Independent Chair arrangements, was not in an anonymised form, either in terms of family or staff, and therefore did not meet the requirements for publication under national guidance. Following the appointment of a new Independent Chair in October 2013, future Serious Case Reviews will be written for publication from the start as is now required.

There are a number of features of the two young children in this case and their family life which might make them identifiable, and so it has been necessary to undergo extensive anonymisation of family details. This also applies to staff, where job titles but not names are retained.

This exercise has also required a small adjustment to some facts, or changes to a summary, where not to do so would make identification possible. However, the report continues to be clear about what could have been done better and, where understood, why things happened.

The adaptation for publication was requested by the new Independent Chair and undertaken by independent safeguarding consultant Alan Bedford, with the support of the report author. The remit was anonymisation and associated presentation for publication, not to re-write, nor to alter the facts or findings of the approved report.

Ofsted reported in January 2013 that it considered local authority child protection arrangements, and some interagency collaboration, was inadequate. The SCR identifies the overlap of findings between the Ofsted inspection and this SCR.

I am satisfied, after taking external advice, that the amended report now published contains the key facts and conclusions in the un-anonymised original.

All future SCRs, undertaken on the Isle of Wight should be published, unless there are exceptional circumstances, should be completed in a timely fashion, and must comply with rigorous standards, retaining complete independence from any agencies on the Island.

**Maggie Blyth, Independent Chair, Isle of Wight Safeguarding Children Board
October 2013.**

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1. INTRODUCTION

- 1.1 In the summer of 2012 baby T aged 3 months was admitted to St Mary's hospital. He had been brought to the hospital by his mother and her boyfriend because he was floppy, unresponsive and generally unwell. Further examination identified extensive bilateral retinal haemorrhaging indicative of severe trauma. The clinical opinion was that it was likely that this had been caused by being shaken by an adult.
- 1.2 The incident was referred to the Serious Case Review Standing Committee of the Isle of Wight Safeguarding Children Board (IOWSCB) that met in July 2012. It recommended to the interim Independent Board Chair that this case met the criteria for commissioning a serious case review. The recommendation was endorsed by her in August 2012.
- 1.3 The review was conducted under the statutory guidance from *Working Together to Safeguard Children 2010*, as current 2013 update with new requirements had yet to be published.
- 1.4 The purposes of a serious case review under this guidance are to:
 - a) Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
 - b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
 - c) Improve intra- and inter-agency working and better safeguard and promote the welfare of children.

Terms of reference

- 1.5 Terms of reference were drawn up by the Serious Case Review Panel. The time period covered by the review is 29th August 2011 to early July 2012 with a summary of the period December 2006 –August 2011. The specific questions identified were as follows:
 - a) How well were the records kept by the agency? Were they complete and clear?
 - b) To what extent was information given by family members and others questioned, challenged or tested?
 - c) To what degree were the children's needs recognised and were they included in any consideration of the needs of the family?
 - d) To what extent were professionals aware of relevant information held by other local agencies and by agencies in the mainland?
 - e) How well were issues of child attachment considered by professionals?
 - f) To what extent were the male partners of the children's mother and relevant men included in the work carried out by professionals?
 - g) Did the plans formulated address the concerns for the children and were the objectives clearly linked to meeting the children's needs?
 - h) In what ways did the CAF process work, or fail to work, effectively in this case?
 - i) How well were thresholds applied in this case?

1.6 These questions have been addressed by all IMR authors and form part of the analysis of this report.

Family Composition

1.7 Family members are as follows, with ages if known as at the serious injury

| Name | Relationship | Age |
|-------------|------------------------------------|------------|
| baby T | Subject of the review | 3m |
| Mother | The mother of baby T , and S | Early 20s |
| father (T) | The father of baby T | |
| S | baby T’s sister | No yet 5 |
| father (S) | S’s father | Mid 20s |
| <i>also</i> | | |
| EP | An ex-partner of mother | Early 20s |
| MGM | Maternal grandmother | |
| The ‘aunt’ | A cousin of mother, known as aunty | |
| The uncle | Mother’s brother | |
| | | |

1.8 The focus of the review is a baby, T, who was seriously injured at the age of three months. He has an older sister, S, aged 4 years at the time of the injury and, because she lived with baby T and their mother, this review includes her. Baby T was living with his mother, and her partner and S’s father-described here as ‘father (S)’- at the time of the injury. Baby T and S came from a close extended family, which included the ‘aunt’, their maternal grandmother (MGM), and her brother, the uncle. Baby T’s father was not known to services in the period of the review

Family tree

1.9 This is not provided as it would make the family identifiable.

Anonymity

1.10 The report has been anonymised as far as possible to protect the identity of the children involved. For example dates of birth, and any specific dates which would assist identification are not used. Some facts in the case are such that they may well aid identification, so some are left out or summarised, and for example places or small services disguised. As is convention, staff are referred to by their job titles

Charges

1.11 Criminal charges in relation to neglect were not ultimately pursued to trial. This was because the medical evidence could not identify the time when baby T received his injuries and four people had looked after baby T shortly before the injuries were noticed.

2. METHODOLOGY

Independence

- 2.1 An independent chair, Phil Green was appointed by the IOWSCB to chair the Serious Case Review Panel ('the Panel'). He started his social work experience in 1976 and has worked as a residential social worker and manager, field social worker and team manager, child protection co-ordinator and guardian-ad-litem. He has worked in the voluntary sector and for local authorities. He is an independent consultant and trainer.
- 2.2 The overview author/independent reviewer is Barry Raynes (referred in this report as 'the author') who is the chief executive of Reconstruct, a training and development organisation focussing on Children's Services. He has thirty years' experience of child protection social work. He has been involved in 30 serious case reviews since 2007 – either overseeing the work of Reconstruct's consultants or producing overview reports. He has written web-based child protection and childcare procedures for more than 50 LSCBs and Local Authorities in England, Wales and Scotland. Barry Raynes has a Masters degree in Public Sector Management and is currently researching a PhD into common language in child protection.
- 2.3 Ruby Parry was the acting Independent Chair of the IOWSCB at the time of the Review and up until September 2013. She is a former assistant director of Children's Services, and has experience of all levels of operational and strategic management and service delivery, having worked in Children's Services for more than 30 years. She qualified as a social worker in 1979 and later gained an MSc in Management in 2003, with a distinction for her work on collaborative working in the public sector.
- 2.4 Neither the Panel Chair nor Author have previously worked on the Isle of Wight and are completely independent of the case. However, in reviewing this document for publication the LSCB has agreed that any future SCRs would not commission independent persons working for the same organisation. It is noted that the SCR author, Chair and Independent Chair work for Reconstruct.

Serious Case Review Panel

- 2.5 The Panel met on seven occasions for either half or full day meetings between 29th August 2012 and 25th March 2013. The overview report was presented to an executive meeting of the safeguarding children board on 16th May 2013.
- 2.6 The Panel comprised:

Barry Raynes attended all Panel meetings as overview author.

| | |
|-----------------------------------|---|
| Phil Green | Independent Chair |
| Designated Nurse Child Protection | NHS Portsmouth and Isle of Wight |
| Serious Case Officer | Hampshire Police |
| Deputy Director, Safeguarding | Isle of Wight Council - Children's Services |
| Virtual Head-teacher | Isle of Wight Council- Education |

Deputy Director
IOWSCB Support

X Children's Centre
IOWSCB Manager

- 2.7 The Council Children's Services' representative left her post during the process of this review. This resulted in no-one being present on the Panel towards the end of the process who could provide further information and insight into the changes that had taken place in Children's Services within the timeframe of this review and address the Panel's concerns about these changes. (A Children's Services representative did attend the last meeting). Whilst this did not delay the timescale for this report it has meant that some of the conclusions are not as well formulated as they would have been had a senior manager been consistently present throughout.
- 2.8 The IOWSCB Manager was not available to attend many of the Panel meetings. This was due to her work commitments which also included being the Island's local authority designated officer and holding management responsibility for the child protection conferencing and independent reviewing officer unit, oversight for the adult safeguarding board and the domestic abuse forum. She was also responsible for commissioning multi-agency safeguarding training. Her absence from the Panel meetings meant that her analysis of the issues affecting multi-agency practice was not as easily accessible to the Panel as it might have been.

Contributions to the Review from Agencies

- 2.9 All relevant agencies provided individual management reviews (IMRs) in two parts; narrative and analysis. The earlier production of narrative accounts assisted the process inasmuch as the Panel was able to understand the story of the events at an early stage but the separation of narrative and analysis caused further delay in the process.
- 2.10 IMR authors have attended Panel meetings to discuss their findings and have reported back that the manner in which they and their reports were received was courteous and helpful. IMRs have been received from:
- a) Isle of Wight Council Children's Services
 - b) The Children's Centre
 - c) The community early years pre-school
 - d) Isle Of Wight NHS Trust (midwifery, health visiting and paediatrics)
 - e) GP Practice: prepared by (the former) Portsmouth and the Isle of Wight PCT
 - f) Hampshire Constabulary
 - g) Isle of Wight NHS Trust (adult mental health services)
 - h) A Health Overview from (the former) Portsmouth and the Isle of Wight PCT

IOW Council Children's Services

- 2.11 This IMR was appropriately critical of Children's Services and went into some depth in terms of systemic issues. Its author required considerable support from the Panel and overview author, and the Panel acknowledges that he may have been placed in a difficult position as it became clear that the problems in Children's Services went beyond practice to management and structure.

Children's Centre

2.12 This was a high quality and critical report.

Community early years pre-school

2.13 Its author had the difficulty of writing an IMR on an independent organisation. The pre-school provision's manager and board were helpful in assisting the author with this and the report was of a good quality identifying learning for this early years' provision and other similar organisations.

Isle of Wight NHS Trust (midwifery, health visiting and paediatrics)

2.14 This was a high quality, critical and thorough report.

GP Practice (prepared by the former Portsmouth and Isle of Wight PCT)

2.15 There were considerable problems associated with this report, not least being the amount of time it took to get it finished. The overall standard was inadequate but the Panel accepted the report on the basis that it provided the basic information to inform the health overview report. Suggestions have been made by the Panel to the commissioner of this report suggesting ways and means that IMRs may be improved in the future.

Hampshire Constabulary

2.16 This was a high quality, critical and thorough report.

Adult mental health services

2.17 This was a high quality, critical and thorough report.

(The former) Portsmouth and Isle of Wight PCT

2.18 A Health Overview Report was produced to bring together the information from all health agencies into an overarching health IMR

Family involvement

2.19 The following family members were invited to, and did, take part in the Serious Case Review;

- The mother
- The maternal grandmother (MGM)
- The 'aunt'

2.20 The author saw the MGM on one occasion, at the beginning of the review when she was not very well and was not able to suggest any particular areas that should be considered.

2.21 The mother was offered two appointments and kept one which was at the beginning of the review. Her views are given at para 5.69. The 'aunt' gave some background detail on the family and talked about a referral that she made to Children's Services in November 2011. The author wrote to the 'aunt' at the end of the Review to tell her that it had finished and to thank her for her contribution and he will write to her again when the report is published.

2.22 Contact was not made with father (S) for procedural reasons

Staff involvement

2.23 A range of staff members have been interviewed by the IMR authors.

2.24 The author visited the Isle of Wight's Children's Services First Response Unit (FRU) gaining an insight into how the system worked and finding out about the workload on the staff there.

2.25 Two meetings were arranged for staff members who had been involved with the mother, S and baby T to meet with the author in March 2013 before the report was finalised. One meeting was for social workers and the other meeting was for health, early years and Children's Centre staff. The purpose of these meetings was to allow the staff members the opportunity to hear the thoughts of the overview author and Panel and contribute their view of the analysis in the report.

Parallel processes

2.26 The parallel processes in this review have been the consideration of criminal prosecution, and the care proceedings on the two children. These have not delayed the process

Dissemination of learning

2.27 The learning from this review will be amalgamated with other recent serious case and partnership reviews and will be integrated into existing safeguarding children training.

Timescales

2.28 This serious case was commissioned in August 2012. It was completed eight months later in April 2013. This is outside the six month timescale of the then current *Working Together to Safeguard Children*. Delays, which were notified to the Department for Education, arose from a number of factors.

2.29 The GP engaged to produce the GP IMR resigned before the IMR was completed, and the Panel was informed late. The Panel was informed that a new IMR author had been

identified but that person was subsequently withdrawn and a further author identified in December 2012.

- 2.30 There were some problems encountered with the timeliness and quality of IMRs submitted and it was necessary for some to be returned to their authors with requests for significant changes and additions.
- 2.31 The IOWSCB was undertaking 2 serious case reviews and 3 partnership reviews (involving a similar degree of work) during the period that this review was conducted and a number of Panel members were involved in several (and one in all) of these. There was only part-time (2 days per week) administrative support for these reviews; from these two days the administrator also provides support to the safeguarding board. Whilst the LSCB administrator was flexible, proficient and competent there were insufficient resources to meet the need. Consequently scheduling meetings was problematic and led to difficulties in meeting the six month timescale.
- 2.32 The chair of the Panel and the overview author were told that the IOWSCB had been concerned about the quality of IMRs produced for previous reviews.

3. SUMMARY OF EVENTS

Background events

(This section looks at the facts. Section 4 provides analysis and appraisal)

- 3.1 The terms of reference set the period August 2011 –July 2012 as the timescale for the review to consider in depth with the period December 2006 –August 2011 to be covered as background information. The following relies heavily on the Children’s Services IMR.
- 3.2 The mother and her family had been known to a mainland local authority Children’s Services since May 2004 when the mother was fifteen years old, and they have been known to Isle of Wight Children’s Services since 11 December 2006 when the mother arrived on the island saying she had been ‘kicked out’ of her mother’s house. She was staying on the island at that time with the ‘aunt’. The mother returned briefly to the mainland and then moved to her own accommodation on the Isle of Wight in early August 2007. The mother was seven months pregnant with S. She had had past mental health problems.
- 3.3 The GP referred her for an urgent assessment. A psychiatrist identified a wide range of symptoms which would have been of concern with imminent childbirth. A teenage pregnancy midwife described the situation as being of ‘huge risk’ for the unborn baby. A Children’s Services initial assessment was carried out 3 weeks later and concluded that the mother’s health had stabilised since the psychiatric assessment.
- 3.4 In August 2007 the mother told health professionals that the mainland Children’s Services had undertaken a core assessment and were planning to remove her unborn child at birth. This was discussed with staff from the mainland and they said that the mother was prone to ‘flights of fantasy’. There was no evidence that a core assessment had actually been undertaken.
- 3.5 An initial child protection conference was convened on the Isle of Wight at the end of September 2007. The mother told the conference that she was ‘fleeing domestic violence from father (S)’, who she said had significant mental health and social problems.
- 3.6 The conference unanimously concluded that the unborn baby did not meet the criteria for registration on the (then) child protection register. However, the conference did conclude that the unborn baby was a Child in Need. S was subsequently born at the end of September and four weeks later she and her mother returned to the mainland. A Child in Need plan was not completed.
- 3.7 In early November 2007 all relevant copies of paperwork were sent to the mainland Children’s Services with a letter expressing concern about the long-term welfare of S due to the mother’s relationship with her mother and father (S).
- 3.8 It is not known when the family returned to the Island, but S commenced pre-school at the beginning of 2011. The first Children’s Services contact was in May 2011 when Children’s Service’s out of hours service were contacted by children’s ward staff from St

Mary's hospital because a young person had taken an overdose and said that he lived with the mother on the Isle of Wight.

- 3.9 Concerns were raised by the out of hour's worker regarding the living conditions at this address which were described as chaotic with lots of comings and goings. An email was sent by the out of hours filtering officer (the on call manager for the Out of Hours Service) to the manager of the referral and assessment team requesting a home visit. There is no record of any response to this email, nor is there a record of any visit being undertaken in respect of the alleged home conditions.

Period one August – December 2011

- 3.10 In the summer of 2011 the mother, who was two months pregnant, and S, soon to be four years old, were seen at the mother's home by the community midwife (CMW). The mother and S were living there with the mother's mother (MGM) and her brother, S's uncle. She told the midwife that the unborn baby's father was father (T). The midwife recorded that S was 'needy' with 'no stranger awareness' because she rushed over to her upon entry and wanted to be picked up. Following this visit the midwife made a referral of the heavy smoking mother to the smoking cessation midwife.
- 3.11 S returned to the community early years' pre-school for the autumn term. The mother identified six people (in addition to herself) who could collect S from the nursery. One of these was a previous partner, EP, who she identified on the childcare registration document as being S's father, (although she had told the community midwife the week before that father (S) was S's father). The rest were family members and neighbours.
- 3.12 During this term, S attended for 42 of 70 agreed days. She was taken to the centre on 4 occasions by the mother and collected by the mother on 8 occasions. For most of this term S was living with her mother in her maternal grandmother's home. The MGM took and collected S on 24 and 21 occasions respectively.
- 3.13 The manager of the early years provision told the Review that S was a happy, lively child who 'lit up the room when she came in' and was well liked by the other children. She said S was friendly with people she knew, caring towards other children and she was always well-dressed in warm clothes, coat and gloves when it was cold. She said the mother was always caring towards her and was never cross with her. S did not look like EP and when the manager saw father (S), she realised that he was likely to be the girl's father. The manager said that S was happy to see her grandmother, the 'aunt', her uncle, and EP, as well as her mother.
- 3.14 The CMW decided that the mother would benefit from the support of staff from an independent Children's Centre (CC), and she began attending in late October 2011. None of the CC's staff members were ever aware of the background history on the mother.
- 3.15 A week later, the 'aunt' phoned children's service's First Response Unit (FRU) and reported that the mother was not properly looking after herself or S, now 4 years old. The 'aunt' said she was S's godmother and was caring for S as the mother was unable to cope. The worker taking the call, whose name was not noted, recorded that the home

smelt of urine, that the mother was currently misusing alcohol, not taking her mental health medication, and that the mother was four months pregnant. The aunt was noted as saying that she had cared for S for one week, and quoted an example where the mother had left S in a t-shirt and knickers for three days. The 'aunt' was of the opinion that S's needs were not met during this time as she had to 'fend for herself' and eat the food she could find within the home. The worker advised the 'aunt' that if the mother did attend (the aunt's) address to collect S, but she did not feel that S would be safe, then she must contact the Police.

- 3.16 During this discussion the 'aunt' mentioned that the mother had been known earlier to Children's Services. The electronic files 'were viewed' and it was decided by a consultant social worker (ConsSW1) that the Common Assessment Framework (CAF) coordinator should liaise with mother to ascertain her plans and what support is required via a home visit. The decision added that a midwife will also be involved with regards to the unborn child and should be included in any planning,'
- 3.17 Later that same day the mother herself visited the First Response Unit having been told by the 'aunt' of the phone call that had been made. The mother saw a CAF coordinator (CAF1) and denied the allegations. The record of this visit states that the mother denied all the aunt's allegations, said she had not drunk in pregnancy, and said that she did not need additional support, only time to 'sort herself out'. She said she knew what a CAF was having been involved with one on the mainland. This account was accepted and the mother was given a CAF¹ information leaflet and ConsSW1, concluded that the mother 'appears to have responded appropriately in gaining support from S's god daughter (*he meant the aunt*)' and that there was 'No further role for the FRU at this time'.
- 3.18 Two weeks later, on a Sunday, S was taken by the mother and the MGM to the local A&E because it was feared that S had accidentally swallowed Nurofen. Blood tests were taken which were all normal and there was no evidence of actual ingestion. No child protection concerns were raised and the mother was given 'keep safe practice' advice. No information was passed onto Children's Services although the GP was informed and this event appears on the health visiting records.
- 3.19 At the end of November 2011 the CMW visited the mother at home as part of a routine visit and later that day she discussed the case at her team community midwife supervision with the named midwife for safeguarding. It was noted that the grandmother's home was 'messy' but the mother was moving to a flat of her own soon. It was noted that S was staying with the 'aunt'. In early December 2011 the CMW visited the mother in her new flat and noted that S was spending a lot of time with her 'aunt'. Two weeks later, because of the increasing concerns, the named midwife for safeguarding discussed the mother with the ConsSW1 in the First Response Unit as part of their 'case discussion meeting'². The decision was that a CAF was required.

¹ Common assessment framework – a system to be used with families of children who are not 'in need' but who have 'additional concerns'.

² A meeting where ante-natal cases are discussed

3.20 Just before Christmas 2011, the CMW visited the mother at home. She recorded that the flat was 'untidy and somewhat disorganised' but was in better condition than her MGM's where she had been living. The mother denied any alcohol or cannabis use but was still smoking 20 a day and awaiting contact from the Smoking Cessation Midwife. S was present at this visit and the community midwife recorded that she was very chatty and cheerful, appearing to have a good relationship with her mother. The midwife discussed completing a Common Assessment Framework (CAF) with the mother and it was agreed this would be completed as soon as possible after Christmas

Period two January – March 2012

3.21 In January 2012, S started a new term at the early years' provision. She was to attend for three days per week and be collected and taken home on the centre's mini-bus. Her attendance rate was consequently better as she attended for 23 of the possible 34 days. She was able to be there for a full day. The pre-school reported S was picked up by mother or EP who was sometimes with father (S).

3.22 The next week a chemist phoned the mother's GP to say that they had prescription treatment available but the mother had not picked up the prescription. On that same day the mother told the CMW that she (mother) had fallen on a cot causing her pain in her abdomen. She was admitted to St Mary's Hospital as she was assessed as possibly being in premature labour. She was transferred to Queen Alexander Hospital in Portsmouth, yet despite the mother's anxiety about premature labour she discharged herself and travelled back to the Island.

3.23 Two days after the admission, the mother was seen at her mother's home by the smoking cessation midwife and Nicorette was prescribed. The MGM told the midwife that an ex-boyfriend of the mother's from the mainland was coming to live with the mother after the baby was born. No name was given and nor was it actively sought. The MGM also reported that there had been previous domestic abuse incidents between the couple on the mainland.

3.24 Two weeks after the admission, a different community midwife (CMW2) and the Children's Centre Family Support Worker (FSW) visited the mother at home to complete a pre-CAF checklist. Little information was recorded but, according to the Children's Centre IMR, the FSW found the flat was somewhat chaotic. CMW2 and the FSW were introduced to EP whom mother called S's biological father. The midwife referred to some 'past problems' during this visit and asked if the mother and EP were 'back together'. The two workers agreed that the 'plan' would be for the FSW to 'be around' when the mother was attending the Centre and that she would 'catch up with the mother and be available if further support was requested.'

3.25 Two days later the smoking cessation midwife visited the mother at home, who reported that S was at the local park with EP. The midwife discussed with the mother the risk of further domestic abuse incidents and that other professionals would need to become involved should new episodes occur. The mother was again concerned about abdominal pain and was referred back to the maternity unit for observation and assessment. The mother was admitted to the maternity unit in the small hours of that

night at 1.10 a.m. but, feeling better, discharged herself...signing a standard 'discharge against medical advice form'.

- 3.26 The next day, the original CMW visited the mother and noted that EP was sleeping in the mother's bed with S. The mother, who was now seven months pregnant, was sleeping on the sofa and said that EP did sometimes share the bed with S.
- 3.27 After another four days, the smoking cessation midwife visited the mother and noted that S threw herself at her and hugged her despite this being the first time that S had met her. She noted that EP was staying with the mother until the new baby is born and added that she was unclear if he was the perpetrator of domestic violence on the mainland. She explained to mother the consequences of any further incidences of domestic violence.
- 3.28 In early February 2012 the named midwife for safeguarding children received the completed pre-CAF from the FSW with a note suggesting that a full CAF was not required. There was no mention of domestic abuse or mental health issues. Six days later, the named midwife for safeguarding children, who did not agree with this analysis, phoned FSW to ask for a full CAF, given the known history, telling the FSW that mother had 'fled' EP as he had been abusive in their earlier relationship, and the concern about him sleeping with S. It was agreed that the FSW would liaise with the CMW to complete a full CAF, which would include discussions about EP and sleeping arrangements would be discussed.
- 3.29 When the mother went to the Children's Centre a week later and the FSW asked her whether EP was S's father (because the midwife had mentioned to her that she had seen a photo of S and she looked very different from EP) the mother tried to explain the differences away, and added that EP had returned home to the mainland. The FSW recorded that 'since EP has left the island and gone back to the mainland there are no longer any concerns about him sharing a bed with S'.
- 3.30 Three days after the mother had said that EP had returned to the mainland, a neighbour of the mother's dropped S off at the early years provision and said that the mother reported going to the mainland to take EP back home, and the car breaking down. There was no indication as to when mother was returning. A worker at the early years' provision phoned Children's Services First Response Unit to express her concerns about the fact that they did not know when the mother would be back. She said that an uncle was supposed to look after S. CAF co-ordinator (CAF1) working in the First Response Unit noticed that the records said that the uncle had learning disabilities so it was agreed that the neighbour would look after S until the mother returned. CAF1 recorded that she had passed the information on to the CMW, who had indicated that a CSF would be useful. The FRU worker decided no further action was needed.
- 3.31 On the last day of February 2012, S was taken by the mother to A&E because of a very small cut on her finger having touched some glass. The cut was treated with steristrips.
- 3.32 On the first Monday in March 2012, the CMW made an unannounced home visit and saw the mother who was asleep under a quilt on the sofa. The CMW noticed that the

home was very smoky and disorganised. The midwife told the mother that she was worried that she would struggle to cope when the new baby arrived. Later that day the mother phoned the CMW to talk about this comment. The midwife explained that she was worried because of the mother's pregnancy history, the mother's smoking, and the mother not being aware of who is looking after S at any one time.

- 3.33 The next day, the mother, and a man she said was a close friend of her mother, went to see the CMW at her office to continue the conversation about the CMW's concerns. The CMW explained again and said she was worried about S as she would 'throw herself at anyone'.
- 3.34 Later that day the mother went to the Children's Centre and the FSW completed a full CAF with her. The mother described S in a positive way as having a lot of confidence and being very happy with people, even people she has just met. The completed CAF was never seen by the CAF co-ordinator although Centre staff delivered at least two copies.
- 3.35 The named midwife for safeguarding recorded contacting Children's Services to request that the CAF be chased and a 'team around the family' meeting be held. There are no records of this conversation on Children's Services or CAF files.
- 3.36 In mid-March 2012 the mother went to see her GP as she was suffering with abdominal pain. She was reassured by the doctor and referred to the maternity unit. She discharged herself against medical advice later that day.
- 3.37 The following week the CMW made a home visit and recorded that the house appeared to be less smoky and there was evidence of preparation for the baby. Six days later the FSW visited the mother to complete a second CAF, this time on the yet to be born baby T.
- 3.38 At the end of March the mother went to hospital in early labour. Baby T was born that day by emergency caesarean section as he had an abnormal foetal trace. He was in good condition. After two days in hospital baby T & the mother were discharged home. Baby T was bottle feeding on Nutramigen (specialised formula milk). No discharge meeting was held.

Period three April - July 2012

- 3.39 At the beginning of April 2012, S (now aged four and a half), started a new term at the early years provision. She attended for 21 of the possible 37 days. That same day, the CMW visited the mother at home and found the flat to be 'crowded, hot and generally untidy'. She found the mother, who had given birth by caesarean section only four days previously, sleeping on the sofa as a male visitor, not identified in the notes, was in her bed. The mother told her that S was staying with her 'aunt'. Safety aspects were discussed with the mother including reducing the risk of sudden infant death. Sterilisation of bottles and making up feeds correctly was also covered. Mother appeared 'bright and cheerful'.

- 3.40 The next day the CMW visited again, found the flat less smoky and S still with the 'aunt'. The CMW contacted the CC about the team around the family meeting and was advised it was still being considered.
- 3.41 The mother had her third visit that week the next day when the FSW called and was introduced to baby T. MGM was also there. The mother said that she had a 'friend' (S's father) staying with her to help her while she recovered from the birth. The FSW believed that he was a friend of S and T's uncle. That day the IOW NHS Trust named midwife for safeguarding received a copy of the CAF, sent from the Children's Centre, some four months after the assessment was first requested.
- 3.42 On the Sunday the mother had her fourth visit of the week when the CMW went to the home. T was ten days old. An unknown male was asleep in the mother's bedroom but the mother did not disclose his name merely saying he lived in (a part of the Island) and had no children himself. S was again absent and was reported to be next door at the MGM's house having Easter eggs.
- 3.43 Five days later, a bank health visitor (HV1) visited the mother and the 14 day old baby T at home. Baby T was showing satisfactory progress. The mother was using formula milk as she had stopped breast feeding. The mother reported they are subject to a CAF and her own mother is supportive but has her own physical health needs. The health visitor's assessment was that she was 'coping' at present.
- 3.44 At 8pm that same evening baby T was admitted to hospital, having been referred by his GP due to concerns that he was unsettled and had a temperature. Baby T was seen and examined by the paediatrician and there was no evidence of serious infection. The health visitor and GP were informed of this. The family history recorded in the Paediatric Record for this admission gives father (S) as the father, and baby T as being accompanied to the ward by his parents.
- 3.45 The following week, the FSW received a phone call from a member of staff from the early years project expressing concerns as they had seen S with a woman who had recently been reported in the local press as having had her child removed from her. The FSW sent an email to Children's Services informing them of this phone call. There are no records in Children's Services of this email being received. This was the fifth time that someone had been in contact with Children's Services in six months.
- 3.46 The next day a team around the family (TAF) meeting took place at the mother's home with baby T nearly 3 weeks old. Present were the mother, the 'aunt', the FSW, the CMW and a social work student attached to the Children's Centre. The health visitor present, HV2, had returned from annual leave and was now aware of 'all the background history' including previous Children's Services involvement both on the Island and the mainland, that the mother has mental health issues and that there had been previous concern regarding alcohol and substance misuse. During the TAF meeting it became apparent to workers that the mother had problems with her memory and the HV2 concluded that it 'was evident that the mother would need a huge amount of support'. During the meeting the FSW questioned the mother about the identity of the person caring for S (when she was seen with a person who was potentially a risk). The mother said that she

had not known about it. The 'aunt', however, said that her daughter was looking after S on that particular day, and that the person was her daughter's friend.

3.47 The TAF meeting notes recorded that the 'lead professional' was confirmed as the FSW and the next meeting was to be six weeks later (by which time baby T would be 2 months old). The following actions were noted

- The safe delivery of the new baby (despite the fact baby T had already been born)
- To enable a friendly positive experience with the Children's Centre
- To enable a safe, consistent routine and environment for S
- Agreeing a security question with the early years setting in case there was ever a time when one of the named familiar adults could not pick S up
- Request that the early years setting undertake some 'stranger danger work' with S due to her over familiarity with strangers
- The mother to be referred for contraceptive advice
- The mother to know who S is with at all times
- Health visitor to see the mother monthly at home and fortnightly at the Children's Centre
- Invite to be made for baby Incredible Years
- Professionals could contact the 'aunt' should the mother disengage.

3.48 Two days after the TAF the mother did not attend the Children's Centre as agreed in the TAF plan.

3.49 The next week, when baby T was nearly 4 weeks old, HV2 told the CMW about the concerns that there had been in the mainland, including alcohol and drug use. The CMW told HV2 that she had no concerns about substance misuse with this pregnancy. The CMW planned one more visit before discharging mother and T.

3.50 In the first week of May, with T at 5 weeks old, the mother took baby T to the well-baby clinic. Her GP had prescribed the wrong Nutramigen milk (it should have been 1 and not 2) and the mother told the health visitor that she had been feeding baby T with baby rice, despite the fact that he was only 5 weeks old. She was advised to see her GP to get the Nutramigen changed. HV3 at the well-baby clinic told the mother that baby T was too young for baby rice. This advice was reinforced by the FSW. The mother also reported that she had fallen out with the 'aunt' because she had been leaving S with other adults.

3.51 Later that same day the mother took baby T to the accident and emergency ward (with father (S) arriving later) because she said he had fresh blood in his stools. Hospital staff noticed there was blood in his nappy. She said she was worried in case she had done something to make him ill. When father (S) arrived he presented the admitting nurse with 7 made up bottles of Nutramigen stating these would only last baby T one night. This contradicted the mother's report that she fed baby T 180mls of milk 3 hourly. There were other contradictory accounts of baby T's care given to the nursing team such as he has his bowels open after every feed to he only had his bowels open three times in the last 2 days. Baby T was kept in overnight for monitoring. Father (S) stayed to provide care for him, but mother went home. However in the morning he asked the nurses to

dress baby T as he said he had not dressed him before. No further blood was observed, he appeared to be well and was feeding normally and he was discharged the following day.

3.52 In the morning, the deputy sister on the children's ward phoned the out of hours Children's Services team. She told them that baby T had been fed with baby rice at five weeks old. The mother's parenting appeared to be a little obsessive; she was bathing baby T four times per day and giving him baby teething gel. She said baby T's father was father (S) and he appeared to be supporting the mother and feeding baby T at night as the mother was taking medication.

3.53 This was fed back to the First Response Unit and, a different consultant social worker from First Response Unit (ConsSW2), decided that a CAF coordinator (CAF2) should contact the HV2 to discuss on-going support for the family. The ConsSW noted that the mother had had previous mental health support.

3.54 Later that day the mother phoned the FSW to say that baby T (6 weeks) had been in hospital with severe constipation. A doctor, she said, had prescribed the wrong formula milk. She was upset as health visitors might blame her for the constipation because she had given baby T rice. The mother told the FSW that S was being looked after by the neighbour. Four days later HV2 phoned the mother for a 'post admission phone contact'. The mother told her that baby T was now feeding on Nutramigen 1 formula milk and was feeding well. There had been no more episodes of blood in the stools.

3.55 The next week, with baby T at 7 weeks, CAF2 phoned HV2 and was told that the mother was 'engaging well with the support that is being offered'.

3.56 Four days later the FSW sent another email to Children's Services stating, that the 'aunt' had raised concerns about the mother not coping very well and having fallen out with her brother T's uncle) who had been named as a person who the mother trusted to care for S and pick her up from pre-school. The referral concluded by the FSW stating 'I am aware that there is a long history with the mother and S in Children's Services and feel that this is a very vulnerable family,

3.57 ConsSW1 of the First Response Unit passed this onto CAF Coordinator CAF2, and asked that he liaise with the referrer to ensure that appropriate support was sought and advice given. A joint visit between the CAF2 and the Lead Professional (the FSW) was arranged, but subsequently cancelled by the FSW due to another commitment. The visit was rearranged for June 2012, 24 days later. This was the seventh time that professionals or members of the public had communicated with Children's Services in seven months.

3.58 A week after the FSW's email to Children's Services the mother phoned the Children's Centre and referred herself for counselling. Later that day the 'aunt', went into Children's Centre with baby T to inform the FSW that she was taking baby T back to the mother after looking after him and S for the previous week. He was 8 weeks old.

- 3.59 Just before the end of May a second TAF team around the family meeting was held at the Children's Centre. Present were: the mother and baby T, the FSW, an early years representative), a student social worker, and HV2. Concerns were expressed by the Children's Centre about the number of people involved with dropping off and picking up S. Actions agreed from the meeting included a handover security question to be agreed with mother (outstanding from the first TAF meeting 6 weeks earlier), the mother to attend baby Incredible Years with her brother if possible, if not then Toddler Incredible Years – June or September 2012. Also early years to advise the school who would be good influences and appropriate friends for S, and baby T to be regularly seen by HV.
- 3.60 After the meeting HV2 sent an email to the GP which contained the following 'ARIA (sic) OS (sic) ONA (sic) CAFAND (sic) THERE ARE CHILD PROTECTION CONCERNS REGARDING HER ABILITY TO COPE AND PARENT EFFECTIVELY (sic) I AM AWARE THAT S WAS PREVIOUSLY (sic) ON A CHILD PROTECTION PLAN³ AND THAT THE MOTHER HAS A LONG HISTORY OF DRUG AND ALCOHOL PROBLEMS'.
- 3.61 Later that evening the mother phoned the out of hours GP service because she thought baby T may have taken a sip of Calpol.
- 3.62 At the end of May 2012 the mother visited the Children's Centre for a counselling session. She explained that her father lived hundreds of miles away and only now spoke to him on the phone. She said that she had lost a baby at 20 weeks, had had two still births and several miscarriages, and had had counselling for this. She was still affected by the loss in late pregnancy and said she sometimes saw that baby when looking in T's cot.
- 3.63 The postponed joint visit by the CAF Coordinator and FSW was also cancelled and the Review understands no further visits were to be made. Baby T was now 10 weeks old. The Children's Centre IMR said that it was decided given the mother's engagement with the Children's Centre, that a visit was no longer required.
- 3.64 In the last week of June 2012 the mother phoned the FSW to cancel her counselling session due to a family wedding and baby T having a cold. The mother said that she would be in the following day but the FSW advised her not to as it was the morning of the wedding. The aunt later told the Review there was no wedding planned.
- 3.65 In early July 2012, three weeks after the joint Children's Services/CC meeting was cancelled at lunchtime baby T (aged 13 weeks) was taken to St. Mary's Hospital by the mother and father (S). He had serious and potentially life threatening injuries and was placed in a medically induced coma. The cause of the injury at that time was unclear. The mother told A & E staff that baby T had been irritable and not himself for the past 36 hours. He had spent the night prior to this admission at his 'aunt's' house and she had given him Paracetamol to try and settle him. That morning he was noted to be pale and not feeding so well.

³ This is not the case, S was discussed at a child protection conference in 2007 and was deemed to be a Child in Need.

- 3.66 St Mary's Hospital phoned ConsSW2 from Children's Services at 11pm to tell them of the events. ConsSW then phoned the filtering officer at the out of hour's team. She was not sure where S was but it was thought that she was being looked after by an uncle. The filtering officer 'checked all case records and became concerned as there were no details of uncle on the system, but some records to suggest one uncle possibly two may have some issues with violence and mental health and another may have been in prison for murder
- 3.67 Southampton General Hospital (to where the baby had been transferred for more specialist care) rang the Children's Services out of hours team at 11pm to say that the mother had told her that S was with her 'god parents' (probably neighbours). Police were contacted and they agreed that they would visit and complete a welfare check on S which was done at 4.30 a.m.
- 3.68 The day after the admission a meeting of professionals took place at St Mary's Hospital chaired by the Isle of Wight NHS Trust head of safeguarding children.
- 3.69 Later that day the 'aunt' visited the Children's Centre to tell staff that she would be caring for S whilst the mother was in Southampton. She told staff that father (S) was S's father and that he and the mother were living together.
- 3.70 At 6pm the Children's Services out of hour's team received a call from Southampton general hospital to say that the consultant paediatric neurologist's view was that the injuries were non-accidental. The Children's Services out of hour's worker informed the police of these developments and they agreed that a strategy meeting would take place the following day.
- 3.71 Two days after the admission, the mother and father (S) were arrested on suspicion of causing the injuries to baby T. Later that day a strategy meeting was held. The next day Children's Services made an application to court for interim care orders for baby T and S and the next day S was examined by a paediatrician and was found to be fit and well.

4. ANALYSIS OF EVENTS

4.1 This part of the report analyses the events set out in the summary, then considers the questions set in the terms of reference.

Period one August – December 2011

4.2 The first contact between professionals and the mother in the Review timescale was when the community midwife met the mother at the end of August 2011. However, S had resumed pre-school in January 2011, and Children's Services had been contacted by the hospital in May 2011 after a young person had taken an overdose and said he lived with the mother.

4.3 Had health professionals read all of the files from the mainland they would have found out that the mother, according to the Health IMR,

- Was 17 years old when she reported to a midwife that she had already had 2 previous pregnancies. This included having a stillborn baby girl when she was 13 years old after being kicked in the stomach when she was 36 weeks pregnant
- Reported previous drug use but stated she had not taken any non-prescribed substances for the past 2 years
- Suffered from anxiety and agoraphobia
- Told the midwife that her own mother had been physically and verbally abusive to her and that she had been 'living on the streets' when she was 14 and 15 years old having been 'kicked out' of her home
- Told a midwife about the episodes of domestic violence from father (T) described as an ex-partner, her mental health problems and said that the mainland's plan had been to remove her baby (S) at birth

4.4 Additionally, during the pre-birth child protection conference held on the Isle of Wight in 2007 the mother reported a history of significant domestic abuse perpetrated by father (S) and how petrified she was of him. This included the mother reporting in excess of '70' domestic abuse incidents although, according to NHS records, these could not be validated by the police.

4.5 The mother told the CMW at the August 2011 visit that baby T's father was father (T) and father (S) was S's father, but that the children had no contact with either of them. The CMW noted that the house was untidy and not child-friendly and that S was 'needy' with 'no stranger awareness': S had rushed over to the CMW to be picked up despite the fact that this was the first time that the CMW had met her. In her records the CMW noted mental health issues, poor living conditions, and a short-term relationship with S's father.

4.6 The CMW told the Review that she had a feeling from this first meeting that this was a troubled family. Such feelings or 'practice wisdom', can be a useful tool in child welfare practice, [Deroos (1990); Kitchener and Brenner (1990)] but it requires reflective supervision to enable the practitioner to move their 'gut feeling' to a reasoned argument. Supervision and management oversight will be a theme of this Review, considered in more detail in the lessons learned section.

- 4.7 The CMW's recording of 'mental health issues' failed to show how she had spoken to the mother about her 'mental health issues'. The phrase itself offers no help to anyone reading a file as it did not determine in more detail what those issues were.
- 4.8 S went back to the community early years pre-school for the autumn term and the mother identified six people who could collect S, one of whom was EP. The early years provision, according to their IMR, saw mother and family members as being very loving, supportive and caring towards S, giving them 'no cause for concern'.
- 4.9 The mother and her family appeared loving towards S. All records about the children's interactions with them are positive. However, the mother did not always know who S was with, and S appeared to have little routine in her life. For example, in the first term that she attended the early years centre she was only brought or collected by the mother on 4 and 8 occasions respectively out of the 42 days that she attended; she was due to attend for 70 days.
- 4.10 The mainland police had records relating to EP in which the MGM had said to them that in March 2010 (on the mainland) EP had threatened to burn down the mother's house with the mother and S inside. He had assaulted the mother in 2009 (nine months previously) by punching her in the face and he had been cautioned for actual bodily harm. There would have been no reason at this point for the early years centre to contact the police to find out this information but, had an initial or core assessment been completed at a later point professionals would have been able to gather this information.
- 4.11 The first contact with Isle of Wight Children's Services (as far as the main timescale for the review is concerned) occurred in the first week of November 2011 when the 'aunt' (the mother's second cousin, their grandmothers were sisters) phoned the First Response Unit with concerns. Although it is recorded that 'the electronic files were viewed' had they been more thoroughly examined the unnamed First Response worker would have discovered reports that the mother:
- Said that she 'fled' from the domestic abuse that she was suffering from father (S)
 - Had suffered multiple abuse episodes throughout her life from the age of 7. These were said to have included physical and emotional abuse within her family of origin, and sexual abuse from unspecified men when she was 15 and later from fellow tenants. Also suicide attempts from primary school age, after which she had mental health services support
 - Had a history of drug use including soft and hard drugs, and alcohol use since the age of 11. The mother had spent a period of 2 years living on the streets of the mainland (from 2005-2007)
 - Had displayed aggressive and impulsive behaviour
 - Had said that she wanted to have a baby as she wanted to be loved and have somebody to love
 - Had very significant mental health and social issues
 - Had suffered from anxiety, agoraphobia and auditory hallucinations

- 4.12 Even in the absence of this available background information the referral was not taken as seriously as it should have been. It has long been noted as one of 10 common pitfalls (Working Together, 2006 version) that referrals from members of the public are not given as much credence as referrals from professionals.
- 4.13 The situation that the 'aunt' described contained some serious on-going concerns. The home smelt of urine, the mother was misusing alcohol at 18 weeks pregnant, she was not taking her mental health medication, and most seriously of all, S at the age of 4, was having to fend for herself. Again phrases were not explored or clarified. For example: how much 'misuse of alcohol', how often, how is S affected; what are the mother's mental health problems, how is S affected; what would be the effect of her not taking the medication; was S in the same T-shirt and knickers for three days; when were those three days?
- 4.14 *Messages from Research* (1995) suggested that child protection work in the UK was predicated on event and not context. This continues to be a theme of child protection work with Working Together 2010 (1.28) stating that 'significant harm (can be) a compilation of significant events, both acute and longstanding, which interrupt, change or damage the child's physical and psychological development. Some children live in circumstances where their health and development are neglected'.
- 4.15 Consequently intervention is often effected when abuse is apparent (an event) but not effective when there are issues of neglect, (context). It is therefore hard to justify the advice given to the 'aunt' to 'call the police if she remained concerned' because this 'contextual' allegation of neglect could not be responded to by the police as they deal with emergency 'events'.
- 4.16 The records again indicate a lack of questioning and professional curiosity. The 'aunt' has made serious allegations, and all the mother has done is to say that they are not true. Yet there is no exploration with the mother about why the 'aunt' might fabricate such a story and no testing of the mother's rebuttal. With no apparent evidence at this time to help decide which version is correct ConsSW1 in the First Response Unit, decided that the mother was telling the truth and that 'FRU have no further role'. According to the ConsSW1, the mother had responded 'appropriately in gaining support from S's god daughter' [presumably the 'aunt']. However, this ignores the fact that it was the 'aunt' who made the allegations.
- 4.17 The potential richness of what the 'aunt' had to say can be seen from what she later told the Review. She said that clothes were changed during this period but that she was never dressed beyond her underwear. The mother did not feed her for three days and S was helping herself to food wherever she could find it, including the freezer. She described the mother as being in a trance like state at this time and S being a child who could not amuse herself but who was always needing attention from adults.
- 4.18 It would appear that a CAF co-ordinator, CAF1, guided by ConsSW1
- Listened to the mother's denial of the allegations,
 - Did not see S
 - Did not re-contact the 'aunt'

- Did not fully read the background information
- Did not ask the mother why the 'aunt' would then, presumably, make up these allegations
- Did not contact the early years provision to find out about S
- Did not ask about the details of the contact from 'Health'
- Did not contact 'Health' to check that they were offering support
- Took what the mother said at face value

...and decided that, 'there was not a role for Children's Services at this time.' The mother's word was taken at face value regarding the support from health and early years (an organisation that doesn't offer support to parents). As a minimum, the mother should have been asked if she agreed to the midwife, GP and the early years' provision being contacted to check about the support that was available to her.

- 4.19 There are serious failings in this episode. The main one is failing to read the background information that should have alerted the social workers that the referral from the 'aunt' warranted at least an initial assessment (and preferably a core assessment) with consequent checks with partner agencies.
- 4.20 The decision to take no further action was also made without thought to the views of S, four years old at the time. A call to the early years centre should have been made in order to see whether S had attended for these three days, how she seemed then and now, and had staff noticed anything unusual.
- 4.21 Even without knowing the background information the collection of information and decision-making is poor. Everything that the mother says is accepted and consequently all that the 'aunt' says is dismissed, there appear to be no probing questions asked of the mother, and the suggestion that the 'aunt' contact the police demonstrated a naïve understanding of the police role in child protection.
- 4.22 There is no evidence of an understanding of neglect by either the CAF co-ordinator or the consultant social worker. It would seem that, in this situation, what could have been a child protection investigation, and what should have been at least an initial assessment, was downgraded first to a CAF and then to a 'leaflet about a CAF'.
- 4.23 The author met with social workers and CAF co-ordinators. They said that during this period (November 2011) the First Response Unit had two consultant social workers and three CAF co-ordinators who, due to the volume of work, were playing the role of duty social workers. They also said that they were under instructions from senior management to reduce the number of Section 47 investigations and initial assessments and increase the number of CAFs.
- 4.24 They further said that the culture of practice on the Island was such that consent from parents for the sharing of information was considered to be a pre-requisite for any work and that, if parents refused, then information was not shared. Although this may be true, there is no evidence that the mother was asked for her permission to share information.

- 4.25 Three weeks after the 'aunt's' referral, S was taken to the local A&E because it was feared that she had swallowed Nurofen accidentally. The GP was informed and this event appeared on the health visiting records. There is no record of any follow up visit by any health staff - which would have been good practice. In itself the actions and decision-making by A&E staff are probably correct, but it added to a picture of poor supervision. The visit was appropriately shared with the GP and, had there been a more thorough collection of information at a later date, this would have been known about more widely.
- 4.26 The CMW, the community midwife, remained concerned about this family and discussed them with the named midwife in group safeguarding supervision at the end of November 2011, having visited the mother the same day. According to health records this resulted in the named midwife discussing the mother's situation with ConsSW1 in the First Response Unit in mid-December 2011 because, according to the NHS IMR, 'of the increasing concerns'. Information was shared by Children's Services that the 'aunt' had raised concerns regarding the mother drinking during her pregnancy. This was the second contact with Children's Services and it appears that ConsSW1 did not tell the named midwife about all of the concerns that the 'aunt' had raised.
- 4.27 The decision made was that a CAF would be completed by the community midwife and health records state that an email was sent to the CMW from the named midwife requesting a CAF. This appears never to have been responded to. The email has not been located. A CAF had been mentioned before, at the beginning of November 2011, but the decision then was not followed up because the mother came into the First Response Unit's office and denied the allegations that the 'aunt' had made.
- 4.28 There is no mention of this discussion, or decision in Children's Services' records although the conversation was, according to the named midwife, part of a regular meeting where antenatal cases were reviewed. The lack of recording of this conversation and decision with the NHS Trust named midwife in the First Response Unit files is a concern and is the first of three such failures.
- 4.29 Just before Christmas 2011, the CMW visited the mother at home. She recorded that on direct questioning the mother denied any alcohol or cannabis use, but was still smoking 20 a day and awaiting contact from the Smoking Cessation Midwife. The midwife asked these questions in response to the recent information gained from Children's Services. There is no discussion about S being left to fend for herself for three days, so this appears to be further evidence that this had not been shared by the FRU with the named midwife.
- 4.30 The referral to the smoking cessation midwife was first made when the mother was two months pregnant (and reporting that she was smoking 20 cigarettes a day). She was now 6 months pregnant yet she had still not been visited.

Period two January – March 2012

- 4.31 The non-collection of the prescription treatment in January 2011 is not of great significance, but does point to a pattern of a lack of routine as it would presumably have been left there for a few days.
- 4.32 The explanation of the abdomen pain caused by falling on a cot could have been treated with some scepticism, which is not to say that it was not true. Unbeknown to professionals (because they had not properly read the background material) the mother was now living with one of two men who had a history of hurting her in the past. It is estimated that 30% of domestic abuse commences during pregnancy (Dept. of Health, 2004). The Health Overview for the SCR reported that whilst there was some good practice identified in the records for this short admission, there was no documented evidence that maternity staff explored some key aspects of social history. This included asking who was caring for S, who was the father of the unborn baby, and whether the mother was in a relationship at this time.
- 4.33 A discussion about the risks to the unborn baby associated with self-discharge against medical advice were discussed with the mother. The Health Overview says that although the discharge letter to the GP was somewhat scant and there was no evidence that phone contact was made with any IOW maternity professionals, as may have been expected in the self-discharge of a vulnerable patient (although the IOW NHS Trust IMR does indicate a follow up) a visit was made the next day as a result of the self-discharge.
- 4.34 The smoking cessation midwife saw the mother in the second week of January 2012 and was told by the MGM that an ex-partner of the mother's was coming to live with her to help look after S. This visit was made four months after the referral which had been made when the mother was only two months pregnant. There was no record of inquiring who the ex-partner was.
- 4.35 The smoking cessation midwife updated the named midwife for safeguarding children and the decision was made that a CAF be requested from the community midwife. (A decision had already been made to do this the previous month). Had the smoking cessation midwife asked for the name of the partner and had health staff then properly checked the records available to them they would have discovered that during the 2007 child protection conference the mother had reported a history of significant domestic abuse perpetrated by father (S) and how frightened she then was of him. The mother had claimed she had experienced in excess of 70 incidents of domestic abuse.
- 4.36 Had anyone decided that this situation warranted further investigation and contacted the Lancashire Police they would have discovered that, according to police records in July 2009, father (S) had written a letter in which he states that he had seen a psychiatrist about depression (getting worse) and hearing voices. These voices he said, had initially told him to steal, then to hurt small animals, now to be extremely violent to people.
- 4.37 Had this further encouraged professionals to contact mental health services in Yorkshire they would have found that their records on father (S) contained a mental health

assessment in 2011 (the year he reappeared on the Island) which indicated a complex offending history, self-reports of committing fatal injuries (which it says were not confirmed in police records) and that no remorse was evident. The record indicated that the father had agreed not to have access to S, and did not wish to pursue access 'at present'. Importantly the record said that if he did see his daughter then consideration would need to be given to contacting Children's Services

- 4.38 Existing research indicates that murdered and non-accidentally injured children, especially those under one year old, are most likely to be killed or injured within the family and usually by a parent or step parent (Brandon 2008, 2009) with both boys and girls equally vulnerable. The abuse usually happens at home, often when the victim is in the sole and temporary care of a (step) father. Younger children are more likely to be killed or injured by the use of direct force, such as shaking or the use of a blunt instrument.
- 4.39 When interviewed by the author, the mother said that she was not concerned about S's father being with her and baby T because the domestic abuse had been focused upon her and not the children. This may indicate that the damaging effect of domestic abuse between adults on children had not been recently explained to her, or it may be the case that she had chosen to ignore this advice. There are no records indicating that these explanations had been made to her recently.
- 4.40 The mother was visited by the FSW and CMW2 in the fourth week of January 2012 for completion of a pre-CAF. The CAF, first asked for in mid-December 2011 and again requested earlier in January 2012 could not be completed, as this visit was to complete a 'pre-CAF'. A pre-CAF is designed to find out whether a full CAF is required. There had been two decisions made that a full CAF was required so it appears to be unnecessary to complete a pre-CAF.
- 4.41 Two days later, the smoking cessation midwife saw the mother and discussed domestic abuse with her. The mother talked about abdominal 'tightening' and went to the maternity unit.
- 4.42 This is an example of how the mother deflected professionals when they were confronting her about the subjects which she found challenging; a discussion about domestic abuse is transformed into one about the pregnancy. The suspicion that this may have been a diversion tactic is reinforced by the fact that at 1 a.m. that night the mother discharged herself against medical advice for the second time.
- 4.43 CMW1 visited the mother on near the end of January 2012 and noted that EP was sleeping in the mother's bed with S, now aged 4 years and 3 months. Professionals had been told that EP was S's father, so this event might not at that time have been especially concerning. The mother told the Review that EP was not S's biological father but that he had lived with them for three years and S saw him as her father. This may be the case but there was an example earlier when the mother had told the FSW and CMW2 that EP was S's biological father and had explained her appearance by saying that she took after her brother's side of the family.

- 4.44 The smoking cessation midwife visited the mother again at the beginning of February 2012 and noted about EP that it was unclear if he was S's father or if he was the perpetrator of domestic violence in the mainland. This seeming failure to ask basic questions appears hard to understand in hindsight, but it should not be under-estimated that people found it difficult to work with the mother, as she often fabricated elements of her story, on top of her real difficulties'. It was also recorded that the interaction between EP and S appeared 'relaxed and comfortable'. This lack of clarity could have been resolved by an examination of the records held by health. The records of this visit further stated that S was at home and 'threw herself and hugged' the midwife despite this being the first time S had seen her. This is the second time that a health professional has recorded S's over-familiarity with people who she had just met.
- 4.45 The named midwife received the pre-CAF from the FSW in mid-February 2012 with a note saying the situation did not need a full CAF. She did not agree with this analysis and phoned the FSW saying that there was more known history in this family and the mother had fled from EP in the past as he was abusive towards her in their previous relationship. She told the FSW that EP was known to have recently been sharing a bed with S. It was unfortunate that the 'more known history on the family' was not recorded in detail. Mid February was two months after the named midwife first requested a CAF.
- 4.46 A week later, the mother went to the Children's Centre and was told that the FSW and midwife did not think that EP looked to be S's father. The mother said S took after the features of her brother's side. She said that EP had returned to the mainland. The FSW recorded that since EP had left the island and gone back to the mainland there were no longer any concerns with him sharing a bed with S.
- 4.47 This is clear evidence that the mother is prepared to lie to professionals as she is not saying that 'EP is like a father to S,' as she said to the Review, and that EP had not returned alone to the mainland, as evidenced by the fact that, three days later, the mother was stuck on the mainland after having returned him to the mainland.
- 4.48 CAF Coordinator 1 from the First Response Unit received the call from the early years centre explaining that the mother was on the mainland and there were no plans made for S. CAF1 spoke to the CMW who indicated 'that a CAF would be beneficial...and...that there was no further action for Children's Services at this time' .
- 4.49 There was a lack of professional curiosity and little questioning about the arrangements. Portsmouth to the mainland area concerned is a car journey that would take over 4 hours without a break. Adding in breaks and ferry would mean a return journey of approx. 12 hours from the Island. Did the mother, EP and her mother leave the day before? Why did the neighbour not know the arrangements?
- 4.50 A CAF had already been requested, so it appears that this had not been recorded by the CAF co-ordinators or, if it had been, the records were not checked. The decision, which appears to have been made by both, was to take no further action because 'it was the mother's responsibility to make appropriate arrangements for her child' according to the Children's Services IMR. This decision ignores the fact that professionals should be concerned because whilst it is the mother's responsibility to make arrangements for her

child, on this occasion, she had failed to do so. This was the third contact that had been made to Children's Services in four months.

- 4.51 S was again taken to hospital at the end of February 2011 because of a small cut. Like her last visit to the hospital this was not in itself a serious issue but, allied with the other events, is it a further example of a lack of supervision?
- 4.52 The CMW made an unannounced home visit in early March 2012 because she had heard about the trip to the mainland. The CMW raised concerns that the mother would struggle to cope when the new baby arrived, to which the mother reported that her mother, brother and the 'aunt' would help.
- 4.53 The mother phoned the CMW later that day to discuss the CMW's concerns. The CMW explained she was worried about the mother managing as a single parent, her pregnancy history, the smoking, and caring for S and not being aware who is looking after her. The next day the mother went to see the CMW. Again the CMW, stressed her concerns regarding S and how although she was a bright, friendly child she would 'literally throw herself at anyone' and that it was the mother's job as her mother to protect her. The mother appeared to the CMW to find the challenge to her parenting difficult to hear.
- 4.54 Later that day the mother went to the Children's Centre and the FSW completed a full CAF with the mother. The CAF form stated that, according to the mother, S, 'has a lot of confidence – very happy with all people – even people she has just met', which is a positive spin on the CMW's concern that S will literally throw herself at anyone. The CAF form recorded that the mother confirmed she had split from father (S) in 2010 after domestic violence, and that (mainland) Children's Services had been involved. Hearing that father (S) saw S a few times a year, there was no inquiry about how S was kept safe at those times.
- 4.55 The lack of professional curiosity and non-specific recording is evident again here. The FSW presumably still believed that EP was S's father so how can it be that she accepts that they split up in 2010 when she knows that they have been together recently? The Children's Centre IMR says that domestic violence was not detailed, nor did it seem to have been discussed with mother.
- 4.56 Staff from the Children's Centre explained to the Review that, when working with families at the CAF level, their overriding concern with many of the mothers with whom they work is to 'engage' them and make sure that they come to the centre. As such they may be uncomfortable with challenging parents, fearing that they might put them off coming.
- 4.57 The desired outcomes of the CAF were –
- To ensure safe delivery of baby
 - To enable a safe/consistent routine and environment for S
 - To ensure the mother continues with studying
 - To enable a friendly positive experience with the Children's Centre

- 4.58 The first two desired outcomes were appropriate, although the second one would have benefited from some measurements, 'how would we know when this had been achieved?' The third desired outcome was based on the mother's assertion that she was studying for a degree in child psychology with the Open University. It would be surprising if this were the case and such a course does not seem to appear on the OU website. It would also be surprising if the FSW believed that the mother was studying for a degree, and presumably the inclusion of this is a further example of an attempt to 'engage' with the mother as opposed to challenge her.
- 4.59 The last desired outcome is not an outcome but a 'process' – a means to an end. What is the point of there being just a 'friendly positive experience'? Such experiences would be, presumably, to ensure that the mother attended the centre and as a consequence improved her parenting of baby T and S. The improvement to her parenting should be the desired outcome.
- 4.60 The completed CAF was never seen by the CAF co-ordinator and Children's Services IMR said it had still not been received by the end of 2012 despite repeated request. This is refuted by the Children's Centre which it says forwarded a number of copies, and said that the CAF was hand-delivered on 2 separate occasions. Both times these were in sealed envelopes addressed to the CAF Coordinators and contained both T's and S's CAFs.
- 4.61 A week later, the named midwife for safeguarding recorded that she contacted, CAF2 in the First Response Unit to request that the 'CAF be chased'. There are no records of this conversation on Children's Services files. This was the fourth contact that had been made to Children's Services in four months.
- 4.62 In mid-March 2012, the mother was referred to the maternity unit because of abdominal pain. She subsequently discharged herself against medical advice for a third time.
- 4.63 Just before the end of March 2012, the FSW visited the mother at home observed the mother responding well to S, playing with her but also asking her to let her mum talk to the FSW.
- 4.64 Although this Review is suggesting that the mother struggled as a parent, there is much evidence in the narrative and the example above, that when professionals saw the mother or family members with S, they saw nothing in their relationship that should concern them.
- 4.65 The FSW completed the CAF form. The Children's Centre IMR described the desired changes and how change can happen is described as 'positive engagement with professionals and the Children's Centre, by building a positive relationship with family support worker and openly sharing information'. That phrase is a suitable example for how 'change can happen' but is not an outcome as far as a 'desired change' is concerned.

- 4.66 The FSW from the Children's Centre became the lead professional. The FSW, says the IMR, did not remember a discussion about who should be lead professional, more that it was taken for granted that she would be as she had initiated the CAFs. She had the following qualifications: NNEB nursery nursing, a Further Adult Education Teaching Certificate, A1 and A2 NVQ assessor's award, Webster Stratton incredible years parenting, (a highly recognised parenting program) and Working with Parents Level 3 parenting certificate.
- 4.67 These are impressive qualifications and suitable for someone working in a family centre with universal and vulnerable families, but it would have been better if a midwife, and later a health visitor had been the lead professional because the mother needed a professional who would work with her in a challenging yet supportive manner, someone who would carefully note down what she said to identify inaccuracies in her stories, and someone who would provide advice, guidance and boundaries. The Health Overview commented that 'It would also have been better if the midwives had liaised with other health professionals, including GPs and health visitors as S's recognised unmet health and welfare needs may have been more relevantly addressed by health visiting input, in conjunction with the Children's Centre staff'
- 4.68 Antenatal visits by health visitors are targeted on the Isle of Wight, and are not able to be universal as per national guidance (Healthy Child Programme), due to staff shortages. The Health Overview says it is difficult to understand how this case did not warrant a 'targeted visit', given the history, and added that it would be fair to say that a health visitor may have been the most appropriate professional to undertake the CAF, and/or to act as lead professional, for this family.

Period three April - July 2012

- 4.69 Early in April 2012, the FSW visited the mother and found out that father (S), who the mother said was a friend of her brother, was staying with her. It is difficult to know whether the FSW should have been aware at this point that father (S) was a potential threat as it is hard to decipher who knew what and when. Health staff had been told by the MGM in January 2012 that a boyfriend, known to be abusive to the mother, was coming to stay with her, but the records do not indicate that they asked the name of this boyfriend. This visit may have been the first time that a worker knew that someone called (the name of) father (S) was living with the mother, and mother had deflected the FSW by saying the man was a friend of the uncle.
- 4.70 Four days later on a Sunday, the CMW visited the mother and became aware of an unknown male asleep in the mother's bedroom. On direct questioning the mother did not disclose his name merely saying which area he lived in, and that he had no children himself. The CMW told the review that she tried hard to find out who this man was but that the mother had been very evasive.
- 4.71 At 8pm after another four days baby T was admitted to hospital. The family history given was that father (S) was the father, which is another example of the mother being untruthful about the paternity of her children.

- 4.72 The first TAF meeting took place on mid-April 2012. The health visitor was now aware of all the background history including previous Children's Services involvement both here and on the mainland, that the mother had mental health issues and that there had been previous concern regarding alcohol and substance misuse. It is recorded that during the TAF meeting it became apparent that the mother had problems with her memory and the H V concluded that it 'was evident that the mother would need a huge amount of support'. The phrase the mother 'had problems with her memory' may suggest that the mother had been caught out telling lies, but recording this as a memory problem is more considerate. The phrase 'would need a huge amount of support' was the first time that any professional had mentioned the extent of help that the mother needed. Both are general, as opposed to specific comments.
- 4.73 The TAF meeting notes included the following actions: the safe delivery of the new baby; to enable a friendly positive experience with the CC; and to enable a safe, consistent routine and environment for S. These appear to have been copied from the CAF, given that baby T had now been born and was three weeks old. In addition, there was a plan about the security question in case there was ever a time one of the (now) 3 named familiar adults could not pick S up; a request for the Early Years setting to undertake some 'stranger danger / protective behaviours work' with S due to her over-familiarity with strangers ; and that the mother should know who S is with at all times
- 4.74 The action for early years to conduct some 'stranger danger' work with S was appropriate, but the fact that there was no similar action relating to the mother appears to place the responsibility for the behaviour on S rather than her mother. This is surprising as the mother did not always know who S was with.
- 4.75 A week after the TAF, the health visitor HV2 made the CMW aware of the concerns that there had been in the mainland and 'the mother's extensive history'. HV2 appeared to have read some (maybe all) of the records from the mainland, but it is hard to know what she had absorbed as the phrase 'extensive history' is a general phrase containing no specific meaning.
- 4.76 Now in early May, with T five weeks old, the mother took baby T to the hospital. Baby T was constipated as he had been fed baby rice. The mother said that he had fresh blood in his stools. The hospital staff noticed blood in his nappy but no further problems. He was kept in hospital overnight. When the father (S) arrived he presented the admitting nurse with 7 bottles of made up milk for the night, a volume contradicting the mother's report on the volume taken. Contradictory accounts of bowel movements were also given.
- 4.77 The next day, the deputy sister on the children's ward phoned ConsSW2, then working in the out of hours Children's Services team, to pass on the hospital staff's concerns. ConsSW2 advised her that she would action the case to CAF2 to contact the health visitor to discuss possible on-going support for the family.
- 4.78 This was the sixth contact that had been made to Children's Services in six months. There is no record that this information was passed on to CAF2 and no evidence to suggest that the FSW, the lead professional, was ever informed. This was another

occasion where the First Response Team downgraded the concern to a CAF, failed to record events and failed to pass on information. There were some concerns about the behaviour of the parents: feeding baby rice, using teething gel, obsessive washing, the mother and the 'father' giving contradictory information, and the fact that the father couldn't dress him despite the fact that he was saying he looked him a lot of the time.

- 4.79 Had the background information been read in conjunction with the information above it is likely that the consultant social worker would have taken a different view, especially given the number of contacts that had been made. An appropriate response to these concerns, when read in conjunction with the known history of this family in the last few weeks and the background information would have been a child protection inquiry. Yet again the response is to downgrade the case to a CAF.
- 4.80 One of the most common, problematic tendencies in human cognition ... is our failure to review judgements and plans – once we have formed a view on what is going on, we often fail to notice or to dismiss evidence that challenges that picture' (Fish, S., Munro, E. and Bairstow, S., 2008)
- 4.81 Later that day the mother phoned the FSW to say that baby T had been in hospital over the weekend with severe constipation. The mother said that a doctor had prescribed the wrong formula milk, and said that she was upset as the Health Visitor might blame her for the constipation because she had given baby T baby rice. The Review understands that Nutramigen is used for babies who have lactose intolerance and Nutramigen 2 is usually given after babies are six months of age and that the use of the baby rice is more likely to have caused constipation than the prescribing of Nutramigen 2. This may therefore be another example of the mother deflecting the blame for her behaviour onto another person, although it may be the case that she is not doing this intentionally and honestly believes that the problem was caused by the Nutramigen 2.
- 4.82 When in mid-May, CAF2 phoned HV2, the health visitor said that the mother was 'engaging well with the support that is being offered' which is an example of a process measurement for progress rather than an outcome. Engaging well is a means to an end, not an end in itself.
- 4.83 The FSW submitted another referral to Children's Services via email saying that the 'aunt' had raised concerns about the mother not coping very well and that she was aware that there is a long history with the mother and S in Children's Services, and felt that this was a very vulnerable family. ConsSW1 of the First Response Unit passed this on to CAF2, and asked that he liaise with the referrer 'to ensure that appropriate support was sought and advice given'. This was the seventh contact that had been made to Children's Services in seven months and the decision is a further example of downgrading concerns to a lower level.
- 4.84 The 'aunt' came into the Children's Centre, a week later, with baby T, to inform the FSW that she was taking baby T back to the mother after looking after him and S for the past week. The mother had been unwell and the 'aunt' had been helping out. However, this is a now an eight week baby being separated from his mother for a week and this should

have been enough to warrant some further questions about the circumstances of this separation.

- 4.85 The second TAF (team around the family) meeting was held at the end of May 2012 where concerns were raised about the number of people involved with dropping off and picking S up at the early years centre. Actions agreed from the meeting included 'Security question to be agreed between the mother and early years– ASAP' (outstanding from the TAF meeting held on six weeks earlier. The security question should have been sorted out at this meeting especially as it has been unachieved for so long). After the meeting HV2 sent an email to the GP which contained the phrase, 'there are child protection concerns'.
- 4.86 It is difficult to understand why a family, where there were child protection concerns, was still being dealt with at a CAF level. This level was designed for families where there were 'additional problems'.
- 4.87 Later that day the mother phoned the out of hours GP service because she thought baby T may have taken a sip of Calpol. It is hard to know how a non-ambulant baby who is only eight weeks old could possibly have mistakenly taken a sip of Calpol unless given by an adult, and this incident should have been treated more seriously than it was.
- 4.88 The joint visit by the health visitor and CAF co-ordinator, planned for June was cancelled and it was decided that, given the mother's engagement with the Children's Centre, a visit was no longer required. A further example of progress being measured by process rather than outcome.
- 4.89 The mother and father (S) took baby T to hospital at the beginning of July with a potentially life threatening condition. The cause of this was, at that time, unclear. During the series of phone calls between hospital and Children's Services staff it became apparent, on checking the Children's Services records that, one uncle possibly two, may have some issues with violence and mental health and another may have been in prison for murder. This information must have been available on the Children's Services files during the previous twelve months but was never considered in any of the decisions made about this family.
- 4.90 A meeting subsequently took place on the next day which has been described in a variety of ways by the IMR authors from NHS, police and Children's Services. After some dispute, the meeting was chaired by the head of safeguarding children, Isle of Wight NHS trust, although it should have been a Strategy Meeting chaired by Children's Services. Whilst it may be the case that at that time, as far as anyone knew, baby T's condition may have been caused by an accidental injury, it would have been appropriate to hold a Strategy Meeting and plan the Section 47 investigation in the event that a non-accidental injury was confirmed especially as the minutes of this meeting contain the phrase 'highly indicative of non-accidental injury'.
- 4.91 Later that day ConsSW1 recorded on case notes that the meeting had been a 'Safeguarding meeting.....awaiting outcome from Southampton re NAI. Case progressed for assessment and attendance at further strategy meeting. Baby T has unexplained

injuries, the consistency of care afforded to baby T and S is also of concern.’ The fact that the consistency of care was now noted to be a concern, following a traumatic head injury, is ironic given that this information was always available to staff. This suggests that knowledge of child neglect and its manifestations may not be as well advanced on the Island as it should be.

- 4.92 Despite the concerns, the mother and father (S) were given unrestricted access to baby T for 42 hours after his admission. Whilst parental contact is very important at these times, the Health Overview rightly concluded that ‘in the context of the known child protection concerns, including reports of past violence, the open access to the ward for nearly two days is of concern’.
- 4.93 The injuries were confirmed as non-accidental at 6pm on the day after admission. Several studies suggest that the abuse of babies, lack ‘intentionality’ and that men's motivation may be to discipline or hurt rather than kill the child, Stroud & Pritchard, (2001). However, Cavanagh et al. (2007) propose a need to focus on the presence of *intention to harm* the victim rather than *intention to kill*.
- 4.94 This is highlighted by other studies which suggest that child killings perpetrated by fathers and stepfathers may be motivated by anger against an intimate partner displaced to the child and may involve jealousy of or resentment toward the child for occupying the mother's attention Alder & Polk, (2001); Wilczynski, (1995). (This Review has no knowledge of, or view on, culpability for the injuries).
- 4.95 Because of the dispute about the status of the first meeting a formal strategy meeting did not take place until the day after the injuries were confirmed as deliberate. This meeting was of high quality, chaired appropriately by ConsSW3 and held in Southampton so that the expert medical staff, amongst others, could attend. The Health Overview report concluded that ‘this strategy discussion was pivotal in terms of the robust multi-agency child protection activity that followed, including continuing section 47 inquiries, on-going criminal investigations, and application for Interim Care Orders (ICO) for both children. Arrangements were also made for S to have a child protection medical on the IOW’. However, there were no minutes or action plan created after this meeting. Everyone who attended took away their own version of what was said and what actions were agreed.
- 4.96 The meeting changed the access arrangement for the mother and father (S). A ‘Contract of Expectations’ was drawn up with the mother that father (S) would be denied access to baby T with immediate effect (the codes for the parents’ accommodation were changed after this episode) and that when baby T was moved from paediatric intensive care to a general medical ward, the mother’s own contact would become subject to supervision arrangements.
- 4.97 The actions of staff following the confirmation of the non-accidental injury up to the end of the timescale of this review, 4 days after the injury, were professional, thoughtful and compliant with procedures, aside from the issue of the minutes of the strategy meeting.

4.98 This professionalism is in contrast to much of the work that had preceded the event. This may be due to the fact that different staff members are involved. Or it may indicate that the Island's professional staff manage a situation better when they are sure of the situation that they are in. It could also be a combination of the two.

5. TERMS OF REFERENCE QUESTIONS

To what extent were professionals aware of relevant information held by other local agencies and by agencies in the mainland?

- 5.1 The following information was available to professionals during the timescale for this review, although that does not necessarily mean that professionals were aware of the information; if they were it appeared to have a minor impact on their decision-making. The information is summarised as follows:
- 5.2 The mother had longstanding social and mental health problems, with symptoms of an emotionally unstable personality and illegal drug use. She had had an abusive childhood, had spent time living on the streets, and had been abused as an adult. She had related a number of pregnancies and miscarriages, some of which were likely to be untrue. There had been at least two relationships, which contained serious domestic violence against her. She had displayed unstable behaviour
- 5.3 The father (S) had told professionals that social workers on the mainland had said he could not see S, and that he had very disturbing voices telling him to be extremely violent. He had been known to be very violent with the mother. He was said to have an emotional disorder, which made him lacking in remorse. He had been reported as saying that he wanted to burn down the house with the mother and S inside and had been cautioned for causing actual bodily harm to the mother while they were on the mainland.
- 5.4 Not all of this information was ever known to one agency or one professional although enough of it was available for them, had they read the background and made use of it in their assessments, to have realised that there were potential risks to S and baby T. For example in May 2012 Children's Services were made aware of baby T's hospitalisation and that father (S) was living with mother. Children's Services acknowledge that information about the potential risks posed by father (S) was on S's file. 'As this had not been read the issues were not highlighted'.
- 5.5 The Children's Centre IMR said it has been very difficult to establish who knew what, implying that the FSW, who was the lead CAF professional, was not aware of the extent of the information available to other professionals. The FSW wrote that the family had 'complex needs and family history' (something of an understatement in the light of what was known). She was also aware of previous domestic violence although this was noted on the CAF record more in a positive context in that the mother told the FSW she had moved away from a negative relationship for the benefit of S. Unfortunately, there was a failure to recognise that the very person whom the mother had 'moved away from' was again living with her.
- 5.6 The Health IMR author pointed out that despite the presence of large mainland records these 'appear not to have been considered in relation to the risk assessment of the changing situation for the family on their return to the Isle of Wight. This included a further pregnancy, the appropriateness of extended family support, the move to independent housing...the presence of various males within the family'.

- 5.7 Information was often fed through to the First Response Unit. A consultant social worker told the Children's Services IMR that the First Response office was usually very busy, sometimes to the point of being hectic and that there was insufficient time or capacity to go back through the records of every case that came in each day
- 5.8 If past information is not being read and used in the making of assessments then what is being used to inform decision-making, presumably only presenting information? The example of the 'aunt's' referral in early November 2011 is a suitable case in point.
- 5.9 The NHS IMR described the large file received from the mainland and that this contained both health and Children's Services information, but there was no clear reference to accessing this information, although health professionals do make reference to 'complex history' and 'domestic abuse'.
- 5.10 The GP would have had information about past family history, and it is regrettable that the GP and practice records feature so rarely in this Review. Although they are involved with the mother and the children they are never included in any discussion or collation of information.
- 5.11 One of the errors made by professionals was to focus upon the mother's needs, as is well documented in the NHS IMR where much of the care provided by health professionals came from maternity services. The Health Overview described the health visiting input as 'limited', which was said to be of concern as this is the key universal service for supporting the health and development needs of pre-school children. Caseload vacancies and staff shortages were said to explain this situation in part, and the Health Overview said there were some failings in targeting care to this vulnerable family. 'This may have arisen as a result of failing to take account of past history, but it also reflects the apparently limited collaborative working between midwifery, health visiting and general practice,'
- 5.12 The information sharing and use of past history in this case was poor; this may result from systemic problems. All the professionals to whom the author spoke told of a culture that feared complaints and challenge from families whose information was shared without their consent. This is further highlighted by the Health Overview report which said that 'Despite excellent national guidance, and local protocols, uncertainty about information sharing is not uncommon amongst health professionals.'

To what extent was information given by family members and others questioned, challenged or tested?

- 5.13 There are occasions when information from family members and neighbours was given to professionals but much of this was accepted at face value and opportunities to explore the issues in depth were rarely taken. Examples of where further questioning would have been appropriate were when:
- Throughout the period of this review S, and later baby T, were often not with the mother. Yet this pattern was unexplored even though S was described as having 'no stranger awareness'

- The information given by the 'aunt' regarding T-shirts and S fending for herself (already covered above) was not explored and then later disregarded.
- S was taken to hospital having drunk Nurofen.
- The mother went to hospital saying that a cot had fallen on her abdomen.
- The mother discharged herself from hospital three times against medical advice when she was pregnant with baby T
- No challenge was made to the mother following information from her mother to the smoking cessation midwife that an ex- boyfriend, (who was known as one who had abused the mother) was coming to stay with her.
- The FSW realised that there was a man living in the household but she failed to make enquiries about his background, he was EP
- The mother went to the mainland with EP after saying his departure made things better
- S attended A&E because of a small cut caused by glass
- The extent of domestic abuse was not discussed when the FSW completed the CAF form despite the fact that the mother said that S saw the perpetrator of the domestic abuse 2-3 times per week
- At that same meeting, the mother's assertions that S was 'happy, healthy and confident...has age appropriate behaviour,' was taken at face value and not checked with the early years' provision. Neither was a question asked regarding the mother's mental health nor the medication that helped her to 'manage well'
- The community midwife realised that there was a man living in the household but she failed to make enquiries about his background, he was father (S)
- Concerns of the ward staff (covered in the previous section in detail) were not followed up
- The FSW told Children's Services that the 'aunt' said, 6 weeks before baby T's injuries, that the mother was not coping very well and this was not explored in any depth

5.14 There were however some examples where the mother was questioned. Two simple examples were

- The issue of S being with a woman who had had her own child removed from her was questioned at the TAF meeting in April 2012
- In December 2011 the community midwife did directly ask the mother about her alcohol and cannabis use.

5.15 Drawing on a sub-sample of 47 cases for which more detailed information was available in their analysis, Brandon *et al* identified a continuum of co-operation between families and agencies. On the co-operation end of the continuum, families showed neutrality or a willingness to engage with agencies and seek help; at the other end of the continuum researchers found hostility, avoidance of contact, disguised or partial compliance, and ambivalent or selective co-operation (Brandon *et al*, 2008).

5.16 It is difficult to judge from the IMRs where the mother would be on this continuum. She was certainly never hostile and spent a lot of time with professionals, so does not appear to be avoiding contact with them. The analysis of events identifies occasions when the mother challenges any criticisms that are made of her, and she is certainly evasive on occasion. The mother also fabricates, sometimes lying about facts, for

example the paternity of the children, but more often perhaps confusing reality with fantasy. She often mentioned her pregnancies and miscarriages but, apart from the births of baby T and S, there are no medical records of any of these.

5.17 It is difficult to properly judge the mother's parenting of the children, and any time a professional observed her with her children the recording was positive. However there are many incidents of concerning behaviour away from professional gaze:

- Accidents
- Inconsistent descriptions
- Inappropriate feeding
- Continual absences away from the children
- Not knowing who S was with
- Discharges against medical advice whilst pregnant
- Continual demands made of health services

5.18 There are elements of this which echo the known symptomology and presentation of fabricated illness; the alleged blood in baby T's nappy, his alleged ingestion of Calpol, and S's earlier alleged ingestion of Nurofen, as well as the total of 23 visits to the GP in 26 weeks and a history including the mother's alleged miscarriages.

5.19 The mother is identified within this Review as exhibiting some evasive and disguised compliance behaviours. Professionals attempting to validate information offered by the mother struggled to establish factual information. This should be balanced with the fact that she in turn did not appear to be given very clear instructions from professionals. Plans, targets and tasks were process driven and placed a high emphasis on engaging with services. It is the author's experience, from training staff throughout England and Wales, that the setting of process driven objectives is a common limitation in child protection practice. It is even more inappropriate when dealing with people where disguised compliance may be a feature. The Children's Centre IMR put this well. 'It has been later discovered that the mother has been selective in what she told the FSW or purposely misled her. Staff at the Children's Centre appear to have been drawn in by the mother as she has been seen to have engaged well with the centre...She told the FSW that if she was disengaging from the support, then the FSW would know because she (the mother) would stop attending. This was perhaps, the mother's attempt to keep the FSW feeling she was fully engaging and to prevent the FSW from visiting her at home'.

5.20 The term 'disguised compliance' was first used by Reder, Duncan and Gray in their book *Beyond Blame* (1993), where it was used to describe situations where parents appeared to agree to plans and to co-operate with professionals, but in reality their commitment was superficial and designed to placate, obscure and disguise their lack of compliance.

5.21 Brandon and colleagues further explored the concept of disguised or partial parental compliance (2008, 2009). They found it often prevented or delayed understanding of the severity of harm to the child, leading to situations where professionals would tolerate longstanding lack of progress, all the while accepting excuses from parents and losing an objective view of what was happening.

- 5.22 Apparently good parental engagement can sometimes mask the risks of harm to the child. Active compliance can lead to a reduction of professional concerns and alertness and there is a risk that the needs of the parents come to overshadow those of the children. Apparent compliance can also disguise the way in which a parent shifts the focus away from allegations of harm, deflecting attention from their own actions to focus on the child as a problem, although this is not always supported by any evidence. Babies are particularly vulnerable in this scenario.
- 5.23 There are examples of the mother deflecting issues when she was challenged by professionals. She told the FSW that baby T's constipation (the hospital stay) had been caused by the GP prescribing 'the wrong milk'. She said that she was worried that she may be blamed for the constipation because she had given baby T the baby rice.
- 5.24 The issue about domestic abuse was discussed with the mother when the smoking cessation midwife talked with her about the risks of further domestic violence, saying that other professionals would have to be involved if there was a reoccurrence. The mother appeared to deflect from this conversation by 'complaining about abdominal tightenings', which resulted in a referral to the maternity unit, and one of the three self-discharges (whilst pregnant) against medical advice.
- 5.25 When not long before baby T's birth, the midwife raised concerns with the mother about her parenting this resulted in the mother having two further contacts with the midwife challenging her view and eventually describing S's over-familiar behaviour to the FSW as being '...very happy with all people – even people she has just met'.
- 5.26 The mother failed to attend a counselling session on saying that her mother was getting married which according to the 'aunt' was something that never happened nor was planned to happen.
- 5.27 The Children's Centre IMR author told the Review that when her untruths were known staff at the Centre were distressed as they had thought there was cooperation.
- 5.28 A professional and skilled worker would have taken an approach of 'respectful uncertainty', Laming (2003) which reflected the fact that, 'work with resistant, hostile, non-compliant (including disguised non-compliant) parents, and dealing with manipulation and deception is a significant feature of everyday child protection practice' Tuck (2013). This would have been a more effective approach to working with the mother
- 5.29 The Health Overview author wrote.... 'With some exception (e.g. the practice of the smoking cessation midwife) I agree with the conclusion of the maternity, health visiting and paediatric IMR author that 'overall there appeared a lack of inquisitiveness and robustness of information-seeking amongst the health professionals involved leading to assumptions being made based on information reported by the family but not challenged. This sums up the general practice of professionals in this Review.

How well were thresholds applied in this case?

5.30 The following descriptors are taken from the *Isle of Wight Thresholds for Interventions* document, introduced in August 2011. Only the factors that are relevant to S, baby T and the mother are listed.

5.31 There are more relevant factors listed under parenting capacity in the ‘in need’ column suggesting that the children should have been seen as Children in Need rather than at the common assessment level, although having said that it is true that this cannot be a clear cut or objective decision. The continual contacts that professionals and the ‘aunt’ were making should have alerted the First Response Unit to the fact that the common assessment level may have been too low for this family.

| Common assessment level | In need level |
|--|--|
| <p>Child development Parents / carers who have mental health / emotional / physical health difficulties Experiencing some difficulties with attachments Relationship with carers may be inconsistent or face disruption Some support from family network Has some difficulty with boundaries and limits</p> | <p>Child development Concerns re. hygiene / clothing Disrupted/disordered attachment with parents/carers No extended or safe family network</p> |
| <p>Parenting capacity Basic care not provided consistently Insufficient awareness of dangers to the Child / Young Person Parents engagement with services inconsistent Parent / carer has some difficulty consistently acting on parenting advice – may have learning difficulty Some difficulties with level of supervision / use of safety equipment Young inexperienced parent (s) with limited support May make some inappropriate childcare arrangements Parents / carers may be receiving assistance for mental health / substance misuse problems Some incidents of domestic abuse Starting to demonstrate difficulties with attachments Parents / carers own emotional</p> | <p>Parenting capacity Parents / carers struggle to provide good enough / safe parenting Limited engagement with services Parent has limited ability to act consistently on parenting advice. May have learning disability Level of supervision can be inadequate – limited use of safety equipment Repeated episodes of domestic abuse Level of supervision inadequate. No safety equipment in use Young inexperienced parents Using multiple carers, sometimes unaware of Child’s whereabouts Parent / carer involved in crime or in prison Difficulties in attachment with parent (s) Parent / carers own emotional needs starting to compromise those of</p> |

| | |
|---|---|
| needs detracting from their ability to parent Child has some positive relationship Child may have different carers | Child / Young Person Child / Young Person has multiple carers Erratic routines / lack of stability Parent lacks insight into how their own behaviour impacts on Child – Child seen as a problem No constructive leisure time or guided play Child affected by incidents of domestic abuse Disorganised / chaotic family life |
| Family and Environment Factors Poor home routines / frequent house moves Some extended family support Child may be witnessing some domestic incidents Family has a limited support network Low income | Family and environmental factors Family is socially isolated Parents / carers find it difficult to obtain employment due to poor basic skills |

5.32 The Children’s Services IMR author identified five opportunities, one outside the timescale for this review, where the First Response Unit could have intervened directly. These were:

| | |
|---------------|---|
| May 2011 | home visit requested by out of hours service |
| November 2011 | concerns raised by the ‘aunt’ |
| February 2012 | S left at nursery while the mother went to the mainland |
| May 2012 | concern expressed by hospital |
| May 2012 | the ‘aunt’ again stating that the mother cannot cope |

5.33 There were however three further opportunities:

| | |
|---------------|---|
| December 2011 | discussion between ConsSW1 and the named midwife for safeguarding regarding increasing concerns |
| March 2012 | discussion between named midwife and CAF2 |
| April 2012 | email to Children’s Services from the FSW regarding S being seen with a woman whose own children had been removed |

5.34 These last three were not included in the Children’s Services IMR because there were no records of these events in Children’s Services files, which means that there were eight contacts (with First Response Unit) between May 2011 and May 2012.

5.35 The Children’s Services IMR author suggested that an initial assessment should have been completed after the contact from the hospital in May 2012 because this was, as far as he was aware, the third contact received by the First Response Unit on this family in six months, (it was in fact the sixth in five months). That IMR said that, ‘the current

threshold document for levels of intervention states that (section 3.3) 'where there have been three or more contacts received about the same family in the course of 12 months, the relevant Consultant Social Worker in the First Response Unit should either commission an Initial Assessment, undertake a home visit and offer the family a CAF, or consult with his or her Group Manager and record why an assessment is not required.'

- 5.36 He went on to explain that ConsSW2 decided that this policy did not need to be followed as there was already a lead professional and a CAF system in place. This logic though appears to undermine the premise of the three contact rule. Indeed it could be argued that six contacts in a five month period is even more worrying if there is a lead professional in place because the CAF process, if working properly, should address the needs of the family and contain professional anxiety.
- 5.37 The Panel and overview author have been left with the view that at every opportunity the First Response Unit downgraded the case without considering the background information available, the pattern of contact or linking the recent information. This would be consistent with the phenomenon described by Marion Brandon as 'start again syndrome' evident in many serious case reviews, particularly cases relating to child neglect.
- 5.38 This continual downgrading of concern even manifested itself after the injury to baby T when it was decided that the meeting should not be a Strategy Meeting because there was a possibility that his condition may have been caused by an illness.
- 5.39 Understanding thresholds in child protection is not simple, decisions made are rarely objective. This section focuses upon the First Response Unit because they are a hub of decision-making, but it should not be ignored that allied to Children's Services reluctance to complete an initial assessment was the fact that no other professional felt able to insist that this should have happened. At one point a health professional and the FSW even decided that the CAF level itself was too high as they suggested that a pre-CAF had identified that a full CAF was not required.

In what ways did the CAF process work, or fail to work, effectively in this case?

- 5.40 There are many examples of the CAF system failing to work, not least of which is that the very fact that it was in place provided the First Response Unit with a reason to not intervene because the case was already subject to a CAF. This family should not have been dealt with at the common assessment level because of the background information available, the risks that the children were facing, the complex nature of the mother's personality, and the evasive behaviour and disguised compliance that the mother presented.
- 5.41 This is easier to see now that the information has been clearly set out. Information was not made available in this way to any professional at the time that they were working with the family. However with appropriate assessments and use of chronologies it could have been. The CAF process failed to work on a number of levels:
- Timescale
 - Co-ordination

- Planning
- Lead professional

Timescale

5.42 A CAF was first requested in mid-December 2011 by the named midwife for safeguarding. The first meeting for this to be completed, although now downgraded to a 'pre-CAF' was 7 weeks after request, and this pre-CAF was received by the named midwife for safeguarding 9 weeks after request. The pre-CAF was attached to a note from the FSW stating that, having completed the pre-CAF a full CAF was not necessary. The named midwife disagreed with this and again requested a full CAF now 10 weeks after the initial request, and this was completed on S 12 weeks after the initial request. Baby T's (then unborn) was completed 15 weeks after the initial request. The first team around the family meeting took place after 18 weeks, i.e. more than four months, after the initial CAF request.

Co-ordination

5.43 There was a failure to contact the GP and early years' provision regarding S, therefore everything that was said about S by the mother was taken at face value. The 2007 CAF Practitioner guidance recommends that when completing the CAF for young children the health visitor and GP involved with the family are consulted. This did not occur in this case and again meant there was no link made to the mainland information held by the health visitor or details of how well the mother's mental health issues were being addressed and progressed by the GP. This is despite the fact that the mother saw GPs (for herself, baby T and S) 23 times in the 26 week period between January and June 2012.

5.44 Mental health services had been in contact with the mother in 2011 (shortly before the core timescale of the Review) for agoraphobia and anxiety and they could have been contacted during the CAF process. The Health Overview author pointed out that The IOW LSCB is a signatory to a 4LSCB Joint Working Protocol about children and young people whose parents / carers have problems with: mental health, substance misuse, learning disability and emotional or psychological distress and said 'this would appear to be of relevance here'.

Planning

5.45 The plans set in the two CAFs were of a poor standard, process driven, not outcome focused and not appropriately measurable. For example: 'Share information multiagency' or 'to engage with the Children's Centre'. There is also no evidence of any monitoring arrangements for these objectives.

Lead professional

5.46 The FSW was the lead professional because she completed the CAF. She said that this was usual practice and there was no discussion about it--despite the fact that this was contrary to the policy then in place on the Island. The Children's Centre IMR is rightly

critical of the CAF practice at their Centre and those issues are being addressed internally.

- 5.47 The CAF process as followed by that Centre and health professionals failed the mother and her children and provided little benefit to them. It would have been better if the community midwife, and then health visitor, had been the lead professional. The mother needed someone to work with her who was confident in their role, experienced, able confidently to challenge her and able properly to record interactions.

To what degree were the children's needs recognised and were they included in any consideration of the needs of the family? Did the plans formulated address the concerns for the children and were the objectives clearly linked to meeting the children's needs?

- 5.48 Professionals were concerned about the care of the children: home conditions were questioned in terms of hygiene, clutter and smoking, additional health visiting was offered and a challenge was made to mother concerning the impact on S of having multiple carers
- 5.49 It is difficult to see how the actions benefited the children directly, particularly S. Most activity was geared towards the mother and her needs. The focus of the CAF intervention was for the mother to 'engage' with the Centre despite the fact one of the key implications of research is that professionals working with highly resistant families need to refocus their gaze towards the relationship between the parent and the child, rather than focusing too exclusively on the relationship between the parent and the professional, (Juffer et al 2007). The NICE guidance on child maltreatment recognises that it is all too easy for professionals to be drawn to the very real difficulties of the mother (and in this case, grandmother too): 'There is a danger that the parents/carers may become the primary client in an attempt to empower and support them while the risk to the child is accumulating.' (NICE: National Collaborating Centre for Women's and Children's Health, 2009:66)
- 5.50 S was rarely seen by the FSW, the lead professional for the CAF, nor were the early years centre involved in passing information onto the FSW about her. An aim identified from the CAF was to enable a safe consistent routine and environment for S, but this was translated into an action for the early years centre rather than there being any discussion with the mother about her responsibility to keep S safe- according to the Children's Centre IMR.
- 5.51 A simple action agreed at the first team around the family meeting in April 2012 was to agree a security question with the mother in the event that other people than those listed collect S from the early years provision. This had not been achieved by the second meeting and appeared to be still incomplete by the time baby T was injured.
- 5.52 At that first TAF meeting, the early years centre was tasked with working with S on stranger awareness. There is no record thereafter that the FSW checked how the task was progressing or whether there were any issues arising from that work. Later, the 'aunt' told the FSW that she was returning the children to the mother having looked

after them for the previous week. There is no record that the FSW discussed the suitability of this with the 'aunt' or asked whether the mother's circumstances had changed. This information was not shared with any other agency.

5.53 These two examples illustrate that the FSW was not suitably trained and equipped for the role of lead professional in such a complex case. They also illustrate that the very degree of monitoring and coordinating required by the case would suggest that a CAF was an inadequate response to the family's needs.

5.54 A review of 210 serious case reviews involving babies under the age of one year concluded that: 'There are repeated examples of ways in which the risks resulting from the parents' own needs were underestimated.... some reviews found that there had been too much emphasis on the mother's needs at the expense of a focus on the baby, either during the antenatal period or after the birth,' Ofsted, 2011 (page 9).

How well were issues of child attachment considered by professionals?

5.55 S's behaviour regarding cuddling and rushing to adults who she did not know allied with the knowledge that she was often looked after by other people, should have alerted professionals to the possibility that she had an attachment disorder. There appears to have been no consideration of this throughout the period that professionals worked with the family.

5.56 The Review agrees with the Health Overview which said there was an apparent difficulty in working with agreements for father (S) not to have access to S, or to be in the household, also indicates bonding and attachment difficulties, and this should have been more robustly explored. This pattern appeared to be repeating itself with baby T with mother being absent overnight when T was in hospital and that he had been cared for away from home the night before his collapse.

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

5.57 There appeared to be no consideration of these issues during any of the work with family. The Health Overview suggests that genograms should be used routinely. If one had been used it would have been simpler to have worked out who S and baby T's fathers were and provided further evidence that the mother was fabricating the truth when discussing paternity.

5.58 There is no reference in any health record to the ethnicity or religious identity of either parent. The child protection conference minutes do not record S's ethnicity and this section is left blank on the Children's Services initial assessment record contained within the health safeguarding record.

5.59 The Pre-CAF assessment tool does not have a section on race, religion or disability, although language is accurately described.

To what extent were the male partners of the children's mother and relevant men included in the work carried out by professionals?

- 5.60 There was very little consideration given to who the men were who appeared throughout the narrative or any consideration of the appropriateness of their contact with the children. Although there is one example of EP being seen helping around the house in January 2012 by the FSW and CMW2, and a judgment made on that basis that he was being helpful there appeared to have been no attempt to engage him in conversation or the assessment. There seemed to be a general reticence to challenge individuals of mother after an initial response, although challenge with difficult families is never easy
- 5.61 This lack of engagement with men is not unusual, but too often has been identified as a serious failing. The Peter Connolly SCR described a similar failure to identify, interview, and conduct background checks on significant males. (Peter Connolly SCR, para 4.1.13).
- 5.62 Scourfield (2001) noted that when professionals do intervene, they were less likely to engage with fathers or partners, who were usually the perpetrators of domestic abuse, than they were with mothers and children. In the absence of engaging with male perpetrators, professionals focus on mothers' failures to protect children, and mothers are consequently given responsibility for controlling and managing male violence.
- 5.63 Mental health professionals had contact with father (S) early in 2011 but unfortunately their assessment of him was not included in any collation of information.

How well were the records kept by the agencies?

- 5.64 The issue of accurate record keeping is a recurrent concern throughout this review and has been poor throughout most agencies. There are many examples of one agency having a record of communication, which is not reciprocated in the other. This includes sharing of information between the Children's Centre and health, the Children's Centre and Children's Services, and health and Children's Services.
- 5.65 Record keeping at the early years centre and the Children's Centre has been identified as poor and this is dealt with by their IMR authors in their recommendations.
- 5.66 When records are made they are jargonistic and non-specific, 'extensive history of domestic abuse' for example.
- 5.67 The health overview author identifies excellent record keeping by the GP on the Isle of Wight whilst at the same time acknowledging that there were concerns about the clarity of records from the GPs in the mainland.
- 5.68 Further failures in case recording would appear to be the lack of chronologies in both health and Children's Services and the lack of a single set of minutes from the strategy meeting in July 2012.

Mother's Views

5.69 The author met her when she was distressed to hear that this report, although anonymised, would be made public. She told the author that the health professionals gave her very different advice about baby T compared to when she had been a mother with S, that she never thought that father (S) could hurt baby T or S, although he had hurt the mother in the past. She said that doctors should never have prescribed the wrong milk for baby T and that she had wanted counselling but the Children's Centre that she attended, wouldn't organise it until she sorted it out herself. At the time the author met with her, both of her children were being looked after by the Local Authority and she was having regular contact with them. They were both subject to care proceedings at the time.

6. LESSONS IDENTIFIED

6.1 Serious case reviews often identify failings and lessons that have previously arisen in other reviews; this review is no exception with:

- inappropriate use of thresholds, inasmuch as thresholds appear to be being used to gate keep using a minimisation of concerns as justification
- over-reliance on less qualified staff playing the role of lead professional in CAF cases
- failure to collate and analyse information, including historical information and use of chronologies
- lack of management oversight
- unspecific recording that uses general terms
- focus on process rather than outcomes
- a failure to record actions
- failure to involve men, or to recognise the significance of male presence in the lives of women and children
- difficulties associated with working with disguised compliance

All of these were present in this review and similar to other reviews on the Island in the last five years which have found

- *'The need for more consistent recording*
- *Inadequate case file and record management*
- *Insufficient training and workforce development*
- *(A need for) changes to, or creation of additional policies*
- *(Better) procedures or compliance with procedures*
- *Improved communication and information sharing*
- *(An improvement of) agencies' internal quality assurance mechanisms*
- *The requirement for a more robust approach to early help or intervention and the application of CAF,' Review of recurrent themes in serious cases & partnership review activity Isle of Wight, 2008 -2012, (2012)*

6.2 This review makes criticism of the practice of some individuals but recognises that the systems in place both allowed poor practice to arise and continue without effective challenge, or by staff not being prepared for what they were asked to do. The practice needs to be considered in the context of workloads, available resources, supervision and training and guidance and oversight from senior managers.

Inappropriate use of thresholds

a) This report is particularly critical of the First Response Unit, their application of thresholds and over-reliance on addressing problems at the CAF level. The findings of this report mirror internal audits of that team carried out in January 2013, and the Ofsted inspection of local authority arrangements for the protection of children (Ofsted, 2013). The author was told, during his initial meeting at the First Response Unit, that 90% of cases are passed back to referrers. This would suggest at least one of two things: that the child protection threshold is too high, or that referrers don't know what should and should not be referred.

6.5 The setting of thresholds at too high a level, and the minimisation of concerns is not limited to the First Response team. In early 2012 when the FSW recommended that the situation did not warrant a CAF following her completion of a pre-CAF. The named midwife for safeguarding children did not agree. Similarly, the health visitor agreed with the CAF co-ordinator in June 2012 that there was no role for Children's Services because the mother was engaging with the services.

Over-reliance on less qualified staff playing the role of lead professional in CAF cases

6.6 Two problems relating to this theme were present in this Review. The first is that more complex families on the Isle of Wight are being managed at the CAF level. The second is the over-reliance on less qualified staff playing the role of lead professional anyway.

6.7 The decision to consider the mother's family to be appropriately managed at a CAF level might have been less significant if the lead professional had been a more confident and possibly more qualified professional, or if Children's Services had been more responsive to the concerns raised from the TAF. On the other hand, had S and baby T been considered to be 'Children in Need' then it is less likely that a Children's Centre worker would have been the lead professional.

6.8 The mother was not an easy person to work with. Marion Brandon et al; (2008, p70) identified the following about the mothers who appeared in the serious case reviews that she analyzed.

- There is often a history of emotional and/or physical neglect, with poor parenting from their own mother (the child's grandmother) and rarely any mention of the mother's father (the child's grandfather)
- The mother doesn't seek, or accept or receive effective treatment for ill health, in some cases illness is used by the mother as an escape. Mental ill health, depression, mood volatility, anxiety, anorexia, self-harm can all be present
- The mother has often spent time in care or looked after by relatives, who often have significant problems of their own
- There have been frequent and disruptive house moves or moves at key times, for example after a death, and the mother often leaves home in early adolescence
- There are concerns about sexual abuse and/or sexual exploitation, and evidence of early sexual relationships
- The mothers have had multiple pregnancies (4 -11) with many losses due to termination, miscarriage, adoption, a child or children being cared for by a relative or removed. The child's mother often appears traumatized during pregnancy or an early pregnancy is concealed
- There is a strong ambivalence to helping agencies
- Often the mothers have survived in spite of an appalling early history and without external support. Alcohol and drug misuse often follow later, but this is sometimes a predominant feature from an early stage

6.9 The mother in this case fitted many of these criteria, further evidence that the lead professional should have been more qualified and/or experienced.

Failure to collate and analyse information

6.10 Significant background information was available to staff but it was not read and properly taken account of in the assessments made of the mother. This criticism can be levelled at health and Children's Services professionals. Staff in the First Response Unit did not appear to take note of the incidents that had been referred to them after August 2011. The review of their 'no further action cases' said that 'ConsSWs did not routinely scrutinise the case history/chronology of the case and tended to adopt the practice of regarding each successive contacts as an isolated incident.'

Lack of management oversight

6.11 When interviewed staff members in the First Response Unit told the author that they would have welcomed more management oversight of their work. There was no evidence of oversight in this case. The Children's Services IMR said that part of the role of the Group Manager of First Response was to 'DIP' sample and quality assure the decision making on a regular basis and undertake regular audits, but no evidence was found that this had been taking place with any regularity or consistency.

6.12 The CAF forms and TAF plans that the FSW produced have been criticised in this report. The most appropriate professional to work with the mother would have been a competent, experienced and confident health visitor, midwife or social worker. It is in making a direct comparison of professionals at that level and the FSW's role as a Children's Centre worker that her practice is found to have been ill-prepared. It should be acknowledged that the FSW stuck with the mother, kept her promises, tried to challenge appropriately as required and performed competently compared to the expectations of her job description.

6.13 She was supervised and her work was overseen by a more experienced manager who either signed off poor quality work or did not look at it in the first place. The Children's Centre should also take responsibility for the poor quality of assessments and plans.

6.14 The IMRs make little reference to supervision and consequently this report is unable to make any detailed judgements. This very absence suggests that either supervision was in some agencies minimal and if, it was occurring, was not being adequately recorded. The absence of supervision records may also suggest a failure by management to audit processes to ensure that appropriate support and supervision was being provided for staff.

Unspecific recording that uses general terms

6.15 There are many examples throughout the review of non-specific terms; 'complex history,' 'mental health issues' 'history of domestic violence' being used in case records. These are written by professionals from all agencies. It may be the case that the worker has understood the detail that made up these terms but, if so, that information was not made available to any reader of the file.

6.16 The problem with this lack of clarity, abbreviation and jargon is that it fails to establish exactly what has happened or been said and leaves opportunity for misinterpretation as a result making it harder to produce specific plans, identify tasks and specify outcome focused practice.

Focus on process rather than outcomes

6.17 The emphasis placed upon the mother's apparent 'engagement' is a constant theme in this review both within the objectives set in plans and as a reason for reducing concern.

Failure to record actions

6.18 This appears to be a problem primarily for the First Response Unit where there are many instances of records being made in one agency which are not recorded on the children's file in the First Response Unit. Furthermore, there are occasions where emails are sent but not read and handwritten CAF documents are delivered but not found.

Failure to involve men

6.19 A key theme to the review was the failure of staff to find out who the men were in the mother's house, even though the same staff members knew that there was a history of domestic abuse from the mother's previous partners.

Difficulties associated with working with disguised compliance

6.20 This review has suggested that the mother was exhibiting disguised compliance and evasiveness. This may have arisen from one or a combination of factors: her fantasies, her emotional and mental health difficulties, or part of a planned deception. It would have been helpful had workers considered whether or not fabricated illness was an issue for the mother.

6.21 The report is therefore critical of the mother's parenting capacity. This description is necessary to convey how professionals, working themselves within a flawed system, should have been working with her more assertively. Had they have done so it is more likely that baby T and S would now be living safely with the mother.

How these themes co-exist

6.22 Any one of these themes in isolation could be problematical but it is their inter-relationship that makes the practice dangerous.

6.23 Asking less qualified staff to work with more families at the CAF level is not, in itself, a problem unless there is an inappropriate use of thresholds which means that less qualified and experienced staff will be expected to play the role of professionals working with more difficult families.

6.24 There is a danger that (less qualified) lead professionals in community based/universal services will encounter problems because information is not shared with them

automatically, so their judgements are inevitably based on partial information. Children's Centre staff were not included within information sharing protocols with health and Children's Services at this time. This is now being addressed within shared agency action plans.

- 6.25 The setting of specific and measurable objectives, rather than relying on 'engagement' as a sign of progress is vital; especially so when dealing with people who present disguised compliance.
- 6.26 Record keeping, using specific terms and reading background information are similarly important but doubly so when dealing with someone who is evasive and fabricates. Thorough, accurate recording and collation of the information given is necessary in order to obtain evidence of inconsistencies and fabrication.

7. WORKLOAD MANAGEMENT AND STAFF TRAINING

- 7.1 Events in this review should be considered alongside the demand on practitioners' time and the context of rising demands. I have been told that there were two consultant social workers in the 'hectic' First Response Unit at this time. There are now three.
- 7.2 All social work duty offices are busy and hectic. My conversation with a consultant social worker from the First Response team elicited the fact that there was 30 minutes available per enquiry to the office. This did not include time off for supervision and training.
- 7.3 Whilst 30 minutes would be too short an amount of time to properly examine the background information in this case I was aware of enquiries being made which were obvious signpost enquiries.
- 7.4 An Ofsted report in 2008 concluded that staff capacity and resources were not the main factors leading to serious injury or death (relative to, for example, poor communication across agencies, poor assessment practices and practitioners not recognising signs of maltreatment). The issue of resources is always relevant, but there were a range of professionals and resources involved with the mother and a proper co-ordination of these services would have been effective.
- 7.5 Staff who are required to complete CAFs appear to be offered a one day training course currently run by one of the CAF co-ordinators. This suggests that the less qualified staff, some of whom may have had no safeguarding training, are completing CAFs without necessarily having the requisite training in assessment, risk or any other child related topic, including child development which is pivotal to any assessment. The training does not appear to consider setting measurable objectives and understanding outcomes.

Recent changes to the structure of Children's Services

- 7.6 Practitioners do not work in isolation from the agencies that they represent. The change to *Reclaiming Social Work*⁴ and the creation of the consultant social worker posts in Children's Services have been mentioned to the author, as have management drives to reduce the number of child protection enquiries and increase the number of CAFs.
- 7.7 Hackney began the planning of *Reclaiming Social Work* in 2006 and had implemented it properly by 2011, winning an accolade from Professor Munro in her report in the process. The implementation period was not only lengthy but also involved considerable changes of personnel; indeed something like 33%-50% of the social work staff group at the beginning of the process were deemed to be not good enough for the model and were removed from their posts before the implementation date. Furthermore and equally importantly the model is not just a change of structure but also of culture and provision needs to be made for service transition.

⁴ Also known as 'the Hackney Model' because it is said to have transformed Hackney's Children's Services performance, is a structure using consultant social workers who manage a team who co-work cases.

- 7.8 Isle of Wight Children's Services appear to have introduced the restructuring to this model without the concomitant checking of social work competence, change in culture and necessary consultation with partner agencies through the auspices of the LSCB. The implementation of this model was introduced in January 2011 and implemented in July 2011. It was the third restructure of Children's Services in four years. Health professionals confirmed to the author in interview that partner agencies were not taken on the same journey as Children's Services staff and were informed of the changes once they were in force.
- 7.9 The Serious Case Review Panel and overview author were of the view that this reorganisation may have been hurried, ill thought through, and was responsible for some of the difficulties identified in this Review.
- 7.10 The critique of the implementation of Reclaiming Social Work in this report is not included to exonerate the poor practice of the social workers. It is designed to illustrate the fact that the problems are so deep seated and endemic that a poorly thought through, hurried implementation of new systems and structures will not address the root cause of the difficulties that the island faces in protecting its children from abuse and neglect.
- 7.11 The First Response Unit, Children's Service's 'front door' has amongst its staff a number of CAF co-ordinators. During the time of this review, owing to the demands made on the team, the co-ordinators played the role of duty social workers; something that has now ceased and they have returned to the role of co-ordinating and assessing the quality of CAFs.
- 7.12 Many Children's Services departments in England employ CAF co-ordinators in this role despite the fact that CAF is fundamentally a process to be used by non-social work staff. It was the view of the Panel and the overview author that the placement of CAF co-ordinators in the First Response team confuses the common assessment framework set for children with 'additional needs', with systems for 'children in need' and 'children in need of protection'. It is too easy for social workers in the team to allocate the case for a CAF when the co-ordinator is so familiar to them and sitting so close to them.
- 7.13 The Panel and overview author were of the opinion that S and baby T, during the timescale of this review, were children whose needs sat between the thresholds of 'in need' and 'in need of protection'. Panel members have further noticed that the consideration of them being 'in need' appears never to have occurred to any professional. This is in keeping with recent internal reviews of child welfare work on the Island.
- 7.14 Health professionals told the author in interview that children are often taken off a child protection plan and immediately stepped down to a CAF level with no consideration of whether the child is 'in need' and consequently no social worker involvement.
- 7.15 The lack of partner agency engagement in the introduction of the *reclaiming social work* model may indicate that there has not been enough thought given to the effect on

those agencies of a raising of thresholds. Any further change in Children's Services child protection thresholds will need to be carefully considered in light of the impact on provider and partner organisations.

- 7.16 As an example the Children's Centre, central to this review has been subject to a 27% cut in its budget from the Isle of Wight Children's Services. This has resulted in it being closed for one day per week, a reduction in staff overall and reduction in management time. Yet during the same period the number of children on child protection plans, CAFs and Initial Assessments, with whom they are working has risen.
- 7.17 It could be the case therefore that, at the same time that Children's Services was raising its threshold, it was reducing support for those very agencies responsible for working with more complex families.

Ofsted Inspection of Local Authority arrangements for the protection of children

7.18 The above inspection was conducted in November and December 2012 and published 15 January 2013 after the IMRs were written. The inspection started four months after the timeframe for this SCR. The overall conclusion of the inspection was that arrangements were inadequate. The findings of this SCR echo a number of findings from the Ofsted inspection, so many of the findings here will not be new or surprising. Below are extracts from the Ofsted inspection report, which did not inspect health services.

- First Response provides a single point of contact for professionals and members of the public who have concerns about a child or young person. Despite there being a clear and relevant threshold document it is not consistently being applied. The quality of contacts into First Response and decisions by them are often of poor quality leading to delays in providing services to those children in need of protection.....Professionals from other agencies reported experiencing delays and a lack of responsiveness from First Response when raising concerns about children.
- The voice and journey of the child is often given insufficient attention in assessments and some are too focused on the adults' needs with little analysis of risk to children. Consequently, case planning is frequently poor
- The quality assurance systems currently used are inadequate and have failed to identify and address major failings in child protection services identified in this inspection.
- The effectiveness of help and protection provided to children, young people and their families is inadequate. Despite a clearly outlined thresholds document the initial response to referrals is variable, lacks consistency of decision making and fails to correctly identify risk. As a consequence not all children are being correctly identified as at potential risk of harm, they are not always being protected and in too many cases their needs are not being responded to in an effective and purposeful way. There is concern amongst some professionals that cases which have had a CAF assessment and where risk has increased are not immediately accepted by Children's Services as meeting the threshold.

- Too many cases are kept at contact stage that should be escalated to a referral and initial assessment. This exposes some children and young people to unnecessary risk and inspectors found too many cases where there was not a timely and robust response to their need for protection.

7.20 The Council and the LSCB are pursuing an improvement programme following recommendations from the inspection.

8. CONCLUSION

- 8.1 Serious case reviews should consider whether the event that led to the review could have been predicted and prevented. In this case the Panel and the overview author have come to the conclusion that the injury that baby T received was both predictable and preventable.
- 8.2 There is considerable research that demonstrates that domestic abuse towards women is associated with poor outcomes for children, that babies under the age of one are particularly vulnerable and are especially vulnerable when they are with men who are not their father.
- 8.3 Father (S) told mental health workers that he fantasised about hurting small animals and people and had been denied contact with another one of his children. The mother said that he had abused her many times and she was aware that questions would be asked if professionals found out that he was having contact with her children. On occasions the mother tried to disguise the fact that he was back in her life. The mother had also described her own troubled history, which she said was caused by her relationship with her mother, yet she was relying predominately on family members to help her with the nurturing role of being a mother to her own children.
- 8.4 There was considerable contact between professionals and the mother and it was known that there were men in the house with her, including father (T).
- 8.5 It is difficult to believe, had professionals been aware of all this information, that they would have not considered baby T or S, to be at risk from significant harm. There had been eight contacts between family members and professionals with the First Response Unit and there was considerable background information available to health and Children's Services staff.
- 8.6 Had this information been read and considered alongside the events described in this review then it would be hard to imagine that professionals would not have been able to predict the risks that baby T and S were facing. Had professionals assessed the dangers correctly and taken appropriate action in ensuring that baby T was not left in the care of father (S) then the harm that has befallen him would have been prevented.
- 8.7 The 14 **RECOMMENDATIONS** are organised into 4 headings – Practice, Process, Management Oversight, and Organisational culture.

Practice

The LSCB to ensure that training and development addresses the following and these are then reflected in the quality of practice on the Island, as evidenced through audit and feedback:

1. The impact on children of the parenting that they experience, must be considered in relation to child development and attachment and an understanding of what is 'good enough', so that poor parenting does not become accepted as the 'norm'.

2. That all professionals understand and apply the 4LSCB information sharing guidance so that all relevant members of staff are confident in knowing the law and guidance on consent and are confident in explaining this to families.
3. That *disguised compliance* is recognised and challenged through clear and measurable outcomes being identified in all child plans, including CAF, and that action is taken when those outcomes are not being achieved in the agreed timescales to safeguard and promote the welfare of children
4. That members of staff record their work using specific descriptions of, for example, violence and abuse rather than rely on generalised terms, such as: domestic violence, sexual abuse, neglect etc.
5. That family trees and case chronologies are used on all cases to enable a full picture of children and their context to be understood
6. That chairs of strategy meetings and discussions compile notes and action plans at the meeting, distribute these as handwritten (if necessary) notes at the meeting and type up said notes and plans and distribute them electronically within one day of the meeting, and that strategy discussions are held in accordance with the 4LSCB procedures.
7. That where domestic violence is actual or suspected, the focus is on the removal of the perpetrator, rather than the children, wherever possible, in line with national good practice guidance

Process

The LSCB to ensure that:

8. Pressures for cases to be dealt with at the CAF level do not continue to result in a lack of social work services to children in need and that thresholds are properly understood across all agencies
9. The role of CAFs on the island is critically evaluated, particularly with regard to Quality and quality assurance mechanisms; Training; Ensuring that CAF Co-ordinators and those completing CAFs understand outcomes and measurements; Electronic transfer of completed CAFs; Involvement of a wide range of professionals in CAFs in accordance with present Island policy
10. Monitoring systems are developed to evaluate these changes and their impact on children

Management Oversight

The LSCB to:

11. Strengthen the role of the Quality and Assurance Sub-Committee to ensure that audits of practice and supervision are created and implemented and that their findings are acted upon.
12. Ensure that all member agencies have effective management and supervision practice in place to monitor and review the quality and effectiveness of safeguarding practice in their agencies, including the use of the professional disagreements/escalation policy

Organisational Culture –

The LSCB to ensure that:

13. The impact of changes to the systems and structures within Children’s Services – and other agencies - are understood by the Board and monitored to ensure that children who are referred for help are receiving an appropriate response and that effective challenge is made where this does not appear to be the case.
14. Lessons identified in this review to be amalgamated with the learning from the other reviews taking place on the Island and disseminated via multi agency workshops hosted by the Board.

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