

**HARINGEY LOCAL
SAFEGUARDING CHILDREN
BOARD**

**SERIOUS CASE REVIEW
'CHILD A'**

March 2009

**Published by the Department for Education
on 26 October 2010**

Second Serious Case Review Overview Report relating to Peter Connelly

This document contains the redacted second Serious Case Review overview report relating to Peter Connelly. This overview report was written by an independent author commissioned by Haringey Local Safeguarding Children Board. It was published on 26 October by the Department for Education. The only editing undertaken by the Department prior to publication by the Department is the redaction of information that it is not appropriate to put into the public domain.

The process of redacting the overview report has involved:

- considering the welfare of children involved in the case;
- comparing the executive summary already in the public domain, with the corresponding overview report; no information that is included in either of the executive summaries has been redacted;
- considering the extent to which information in the overview reports is capable of being used to identify living individuals whose identity is not already common knowledge;
- considering whether information that is by its nature sensitive personal data under the Data Protection Act 1998 (for example, because it is information about a person's physical or mental health or condition, his / her sexual life, or the commission or alleged commission by him / her of an offence) is likely to have already been made public (for example, as part of the criminal trials) and whether its inclusion in the reports is necessary to give a complete picture of events;
- redacting personal data or information which would breach reporting restrictions imposed by the Court; and
- redacting any personal or sensitive personal data, including clinically confidential information, that has not already been published and which cannot be justified as necessary or relevant, bearing in mind the overall purpose of publishing the overview reports.



SERIOUS CASE REVIEW: CHILD A

Date of Birth: 1st March 2006

Date of Death: 3rd August 2007

Overview Report Writer: Alan Jones

1ST MARCH 2009

This overview report was written by an independent author commissioned by Haringey Local Safeguarding Children Board. It was published on 26 October by the Department for Education. The only editing undertaken by the Department prior to publication by the Department is the redaction of information that it is not appropriate to put into the public domain. An explanation of the redactions is set out on the previous page.

1 INTRODUCTION

1.1 RATIONALE FOR SERIOUS CASE REVIEW (SCR)

- 1.1.1 Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires Local Safeguarding Children Boards (LSCBs) to undertake reviews of serious cases in accordance with procedures set out in chapter 8 of *Working Together to Safeguard Children* (2006).
- 1.1.2 When a child dies, and abuse or neglect is known or suspected to be a factor in the death, the LSCB should conduct a Serious Case Review (SCR) into the involvement that organisations and professionals had with that child and their family.
- 1.1.3 The purpose of an SCR is to:
- 'Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
 - Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result and
 - As a consequence, improve inter-agency working and better safeguard and promote the welfare of children' (*Working Together to Safeguard Children 2006, Chapter 8 8.3*)
- 1.1.4 When a child dies non – accidentally who is subject to a child protection plan and the process of review, it raises the question of whether any failings that may be identified are systemic: i.e. are they typical of the way that other cases, which are not associated with a child's death, may have been dealt with? Equally, a child's non-accidental death may be a tragic event but may not signify any incompetence in the system: it may be the result of an unfortunate but competent error, and if so practitioners should be defended. A child's death may be the result of something that could not have been known about. The findings of the review may have lessons which have widespread application within the safeguarding and child protection systems.
- 1.1.5 It is important for a serious case review to understand the difference between foresight and hindsight in reaching any judgements and learning any lessons. It is difficult to apply the discipline of hindsight only when the consequence of a tragic event is already known. The staff involved at the time could only act with foresight. However, any lessons can be learned with the benefit of hindsight but they should be applied with the understanding that subsequent staff will also only be able to work with foresight. This is particularly apposite for practitioners in Haringey, for whom this is the second review into the

death of Child A. It is being conducted in the wake of a criminal trial and unprecedented media coverage and popular reaction. It is probably best to treat the review as if it was addressing any case which presented itself in a similar way, and in any other authority.

- 1.1.6 Judgement about the performance of any individuals is not the remit of an SCR. Its purpose is to learn any lessons, to seek effective solutions and to apply them rigorously; to change the structure and culture of agencies where this is necessary.
- 1.1.7 The objective of the Individual Management Reviews (IMRs) that form the basis for the SCR, is to give as accurate an account of what originally transpired in an agency's response to the child and their family, to evaluate it fairly, and if necessary to identify any improvements for future practice. IMRs should also propose specific solutions which are likely to provide a more effective response to a similar situation in the future.
- 1.1.8 This report is based on IMRs commissioned from professionals in the main independent from their commissioning agency. The report author is required to indicate whether he has confidence in the findings of an IMR. He judged them all to be comprehensive, thorough and to have reached appropriate conclusions.
- 1.1.9 The report's conclusions represent the collective view of the Serious Case Review Panel, which has the responsibility, through its representative agencies, for fully implementing the recommendations that arise from the review. The author has considerable respect for the competence of the panel. There has been full and frank discussion of all the significant issues arising from the review.
- 1.1.10 Where the author differs from the panel view this is indicated and the reasons are provided. The author accepts sole responsibility for the quality of the report, and for his conclusions, where they may be different to those of the panel.

1.2 CIRCUMSTANCES OF CHILD A'S DEATH

- 1.2.1 On 3rd August 2007 at approximately 11.30am Ms A called the London Ambulance Service (LAS) to her home address. The attending paramedics took the apparently lifeless body of child A (aged 17 months) to the North Middlesex University Hospital (NMUH).
- 1.2.2 Ms A is the mother of child A, a white male child.
- 1.2.3 In spite of efforts by Ambulance and hospital staff to revive him, child A was pronounced dead at 12.10pm. On initial examination, he was

seen to have bruising to his body, a tooth missing, a torn frenum and marks to his head.

- 1.2.4 The Police Individual Management Review (IMR) referred to a post mortem completed on 6th August 2007 which revealed further injuries (a tooth was found in child A's colon and eight fractured ribs on the left side and a fractured spine were detected). The provisional cause of death was described as a fracture / dislocation of the thoraco-lumbar spine.
- 1.2.5 Police enquiries established that at the time of child A's death, Ms A's boyfriend Mr H lived at her address; Mr H's brother, Mr L, his fifteen year old girlfriend F and his [REDACTED] children had been staying there since 17th July 2007.
- 1.2.6 Ms A, Mr H and Mr L all faced criminal charges. Following a trial that concluded in November 2008, all three were acquitted of murder but Ms A pleaded guilty to causing or allowing the death of a child. Mr H and Mr L were convicted of the same offence. Decisions regarding the date for sentencing will be made in the Central Criminal Court in April 2009.

1.3 STATUS OF THIS REPORT

- 1.3.1 Haringey LSCB initiated this SCR in response to the direction of the Secretary of State: Department of Children, Schools & Families, in December 2008. A previous SCR on the case had concluded in final draft in July 2008. The Executive Summary of this SCR was published immediately following the conclusion of criminal proceedings in November 2008. The Ofsted evaluation found it to be 'inadequate'.
- 1.3.2 A new, independent Chair was appointed to the LSCB in December 2008. He convened a new Serious Case Review Panel, membership of which was almost completely changed and at a higher level of seniority than that of the previous SCR. Final terms of reference were agreed by the Panel on 6th January 2009 and the scope of the review widened to include the period when Ms A was pregnant with her first child.
- 1.3.3 Each agency represented on the SCR Panel commissioned independent writers to draft IMRs. Mr Alan Jones, an independent consultant and ex-Assistant Chief Inspector of the Social Services Inspectorate, was commissioned by the Panel to collate the IMRs into an Overview Report.
- 1.3.4 The Panel met seven times between 11th December 2008 and 25th February 2009 and agreed the draft overview report and executive summary. Alan Jones met the IMR writers separately on one

occasion. Haringey LSCB agreed both reports on 27th February 2009.

- 1.3.5 The Executive Summary will be made public and the recommendations will be acted upon by all agencies, in order to ensure that the lessons of the review are learned.
- 1.3.6 Following acceptance of this report by Haringey's LSCB, a confidential 'briefing note' encapsulating key messages and agreed recommendations will be circulated to relevant managers in each of the agencies that contributed to this SCR.

1.4 INVOLVEMENT OF LOCAL AGENCIES

- 1.4.1 At the time of his death, child A (then aged seventeen months), child ■ (aged ■) and child ■ (aged ■) were subjects of child protection plans:
 - Child A's name had been on Haringey's 'child protection register' under the category of physical abuse and neglect since 22nd December 2006
 - Child ■'s name had also been on the register since 22nd December, under the category of neglect
 - Child ■'s name had been on the register since 16th March 2007, under the category of physical abuse
- 1.4.2 During the period covered by this SCR, the following agencies were involved with child A and/or his family:
 - Haringey's Children & Young People's Service (CYPS) (conducting S. 47 enquiries, undertaking joint investigation with the police, and subsequently acting as the lead agency in the core group for implementing agreed child protection plans)
 - Haringey's Teaching Primary Care Trust (HtPCT) (providing health visiting, general practice, primary care mental health and school nursing services and supporting the child protection plans)
 - Whittington Hospital NHS Trust (providing A&E, out patient, day patient and in patient care and diagnostics including pathology and radiology)
 - North Middlesex University Hospital (NMUH) (offering A&E, ante and post-natal care)
 - Great Ormond Street Hospital (GOSH) providing on behalf of HtPCT paediatric medical services for Haringey including the designated and named doctors for child protection and the paediatric A& E and inpatient service at NMUH
 - Metropolitan Police Service (MPS) (working with and alongside the CYPS to jointly investigate reported injuries to child A, and where

necessary recommending prosecution for a criminal offence to the Crown Prosecution Service.)

- The Epic Trust and Family Welfare Association (FWA) (via the HARTS service offering specific tenancy and family support using an Individual Support Plan)
- Two of Haringey's schools (providing educational services for child A's older ())
- Haringey's Legal Services (providing legal advice to CYPS)
- Haringey's Strategic & Community Housing (organising provision of long term temporary Housing Association accommodation for the family)

1.5 INVOLVEMENT OF FAMILY

1.5.1 Child A's mother, father, maternal grandmother and a family friend, Ms L, were given a written invitation to contribute to the review. Mr A took up the opportunity. No response was received from the others. Mr A was interviewed by the report author and the administrator took a note, which Mr A approved as accurate.

1.5.2 In reporting the views of individuals who received services, the Review Panel is not endorsing those views as accurate or as a fair assessment of the services they were given. They are the subjective views of the service user and should be considered with respect, in that they may offer lessons for the services involved.

1.5.3 The following extracts from Mr A's interview are set down below:

1.5.4 *"From day 1, that is in December 2006, Social Services always took the mother's point of view – so much so that I wasn't allowed to take (Child A) and I was never assessed as a viable carer at this point. There was one visit from (SW2) to my flat; I mentioned about (Mr H) being around the house. Nothing I said was taken on board by either of the social workers. (Child A) was placed with (Ms A)'s best friend – I'm pretty sure this was against protocol. I would have taken time off work then.*

When (Ms A) moved house she didn't allow me access – she was pushing me out of the picture, but also the social workers were pushing me out of the picture – that's how it felt.

I can't remember if I was invited to the Child Protection Conference in December – I did go to a couple of core group meetings and I was at the meeting the Monday before (Child A) died. I felt sidelined – an extra in the play. Even after (Child A) died I was asked what my contact with the children was – every night I had a nightly phone call but these were cut when the children first went into care. This was (STM2) – who later contacted me to say things had changed, after (Ms A) was arrested.

I mentioned (Mr H) being around the house – I'm pretty sure this should be in (SW2)'s notes.

What was your early experience of agencies?

I had no involvement. With Housing my first property was totally inadequate – (Ms A) was pregnant. The Health Visitor pushed Housing into getting H..... Road. This was the first time I've ever had any involvement with agencies, even growing up.

When we were together, me and (Ms A), I was fine with the care of the children – there were no adverse reports from schools or medical teams.

Even when (Child ■) and (Child ■) were put on the Register, no social worker approached me with this – it was only because (Ms A) told me that I knew. (Ms A) had been brought up under a culture of social services – she probably knew how to deceive them. In this respect it's important for social workers to inform the other parent.

Where children are on the Register the emphasis may need to change to protecting them rather than keeping the family together. It may have been better if (Child A) and my other children were taken into care. I don't believe the interests of the child were heard in this case."

1.6 MEMBERSHIP OF SERIOUS CASE REVIEW PANEL

1.6.1 The membership of the SCR Panel was determined as follows:

- Graham Badman (Independent LSCB Chair)
- Eleanor Brazil: Interim Deputy Director Children & Families (CYPS)
- Jan Doust: Head of Children's Networks (CYPS)
- Caroline Bates: Detective Superintendent Metropolitan Police SCD5
- Dave Grant: Borough Commander, Metropolitan Police
- Dr. David Elliman: Consultant Paediatrician / Designated Doctor for Child Protection Haringey PCT & Great Ormond Street Hospital
- Penny Thompson: Deputy Chief Executive Haringey tPCT
- Judith Ellis: Director of Nursing GOSH
- Deborah Wheeler, Director of Nursing, Whittington Hospital
- Julie Halliday, Director of Nursing, North Middlesex University Hospital
- John Suddaby, Head of Legal Services Haringey Council
- Denise Gandy, Head of Housing Support & Options
- Howard Jones, Director of Services, Family Welfare Association (renamed Family Action in September 2008)
- Sarah Peel: LSCB Training & Development Officer (CYPS)

Author's acknowledgement

The review was led by Graham Badman, the recently appointed independent Chair of Haringey LSCB, who also chaired the Panel meetings. The author is indebted to the support and guidance he received from Graham Badman, and also the very considerable professional and administrative support which was provided by Sarah Peel (LSCB Training & Development Officer), the administrator to the review process.

2 THE CONTEXT

2.1 In order to fully understand and do justice to professional actions in safeguarding and protecting children we need to see them in the fullest social, economic and knowledge contexts in which they take place.

2.2 To understand an individual professional's actions in social and health care three influences should be taken into account. Each aspect influences the other level, although they have relative freedom from each other:

- **Structure:** including government policy, the law, departmental policy, resources, governance, organisational structures, programme, operational guidance, and senior management.
- **Culture:** including professional training, departmental training, line management, staff supervision, operational guidance, custom and practice, interagency training.
- **Biography:** reflecting the individual's attitudes and values, personal circumstances, personality, experience, and their performance in the job.

2.3 It is important for senior managers to understand the inter-relationship of these aspects if they are to understand the performance of their staff in the agency.

2.4 There is a wider context within which the agency operates. At its widest point, we have the socio-economic context. Within this is the political, or policy context and the immediate context for practice of safeguarding and child protection responsibilities.

2.5 Socio-economic context

2.5.1 When the social worker sets out to intervene with a family where safeguarding the children is a concern they are hopefully experiencing the support of their agency and that of other agencies, including the police. They are doing so, however, in a wider societal context which will have its own influence on them.

2.5.2 A UNICEF report in 2007 claimed that children growing up in the UK suffer greater deprivation and have worse relationships with their parents than those of any other wealthy country in the world. The

Children's Commissioner acknowledged that the report accurately highlighted the troubled lives of children: "We must not continue to ignore the impact of our attitudes towards children and young people and the effect it has on their wellbeing." The research team assessed the treatment of children in six different areas including their material wellbeing, their health and safety and behaviours and risks. Although the data is not current, it does give an important context to the work of staff in child protection. (*UNICEF: The State of the World's Children 2007*)

- 2.5.3 A well-researched article in the *Lancet* in 2009 reported that child maltreatment remains a major public health and social welfare problem in high income countries. One in 20 children is physically abused and one in 10 is neglected or psychologically abused. However, official rates for substantiated child maltreatment and the consequent harm that it does to the future development of children, are much lower. The report claims that neglect is at least as damaging as physical or sexual abuse but is given less public attention. A substantial minority of children are maltreated by their caregivers and for many children it is a chronic condition. It has long lasting effects on the mental health from childhood to adulthood. (*The Lancet vol 373, January 2009*).
- 2.5.4 One measure of the priority given to children's welfare in any society is the resources which it is able to deploy to support them. The last 40 years have seen huge increases in the resources deployed to support and protect children which have redefined for the better the way in which we view the meaning of their welfare. Many current government programmes are aimed to improve matters further. However many resources there are, the social worker is always faced with discerning the priority case from among the many which are in need but will have to manage with a lesser service or not at all.
- 2.5.5 The government's biennial reviews of serious case reviews into the non-accidental deaths of children make it clear that they occur in every authority. They occur more frequently in larger authorities and in those with the poorest socio-economic conditions. This is not necessarily because the families are poor but because they are harder to identify among the families experiencing equally difficult conditions but who do not deliberately harm their children. More than half of them take place in the care of universal services without referral to the child protection system. The most vulnerable are young children who live in families where substance misuse and domestic abuse is a feature, and in families where parents are uncooperative with the services which are trying to help them. A small but significant number of child deaths take place in families in which an unrelated man has recently joined the household.

2.6 Policy Context

- 2.6.1 The Children Act 2004 and associated government guidance, introduced following the Public Inquiry into the death of Victoria Climbié, created two new governing bodies in every local authority area:
- Children & Young People's Strategic Partnerships, or Trusts, with the responsibility to develop early intervention in the lives of children and families. They are to do this through local delivery by multi-disciplinary teams of professionals, using the Common Assessment Framework and an identified Lead Professional. Eventually the introduction of Contact Point will enable professionals to know which agencies are involved with every child. Local authorities vary in the progress they have made in introducing these new arrangements. The Partnership agencies with a responsibility to deliver services to children and families have had a duty since May 2005 to fully implement S11 of the Children Act 2004, which requires them to transform themselves into safeguarding agencies.
 - Local Safeguarding Children Boards were introduced from April 2006 with a two fold duty:
 - To safeguard: to protect children from the risk of significant harm. All authorities were required to ensure that their child protection systems were sound before embarking on their wider safeguarding responsibilities; and
 - To promote the welfare of children: to ensure that children grow up in circumstances which enable them to make a successful transition to adulthood.
- 2.6.2 The LSCB has the primary responsibility to monitor the effectiveness of the delivery of Partnership services to safeguard and promote the welfare of children. Part of the task of the LSCB is to advise the Partnership on their safeguarding responsibilities; to evaluate local policies, procedures and practice - including through the use of the Serious Case Review; and to ensure that all agencies comply with their statutory duties under S.11 Children Act 2004.
- 2.6.3 The main government guidance for safeguarding and protecting children is *Working Together to Safeguard Children*. When it was revised in 2006, every local authority was required to update their local procedure in the light of any revisions made. It recognises that there is a spectrum of risk to children and that in some instances children will need to be removed from the care of their parents, even permanently.
- 2.6.4 There is an emphasis, which in the view of this author is more pronounced in other government guidance, on the need to support families, respect parental choice and work in partnership. All of these principles are valuable, but when unqualified, do not sufficiently recognise that there are many parents who find it difficult use support, fewer who are antisocial and very uncooperative, and a small minority

who are intimidating to staff and dangerous to their children. The lack of balance in the guidance can create an ethos in which staff feel that they are required to work with parents' wishes, instead of challenging and if necessary confronting their parenting behaviour.

2.7 Safeguarding and Child Protection practice

2.7.1 There are four balances to be struck by practitioners in carrying out their safeguarding and child protection duties. Each of the balances has a threshold which indicates when the balances may be being lost:

1. Societal: the right to family privacy versus intrusion because of a child's needs. The threshold is the voluntary offer of additional services which the parents are entitled to refuse.
2. Voluntary family support versus safeguarding children – the threshold is lower than vulnerability – it includes the signs of complexity and acute need, including the risk of harm, which may flag the need for child protection enquiries. It is important that when parents are assessed for services that practitioners look to see whether there may be more to be concerned about beneath the presenting need.
3. Being subject to a child protection plan versus not being subject to a child protection plan - the only balance for which we currently have government indicators that the threshold may not be effectively met. The indicator is those children for whom there has been the need for a further child protection plan within 12 months. These cases are frequently the focus of enquiry and analysis to find out if the balance struck was generally sound. The threshold is the level of harm or the risk of further significant harm – and the motivation and capacity of the parents/carers to care for and protect their child.
4. Removing a child from the care of their parents through taking care proceedings versus providing support and protection while the child remains in the family home. We need to ensure that we do not attempt to take into care children who do not need it, and that we return children to parents who can care for them adequately. The threshold is the level of harm to the child, the child's best interests, the motivation and capacity of the parents and the length of time it is likely to take to improve the quality of parental care, which will reflect the suffering the child will continue to experience.

2.7.2 At the interface between universal services for children, particularly health services and schools, and specialist services for protecting children, there is a negotiation to be agreed over responsibility for the management of the safeguarding concern about a child. It is commonly

called the 'threshold'. The management responsible for the respective groups of services need to agree in theory and practice which cases must be properly contained by universal services, which ones should be consulted about, and which need to be referred to specialist services. If this is not done, children will either risk falling through the net of protection or specialist services will be overwhelmed by the sheer numbers referred to them by over-anxious staff in universal services.

- 2.7.3 There is sometimes confusion about what is meant by intervention in safeguarding and child protection. Procedures should place the practitioner in the right place at the right time to respond on behalf of their agency; Practice is the authority, understanding, knowledge and skills which the practitioner needs to bring to bear on the situation. It is necessary and important to follow the agency's procedures but it is responding with the appropriate practice that is also crucial.
- 2.7.4 In any kind of work that involves something as complex as working with people, mistakes will sometimes be made. Such mistakes are tragic and deeply regrettable when they result in emotional or physical harm to a child. Nevertheless, it has to be recognised that on occasions agencies act in good faith when in possession of incomplete information and with limited over the situation. In safeguarding children we should do as much we can to minimise mistakes because of the consequences for the child. However, we have to make decisions and to take actions. To be defensible, decisions have to be understandable and based upon the best information available at the time, even if they are mistaken. The competent action which is one that:
- takes full account of all the available facts; and
 - follows standard practice for the situation which is faced.
- 2.7.5 In the field of safeguarding and child protection practitioners rarely observe the abusive incident taking place. They work with uncertainty and often have to work with facts that do not meet the threshold of evidence. They must do without that level of certainty and still act to protect the child. They also need to bear in mind that the responses parents/carers make to their inquiries may be self serving: minimising, misleading, evasive and even untruthful. While bringing a generally positive attitude to a family, practitioners need to start with a healthy scepticism and a mode of relationship which is primarily observing and assessing of the motivation and capacity to parent. Where there are indications of possible maltreatment, the practitioner needs to be questioning and even sceptical of the account that is given.
- 2.7.6 If they are not to trap themselves into inaction practitioners must be prepared to work only with 'reasonable inference'. Reasonable inference is when we:
- follow and take full account of the facts;
 - make a proportional response to them - without prejudice to the service user; and,

- keep in focus that the paramount concern is the welfare of the child

2.7.7 We have learned from hard experience and from a series of government sponsored reviews of serious case reviews that there are a small minority of anti-social, even dangerous, parents/carers who do not readily cooperate with services that are trying to help them improve their parenting of their children. These are people who have probably experienced damaging childhoods. They may have no strong sense of right and wrong and they may readily put their own needs before those of their children. They may behave recklessly with their children's welfare. They are not always easy to identify. They can be very plausible, very manipulative and superficially compliant, and it is very challenging for busy and hard-pressed practitioners to pick them out from among parents who are not functioning well but who have a capacity for concern.

2.7.8 There is demonstrable danger in the man that preys on vulnerable women, who are unable or unwilling to protect their children from him. One of the most dangerous of these situations is where an anti-social man who is unrelated to the children joins the household. The woman may not be able to stand up for her children and protect them because he is too frightening or she may turn a blind eye to what is going on because she has a greater need of him than she has a concern for her children. She may minimise his importance and involvement to others. It is essential that once there is awareness of the existence of any unknown man in a child protection investigation, professionals in authority insist on knowing his identity and check out his background thoroughly.

2.8 The Haringey context

2.8.1 Haringey is an ethnically diverse outer – London borough situated to the north of central London. Of its registered population of 224,000 people, nearly half come from minority ethnic backgrounds and around one quarter are under the age of 20. The population has high turnover and includes a significant number of refugees and asylum seekers. Over 160 languages are spoken by children and young people in the borough. Long term unemployment is a serious issue for the borough; in October 2005, 7.8% of Haringey residents were claiming the job seeker's allowance, compared to 4.6% in London as a whole and 3.2% nationally. It is estimated that 31% of household are living in unsuitable accommodation.

2.8.2 The report following the JAR inspection of November 2009 states that there are 55,600 children and young people under the age of 20 living in the borough. Of these, 204 are on child protection plans, 723 are young carers 335 are unaccompanied asylum seekers, of whom 87 are in the care of the council. 377 children and young people are registered with the youth offending service, and 484 children and young people

are looked after by the council, 61% of whom are placed outside of Haringey's borders and 23% of whom are in placements that are in placements more than 20 miles away.

- 2.8.3 The Haringey Children and Young People's Partnership Board was established in 2004. It includes the Metropolitan Police, the Haringey Primary Care Trust (PCT), the community and voluntary sectors, the North London Learning and Skills Council (LSC) Connections and the College of North East London (CONEL). The Children and Young People's Plan 'Changing Lives' was published in April 2006, building on a comprehensive needs analysis document 'Knowing our children and Young People – planning for their futures'. Haringey is in the process of setting up three area based children's networks which will bring together a range of agencies working with children and young people to deliver better outcomes. Haringey Local Safeguarding Children Board was established in 2005.
- 2.8.4 Primary care for children in Haringey is provided by the Haringey Primary Care Trust (HtPCT). HtPCT was responsible for GP and Children's Community Services at the time of Child A's death, with Great Ormond Street Hospital providing Community Paediatric Services. Since April, GOSH has provided Community and Paediatric Services, commissioned by the PCT, now known as NHS Haringey. Historically the children's services had been under – resourced for a long time. Following a Health Equality Audit a number of health visitor posts were moved from the west part of Haringey, and a system of coloured folders for targeted children was set up. The health visiting service was under pressure in 2006/07 because, although most vacancies had been filled, there was 8% sickness absence. The system was changed to team caseloads with individual allocations of blue and red folders, and individual caseloads averaged 607 families in 2007. The standard for seeing families was 4 weeks unless more frequent contact with children on the register was agreed in the child protection plan.
- 2.8.5 There was a reorganisation of Haringey's Children and Young People's Service's Children's Teams in December 2006. Its overall aim was to move towards specialist teams. The new structure was accepted, but not necessarily universally by staff by January 2007, as evidenced in the testimony of some social workers. The reorganisation involved the transfer of cases between teams. It did not appear to have an adverse impact on the child A case although the staff felt that the practical aspects of the changes were not handled well. Social workers considered that the amount of administrative support to them had decreased over the years, and the introduction of the new case recording system, Framework I, had been responsible for many new administrative tasks. The caseload of the social worker responsible for leading on the child protection plan for child A had almost doubled from January 2007 to July 2007 and was 50% above the caseload recommended by Lord Laming in the Report of the Public Inquiry into

the death of Victoria Climbié. The social worker described her caseload as made up of various ‘types of case and categories of registration’ and that ‘it was a lot of work’ and that she ‘never had time to do everything.’ Both social workers were regarded as well qualified to be the allocated social workers on a case like that of child A. Their social work knowledge, skills and experience were thought to be matched to the complexity of the case.

- 2.8.6 There has been some examination of the resources available to the service at the time and consideration of both the budget available and the budget pressures informs a recommendation.

3 THE FACTS, FINDINGS, AND CONCLUSIONS

- 3.1 In order to manage an account of agencies’ involvement with child A and his family, the author has divided the period into six phases. The separate involvement of each agency and the inter-agency involvement with the family is summarised and then analysed.

3.2 First period: early background 1981 – [REDACTED] 1999

- 3.2.1 Ms A was born in Leicester in 1981, where she lived until 1984, when her mother and step-father separated. Their relationship was reported to be violent and both she and her brother witnessed domestic violence. Her brother stayed with his father in Leicester while Ms A came to live in London with her mother Mrs AA. Ms A understood her stepfather to be her real father throughout her childhood.

- 3.2.2 Her step-father died unexpectedly in March 1988, and her brother joined his mother and sister. He had difficulties settling, with ‘challenging’ behaviour. He was reported to be violent at school, and towards his sister at home. He truanted and started offending.

- 3.2.3 In May 1990 her brother was placed on the London Borough of Islington’s child protection register for physical abuse, [REDACTED]

[REDACTED] . Mrs AA was cautioned. [REDACTED]

- 3.2.4 In 1991, aged 10 years, Ms A was placed on the child protection register, under the category of neglect. There were concerns about her appearance and her hygiene; the parenting she received was inconsistent and there is evidence that it was abusive. [REDACTED]

██████████. She was removed from the child protection register in June 1992. She was referred to Child Guidance and thought to need a special educational setting. She was known to be attending a residential placement in 1993, described by Islington Social Services as a boarding school.

3.2.5 She met her future husband in 1997 when she was 16 years old. Nothing is known from records about his background.

3.3 Second period: April 1999, ██████████ – to the first child protection concern on 11th December 2006.

3.3.1 The agencies in Haringey involved with the family in this period were – HARTS (Epic Trust), general practitioner and primary care mental health worker, health visiting, housing and the school.

3.3.2 Ms A became pregnant in early ██████████ with child ██████████ who was born on ██████████.

3.3.3 Ms A became pregnant with her ██████████ child, ██████████ according to her husband, in late ██████████, and child ██████████ was born on ██████████. Ms A experienced post-natal depression and struggled to cope with ██████████ small children.

3.3.4 On ██████████.5.2001 Mr and Ms A presented themselves for housing assistance as they could no longer live with a relative of Mr A in a one bedroom council tenancy in N.17. The family's application was approved on ██████████.01 and they were offered temporary bed and breakfast accommodation. After ██████████ they requested larger accommodation, and were granted it on ██████████. The health visitor had supported their request. While at this accommodation Mr and Mrs A married on ██████████ at Haringey Civic Centre.

3.3.5 According to Mr A their marriage began to experience serious difficulties illustrated by an incident on ██████████ 2003 when Mr A returned home having been drinking and had a row with Ms A over her alleged rough handling of child ██████████. He left and went to stay with ██████████. ██████████. During that year according to Mr A, Ms A befriended a local man. Mr. A thinks that she fell in love with him but that it was not requited.

3.3.6 In mid 2005, Ms A became pregnant with child A, but the parents' relationship continued to deteriorate and they began to row. By ██████████ 2006 Ms A's man friend had moved away, and according to Mr A she took it badly. Through this friend Ms A had already met Mr H whom Ms A was to describe to others as only a friend. Mr A says that he did not like Mr H and following a number of occasions on which he saw them together, he and Mr H rowed. On ██████████.2006 Mr A left the family home. Mr A says that initially he saw the children 2 or 3 times a week

but from [REDACTED] 2006 he was not allowed in the home as Mr H was there. He saw the children much less frequently.

3.3.7 On 03.08.2006 Ms A was referred by PMHW, the primary care mental health worker at the GP practice, to HARTS, a voluntary sector service funded through Haringey Council's Supporting People Programme, to provide housing related support. She was referred because Ms A had [REDACTED] children, [REDACTED], was separated from her husband, and had a history of depression. The purpose was to support her in relocating from her accommodation. After some failed attempts by HARTS to contact Ms A she completed an application on [REDACTED].06. RAC1, a referral and assessment coordinator, visited the home and had no concerns about the welfare of the children she saw.

3.3.8 On [REDACTED].06 Ms A contacted RAC1, explaining her circumstances had changed following a visit to the hospital because child A had bumped his head and social services had become involved. Ms A said that she was scared and would like support as soon as possible. Her case had been placed on a waiting list with a waiting time of 2 – 6 weeks. Following the phone call it was allocated the same day to the Family Welfare Association, which, as part of the HARTS service provides support to more complex families, including those where there are child protection concerns.

3.3.9 Ms A and her [REDACTED] children were registered with the same GP. They were first registered on 15.04.2003 when the parents were together with their [REDACTED]. The practice began as a single-handed one in 1992 but six years ago it changed to a personal medical services contract (PMS). Gradually it evolved to the GP plus an employed doctor, a locum, a practice manager, the PCMHW, two part time nurses and five receptionists.

3.3.10 When Ms A joined the practice, she had already been diagnosed with depression and prescribed [REDACTED] by her previous GP. In July 2005 the current GP referred her to the PMHW because Ms A presented as irritable and crying, and he diagnosed anxiety and depression. She was prescribed [REDACTED] intermittently over the following two years.

3.3.11 The role of the Primary Care Mental Health Worker was a relatively new service, a national initiative, the key purpose of which is to help GPs meet the needs of 'the majority of people who are suffering mental health problems, who do not require the specialist services of secondary mental health care'. The service was provided 1.5 days per week. There was no formal assessment of people's suitability for the service. In Ms A's case it was intended only to last until [REDACTED] 2006. The PCMHW had no concerns about the impact of Ms A's mental state on the care of her children. Ms A's concerns were focussed on her leaving her husband, maternal grandmother's drinking, and the impact of this on the care of her grandchildren.

3.3.12 There had been concerns that Ms A would experience post natal depression following child A's birth but this was not diagnosed. PMHW wrote to the health visitor on [REDACTED].06 to let her know that Ms A was to see the GP to restart [REDACTED] and that she would like to have her children weighed. The GP could not recollect discussing Ms A's progress with PMHW but said that he would have done so informally. He knew that the worker had referred Ms A to a number of voluntary agency support systems, and did not regard it as necessary to refer her to social services.

3.3.13 The family's first contacts with the health visiting service were before and after the birth of their first child, child [REDACTED], in [REDACTED]. The family lived in Islington and Ms A was [REDACTED] years old. They were assessed as a vulnerable family. Concerns included the fact that they shared the home with Ms A's mother Mrs AA, and were living in untidy, unclean, cramped and unsuitable accommodation. They knew that Ms A was known to social services from her childhood, and had been on the child protection register. [REDACTED], and that Ms A had been 'in care' and placed at boarding school.

3.3.14 The new birth visit found that Ms A did not have a close relationship with her mother, and needed help with parenting skills, although her partner Mr A was supportive and in work. Ms A was a very heavy smoker – 60 cigarettes a day. She was assessed [REDACTED]. There were concerns about home safety throughout all contacts, and safety advice was offered by the health visitors.

3.3.15 The family moved to Haringey in [REDACTED] following the birth of their [REDACTED] child. The transfer referral of [REDACTED] highlighted a vulnerable family; previously unsuitable housing that was unsafe, which had led to the family being re-housed that day; and the mother's depression. It is unclear whether Ms A's history of child protection and being in care was part of the information transferred about her, although this information was in the health visiting records.

3.3.16 [REDACTED] received their immunisations on time and their developmental checks when they were due. However, child [REDACTED] was referred to the Child Development Clinic (CDC) on [REDACTED] for concerns about [REDACTED] behaviour. [REDACTED]

3.3.17 Following child A's birth at the North Middlesex hospital on 01.03.2006, the health visitor undertook a new birth visit, and found him to be

developing well and breast feeding. Ms A's history of post natal depression was noted, that she was well at present, was seeing a PCMHW at the GP's surgery, and the conclusion of the assessment was to 'follow up mum's progress'. A family health needs assessment was also undertaken which identified [REDACTED] for both child A and Ms A, and discussed hygiene, smoking, health and safety. The home was very untidy but the parents appeared loving towards the children. The case was placed in a 'blue folder' denoting a cause for concern.

3.3.18 Involvement of primary school 1 with the family began in [REDACTED] with an application for a place at the nursery for child [REDACTED]. [REDACTED] started at the nursery in [REDACTED] when [REDACTED] was [REDACTED], and transferred to the infants' school in [REDACTED], child [REDACTED], started at the nursery [REDACTED]. The children's attendance was reported to be good.

3.3.19 On admission to nursery in [REDACTED], child [REDACTED] was noted to have [REDACTED]. Shortly after that, [REDACTED] was on the school's special education needs (SEN) register, and Action Plus (where an external agency is involved with the pupil). [REDACTED] was on the caseload of the [REDACTED] time at school 1.

3.3.20 [REDACTED]

3.3.21 Most incidents which concerned the school were more related to Ms A's behaviour than to that of her children. If they were raised with her by the staff she would become very angry. They included:

- following a suggestion by staff that Ms A cut her children's hair to deal with repeated infestations of head lice
- Ms A shouting loudly from the other end of the school hall demanding the head teacher's attention
- using bad language and intimidating other parents outside the school gates at the start of the school day
- complaining vociferously about a teacher who had been trying to be helpful to her

3.3.22 They considered that Ms A was not truthful about claims that she was assiduously dealing with the head lice problem. Her volatility and difficult relationship with school staff made staff reluctant to take up

matters with her. Ms A's vulnerability as a parent was further demonstrated in incidents when she became upset when [REDACTED]

3.3.23 For most of the time it was maternal grandmother Ms A who brought and collected the children from school. Mr A was more involved in the early years of their attendance. The school were aware of the parents' marital difficulties and that Mr A had left the marital home. During the [REDACTED] 2006 Mr H was seen with Ms A at the school and introduced as a friend. However the nursery nurse met them by chance in the locality and Ms A introduced him as her boyfriend. On one occasion he came into school with the two younger children in a buggy, to collect one of the [REDACTED] who was unwell, after the school had contacted Ms A. Although [REDACTED] had mentioned Mr H at school, [REDACTED] was not unwilling to go off with him.

3.3.24 There are two incidents towards the end of this period which could have been seen as significant in the light of the child protection event which was to follow shortly afterwards. Their significance was not understood, not communicated, and not even taken into account at the child protection conference which was to follow.

3.3.25 On 18.09.2006 Ms A took child A to the surgery with a cough and nappy rash. The GP recorded that in the course of the consultation she complained that the baby bruised easily, and that she might be accused of hurting him. Child A was six months old. The GP could not recall whether he had examined the child beyond what was necessary for a nappy rash and a cough. He could not remember whether he had considered how the baby might bruise if he was not mobile. The GP had received recent child protection training and had been on the Area Child Protection Committee (ACPC) in the past but he did not give it any significance nor did he think to discuss it with a health visitor.

3.3.26 The next incident also stemmed from a visit to the surgery, on 13.10.06, by Ms A, who was concerned that child A had fallen down the stairs the previous day. The GP examined him and he had a bruise to the left breast and left cranium. He did not enquire about any detail of how this could have occurred or the height of the stairs, and recommended that Ms A install gate protection. He did not consider informing the health visitor or pursuing it further.

3.4 Analysis

3.4.1 The Children Act 2004 and related guidance under the government's *Every Child Matters* agenda emphasises the need for early intervention in the lives of vulnerable children, in order to support parents with social needs so that those needs are addressed early enough to

prevent them from becoming more serious. Every local authority and its Children's Partnership or Trust is required to develop local delivery of services, through increasingly multi-disciplinary teams, using the Common Assessment Framework (CAF), a lead professional, and ultimately the introduction of Contact Point. The CAF has been adopted by health and education staff in Haringey, supporting children in universal settings. It is currently used more as a referral tool than it is for assessments.

- 3.4.2 By any reasonable measure, Ms A's children were vulnerable – that is, they were entitled to an offer of an assessment to see if the family were in need of additional services. The health visitor had identified the children as being vulnerable; the mother was receiving support for her mental health needs; the family had housing needs; and the school was concerned about both child ■'s behaviour at school and the behaviour of Ms A as a parent, as well as her relationship with the staff. However, there appeared to be a view that the standards of family care of the ■ school-age children was not any different from that of many other families in the borough. This suggests that the expectations of parents are too low, and that many children may be experiencing unacceptable levels of neglect and emotional deprivation, without testing whether parents would improve their parenting if offered constructive challenge and support.
- 3.4.3 There was some inter-agency cooperation. The health visitor had supported the parents in their request for re-housing and the PCMHW had requested the help of HARTS to support Ms A in further efforts to secure better housing. In many primary care teams there is, however, much closer liaison between health visitors and GPs. In this practice it was exceptionally distant because the organisational arrangements to ensure good communication and a close working relationship between the two professions were not in place.
- 3.4.4 Without knowing what was to happen subsequently, the first incident presented by Ms A to the GP should have suggested that she had anxieties about the care of her son or even fears that she might harm him. This should have led to a sensitive exploration of her concerns by the GP and possible referral to a health visitor who will have experience of parents with these kinds of worries, and would be able to make a more holistic assessment of the event. The threshold of concern at this point was the vulnerability of the child, and should have led to consideration of the need for a CAF to be undertaken. It is not possible to know with certainty what is in the mind of a parent and what may have motivated them to come to a surgery in those particular circumstances. With benefit of hindsight it seems more likely that she had fears about what might happen to him, and wanted to prepare the GP for the eventuality that she might be bringing him with bruises to the surgery some time in the future.
- 3.4.5 The second incident was more concerning than the first because the mother was reporting that her child had actually become injured and

she wanted him checked by the doctor, although she did not believe that he had suffered any broken bones. Taken together with the first incident a more concerned view should have been taken of it by the GP. Instead it was treated as a separate, coincidental happening, and the mother's account was accepted at face value. The threshold now was safeguarding, and it justified the involvement of a colleague, a health visitor, who could make a visit to the home and assess both the home setting and Ms A's relationship with her child. The GP took no action because he was never concerned about the incidents, and did not report them to the hospital when he made the referral on the 11 December.

3.4.6 An issue for the review is whether most doctors in Haringey would make the same assessment of the presentation as child A's GP or whether his response was idiosyncratic. If the former, then it suggests that there is an extensive training need to be met. The Panel take the view that the majority of GPs would have understood the significance of the incidents and taken action. However, there may be a minority who need briefing or training of some kind.

3.5 The third period: from the first serious alleged non accidental injury to child A on the 11 December, to the end of the initial child protection conference on the 22nd December 2006.

3.5.1 On 11.12.2006 Ms A telephoned the surgery and spoke to the GP. She told him that child A had a swelling on the head and asked what she should do. He invited her in, explaining that there was nothing he could do until he examined the child. He recalled that when she arrived she was in an excited mood and talking very fast. She didn't know how it had happened but she had found him in the back seat of the car. He had been in the care of her mother (Mrs AA). When child A was examined, he found a frontal haematoma with a discolouration of the nose and bruises over the body which suggested to him that they were probably non – accidental. He told Ms A that he was going to refer child A to the hospital, wrote a referral letter and gave it to her to take to the hospital. He phoned the hospital to let them know that they were coming. There is no record in the patient log of a telephone call to the Whittington Hospital. An hour or two later, Ms A telephoned the GP to ask him to phone the hospital to tell them that she was a good mother and that she would not harm her child.

3.5.2 It is not clear, and the GP cannot recall, why he referred Ms A to the Whittington Hospital. He would normally refer to the North Middlesex Hospital, and the GP could only assume that Ms A had requested the Whittington. That the assessment and treatment took place at the Whittington made it harder for professionals to track his hospital care.

3.5.3 At the Whittington child A was seen initially by a registrar who subsequently consulted Consultant Paed 3, the named doctor at the hospital. A number of bruises were seen on his body and documented

on a body map. Ms A said she did not know when or how the swelling on child A's forehead had occurred. She attributed the other bruises to him climbing and falling and bruising easily, as well as her slapping his body in play.

- 3.5.4 The body map made at the time shows extensive bruising to his buttocks and other bruises to his face and chest, including the swelling to his forehead which had triggered the referral from the GP. There were also some minor scratches which Ms A said were caused by one of their two dogs. Child A was admitted for assessment. [REDACTED] [REDACTED] test were done in order to assess whether child A did bruise easily. The test results indicated that he was not suffering with any condition which would mean that he would be susceptible to bruising easily. A referral form was faxed to Haringey CYPS social workers the same day as the referral.
- 3.5.5 A strategy meeting was held the next day: 12 December. It was attended by a social worker and a detective constable from the Metropolitan Police. There was agreement to undertake a skeletal survey of child A, and to conduct medical assessments of the other children later. The social worker was to liaise with the health visitor. She also reported on the older children with information which it is believed was obtained from the school. The initial skeletal survey revealed what might have been an old fracture of the right tibia, but a bone scan showed no abnormality.
- 3.5.6 There was clear concern about child A's welfare and a decision was made that he could not return to the family home until the s.47 enquiries and police investigation had been completed. Ms A's agreement was sought by the local authority for him to be accommodated elsewhere in the meantime. She suggested a family friend, Ms M, as her first choice, or child A's father as an alternative. The local authority decided subsequently to place him with Ms M when he was ready for discharge from hospital.
- 3.5.7 As well as setting out the history and Ms A's explanations, the Paediatric Assessment Proforma also indicated that the parents were separated and that 'mother has a friend, Mr H. He is not alone with the children'. It was recalled by the consultant later that at that time Ms A insisted that Mr H was not her boyfriend and that he was never left alone with the care of the children.
- 3.5.8 Child A was discharged from the ward to the care of Ms A's friend, Ms M on 15 December. He had to return for further X rays to his right and left tibia to check for possible fracture. This was done by [REDACTED] and the social worker was informed that the signs of an old fracture were no longer visible.
- 3.5.9 On [REDACTED] the police received a fax referral from Haringey children's social care, a few hours before the strategy meeting. It

contained the basic facts reported by the GP. DC1 was assigned to be the investigating officer and attended the meeting. Consultant Paed 3 stated that child A's blood tests were normal, and this was confirmed in a detailed letter from her dated 14 December, in which she concluded that the combination of bruising seen 'is very suggestive of non accidental injury'.

- 3.5.10 While at the hospital, DC 1 interviewed Ms A under caution. Ms A provided the police officer with a number of hypothetical explanations of what may have caused the injuries to child A: not being gentle with the children (but never hitting child A); he had fallen from the settee – having pulled himself up; throwing him up and catching him when playing; him head butting his cot bars; the dogs causing him to fall over; playing with the other children. Ms A was unable to provide the police with any clear explanation for the injuries and denied that she or her mother was responsible.
- 3.5.11 On 13 December the police officer and the social worker made a joint visit to the school to interview the [REDACTED] older children, [REDACTED]. They were seen separately. The children gave no suggestion that their mother chastised them by hitting them or that there had been any men in the home since their father left. The teaching staff gave no indication that they had any concerns about the welfare of the children.
- 3.5.12 On 19 December, DC 1 arrested Ms A and Mrs AA. During their interview neither gave any specific explanations of how the injuries occurred but gave the same possible causes as previously. They identified only Ms A and the children as living in the home, and Mrs AA staying occasionally. However, there was no direct questioning of either of them on who else might access the home or any associates. The police were aware that Mr A and Ms A were separated, and that there was a man called Mr H who was mentioned but only as a 'friend'. Although not recorded, the police were clear that there was no suggestion that Mr H stayed at the home or was in any relationship with Ms A or ever looked after the children. Both were bailed pending further police enquiries.
- 3.5.13 The Children and Young Persons Service (CYPS) records state that a home visit was undertaken by the social worker that day to see Ms A and Mrs AA but the content of the meeting is not recorded. On [REDACTED] [REDACTED], Islington CYPS provided background information that Ms A and her brother had been subjects of child protection plans and that Mrs AA had received a police caution for physically assaulting her son.
- 3.5.14 The health visitor had informed the social worker on [REDACTED] of Mrs A's past post-natal depression. The health visitor had no concerns about the children's care, and confirmed that Ms A attended the clinic to weigh child A, although his immunisations were not up to date. The record of a CYPS meeting between the social worker and three managers on [REDACTED] indicated that child A would be

accommodated under S. 20 of the Children Act 1989 (a voluntary arrangement with the parent's agreement) pending completion of the child protection enquiries under S. 47 of the same Act, and the medicals on the other children. A possible placement was identified. The social worker informed the parents on [REDACTED] that child A would be accommodated by the local authority unless an alternative carer was identified by them. Ms A said that she would prefer child A to be placed with his father or with a friend, Ms M. She would not allow her mother to babysit again. Mr A offered to take time off from work and to obtain a reference from his employer, but his offer was not taken up, apparently because Ms A alleged that he had slapped the children in the past.

3.5.15 There was a difference of view within the CYPS about who should care for child A on discharge from hospital on 15 December. The social worker thought he should go home or to the family friend. Her team manager disagreed. In her view, the injuries to child A were too serious to make this informal arrangement. They took it to the senior team manager, who supported the social worker. The service manager was also consulted but it is not clear who in the end took the decision. Child A was discharged to Ms M's care, with a written agreement as to the conditions, signed by Ms A, Ms M and the social worker. Ms M agreed to supervise any contact between child A and Ms A and Mrs AA, and to inform CYPS if she had any concerns.

3.6 Analysis

- 3.6.1 The balances to be struck at this point were to decide:
- a) Whether S. 47 enquiries should be initiated - leading to the possibility of convening a child protection conference or not doing so. The injuries were significant, meeting the threshold for care proceedings. The local authority correctly initiated the enquiries, and the possibility of a joint investigation with the police. The investigation was not done jointly, with the social worker visiting the home first and the police officer visiting and interviewing Ms A afterwards.
 - b) Whether care proceedings should be initiated to seek to remove child A to the care of the local authority as a looked after child. Legal services agreed that the threshold had been met, but CYPS elected for a voluntary arrangement with the parents, and even one which was chosen by Ms A. Ms M was a person whose first loyalties could be considered to be with Ms A. It would be difficult for the social worker to be sure that Ms M could monitor the situation objectively, and she was a person that the authority knew little about. As described above (3.5.15), there was a difference of view among managers, and it should have been of concern that the social worker took a view that did not have sufficient regard for the seriousness of the injuries or the danger to the child. To place child A with the family friend was the wrong judgement and gave Ms A the wrong message; that the authority was not too concerned about

the injuries to child A. However, the managers were literally following the instructions in their own operational guidance, which directs that before using one of the department's foster placements every effort should be made to place the child with family or friends. It does not qualify the guidance for children who are considered to have been the subject of non-accidental injuries.

3.6.2 The most significant issue needing to be taken into account at this stage was the medical opinion that the child's injuries were non-accidental, and that no adult was accepting any responsibility for them. They were offering hypothetical explanations which blamed pets, other children, or indeed the child himself. That should have been taken as a potentially worrying indication of the lack of concern in the adults involved. It would have been reasonable for CYPS to infer that an adult had inflicted the injuries and that there was an intention to cover up for whom was responsible. It may not turn out to be true, but it would be the reasonable inference at this stage.

3.6.3 There were two other problems with the enquiries and the joint investigation at this stage:

- a) There was too ready a willingness to believe Ms A's accounts of herself, her care of the children, the composition of the household, and the nature of her friendship network. The appropriate mode of relationship with the parent/carer should be at first an observing/assessing one; and where there are indications of possible harm a questioning and even sceptical one. Her account may well prove to be accurate when tested over time but at this stage it should have been assumed that it may be self serving. The danger is an over-identification with the service user in a wish to support and protect the child's place in the family. There was already reason to believe that she was not being truthful about the injuries to her child.
- b) The other problem was the failure to establish the identity of Mr H, to interview him, and conduct checks on his background. He was the friend that Ms A claimed was peripheral to the family and was not left alone with the children. One of the potentially dangerous scenarios in child protection is an unrelated man joining a single parent family. Ms A's account of his role was accepted too readily. The SCR Panel have agreed that in future it will be standard practice in relevant cases for both the police and CYPS to interview and thoroughly establish any such man's identity, his background and his involvement with a family. It will be the responsibility of the wider safeguarding agencies to report the existence of these men when they become aware of them.

3.7 The initial child protection conference on 22.12.2006

3.7.1 The next step in the process, where the criteria for S.47 enquiries have met the threshold, is to hold a child protection conference. Its purpose is to bring together all the agencies which have an involvement in the

case, to receive written and verbal reports, share information, decide whether there are grounds for making child protection plans on the children, and to formulate the objectives of any plans. Consideration should be given to whether there are grounds to justify care proceedings on some or all of the children. The parents are invited to attend and any written reports are shared with them beforehand. They can be excluded for part of the proceedings. If they are of an age, the children can attend.

- 3.7.2 The conference was held at the [REDACTED] district social work office and lasted one hour and thirty minutes.
- 3.7.3 The GP did not attend because he was not invited. It was not his practice to attend these conferences or to send a written report of his views, but he would give a verbal report over the phone if it was requested. He had received the paediatrician's report before the conference but this did not prompt any action. With regard to any wider safeguarding concerns about the children he regarded delayed immunisations as commonplace and not significant, and the persistent head lice as no indicator of neglect.
- 3.7.4 The PCMHW was invited to the conference and did attend. Her reason for being there was that she had relevant information about Ms A through her work and to clarify that Ms A did not have a mental illness. She knew of Mr H's existence but had been led to believe he was only a friend, and was not in an intimate relationship with Ms A. She was not subsequently a member of the core group.
- 3.7.5 Consultant Paed 3 from the Whittington Hospital was invited but gave her apologies because she had an outpatient clinic and contributed a detailed written report. Nobody was sent instead to represent her views. A doctor from the Child Development Centre was also invited but gave their apologies.
- 3.7.6 A legal representative of the local authority was present. Haringey's operational guidance requires a lawyer to be present at an initial child protection conference unless released specifically by the conference chair as not required. Ms A also brought a legal representative.
- 3.7.7 The police were represented by the investigating police officer and they record subsequently that child A was placed on the child protection register for physical abuse and neglect, and child [REDACTED] also for neglect. The police say that they understood that child A would not be returned home until the police investigation was completed, and noted that this is not recorded in the minutes.
- 3.7.8 The other professionals present at the conference were the child protection advisor who was also the Chair; an administrator, the health visitor, school nurse, the children's school head teacher, a project

worker and assistant manager from HARTS, the social worker and two team managers.

- 3.7.9 On the whole the minutes of the conference appear to be very congruent with what had transpired in the agencies up to that time. They are summarised in the following paragraphs.
- 3.7.10 The paediatric report was recorded fully and concluded that child A's injuries were 'very suggestive of non accidental injury.' Although the injuries were sufficiently serious to meet the threshold for initiating care proceedings, there was no discussion recorded of the need to consider this, either in the meeting or afterwards.
- 3.7.11 The social worker reported that Ms A was not able to give any explanation of how child A's injuries occurred. There were concerns about the children getting injuries and the lack of supervision in the home. Ms A had rent arrears which would need to be cleared if she was to be re-housed. Ms A found it difficult to keep up with the housework and on top of the laundry.
- 3.7.12 The [REDACTED] other children were described as making good progress in school, or at home and as having a good relationship with their mother. There were no concerns about their parenting or their development when they were assessed by the SpR at the Child Development Centre following the injuries to child A. In a situation in which it might be thought that Ms A would make an effort to present her children well, child [REDACTED] was described as wearing dirty clothes - especially [REDACTED] socks, and child [REDACTED] as wearing dirty clothes and being in need of a bath. In the Panel's view, the Head Teacher understated the school's difficulties with child [REDACTED] and made no reference to the difficulties the staff had in their relationship with Ms A.
- 3.7.13 The social worker reported on child A. Her information about his experience in the family home was second-hand from Ms A, who said that he liked to rough and tumble. He had a good attachment to his mother, smiles and is happy. There was a concern about the lack of supervision of both him and his older [REDACTED], child [REDACTED]. Ms A had relied on Mrs AA to babysit for her to give her respite time and to do her shopping. Ms A acknowledged that she had to take more control of the children. Child A had a good relationship with his father, which was seen when he went for his bone scan when only his father could calm his distress.
- 3.7.14 The health visitor reported that child A seemed fine and happy and that there were no concerns about parenting.
- 3.7.15 The PCMHW reported that Ms A had good insight into her difficulties and requested anti – depressants when she needed them. Ms A and her husband used to drink heavily; they described it as binge drinking but it had decreased recently. She had seen child A with Ms A and he

was calm and smiling and looked like a happy child. Ms A had support from Mrs AA and from her friend Mr H. [REDACTED]

- 3.7.16 HARTS/FWA had not yet begun their work with Ms A.
- 3.7.17 The police had information on Mrs AA but had not been able to access the detail of it. There had been no reports of domestic abuse. They reported the current police investigation into child A's injuries.
- 3.7.18 The social worker had obtained some information from Islington CYPS and it was reported in explicit detail. Ms A was upset about this information being shared and was concerned about confidentiality. Ms A had been on the child protection register after being beaten [REDACTED]. The abuse had only recently come to light when she told her mother about it. She was later regarded as being beyond control. She only learned the true identity of her birth father last year. It was considered important to share this information because of its possible impact on Ms A's current parenting, and because of her possible need to be helped to work through her feelings about it.
- 3.7.19 Ms A reported that she had no problems with the housework but had some trouble with the laundry. She agreed to get rid of the two dogs. She expressed concern that the school had not told her that child [REDACTED] was working below [REDACTED] abilities. As much as she tried to supervise the children she said that she may miss things.
- 3.7.20 In summarising, the chair reminded the conference that the paediatrician was of the opinion that the injuries to child A were non-accidental in nature. No adult had given any explanation of how child A had sustained these injuries and who was with him when he sustained them. This was very concerning for a nine month old baby. No reference was made to the possible significance of Ms A's relationship with Mr H, the only reference to it coming from the report from the PCMHW, although it was also mentioned in Cons Paed 3's report. The school were aware that Ms A had referred to him as her boyfriend to the nursery nurse, but this was incorrectly considered to be hearsay at the time, not reliable and therefore not reported.
- 3.7.21 The social worker had found Ms A to be cooperative. She had asked for help from mental health and HARTS. The social worker recommended that child A should only be registered for neglect, and not for physical injury. She also recommended that child [REDACTED] be registered for neglect because of [REDACTED] age and vulnerability. Her team manager agreed with her in part but considered that child A should also be registered for physical abuse due to his injuries. Child A was eventually registered for both categories. Most participants agreed that child [REDACTED] should also be registered for neglect. None of the conference members supported the registration of [REDACTED]. The chair

agreed with registration for the [REDACTED] children noting that child A has significant physical injuries with no explanation, and that it is more by luck than judgement that child [REDACTED] was also not injured.

3.7.22 Ms A stated that she did not agree with the category of physical abuse as she does not hit her son. She accepted him being registered but not [REDACTED]. She said that he is not a little baby but is huge, climbs, is boisterous and that she had never hit him. [REDACTED].

3.8 Analysis

3.8.1 Child A was the subject of a child protection conference with injuries so serious that they met the threshold for care proceedings. Although it cannot be known for certain how the injuries occurred the medical view of the causes of the injuries went as far as it could in offering a non – accidental opinion, and it was gradually discounted. This was lost sight of during the conference perhaps because such injuries are commonplace, the reasons for them were not believed, the child was not perceived to have been really harmed, or that there were low expectations of parental care. The likely explanation is that they were not regarded as sufficiently serious and the parent's account of possible explanations was perceived to be plausible. This was borne out by the varied opinions on the need for Child A's registration for physical abuse and the implication of the Chair's remark that implied that the injuries had been due to neglect. Too little significance was given to Ms A's own childhood experience of serious physical and emotional abuse and the possible impact of it on her own parenting.

3.8.2 Neither the paediatrician nor a representative of the hospital medical team was there to advocate for the reality of the child's injuries. The doctor was apparently shocked to discover later that child A returned home when he did. There was the real possibility that force had been used on him by an adult and that nobody was accepting responsibility. Somebody was covering up. That was the reasonable inference and it should have guided the initial interagency response. It could have been stated unequivocally to Ms A that she was not believed and until a more believable account was given a very serious view would be taken of the risk to child A and the other children. It is difficult to understand how this 9 month old child could be returned to the family home after he had been seriously injured, possibly deliberately, by an adult and there was no resolution to the question - who did it? It is reasonable to presume that Ms A was hoping to get away without either admitting to it herself or disclosing the identity of the perpetrator. On the face of it, it suggests that Ms A might be a callous person who is either unable to feel remorse for injuring her child or hopes she may not have to disclose the person who did it. It is the view of the author that just as

the services have been testing her she is testing the resolve of the services. It is regrettable that not more attention had been paid to her own background history and her likely capacity to be able to understand and possibly manipulate such services.

3.8.3 The services had put themselves in a weak position by making the pragmatic decision to place child A with a family friend, as if a temporary alternative was needed to a good home. In doing so, they signalled to Ms A that they didn't regard the injuries as too serious, they had no serious concerns about her parenting, and that they expected to return him to her care in the foreseeable future. The mode of relationship with Ms A was that she was probably a careless parent in need of family support. Close monitoring of her care of her children would be undertaken as a warning, to ensure that they did not experience further injuries as a result of her lack of supervision.

3.8.4 The mode of relationship that was needed was an authoritative one, reflecting the fact that her child had probably been injured with force by an adult and for which she showed little remorse or concern. All her children received neglectful care -

[REDACTED]
[REDACTED]. Ms A intimidated the staff with her volatile emotional states so much so that they were reluctant to approach her with concerns about the children or her own anti social behaviour. She was in rent arrears and she drank and smoked heavily with little regard for the impact of it on her children's welfare. The questions to be asked at this stage are: 'What have we got here?' And 'Who have we got here?' The local authority staff appeared to have made up their minds on these questions before the conference was held, and more importantly, before it was possible to answer them properly. There was too great a willingness to believe Ms A's account and not to stay with the facts of the injuries as assessed by the medical staff.

3.8.5 In the Panel's view, an insufficiently serious view was taken of the first injuries to child A on 11 December. Despite the medical opinion that it was reasonable to believe that his injuries had been inflicted non-accidentally, the other agencies at the initial child protection conference took the view that they were most likely caused accidentally by others including other children, pets and child A himself. It is important to reflect on the process which took place at the conference. The majority of the members of the conference are not specialists in child protection. Their function is to bring safeguarding awareness to their daily work with children e.g. school; and to work in promoting the children's welfare e.g. Family Welfare Association. They do not carry the main responsibility for protecting a child and it was unwise for the conference Chair to give them that responsibility for deciding the basis of the child protection plan. It is the role of the Chair, with their experience and expertise, to guide the members to a conclusion and note any

dissenters. As it happened at this conference the chair appeared to share the views of the generalists.

- 3.8.6 The lack of belief in the seriousness of child A's injuries was reflected early in the decision to place him with a family friend of Ms A's choosing. This was a woman who was entrusted to take the children to church with her each Sunday. She was chosen after considering and rejecting child A's father because Ms A alleged that he had slapped the children in the past. It is not known whether this was clarified with Mr A, to get his view, or whether his wife's version was accepted at face value. In placing child A with the family friend he was kept in Ms A's orbit of influence. It signalled to her that the services were not seriously concerned about the injuries to her child, even though there were S. 47 enquiries initiated and the police were investigating an alleged crime of which she was a suspect. If she was not the perpetrator then she was likely to be covering up for somebody else.
- 3.8.7 No reference was made at the child protection conference or in the S.47 enquiries to the two earlier incidents which preceded the serious injuries on 11 December. These were only identified as a result of the inspection of the GP's records for the earlier serious case review. It was a serious failure of the child protection process not to invite the GP to the conference, especially as he had referred Ms A to the hospital following the injuries to child A. The previous incidents should have been brought to light. A written report should have been requested, and if not provided, this should have been taken up with the health authority. However, given the views of the GP, it seems likely that the earlier referrals would not have been brought to the attention of either the enquirers or the conference. Knowledge of them should have strengthened any concerns about Ms A's parenting.
- 3.8.8 Even only with foresight these should have been regarded as possible 'cries for help' on the part of Ms A. She was volunteering anxiety about her care of child A. The first incident met the threshold of vulnerability and the possible need for additional services; the second met the threshold of the possible risk of significant harm. At the very least there should have been a visit to the home to discover how such a young child could have fallen down the stairs, if he ever did. With benefit of hindsight it is equally plausible that Ms A was anxiously preparing the GP for the possibility that she would be bringing child A to him with bruises.
- 3.8.9 The Panel accepts that the agencies at the child protection conference could not know for certain how the injuries had occurred. The medical opinion went as far as it could and it was effectively discounted. It is right not to be over-reliant on a medical opinion on injuries to a child. It is right that the alleged injuries need to be seen in the round, holistically, weighed against all elements of an assessment. In this case, the other elements supported the medical view that injuries were non-accidental and the alternative explanations were not persuasive:

Ms A had a history of severe child maltreatment; she was generally careless in her parenting; her children showed evidence of acting out behaviour and in the school setting she was a difficult person with whom to relate. Mr A, when asked, said his wife had been lazy in the care of their children from the first, although he did not believe she would physically harm them. In a situation of uncertainty and where there is risk of harm to a child, it is right to exercise caution in the child's favour. The welfare of the child is the paramount consideration.

- 3.8.10 The interagency judgement appeared to be that child A's injuries were probably accidental; although the Chair of the conference did remind them of the medical opinion and that no disclosure had been made by the adults, although Ms A had offered hypothetical possibilities. This was despite knowledge of risk indicators: that Ms A had been subject to severe child maltreatment as a child and placed on the child protection register herself; that Mr A had reported that his wife was having difficulty in caring for all of the children; that Ms A was sufficiently depressed to need the support of a mental health counsellor; that Ms A was very young when she began her family; that she was a single parent; and that child A was the [REDACTED] child in a still very young family. It is hard to understand in those circumstances why the interagency response to child A's injuries gave the weight of their opinion to the hypothesis that the injuries were accidental.
- 3.8.11 The paramount consideration for services at this point was the welfare of the child. In the panel's view the need to protect the child was not kept sufficiently in focus by the agencies involved, in particular by the staff of CYPS, and the conference Chair. The interagency response faced a situation where the reasonable inference was that the child had faced 'deliberately' inflicted injuries by an adult, and nobody caring for the child was prepared to disclose who had done it. The adults involved would prefer to cover up for each other rather than to put the welfare of child A first. It gave a possible indication of the moral climate in which the agency response would need to work.
- 3.8.12 The only leverage which the interagency response has in this situation is the motivation and sense of responsibility which the parents/carers demonstrate for the child. The S.47 enquiries by CYPS, the investigation by the police and the child protection conference were all opportunities to discover the extent to which the parents /carers loved their children, and were able to express their responsibility to care for and protect child A.
- 3.8.13 Although perhaps not consciously, a parent/ carer in Ms A's situation is testing the resolve of the safeguarding and child protection systems. She has not yet found it necessary to disclose what has happened to child A, and in particular who has caused the injuries. From the beginning she is given every indication that she may not need to do so. Placing child A with a family friend is a clear indication that services want, if possible, to keep the child with the family, despite the injuries.

They are not being taken too seriously. Her plausible accounts of how the injuries may have occurred – she has not seen them happen herself – are treated with even-handedness. She is not unequivocally confronted by the police and CYPS that they do not believe her accounts, and that it will influence their decision whether to attempt to remove child A from her care through care proceedings. She can reasonably infer that the services need her to care for Child A more than she needs to be honest with them.

3.8.14 Hovering in the background to the situation is Mr H, the male friend of Ms A. The nature of his relationship to Ms A is not known, the extent of his involvement with the household is also not known, and most importantly his possible criminal background, anti-social behaviour or general background, is not known. A man joining a single parent household, who is unrelated to the children, is well established in research as a potentially serious threat to the well-being of the children. He needs to be checked out and his involvement with and relationship to the children carefully assessed. His existence was known during the S. 47 enquiries and the police investigation but his identity was not established through Ms A and he was not interviewed. Ms A's account of his relationship to her and his involvement with the children was accepted at face value. It was an indication of the lack of thoroughness of the police investigation and the S. 47 enquiries and the danger of accepting an account from a service user whom they have only just met. It was another indication to her that she was not in serious difficulty from the services involved.

3.8.15 There are two balances to be weighed when a child is subject to S. 47 enquiries which lead to a child protection conference:

- whether to make the child subject to a child protection plan and whether that child is sufficiently safe to remain at home protected and supported by a child protection plan, or,
- that care proceedings should be instigated in an attempt to remove the child to care.

3.8.16 The central purpose of the S.47 enquiries leading to the child protection conference and the contributions of the agencies who know the family is to establish who and what they have to work with if they decide to return the child to the care of the parent (s) under a child protection plan. The threshold is the extent of possible maltreatment which the child will have to endure while support provided to the parents improves the quality of care.

3.8.17 The child protection conference appeared to take a fairly sanguine view of the care which child A was likely to receive. The paediatrician could not attend the conference to reinforce her opinion that the injuries had been non –accidental; the child was under the supervision of a family friend; the beliefs as to the cause of the baby's injuries were equivocal; the conference debated whether the reasons for the child protection plan need include physical injury to child A; not all the children were

considered to be in need of a child protection plan; and no consideration was given to the need for care proceedings in respect of child A, even though the threshold had been met. Legal services were represented to hear the concerns first hand. It is not evidenced that they contributed to the discussion, although they gave verbal advice immediately following the conference that the threshold for care proceedings was met. One might conclude from all of the above that the threshold of concern was far too high.

- 3.8.18 Little significance was given to the possibility that a small baby had been injured deliberately, with no account given of it by the adults involved; the expectations of parental care in the family were low; as were the expectations of the services to influence events in the family.
- 3.8.19 It is important to explore why the child protection conference decided that child protection plans were not required on the [REDACTED] older children, [REDACTED]. It is true that no concerns had been expressed by the agencies about the care of these [REDACTED] children, and there was no indication of neglect or of injury when they were examined shortly after child A's injuries came to light. However, two children had been assessed as being neglected, and one in addition as being physically abused. Either these two children were being selected deliberately for maltreatment or they exhibited the vulnerabilities of generally neglectful parenting because they were younger. As the adults had refused to disclose what had happened to child A it was reasonable to conclude that all the children could be at risk of significant harm, and all of them should have received the added security of a child protection plan. It is an important signal to other agencies that they should carefully monitor their welfare.
- 3.8.20 The fact that children are on a child protection plan is an important signal to other agencies that they should carefully monitor their welfare. Discriminating between the children in this way can be a way of agencies trying to be fair or to reward the parent by saying that not all her parenting is poor. Not only were all of these children experiencing a level of neglectful care but it can give the wrong message to parents; that they only need to improve their parenting in respect of some of the children.
- 3.8.21 The child protection conference and the CYPS staff in particular, were faced with a decision whether to initiate care proceedings in order either to attempt to remove child A into care or to strengthen their powers to protect him at home. The process of doing so would signal the seriousness of their concerns to Ms A, and the process of care proceedings itself would bring home an additional reality to the parents/carers. It would also offer the opportunity of a disclosure of who caused child A's injuries.
- 3.8.22 There is a balance to be struck between protecting a child from the risk of further significant harm, and undermining his attachment to his

family, in particular his parents, but also his siblings. It needs to take into account his age, the seriousness of his injuries, the quality of his relationship to his parents, and the realistic ability of the child protection system to supervise his welfare sufficiently closely to prevent further harm, as well as to improve the parenting.

3.8.23 The local authority has in addition to take into account the 'no order' principle of the courts: not to make an order unless it can be demonstrated that the child will benefit more than if it was not made. The local authority had already indicated a view of the seriousness of the harm to child A by making a voluntary arrangement with Ms A to look after him under S. 20 of the Children Act, under which she could request his return to her care. At the time of his hospital stay they could have applied for an interim care order and placed him with their own foster carers. Indeed, when he was placed with the family friend he was being looked after by the local authority as she was made a temporary foster carer. In placing him with the family friend they made themselves dependent on her willingness to act as their agent rather than Ms As. At face value the arrangement was expedient: even the operational guidance recognised that it was pragmatic but it was not appropriate where a child may have been deliberately harmed in the family and where nobody had accepted responsibility.

3.8.24 Acting authoritatively by taking care proceedings would not preclude the possibility of returning child A to his family when the local authority judged that he would be likely to be safe. It would remove the pressure to make an early decision to return child A to the family home and would not prevent Ms A from having frequent and regular contact with him if she wanted it. It would address the overriding consideration in this case that it was likely that the child had been deliberately injured and no adult was prepared to disclose how and by whom. It would allow time to undertake further enquiries into what was going on in the household, to make enquiries of neighbours if necessary, to establish the identity and background of the male friend, and most importantly to make a continuing assessment of Ms A's motivation and capacity to care and protect her children.

3.8.25 Section 47 enquiries create a crisis for the parents / carers. They represent a threat to their existing coping strategies and should open up their feelings for a period of time so that the social worker can access their attitudes and the depth of their feelings for their children. It may reveal crucially the capacity of the parent to be open to help. The judgement whether the child can safely be returned home depends not just on the parents' motivations and capacities to parent but their ability to accept and use the support of the social worker in their protective role. The worker is assessing not only the parents' willingness to comply but the genuineness of their motivation to co-operate and collaborate in the interest of their children.

3.8.26 There may not have been sufficient awareness on the part of the participants, and particularly the Chair, of the dynamics of the relationships between the participants, and the part that procedures could play in minimising any adverse effects from them. Ms A's presence in the meeting will have had an influence on the agency representatives who may have felt that they needed to protect their relationship with her as they have to work with her in the future. The impact of her presence would be compounded by the fact that she was accompanied by a solicitor. Ms A was apparently a dominating and forceful personality who may have intimidated people in the meeting and certainly had done so outside of it. Most importantly there was reason to believe that she had not been frank about the injuries to child A and who had caused them. There is provision to ask a parent to leave a meeting for part of the time, to check that there are not things being held back because of her presence, and to establish representatives' views about which children may need to be registered and on what grounds. The Chair needs to bear in mind that most of the participants are generalists in safeguarding and they may need to be given a clear steer from those who are specialists in child protection. In this case it seems likely that the specialists and generalists were genuinely of the same mind.

3.9 The child protection plan

3.9.1 Once the decisions have been made at the initial child protection conference the most important output is the quality of the child protection plans on the children. The components and objectives of the plan are decided at the conference, and it is the task of the social worker and their team manager, in conjunction with the core group, to work out in detail the tasks, roles, and methods which will be used by the group collectively to achieve them. It is crucial that everyone understands the overall purpose, the risks to the children, the importance of delivering their tasks, the importance of communicating any concerns and of meeting together to review progress. The central role in the group is that of the social worker, who must agree the design of the work and co-ordinate its delivery.

3.9.2 In this case the agreed objectives were to complete a core assessment; legal services were to be contacted if the children suffered further injuries; HARTS were to offer specific help with parenting and housing issues; there was to be a full assessment of Mrs AA's role; the PCMHW would provide continuing support; the need for psycho –therapy would be considered; and the social worker would conduct fortnightly announced and unannounced visits.

3.10 Analysis

3.10.1 The components of the plan were never developed, at least in writing. It is the role assigned to the social worker which indicates to the Panel that the plan was wrongly conceived. If it was carried out literally, then

it would not have the desired impact on Ms A's parenting and might not prevent further neglect or injuries to child A if the element which had caused it in the first place was still present. We know from interviews with the staff, including the social worker and the child protection advisor who were involved with the family at the time, that they had no particular concerns about the case. It was regarded as a routine case, with injuries occurring as a matter of course, which would attract their standard and well-tried approach to a family.

3.10.2 The indications from the records of agencies and the conference is that nobody knew what the psycho-social problems / needs, reflected in child A's injuries and neglect and child ■'s neglect, possibly were. The implications of the interagency and local authority actions appeared to be that this kind of occurrence was not surprising in a family like this. This is confirmed in an examination of the case records and interviews with staff. The significance of the injuries to child A, even though they reached the threshold for care proceedings, were not regarded as very serious, and probably occurred for the reasons Ms A had provided.

3.10.3 Child A could therefore eventually be returned to his family with supervision of his welfare via formal monitoring visits, with the awareness of other agencies; practical and housing advice from FWA; sessions with the PCMHW; and the future possibility of attending parenting classes. Nobody seems to have asked the question whether Ms A was educable through these methods; and if she was, whether these were the intervening variables which would improve her motivation and capacity to care for and protect her children.

3.10.4 What was required was an authoritative approach to the family, with a very tight grip on the intervention. Ms A needed to be challenged and confronted about her poor parenting and generally neglectful approach to the home. Clear targets should have been set with short timescales, particularly in respect of the way she turned the older children out for school, and her upkeep of the home. What needed to be achieved was not those goals in themselves, as important as they are, but her response to the demands placed upon her; to discover her motivation and capacity to be a responsible parent. It is likely that these demands would have proved to be stressful for Ms A to achieve. It would have brought to the surface the emotions deriving from her deprived background and would probably be reflected in anger, resentment and protest. It is the function then of family support to provide the compassion, empathy and encouragement to persevere.

3.10.5 It is reasonable to conclude at this stage that, for a case which reflects the highest level of concern that we have for a child's welfare, the intervention was:

- lacking urgency – key agencies missing from the child protection conference
- lacking thoroughness – not checking out Ms A's friend Mr H

- not authoritative – the attitude to child A’s injuries, lack of care proceedings, the placement, delay in possible prosecution
- not challenging to the parent – responsibility for the injuries, child protection plan
- not showing enough focus on the children’s welfare – the injuries to child A, limiting the child protection plans, the unknown perpetrator
- taking too high a threshold of concern – the placement, returning him home, lack of care proceedings, routine approach
- not enough focus on the children – fortnightly visits
- expectations of the family were too low – by all agencies, including schools – not sufficiently challenging of the poor parenting
- expectations of what the services intended to achieve were too low - monitoring with low level support.

3.10.11 The process is complete and for better or worse the plan now needs to be delivered. It is important that it is regarded as provisional so that if it is not meeting its objectives it can be reviewed and revised. It is also important to have measures of success in place for each of the objectives so that progress can be monitored; and to try to anticipate what the indicators will be if the plan is not achieving its objectives, so that there can be a decisive response to any serious failings in the work.

3.11 Fourth Phase: from 23 December 2006 to the first review child protection conference on 16 March 2007.

3.11.1 Social workers visited the family home on 24th, 27th, and 29th December 2006. Ms A saw her son three times on Christmas Day. On [REDACTED], as a result of discussions with legal services, children’s social care decided not to pursue care proceedings but to carry out a risk assessment and continue to work with the family. It was agreed that it would be premature to return child A home without one, as the police investigation was continuing. Ms A asked when her son would be returning home. On [REDACTED] 2007 the informal foster carer asked for Ms A to have unsupervised contact with child A.

3.11.2 PW1 from FWA visited on [REDACTED] and found the home disorganised, smelly and dirty: it smelled of urine from the dogs which had not been removed as Ms A had promised at the child protection conference. This raised questions about her motivation for change. PW1 phoned the social worker but she was on sick leave. She left a message for the Team Manager, who did not get back to her. Ms A failed to keep her appointment with the PCMHW. On [REDACTED] the health visitor (HV) rang Ms A to ask her friend to bring child A to the clinic. At this time the Crown Prosecution Service (CPS) are asking the police for further medical evidence on the injuries caused to child A before they can consider prosecution.

- 3.11.3 The first core group meeting was held on 10 January 2007 and Ms A attended with child A. The FWA remit was for practical help including improving the conditions in the home. The remit was changed to include direct work to address Ms A's relationship with child [REDACTED]. Visiting frequency was reduced from weekly to fortnightly and then to monthly. The school did not attend although they provided a report. There were minutes of the meeting. Child A was to attend the health clinic once a month, to have a one year developmental check, and Ms A was to be referred to 'Mellow Parenting', a health facility to improve parent/child relationships through group work. The child Mellow Parenting would focus on was child [REDACTED], as child A was too young to fit the criteria of the programme – although it is not clear the the Core Group understood this - but it was agreed that he could accompany them and hoped that the improvements in parenting skills would transfer to the other children. The programme would not start until [REDACTED] 2007. Ms A spoke to the PCMHW on the [REDACTED], angry that child A had not been returned to her care.
- 3.11.4 FWA visited on [REDACTED]. PW1 had the feeling that Ms A was playing one agency off against the other. Ms A saw the PCMHW on [REDACTED] and was angry because child A was not being returned to her care. She saw another GP in the practice on [REDACTED] and wanted counselling for [REDACTED] children. At the review strategy meeting on 24 January attended only by the police and social workers, it was agreed that child A would be returned home. The police did not know how long it would take to conclude their investigation and did not object to child A returning home as long as the dogs were removed. The paediatrician was consulted and refused to write another report. It was agreed that child A would be returned home on 26 January subject to the dogs being removed. There were no notes or minutes of the meeting. Child A was seen by the GP on [REDACTED] with impetigo in both groins. On that day Ms A saw the PCMHW and reported being happy that child A had returned home, angry at being told what to do, and that she was finding her male friend helpful. On [REDACTED] the housing association make her an offer of long-term temporary accommodation.
- 3.11.5 Over the next month the social workers changed. All the children were seen by another GP in the practice – they were all judged to be well and happy but should be assessed again. Ms A was seen for her smoking habit. The core group meeting of [REDACTED] was cancelled and rearranged for [REDACTED]. Ms A moved the family to their new four bedroom home on 19 February. Ms A remained with her existing GP but moved to a different health visiting service. Ms A cancelled her visit with PW1, who had not been informed that child A had returned home. SW2 visited on 20 February and saw all the children; Ms A was affectionate with them and complained about the need for their registration. On [REDACTED] there was a telephone transfer between the health visitors.

- 3.11.6 On SW2's visit to the family on [REDACTED], child A was seen to be head-butting the floor and his mother several times. The HV was also there and Ms A wanted the dogs returned as the house was now more spacious. SW2 observed a good relationship between child A and his mother. In the Head Teacher's early report to the upcoming review child protection conference on 16 March, which she could not attend, she considered that [REDACTED] but that neither child was at risk of abuse.
- 3.11.7 On 5 March the school nurse phoned the social worker to say that she had observed Ms A that day shouting loudly at child [REDACTED] close to [REDACTED] face and slapping [REDACTED] cheek outside the school. The social worker discussed the matter with her team manager and agreed that she should see Ms A. Child [REDACTED] was seen alone and confirmed [REDACTED] mother's assault for kicking out at Ms A's friend's [REDACTED] year old son. [REDACTED]
- Ms A had already agreed to attend a parenting programme and the social worker proposed no further action.
- 3.11.8 In conjunction with an incident with a cooker on the night of [REDACTED] which Ms A reported to the school but did not report to the social worker, a teacher at the school said that 'Ms A was damaged, and living on the edge, and does not know how to cope.' On a visit to the home that day the social worker saw child A 'happy and smiling'. On [REDACTED] when PW1 (FWA) phoned Ms A to make an appointment to visit, Ms A told her about the slapping incident. PW1 phoned the social worker to report it but the social worker already knew about it. On 8 March the social worker saw child A and child [REDACTED] at home and they both presented as happy and friendly. Ms A said that she was intending to keep the dogs despite the social worker's misgivings. The same day, Mellow Parenting interviewed Ms A for their programme, and Ms A said that she has no partner.
- 3.11.9 On 13 March the SW interviewed Mr A. This was the first time that he had been seen since the December incident at the Whittington hospital. Mr A wanted more contact with his children and he was advised by the SW to get legal advice. He said that Ms A had a boyfriend whom he had seen at the family home. He did not believe that Ms A would hit the children. On [REDACTED] the PW at FWA did a handover to her colleague on a home visit. There were three sets of visitors while they were there and they were not reported to the social worker. In a telephone call to Ms A the social worker referred to Ms A's claim that she had a boyfriend. Ms A angrily denied it but did say that she would like to date her friend Mr H. On [REDACTED] Ms

A did not attend (DNA) her visit to the health clinic because [REDACTED].

- 3.11.10 At the review child protection conference on 16 March the police did not attend. They were not informed of the face slapping incident with child [REDACTED] until [REDACTED] and entered it onto their records on [REDACTED]. Child [REDACTED] is made subject to a child protection plan for physical injury as result of the incident on 5 March. It was a recommendation of the review child protection conference that the social worker should increase the frequency of her announced and unannounced visits to weekly. There should be monthly contact with the HV either at the home or the clinic.

3.12 Analysis

- 3.12.1 During the period following the initial child protection conference the youngest children were seen regularly by the social worker, and collectively very frequently by the HV, the FWA PW and the GP. The older children were seen almost daily during the week as they attend school regularly. What was seen of the relationship between mother and the [REDACTED] younger children was assessed positively. It is noteworthy that almost immediately following the initial CP conference the home is described as disorganised, dirty and smelly. No comments to this effect were made later which presumes that standards improved. Ms A also complained vociferously to and about the agencies, either about her child not being returned to her or about two of her children being registered, despite the serious fact of the injuries to child A and the neglect of both younger children, with nobody accepting responsibility. She also constantly complained about the dogs being kept away from the home. This suggests someone who is quite shameless, and without much conscience.
- 3.12.2 The incident on 5 March where she strikes child [REDACTED] on the face, in public with very little provocation, should have been responded to much more authoritatively. It gave Ms A the wrong message – that the authorities were not too bothered. This was not smacking or considered parental discipline but a shocking loss of control directed to the most vulnerable part of a child's body. It was a very depersonalising thing to do to [REDACTED]. It was an assault and the police should have been informed and a strategy meeting called. If that had been a first incident in another family it would have justified a strategy meeting and possible S. 47 enquiries. The police were not informed even though it was a criminal assault; this seemed to reflect the low expectations which many of the agencies in Haringey appeared to have about families like this.
- 3.12.3 The most fundamental problem in the interagency approach to Ms A during this period was the passive acceptance of her continued poor parenting. No demands were made on her to improve the cleanliness of the home or to send her older children clean and presentable to

school. Her demanding attitude to child A's return, the children's registration, and the return of the dogs were not challenged firmly. When Mr A reported to the social worker that Ms A had a boyfriend that went back to [REDACTED] of the previous year, this is not pressed, although Ms A practically admitted that Mr H was her boyfriend. He continued to be anonymous even though he must have been having some contact with the children. The social worker did not enquire about his identity or ask to meet him. It would have been interesting to know whether Ms A would have refused the information and what it was thought to signify. She was not asked.

3.13 The fifth phase: from the first review Child Protection Conference to the second review Child Protection Conference on 8 June.

- 3.13.1 The revised child protection plan contained some of the same objectives as the previous plan but in addition, child A was to be referred to the Child Development Centre for his head butting problem. The frequency of the social worker's visits was increased to weekly; presumably this was due to child [REDACTED] being made subject to a child protection plan for physical abuse. It was noteworthy that the only box ticked for child A's registration was neglect. The date of the next core group meeting was fixed for 29 March.
- 3.13.2 On [REDACTED] the social worker telephoned Ms A to arrange an appointment for [REDACTED] and Ms A was angry that child [REDACTED] had been placed on the register. When Ms A attended the clinic with child A on [REDACTED] she reported concerns about his head butting and allergy testing. Child [REDACTED] was seen at the clinic with Ms A on the [REDACTED] and [REDACTED] expressive and receptive language was reported to be good. Ms A saw PMHW on 23 March and said she was coping but was feeling low that day. She was angry and upset with the social work service because the high frequency of visits she was receiving prevented her relaxing and enjoying her children. She had also been offered drop-in counselling sessions starting the following week. This session was the penultimate one with PMHW. The FWA had no contact with Ms A during this period due to [REDACTED] and illness.
- 3.13.3 The core group meeting was held on 29 March and the FWA PW failed to attend because she was given the wrong venue. The HV took on the task of referring child A to the Child Development Centre. No time or venue was given for the next core group meeting (02 May). [REDACTED] the social worker's Senior Team Manager did a solution focussed brief therapy session with Ms A as part of her training in the method.
- 3.13.4 At 4.40 pm on 9 April, Ms A took child A to A&E at the North Middlesex Hospital. The triage nurse noted a large boggy swelling to the left side of his head. Ms A's account was that four days before, he had been pushed by another child his age against a marble fire place. Apart from being grizzly over the next two days he had

seemed fine and then he had woken that morning with neck pain, holding his head to the left side. He had a small, round bruise on his right cheek, and obvious head lice, as did his siblings. He was also noted to have petechial spots on the back of both arms. Tests were done for meningitis because of the rash and neck stiffness, although this was eventually ruled out. His throat was noted to be slightly red. Another report said that he had multiple bruising. Body maps indicated bruises and scratches on his face, head and body.

- 3.13.5 Ms A said that she had a friend in the waiting room who had witnessed the fall, and she was fearful that child A would be taken into care because he was on the child protection register. The friend is now thought to have been Mr H. She said that the swelling had only come up that day and there had been no further trauma since the original injury on [REDACTED]. He was admitted to a ward for 48 hours observation. A man referred to as his father was present on two evenings but didn't stay. Ms A is reported to have stayed with him throughout his stay. It is not certain who was caring for the children during this time. .
- 3.13.6 The hospital noted that Ms A was tearful because of her fear that child A would be taken away. She said that the child was always banging his head and that he head bangs. She said that the social worker could confirm this and that is why child A is being referred to the Child Development Centre. Ms A also said that at the last CP conference she was told that if child A ever had another injury, bruise or accident he would be taken away from her. She reiterated that it was an accident and that child A did not become unwell until that day.
- 3.13.7 When interviewed by the SHO later that evening, Ms A elaborated on her account and said that child A had been playing with a friend's [REDACTED] son, and when child A had fallen, this little boy had sat on him and was hitting him. There was a faint bruise on child A's head at that time and over the weekend Ms A had noticed faint bruising around child A's eyes and he developed an upper respiratory tract infection but was otherwise well. By the day of admission she noticed he was unsteady on his feet. By the afternoon he was hot so she gave him Ibuprofen but he continued to hold his head so she brought him to A&E. When Ms A first spoke to the social worker on the telephone on [REDACTED] she said that she had taken child A to the hospital with suspected meningitis, and then went on to explain about the injury. When the social worker spoke to the hospital nurse on the telephone the nurse confirmed that the child had been brought because he was injured but it was not viewed as non-accidental because the mother had stated that the injury had been caused by another child.
- 3.13.8 The admission occurred over the [REDACTED] and child A was seen by different doctors during the 2 days he was observed

and assessed, and the usual shift transfer arrangements were not in place. By the time the final team of doctors assessed child A the original reason for his admission appeared to have been lost, and they speculated that he had experienced some kind of allergic reaction. [REDACTED]

[REDACTED]. The social worker, with the agreement of her team manager, agreed the discharge over the telephone with an undertaking to make a follow up visit to the home. He was discharged on 11 April. The SW visited on 24 April.

3.14 Analysis

- 3.14.1 These injuries were as serious as those that child A had received on 11 December. Even Ms A said that he had received a blow to the head, and admitted that she had waited four days to bring him to the hospital. As a child subject to a child protection plan she was in principle the least reliable witness to trust, yet everybody appeared to accept her account uncritically. There was no suggestion that her friend was interviewed to confirm her account and her own story elaborated as time went on. If the procedures had been followed there should have been a strategy meeting with the police informed so that they could have investigated the account. There should even have been a reconvening of the child protection conference as further injuries had taken place to child A. Child A should not have been returned home without an investigation and further s.47 enquiries being undertaken. It is very hard to understand why both the doctors and the social workers took such a sanguine view of the injuries.
- 3.14.2 This is an example of an over-reliance on medical opinion, not that the doctors were asked formally if the injuries could be considered to be non-accidental. Because they were not ruled in as non-accidental they were then treated as if they were accidental. Nobody could be sure of the cause of them but child A was subject to a child protection plan and the presumption should have been that they were non-accidental, until proven otherwise. The onus should have been on mother to substantiate her claim that the injuries were accidental and there should have been a thorough investigation into her account of how the injuries had occurred. Otherwise there was little point in child A being the subject of a child protection plan.
- 3.14.3 It was for the social workers in CYPS to make the final decision about whether to return child A home although the doctors could have asked for the child protection conference to be reconvened. In order to establish all the available facts, the police would have to be involved. Given the history and background to the case it was a reasonable inference that child A had been injured non-accidentally. The onus should have been on the parent to prove that it had

happened accidentally in the context of s.47 enquiries and a joint investigation by the police and CYPS. There should have been a strategy meeting and the child protection conference should have been reconvened. An interim care order should have been sought to prevent child A's removal from the hospital, and to place him in foster care, while the investigation and a reassessment of his care at home took place.

- 3.14.4 The Panel take the view that the threshold of concern in the child protection system at the time was too high. Both the hospital and the social work staff were too willing to believe the plausible accounts the mother was offering to explain child A's injuries. In the more holistic context of the case the explanations offered by Ms A should have been questioned. A different assessment of Ms A's parenting and her motivation to protect and care for her son should have been considered.
- 3.14.5 The safeguarding and child protection system's expectations of Ms A's parenting in respect of her responsibility to care for and protect her child were too low. There seems little point in making a child the subject of a child protection plan if the parental care of the child continues unchallenged; and the child continues to be subject to the same harm which precipitated the need for the plan in the first place.

3.15 Chronology of events (continued)

- 3.15.1 Child A was discharged home on 11 April. The hospital informed the HV who telephoned Ms A and arranged to make a home visit on [REDACTED]. On [REDACTED] the HV referred child A to the Child Development Centre for his head banging and head butting behaviour. On [REDACTED], Ms A was informed that the first meeting of the Mellow Parenting programme would begin on [REDACTED]. On [REDACTED] the FWA PW telephoned Ms A to make a home visit and was told by Ms A that she wanted a copy of the OFSTED report on the next school for the [REDACTED] older children, and help with milk tokens. The visit was arranged for [REDACTED]. On [REDACTED] the Child Development Centre refused the referral of child A because it contained insufficient information.
- 3.15.2 The SW visited the home on 24 April and saw all [REDACTED] children. Child A appeared unsteady on his feet and the social worker discussed this with Ms A. The discharge report of 17 April from the hospital refers to Ms A reporting a trivial head injury, caused by playing with siblings, a few days before admission. The PW FWA visit of [REDACTED] was cancelled and it is not clear by whom. Ms A did not attend the Mellow Parenting on [REDACTED] because the taxi did not arrive.
- 3.15.3 The core group meeting was held on 2nd May. It was attended by the SW, head teacher, health visitor, and the FWA PW who was late. The school was concerned about Ms A sending [REDACTED] to school too early; SW to make an appointment with the Child and

Adolescent Mental Health Service for child A; HV to visit the family on the [REDACTED]; and Ms A to take the dogs to the RSPCA to find out if they will do a risk assessment; SW to arrange money to purchase a fireguard; and maternal grandfather from Leicester to visit for a week and the family to go to the seaside.

- 3.15.4 Child [REDACTED] and Ms A attended Mellow Parenting on [REDACTED]. The arrangements that were made for the care of child A while they were there are not known. On [REDACTED], child [REDACTED] and child [REDACTED] attended for health assessments. On [REDACTED] the health visitor saw child A at home and observed him to be a lively and active toddler. He is clean and appropriately dressed. There is no fireguard. Child [REDACTED] is talkative and playing happily. A CAF referral is completed with Ms A and an appointment made for her and child A at the clinic on [REDACTED]. On [REDACTED] Ms A and child [REDACTED] attend Mellow Parenting. Nothing is known about the childcare arrangements made for child A.
- 3.15.5 On [REDACTED], Ms A for health record purposes names Mr H as her next of kin and records him as a friend. On [REDACTED] the CDC inform the HV that they have discussed the referral and consider that it would be more appropriate for CAMHS. They would reconsider if they had more information; for example, about the child protection plan. On 16 May the FWA PW makes a home visit and sees child A and child [REDACTED] playing happily. It was not possible to arrange another visit at that time because Ms A was busy and PW faced annual leave and training. Ms A did not attend Mellow Parenting on [REDACTED]. On [REDACTED] child A was seen by the GP for urticaria which started that morning and he was covered with a rash. That same day Ms A attends A&E at the North Middlesex University Hospital with [REDACTED]. The chronology states that there was a letter to the GP from NMUH but it is not in the GP records and he cannot recollect ever seeing it. On [REDACTED] Pathmeads Housing Association commenced legal proceedings for possession of the family home; a routine procedure. On the same day all [REDACTED] children were seen by the social worker and were well and playing happily. On [REDACTED] the police realised that the original investigation of the injuries of 11 December has been mislaid due to changes of staff and resurrected it as a matter of priority.
- 3.15.6 On [REDACTED], the social worker requests a paediatric assessment of child A before the new child protection review conference on 8 June. The reasons given for it are mother's concerns about him head butting people and furniture and a possible high pain threshold. He is described as a happy, sociable boy who smiles and likes to engage with his mother and his siblings. He seems to be interested in his environment and shows a healthy, inquisitive nature. He is being referred because there may be an organic reason for his behaviour. The same day, Ms A attends Mellow Parenting with child [REDACTED] but without child A whose care and whereabouts are not noted because so far as Mellow Parenting understood, child A was not the focus of

their attention. On [REDACTED] the FWA PW fails to make an appointment with Ms A because she goes to Mellow Parenting on a Thursday. On [REDACTED] Ms A does not arrive for her appointment with child A at the health clinic. On [REDACTED] Ms A attends Mellow Parenting with child [REDACTED] and without child A, whose care and whereabouts are not known.

- 3.15.7 On [REDACTED], the school's report for the review child protection conference on 8 June is sent to the SW. While the attendance of [REDACTED] is reported as good, [REDACTED]. On the same day the social worker makes an unannounced visit to the home and observes a bruise under child A's chin. Ms A says it was caused in a squabble with a child of a friend. The SW requests that Ms A take child A to the GP. Child A was taken to the A&E at the NMUH who were aware that he was on the child protection register. The SW acknowledged to the police that child A was clumsy and he does fight with his other siblings. At the hospital a history was taken. Ms A's account is that a friend had been staying with them between 25 May and 28 May and she thought the bruises were caused by rough play with a 22 month old child. Later the account changed to child A being at Ms A's friend's home that day and he bumped into the wooden frame of a sofa. The friend had witnessed the incident.
- 3.15.8 At the hospital child A was observed playing happily in Ms A's presence and he was very active. During the consultation he banged his head once and fell twice onto his bottom. There were multiple bruises and scratches of different ages and some could be explained by normal rough play and falls. There were grab mark bruises on the lower right leg that doctors were particularly concerned about and Ms A said that she had grabbed his leg to prevent him falling off a sofa. The social worker was happy for child A to be discharged home because a friend would be staying with the family over the weekend. The SW would pick up things on the following Monday.
- 3.15.9 The police were informed. They elected not to undertake a joint investigation but to allow the social worker to look into it and to call them in if she felt that they had a role. They would stand by and if the child needed protection then they would take emergency action. This was never requested of them, and would not have been appropriate because the child was already in a place of safety. CYPS felt an investigation was required, but the injuries could be accidental or could be due to a medical condition. There was some support for the view that they could have been caused by a stranger. On 3 June, when the HV contacted Ms A about the failed appointment, she was told what had happened. When the HV could not contact the SW or her manager she contacted the hospital, who added that child A also had an infected finger when seen, that the findings were

inconclusive, and that Ms A was observed to have bonded well with the child.

- 3.15.10 The police were convinced that the injuries were non accidental. They requested that a strategy meeting be arranged and this took place on 4 June. Present were the police, and the team manager and senior team manager from CYPS. The police disagreed with the team managers about any difficulty in obtaining an emergency protection order. Agreement was reached to: undertake s.47 enquiries; hold an urgent legal planning meeting to consider care proceedings; fast track a paediatric assessment; make arrangements for child A to be supervised at the family home by the family friend (Ms M); draw up a contract with Ms A; identify a child minder to assist with the care of the children during the day; and continue an ongoing joint investigation by the police and children's social care. The original plan by CYPS was that child A and child ■ would stay at the home of the family friend, but Ms A objected, pointing out that the friend did not have sufficient accommodation. The arrangement was then made that the friend would stay with the family. Ms A was arrested when she reported for the original bail condition. She was interviewed and she offered a variety of possible causes for the injuries and no admissions were made. When the CDC were contacted the same day for an urgent appointment for child A whom they were told was on the child protection register, they thought they would be able to see him in July or August.

3.16 Analysis

- 3.16.1 The value of an unannounced visit by the social worker was demonstrated in bringing these injuries to child A to light. The worker acted correctly and assertively in not accepting Ms A's explanations at face value, and insisting that child A's injuries be assessed by a doctor at the hospital. Although the view developed that the injuries were inconclusive in respect of being non – accidental, the earlier view was that this was a possible explanation for some of the bruises, and that the grip mark on child A's leg was concerning. Although Ms A had explanations for all of the injuries, she had not been sufficiently concerned about them prior to the visit to seek advice and help. It was reasonable to infer that the injuries were of a non-accidental nature.
- 3.16.2 The police held strongly to the view that the injuries were non-accidental but they did not do their duty by accepting the responsibility to investigate the injuries. They left it to the social worker who is not trained in criminal investigation work. Neither did the police undertake a joint investigation with the social worker. It was not appropriate for the police to offer to take the child into Police Protection in those circumstances, although they were correct to argue that there was a case for CYPS taking out an emergency protection order. The team managers were of the view that it would

not succeed, even though child A had been sufficiently seriously injured in the past to meet the threshold for care proceedings. They did not consult their lawyers to get their advice.

- 3.16.3 The strategy meeting on 4 June lacked a medical input but did have a report from the examining paediatrician. The social worker was on sick leave. This was a further example of an over-reliance on the medical opinion. Seen in the round it was reasonable to infer that the injuries were non-accidental. The proposed solution was even less safe than the one in response to the first injuries. This time the family friend was to be asked to supervise child A's care in the family home. The operational guidance did require them to try to make a placement with a family or friend before using their own foster care placement but this was a child subject to a child protection plan, and the arrangement was in the family home.
- 3.16.4 Neither the social workers nor their managers, nor the child protection advisor, from their own accounts, at any time seriously thought that child A was being harmed or was at risk of harm. They thought of the case from the beginning as a routine, low risk case, requiring family support, and never changed their minds. Key incidents were treated as a series of unrelated, unfortunate events and assessments were never re-evaluated.
- 3.16.5 Part of the terms of reference for the SCR was to examine whether any models of practice had an influence on the way that the case of child A was managed. A model of practice being partially used in children's social care was Solution Focussed Brief Therapy (SFBT). SFBT is a method of intervention which attempts to improve the parents' care of their children by emphasising a focus on their strengths. It has a value base as well as its own methods and skills and adherents go through a period of training and their practice skills are mentored. The senior management of CYPS introduced it as a pilot project within the Safeguarding Team, on the basis of an offer of training which would skill their staff in family support work and create a common ethos around which social workers in the department could work in supporting families. It was seen by some senior managers as appropriate to child protection and at one point they supported a pilot to develop the approach in S.47 enquiries and child protection conferences. Not all staff adopted it, including SW1 and TM1 in the child A case, and the child protection advisor considered unsuitable for child protection in general and certainly for S.47 enquiries and conferences. However, some staff believe that it did create an ethos which above all emphasised the importance of supporting parents.
- 3.16.6 It would be reasonable to infer that the approach may have had some influence as it was being piloted in the social work team that worked with the family from [REDACTED] 2007. The STM was one of the key drivers for the pilot and had conducted an interview with Ms

A using the approach in [REDACTED]. Despite this, there is no evidence from staff interviews or case records that it had a direct impact on the case.

- 3.16.7 This approach may have a place in family work, and emphasising the strengths of parents is important. But it is not compatible with the authoritative approach to parents in the protective phase of enquiries, assessment and the child protection conference if children are to be protected. When the social worker, their manager, the conference chair and the core group are confident that the parents are giving genuine cooperation with the staff, then a family support approach alone like this one is appropriate, as long as there is continued awareness that the assumptions may be mistaken.

3.17 Chronology of events (continued)

- 3.17.1 On 5 June Ms A and Ms M, the family friend, met with the team manager to sign a written agreement to the effect that Ms A and child A did not have unsupervised contact. There was also to be a childminder for child A and child [REDACTED] on particular days. The agreement was to be reviewed in two weeks. [REDACTED] the SW received a letter from PMHW notifying the end of her work with Ms A. Ms A was coping well at present, enjoying life more, and felt more energetic and motivated. She was no longer on medication and would contact the GP if there were signs of deterioration. Relapse prevention had been discussed and Ms A knew the signs and triggers. Ms A did not want further counselling at present but would approach the GP if she changes her mind.
- 3.17.2 On [REDACTED] the police noted that the social worker updated them on the contract. The social worker was not aware of the agreement to have a legal planning meeting. She said she would speak to her team manager and get back to DC2. DC2 recorded that the legal planning meeting was required as the police felt that while their investigation into the injuries was still taking place, child A should be removed from his mother's care. On the same day the school report for the review child protection conference on 8 June was sent to the social worker. [REDACTED]
- 3.17.3 Also on this day a letter arrived from Ms A's solicitor to the social worker, requesting a copy of the medical report from NMUH. There was also a telephone call from the police to the social worker asking her to arrange for them to photograph child A's injuries. Ms A said it wasn't convenient and the SW left it for them to arrange it directly. The HV telephoned the SW to give her apologies for the review child protection conference on 8 June, and that she planned to contact Ms

A to attend the clinic that day, and the GP the next day for child A's immunisation.

- 3.17.4 At the clinic that day, the family friend reported that child A was head banging less and was alert and active. The HV noted that he was walking well and was sleeping through the night and the afternoon and ate well. However he had experienced weight loss; his hair was thin in places; he had scabs on the head and was scratching a lot which was causing hair loss. The HV was to review the weight loss in one month and to report it to the GP if there was further weight loss. Child ■ was also brought to the clinic the same day by the family friend. ■ had bruising on ■ right cheek, caused, said the friend, by a fall when collecting the older siblings from school. ■.
- 3.17.5 On ■, the police recorded an update of their understanding of the current situation and DC2 had spoken with the team manager about the need for an early legal planning meeting. The team manager assured her that they have both the procedures and the structures in place to do this. DI1 agrees that the police will expedite both investigations. ■ SW2 met with Mr A, child A's father, and went through her report to the child protection conference to be held the next day. The same was done with Ms A who indicated that she is unhappy with the police investigation and said she would be seeking legal advice. She reiterated that she would never harm child A. Child A also received his 3rd MMR immunisation at the GP's. The reception staff thought that the woman who took him was so ill tempered and abrupt that they made a note of it. Ms A attended Mellow Parenting with child ■ but without child A, who was presumably in the care of the family friend on this occasion, although his whereabouts at these times have never been established.
- 3.17.6 On 8 June the review child protection conference is held. The police did not attend but sent a report and DC2 spoke with the conference chair outside the meeting to express concern about the delay in holding the legal planning meeting. The Head Teacher did attend and reported that ■. In the meeting she is reported as saying child ■'s attendance and punctuality was good, whereas it was only 90%. There were no concerns about ■. The paediatric consultants from the Whittington and NMUH did not attend, nor did legal services, the education welfare officer, the designated nurse, the school nurse leader, the HV, or the FWA PW. The school nurse did attend, as did Ms A and Ms M, as well as Mr A, and the social worker and her team manager, the Chair and minute taker. The current registration status of the ■ children remained.
- 3.17.7 The minutes subsequently produced recorded wrongly that it was an initial child protection conference; it was a review. The minutes

record the SW as saying that child A was treated for a form of meningitis, which turned out not to be the illness itself. She said that Ms A had reported child A as being pushed over by another child the evening before taking him to the hospital, which had caused a swelling to his head. Ms A's original account was that it had taken place four days before she took him to the hospital. Ms A told the conference that she was not aware that child ■ was underachieving at school, whereas she had been told this at the previous conference and made the same remark. In relation to Ms A's account of child A receiving the injuries as a result of rough play with other children, the SW reminded her of her situation, and the reason she had been asked not to have the care of other children while her own were on child protection plans.

- 3.17.8 The social worker took the conference through the injuries of ■ and said they could not all be explained by Ms A's account. The bruises were of different ages, and injuries were noted to the lower back area, the front chest area, face, ear, and chin. The reasonable conclusion from the medical examination was that the injuries were probably non – accidental. The meeting was informed that a legal planning meeting was to be held within the next week to inform future decision making. The school nurse reported that child A's weight had decreased significantly, from the 75th centile to between the 25th and 50th centiles.
- 3.17.9 The conference chair expressed her concern that child A was experiencing the same injuries for which he was originally placed on the child protection register. In addition, if they were caused by child A's own behaviour as mother claimed, then they should be occurring continuously rather than in a pattern of serious but intermittent injuries. The police report said that Ms A had been arrested and bailed for the injuries on ■ and the investigation was continuing. The social worker was asked to make a minimum of fortnightly home visits, which was less than after the previous conference. The conference agreed to put in place arrangements for observing child A and ensuring that Ms A did not have unsupervised contact with him during the day. This included her attendance at Mellow Parenting. Mellow Parenting were never told of this arrangement and as child A was too young for their programme they were not concerned when he was absent.
- 3.17.10 The conference agreed that next meeting of the core group would be held on 20 June. A legal planning meeting would be held. The next conference was arranged for 9 November. On the same day the police photographed child A's injuries.

3.18 Analysis

- 3.18.1 The review child protection conference followed on closely to the injuries to child A on ■. It was an opportunity to be updated on

events, to take stock, to review the assumptions of the current child protection plan, and to renew the plan where it was necessary. The attendance at the review conference was very poor under any circumstances but given that there had been two sets of serious injuries to child A since the last conference it is difficult to believe that child protection was given priority in the child protection and safeguarding systems. Of the four protecting agencies only the social workers were represented, with doctors, lawyers and police officers absent. They did not send substitutes. Those assigned tasks in the child protection plan should have been invited and present. The FWA PW was not invited, nor was she informed of the dates of this or other professionals meetings after [REDACTED] 2007.

- 3.18.2 The meeting was an opportunity to review what had happened between [REDACTED]; for the doctors to speak of child A's injuries believed directly and advocate for him if necessary; the police that the injuries to child A were non-accidental and could have strengthened their case for a legal planning meeting by attending. The lawyer could have heard the evidence and discussion first-hand from the people present. It was a critical meeting but there is no sense that it was given due weight either in the way that it was organised or in the way that it was responded to.
- 3.18.3 The picture painted by the head teacher of child [REDACTED]'s attitudes and behaviour in school had essentially been the same one for months. It was a concerning picture of an unhappy young child acting out [REDACTED] distress in a very obvious way in school. It appears that nothing was done to address the feelings which underlay the behaviour; nobody appears to have sat down with child [REDACTED] and given [REDACTED] an opportunity to talk about what was causing [REDACTED] to behave in this way. Either the school did not see it as their job or the expectations of the children's behaviour were too low.
- 3.18.4 Both the social worker and the conference Chair grasped the nettle of the gap between the nature of child A's injuries and Ms A's explanations for them. The implication of their statements was that either Ms A or someone else was harming the child. There is no indication of Ms A's reaction to the accusations. However, there was a lack of congruence between their views as expressed in the meeting, and their professional actions. They had made an even less secure arrangement this time with the family friend. There was no plan for what was to happen when the arrangement ended. They had made authoritative statements to Ms A. How would they follow them through with authoritative action?

3.19 Continuation of the chronology of events to [REDACTED] 2007

- 3.19.1 On [REDACTED] the FWA PW telephoned Ms A, who told her that the [REDACTED] were transferring to the new school and that the social worker had made an unannounced visit to the home and found child A with

a bruise on his head as a result of a fall. She had been arrested. Her friend had witnessed the fall and was now living in the home. PW had not been informed of the injury or Ms A's arrest. She phoned the SW who did not return the call. A visit was arranged for 15 June. At the school's admissions interview for the new school on [REDACTED] Ms A attended with her children apart from child [REDACTED]. No member of the school staff was aware of [REDACTED] existence or that the children were subjects of child protection plans. On [REDACTED] a routine weekly child protection meeting at the NMUH discussed child A. The same day Ms A informed the social worker of the new school admission and told her that they would be starting on [REDACTED]. S.17 money was given to Ms M for caring for child A. Ms A attended Mellow Parenting with child [REDACTED] and child A did not accompany them. Legal services were processing the social work team's request for a legal planning meeting; there was an initial delay in offering dates. On [REDACTED] the police asked the SW again about the date for the meeting.

- 3.19.2 On 15 June the FWA PW made a home visit. Ms A's friend Mr H was present. Ms A was upset at being arrested for the injuries to child A because of a fall which had been witnessed by a friend. Ms A was happy to speak in front of her friend because he knew everything. Ms A confirmed that the [REDACTED] older [REDACTED] were changing school and she would prefer PW not to contact the SENCO in respect of child [REDACTED] until [REDACTED] had a chance to settle in. PW agreed. There is no indication that she informed the SW. The date of the next visit would have to be delayed as Ms A was too busy the next week. The childminder telephoned the SW to say that child A had a bruise under his chin. The mark was similar to the one on the body map and Ms A confirmed that it was the same one from the [REDACTED]
- 3.19.3 The SW contacted legal services about the legal planning meeting. On [REDACTED] further s.17 monies were given to Ms M for the care of child A. The SW telephoned the child minder to see the children the following day. The childminder reported that child [REDACTED] was hungry on arrival and that child A was dirty and had a dirty nappy. Ms A telephoned the social worker that day to say that since child A had been cared for by the childminder he was sick after his evening meal. Ms M had spoken to the childminder who apparently gave him a snack after each meal. The SW suggested that she take it up with the childminder. She asked Ms A if child A had nappy rash. Ms A replied that he does on occasion when he is teething and when collecting him from the crèche at Mellow Parenting his clothes were wet.
- 3.19.4 On 19 June child A and child [REDACTED] were seen by the SW at the childminder's home. Both children interacted well with the three other children being looked after. The childminder did not convey any concerns about the children. On [REDACTED] the police contacted the SW about the date for the legal planning meeting. She said the papers had been passed to the team.

- 3.19.5 A core group meeting was held the same day and the issues covered were: that child A did not yet have an appointment at the Child Development Centre on [REDACTED]; police to complete their investigation; child A attended for his immunisations on [REDACTED]; an appointment to review his weight to be arranged; Mr A's capacity with the children was to be assessed; and the legal planning meeting. Ms A and child [REDACTED] were seen by the SW and Ms A was advised to see the GP but the reason for it was not given. On [REDACTED] the weekly child protection meeting at NMUH continued to review their treatment of child A and was awaiting feedback from the police and CYPS. The health records for the [REDACTED] older children were to be transferred with plans for each of the children: to make an assessment of child [REDACTED]'s needs; to see child [REDACTED] for a health review before the end of the school term; to review the height and weight of child [REDACTED] before the end of term. Ms A, child [REDACTED] and child A attended Mellow Parenting. Legal services emailed the social work managers for dates for the legal planning meeting.
- 3.19.6 On [REDACTED] the police contacted the social worker about the legal planning meeting. She reported that legal services had been in contact to arrange a date. On [REDACTED] Ms A left a message for the social worker that it was her birthday and she would be going away with the children. Ms A did not attend Mellow Parenting, reporting that she had to look after a 'sick uncle'. The school record of 29 June shows that [REDACTED] were away from school between 29 June and 5 July and that the absence was authorised. Apparently it was the practice to authorise all absences for purposes of statistical returns.
- 3.19.7 Ms A was eventually contacted by the school and she explained about the sick uncle. [REDACTED] there was a message from the childminder for the SW that Ms A had taken the children away. The SW tried to contact Ms A on three occasions that day without success. Around this time the head teacher of the previous school spoke on the telephone to the deputy head teacher of the new school to provide information about the children, their child protection status, and contact information about the social worker. This transaction was not recorded and the deputy head recalls it but not the information that the children were on child protection plans. The teachers at the school were not informed of the child protection status of any of the children attending the school.
- 3.19.8 On [REDACTED] the FWA PW tried to contact Ms A to inform her about the result of her discussion with Pathmeads Housing Association but there was no answer. On 2 July the SW made contact with Ms A who said that she was looking after her unwell uncle in Cricklewood. She would be returning on either the 4th or 9th July, depending on his health. Ms A had not taken child A to the GP for his sore scalp as she had been too busy, but she would do it on her return. There is no

indication that the SW attempted to obtain the uncle's address. [REDACTED] [REDACTED] the school nurse sent a letter to Ms A to make appointments to see the children, and contacted the school to make arrangements. When she learned of their absence she informed the SW who already knew about it.

- 3.19.9 On [REDACTED] the police contacted the social worker to ask her to obtain information from the GP for their case. On [REDACTED] the social worker and her team manager discussed the implications of Ms A's stay in Cricklewood with the children. The team manager advised the SW to ask Ms A to return home as there was probably very little she could do for the uncle with [REDACTED] children to look after. On [REDACTED] the police spoke with the SW about the progress of their investigation and the SW agreed to assist the police in obtaining a statement from the GP. A letter from the SW to the GP of the same date asks for a report but makes no reference to a police statement. There is no evidence that the GP responded. That same day Ms A attended Mellow Parenting with child [REDACTED] and child A. On [REDACTED] the police completed their review of the original medical opinion on the injuries from 11 December and supported the findings that suggested non-accidental injury.
- 3.19.10 On 9 July the SW made contact with Ms A, who was back in Haringey. She was at a walk in clinic for child A, and said that child [REDACTED] had a cold. Ms A telephoned the HV to say that she could not keep the appointment that day as the children were unwell. The appointment was rescheduled for [REDACTED] Ms A went into school at the request of the school, because child [REDACTED] had a splinter in [REDACTED] as a result of an accident on the playground equipment. The school are not allowed to remove a splinter. They noted that Ms A was gentle, caring and re-assuring with child [REDACTED] while removing the splinter. On [REDACTED] the FWA PW tried to contact the SW and left a message, the SW not having responded since the original message left on [REDACTED].
- 3.19.11 At a home visit [REDACTED], SW2 sees all the children and child A has an ear which is red and looks sore. Ms A showed the SW the medication which had been prescribed for it at the walk in centre. Child [REDACTED] attended for a health review in school and Ms A was seen later in the day. Child [REDACTED] was not observed with [REDACTED] mother but [REDACTED] appeared to have a good relationship with [REDACTED] had head lice and Ms A was advised to treat it immediately. Child [REDACTED] was clean and dressed appropriately. Child [REDACTED] also received a health check that day. [REDACTED] also had head lice. It was noted that [REDACTED] [REDACTED] occasionally. The SN planned to review [REDACTED] and Child [REDACTED]'s health the next term.
- 3.19.12 On [REDACTED] the HV was informed of the WIC attendance. That day, Ms A attended Mellow Parenting with child [REDACTED] and without child A. The SW emailed legal services to offer either [REDACTED] 25 July for the legal planning meeting. The FWA PW was on sick leave and

annual leave until [REDACTED]; this was not communicated to anyone. On [REDACTED] Ms A telephoned the HV to postpone her [REDACTED] appointment to the [REDACTED]. The HV phones the SW, who will follow up the head lice with Ms A on the next home visit. On [REDACTED] legal services agree the date for the legal planning meeting with the social workers for 25 July.

3.20 Analysis

- 3.20.1 During this period, and during every other period that has been reviewed, observations are made of the children, their interaction with each other and with their mother, which are reassuring to the professionals involved with the family. There can be little doubt that these observations are accurate and believed to be genuine. They help to reduce the concern created when child A is injured periodically and they undermine resolve when professionals are prepared to act authoritatively. It is a big decision to remove a child from the care and ambience of his own family, including his relationship with his siblings, especially when there is no decisive act which makes the decision for the professionals and they will have to accept the full responsibility themselves.
- 3.20.2 At no point did it occur to anyone that the injuries were caused by someone else apart from Ms A. On the basis of the observed interactions with her children it seemed to be incongruous and unlikely. They did not appear to be afraid of her. However, Ms A was an extraordinarily neglectful parent and antagonistic to authority figures, and acted this out in the school setting. In addition her [REDACTED] child was acting out in a very unhappy way at school. She could be compliant, particularly in her attendance at Mellow Parenting where she attended most of the sessions. The biggest failure of the intervention with Ms A was not to find how deeply she loved her children or would go out of her way to care for them properly. Very few demands were made on her either in her care of the children or her care of the home. She was usually in charge of the family and of the intervention which was aimed to protect her children and promote their welfare.
- 3.20.3 The Cricklewood episode is a case in point. [REDACTED] of her children are subject to child protection plans, she has recently been arrested for allegedly harming her youngest child, she is the focus of a police investigation, even the social workers are sceptical of her account, and she decamps with all the children without warning or permission. The police are not informed and it does not appear as if she is asked for the address where she is staying so that the authorities locally can establish that the children are safe and the account which she had given is true. She is not tested to see if she is a responsible parent and is not warned of the possible consequences when she returns. Presumably she did not want to risk not being given permission or the possibility that checks would be made, and she

shrewdly judged correctly that there would be no consequences when she returned. When she returns child A has a sore ear which it is assumed has been due to an infection but this is not checked out with the doctors who examined him, to find out if there may have other explanations for the condition. She could have been questioned about the whole episode and checks done to verify her story that she had been looking after this uncle in Cricklewood. Ms A constantly tests the safeguarding and child protection systems and they are always found wanting. (It emerged in the course of the later trial that this story was a complete fabrication)

3.20.4 Another example of the failure of the child protection system to act authoritatively in respect of Ms A and protecting child A, is the failure to arrange an early legal planning meeting to consider the need for care proceedings in respect of child A. In respect of the injuries to child A discovered on [REDACTED] the medical opinion is that some of them could be non-accidental; the police are strongly of the view that they are and constantly press for an early meeting; and even the conference expresses scepticism about Ms A's explanations for them. Despite that, it takes seven weeks to arrange the meeting. The delay is due to a combination of administrative failures on the part of legal services and lack of urgency on the part of the social work managers. To make a wrong decision is regrettable, but to lack urgency in facing it is unacceptable. Legal services completely accept that and they have put in place systems and safeguards which should prevent it recurring in the future.

3.21 The sixth phase: from [REDACTED] to 3 August 2007: the final [REDACTED] weeks of events leading to child A's death.

3.21.1 On 18 July Ms A and child A were seen at the clinic by the HV. His weight had reduced to the 25th centile although his appetite was described as good. It was reported by Ms A that he had been seen at the Walk-in clinic on 9 July and treated with cream for his head scabs. He had also been given antibiotics for his ear infection. His left ear was red on the outside and his lobe appeared to be infected. Mother explained that she had caused the bruising around his ear while she had been trying to clean it. There was to be another appointment to discuss diet and nutrition. Child [REDACTED] was seen at the same clinic and the bruising under [REDACTED] right eye was explained by Ms A as being due to falling out of bed and hurting [REDACTED] face on a toy.

3.21.2 The HV informed SW2 that Ms A had taken child A and child [REDACTED] to the health clinic. Child A had an ear infection and a small bruise under his chin and Ms A reported that it had been caused while she was trying to clean his ear and he struggled. Child A had lost weight and child [REDACTED] had a bruise under [REDACTED] eye. Ms A was advised to go to the walk in clinic at the NMUH. The SW tried to contact Ms A without success, discussed the matter with TM2 and agreed that she should discuss her concerns with Ms A.

- 3.21.3 On late afternoon of 19 July, Ms A attended the walk in centre at the NMUH. The WIC referred child A to A&E, where his inflamed ear was described as a sudden onset ear infection. Ms A said that he had been seen two weeks ago by the GP and treated to good effect but then developed sores on the head. It was noted that child A was well groomed and nourished and that there were no unexplained physical injuries. A history was taken and he was assessed and described as alert and looking around. He had an infected scalp with bloody scabs, head lice and blood around the left ear where he had been scratching. He looked grubby and the middle finger of his right hand was infected in the nail bed. Ms A said that he had developed a hives reaction on his head to red Leicester cheese, which had become infected from scratching. They had difficulty cleaning child A's ear because he would not stop moving around and did not want them to touch his ear. A&E noted that child A was on the child protection register and notified the local authority emergency duty team about his departure.
- 3.21.4 Earlier the same day the SW had telephoned Ms A to ask if she had gone to the walk in clinic. Ms A said that she hadn't as the queue was so long but she would be returning there today. Ms A explained that child ■'s bruise had been caused when ■ fell out of bed and hit ■ face against the toy box.
- 3.21.5 On ■ during the day, Ms A attended the final session at Mellow Parenting with child ■ and child A. ■. Ms A completed a health questionnaire as part of the completion of the programme. ■. On the same day Ms A was sent a letter for her appointment with the CDC on 1 August and a parental questionnaire was enclosed.
- 3.21.6 On ■, Ms A came to school with the buggy, accompanied by a 14/15 year old young woman. The staff assumed that this was a member of the family. The same day the NMUH note of the conversation with EDT was received and it noted that child A and child ■ had head lice. They were given medication for it. On 23 July the childminder phoned the SW to say that she can no longer care for child A and child ■ because of their head lice. Other parents had complained. She would take them back when it had cleared. She thought child A's ear infection was worse. The SW phoned Ms A and expressed concern that the infection was taking too long to clear up and that Ms A should take him again to see the GP. On ■ the HV phoned Ms A because she did not turn up for the planned

appointment that day. It was rearranged for [REDACTED]. On [REDACTED] the FWA PW discussed at an agency team meeting her difficulties in making an arrangement for a home visit with Ms A. The same day the SW phoned Ms A after she had taken child A to see the GP. Apparently the GP was unable to prescribe more antibiotics, was not concerned, and thought child A might have had an allergic reaction to the head lice treatment. The SW received a copy of the letter offering Ms A an appointment with the CDC on 1 August. The legal planning meeting between the SW, TM and the legal advisor took place, and the decision was made that the case did not at present meet the threshold for care proceedings.

3.22 Analysis

- 3.22.1 The review has focussed on the last two weeks of child A's life because it is generally thought that the failures to protect him were particularly marked during this period. The final two weeks of contact by agencies with child A and the A family was probably the most intense of all the periods of involvement described above. A number of decisions culminated during this period, all of which provided opportunities to influence events for the better. However nothing they did suggested that they had any greater concerns for child A's welfare now than at other times during the agency and inter-agency involvement.
- 3.22.2 Nothing illustrates the lack of authoritativeness and the failure to communicate effectively more than Ms A's attendance at the Mellow Parenting programme. This health-led programme offered an intensive day long experience of social learning and support to parents with relationship difficulties with their children. They emphasised their confidentiality so that parents could relax and learn. They did have a safeguarding threshold of concern about parents' care of their children but it is not clear if this is explained to the parents before they join it.
- 3.22.3 Ms A was referred to Mellow Parenting following the original injuries to child A because of concerns about her parenting. By the time she started the programme there had been serious incidents of injuries to her children, two with child A and one with child [REDACTED]. The mutual understanding between those who had referred and those providing the programme was full of ambiguity. The programme providers were aware that child A was on the CPR but only for neglect. They were not asked to assess Ms A's parenting or make report on her progress as a matter of routine, or to give particular attention to the welfare of child A. He could not be the child who was the focus of the work with the parent because he was too young for their purposes; this was to be child [REDACTED]. They were happy to provide the creche facility for an additional child but they did not realise, and they were not

asked, to ensure that child A attended every session so that he could be supervised and observed.

- 3.22.4 The social workers who commissioned the programme saw Mellow Parenting as an important immediate arrangement for the protection of child A and child ■ and also for the longer term in helping Ms A to be a more thoughtful parent. They assumed that both children would be attending each week, while Mellow Parenting only assumed that if the parent attended they would do so with the 'target' child. There was no arrangement to inform the social worker if Ms A did not attend, and crucially none if child A did not accompany them. Ms A attended 9 of the 13 sessions with child ■ but child A only accompanied them on 4 of those sessions. Nobody knew who was looking after him on those days when he did not attend.
- 3.22.5 The long awaited legal planning meeting eventually took place on 25 July. The lawyer was relatively inexperienced in advising in care proceedings and it became clear that the SW and her TM were reluctant to consider care proceedings; they did not see the necessity for them. The conviction demonstrated at the child protection conference on the 8 June had dissipated. Despite the long delay the lawyer was without the medical report of the injuries on ■ ■■■. The background information was incomplete. On that basis the lawyer did not think they could advise on whether the threshold was met at that time. In any event, even if the threshold had been met, it was the TM's decision whether to initiate them or not. The threshold was met. The original injuries to child A met the threshold for care proceedings and that carried through alongside any subsequent injuries. Legal services accept completely that the service in this case was inefficient and did not meet the standard required, and they have made improvements to prevent a recurrence. They also accept that they have an independent safeguarding responsibility to any child, and that if they disagree with the decision of a TM then they have a duty to make representation to managers responsible for them.
- 3.22.6 It can be an unfortunate feature of the understandings in the work that whether the parent is prosecuted or not can become conflated with the degree of risk to the child, and whether care proceedings should be initiated. They are different considerations with different thresholds for action. However they can be become unhelpfully misunderstood around the injuries to the child and the medical opinion. The police are concerned with evidence and place importance on the indications of injuries and the weight which doctors will give to them. Other services can also place importance on the medical opinion of the injuries, too much importance, and they wait for the outcome of the police and CPS' view of them. If they are not to lead to a prosecution the cause of the injuries can become regarded as uncertain and even accidental. The police accept that it

took an unacceptably long time to resolve the position on the original injuries to child A.

- 3.22.7 The delay was due to a combination of administrative failure, a change of jobs, collecting evidence at the time, and the very long time it took to obtain a second medical opinion. That opinion was that the injuries were probably non-accidental but the CPS judged that it was not strong enough for a successful prosecution.
- 3.22.8 There was an unacceptably long wait to offer an appointment to child A at the Child Development Centre (CDC), given that he was a child on the CPR and subject to a child protection plan for both physical injury and neglect. He should have been regarded by those referring him as subject to s.47 enquiries, as this was indeed his status, but he was not regarded as such. The CDC say that if this had been made clear when the TM pressed for an early appointment they would have seen child A within 48 hours. There were prior delays caused by the doctors wanting more information to judge whether the child's needs met their criteria, and at one stage they thought he would better referred to CAMHS, who disagreed. The main problem was the basis on which he was being referred to the CDC, for head banging and for head butting people and objects. There was also concern that he suffered from a high pain threshold and that there might be an organic reason for both conditions.
- 3.22.9 In the view of the panel, the main reasons for which he should have been referred, was for an assessment of the seriousness of his neglect, the impact of it on his development, and whether it was likely that there was any other explanation for the head banging and head butting than the pain and frustration he was experiencing at the hands of those caring for him. Even the family friend noticed that the head banging disappeared while he was in her care. Given the seriousness of the injuries which child A had been experiencing all along, the referral looked like casting around for any kind of explanation for his injuries than that he was being harmed by someone with access to him. In the history which was taken at the CDC on the 1 August one of the hypotheses to be tested when he was eventually to be assessed, was whether there was an organic basis to his self harming behaviour. Whether the CDC doctors should have taken a more serious view of child A's presentation at the interview has been the subject of another review.
- 3.22.10 Child A was seen with Ms A by his GP on 26 July. The GP has said subsequently that he had considerable misgivings about child A's appearance and demeanour at that appointment. He felt that child A was in a "sorry state". However, he did not take any action to alert others to his concern. He assumed that others would have similar concerns and would be in a better position to take action. He knew that child A had an appointment at the CDC in a few days.

- 3.22.11 The FWA assumed a family support role in attempting to safeguard child A and his siblings. They became involved from the first child protection conference and were part of the core group aimed at safeguarding the children and supporting Ms A's parenting. However, despite being in contact with the family until child A died, FWA were not invited to or informed about any professionals meetings after [REDACTED] 2007. The SCR Panel consider that the FWA staff only had a peripheral impact on the functioning of the family and it is important to understand the reasons for that. The main problem was that it was not established that there was a basis to work in a family support mode with Ms A. This was assumed to be self evident from the beginning whereas events demonstrate that Ms A marginalized the worker as she did with every agency who was involved, including most importantly, the social workers. The only way in which a family support worker could succeed in this case, was if the local authority as the lead agency was authoritative, in charge of the intervention, and that the parent understood that the family support agency was their opportunity to improve their parenting. The social worker should have set the expectations and made the consequences clear if they were not met, and the job of the family support worker was to help the parent to meet them. No expectations were set and the family support worker had the job of persuading the parent to work on their needs. The worker needed the parent more than the parent needed the worker, which was true of all the relationships in which Ms A was involved, which was why she was not motivated to change. There were some complicating factors [REDACTED] and illness of staff, and the lack of supervision and support within the agency. The family support worker was marginalised within the core group from the beginning, and was treated as such by the social worker in her lack of communication with her, but the worker too could have been more assertive. However, fundamentally the whole approach was misconceived and the role of the FWA PW suffered because of it. She did well to persevere in the circumstances. The agency has learned the lessons.
- 3.22.12 During the last few days of child A's life he stayed overnight with his father, spent a day in the crèche at Mellow Parenting and was seen by his social worker. None of these people felt concerned about his safety. It can only be assumed that he was as well as he appeared to be at those times. The serious injuries were to come later.
- 3.22.13 On [REDACTED] the FWA PW met Ms A in the street with child A in the buggy, and Ms A explained about child A's head condition. She said that her [REDACTED] children were fine and that she would like to take them away, but thought that it would not be allowed. She had not been able to return PW's calls because she did not have credit on her phone. PW tried to make an appointment for a home visit the following week but Ms A was evasive. The same day child A was taken to the GP for his scalp condition. He was in such a sorry state

that the GP recognised intuitively that he was in a bad way but did nothing because he thought others would do something, and the child was being seen at the CDC in a few days. On 30 July all [REDACTED] children were seen on a home visit by the SW on their own and with their mother. Child A was in the buggy, alert and smiling but overtired. His ear was sore and slightly inflamed. He had white cream on the top of his head and Ms A thought the infection had improved. In respect of his ear Ms A reported that he was picking the scab.

3.22.14 [REDACTED] liked their new school and appeared well [REDACTED]. They asked the SW if she had brought drawing materials for them. They had stayed with their father the previous weekend and child [REDACTED] said that [REDACTED] had attended two football matches. Ms A had a GP appointment and she had arranged for a friend to look after the children. At the GP's she presented [REDACTED]. She said that she was not depressed but she was feeling stressed and worried because of the attention of social services. She said that she had reported the grab marks on child A and then was accused of harming him.

3.22.15 On 31 July the police met with the Crown Prosecution Service (CPS), who advised no further action on the prosecution.

3.22.16 On 1 August Ms A took child A to the CDC appointment, accompanied by her friend Ms M, whom the doctor took to be a foster carer for child A. Child A was unwell with a temperature and a runny nose. Ms A shared her concerns about his behaviour. A paediatric social, developmental and family history was taken. Ms A became tearful when reporting that CYPS had accused her of causing the bruises to child A. She said that he was a much wanted [REDACTED]. Numerous bruises were noted and his weight was on the 9th centile. The doctor concluded that he was unwell and miserable due to a possible viral infection. He had a history of recurrent bruising and recurrent infections; a history of abnormal behaviours – aggression, head-butting, head banging and hyperactivity – and there is a possibility that he might have some underlying metabolic disorder. The doctor thought he should be in hospital and advised Ms A to go to the GP or the hospital A&E if he did not get better. No reports had been provided of his previous admissions and attendances at the Whittington and NMUH for possible non-accidental injuries and no request was made for any.

3.22.17 On [REDACTED] Ms A telephoned the SW about the CDC appointment which had taken place [REDACTED]. Child A had a temperature so the assessment could not be carried out. He had a fungal infection on his ear and scalp and needed to continue with his antibiotics. He was to be seen in three weeks for the assessment. Ms A said she

felt listened to and was able to share her concerns. Ms A did have an appointment with the HV but she was waiting to collect her medication and left a message for her. The SW appeared to confirm with her that as she had seen the paediatrician she did not now need to see the GP.

- 3.22.18 On 2 August Ms A was seen by the police and at the social services offices and was told that both prosecutions would not be pursued. That day Ms A phoned PW FWA to report on the meeting with the CDC. PW wanted to make an appointment for the next home visit but Ms A refused, wanting to enjoy the school holidays with the children. PW was on training and annual leave herself. PW agreed to contact Ms A early in September prior to the next review CP conference on the 12 September. The final s.17 monies to the child minder were paid; the last payment the STM noted that would be needed given the CPS decision. Ms A failed to attend the GP appointment arranged a week earlier for child A.
- 3.22.19 On 3 August the London Ambulance Service responded to a 999 call at 11.35am. The caller was Ms A who reported a 17 month old child, taking antibiotics, now not moving. She couldn't wake him up. She reported to the crew that she had last seen him at approximately 1 am and that he had been unwell recently with a fungal infection. Ms A travelled in the ambulance to NMUH with child A. He was pronounced dead at 12.19 pm.

4. CONCLUSION

- 4.1 The SCR Panel is of the view that almost all the staff in every agency involved with child A and the A family were concerned to play their part in safeguarding child A and supporting Ms A to improve her parenting. They were deemed to be competent in their safeguarding and child protection roles as they understood them to be, based on their experience and qualifications. Their responses are likely to be the same as those of the majority of staff working for children in most parts of the country. In this case, the practice of the majority, both individually and collectively expressed as the culture of safeguarding and child protection at the time, was incompetent and their approach was completely inadequate to meet the challenge presented by the case of child A.
- 4.2 The uncooperative, anti-social and even dangerous parent / carer is the most difficult remaining challenge for safeguarding and child protection services. The parents/ carers may not immediately present as such, and may be superficially compliant, evasive, deceitful, manipulative and untruthful. Practitioners had the difficult job of identifying them among the majority of parents who are merely dysfunctional, anxious and ambivalent. The interventions were not sufficiently authoritative by almost every agency. The authoritative intervention is urgent, thorough, challenging, with a low threshold of

concern, keeping the focus on the child, and with high expectations of parenting and of what services should expect of themselves.

- 4.3 Everybody working as 'safeguarders' in the safeguarding system, ie. Especially those working in the universal services provided by health, education, early years and the local police, needs to become more aware of the authority in their role, and to use it to safeguard the children as well as to support parents. The mode of relationship with parents, especially on first meeting them needs to be observing and assessing as well as helpful. Those agency roles which are the protectors – doctors, lawyers, police officers and social workers – need to become much more authoritative both in the initial management of every case with child protection concerns, and in the subsequent child protection plan. It is crucial to be sceptical of the accounts which are given for any maltreatment of the children, and they should be tested thoroughly against the facts. The reasonable inference must be the basis of any action less than care proceedings or prosecution.
- 4.4 Implicit within this report has been the consideration of the resourcing of children's social care in Haringey. It is clear that there were budgetary movements in the periods 2005/06, 2006/07 and 2007/08, but these did not reduce the overall quantum of resource. Within the scope of this review it is difficult to determine whether or not that quantum of resource should have been deployed differently. However, what is clear from the detailed consideration of workload and deployment of frontline staff, is that further resources in themselves would not have impacted on the outcome of this case.
- 4.5 It is important to remember that every year many children die non – accidentally in our country and some of them in similar circumstances to those of child A. This is not a problem restricted to Haringey and we must learn the lessons. The problem is not just the tragedy of an individual child's death but that many more children may be suffering hardship 24/7 because services do not effect sufficient improvement in the parenting.
- 4.6 Only a small minority of children will come forcibly to our notice through their deaths. A larger group are at risk of suffering significant harm and an even larger group experience impoverished childhoods. Much of this should be avoidable through an improvement in parenting and an improvement in the abilities of universal and targeted services for children to identify the different levels of risk and need and respond to them effectively.
- 4.7 Child A's horrifying death could and should have been prevented. If the assumptions and approaches described in this report had been applied by the four protecting professions, the developments in the case would have been stopped in its tracks at the first serious incident. Child A deserved better from the services which were there to protect

him, and they in turn deserved better than the ethos which influenced their work at the time.

- 4.8 In reviewing the services' responses to child A and his family, the Panel concludes that nothing less than injuries that were no accidental beyond all reasonable doubt would have caused him to be moved to a place of safety. When they did come they were also catastrophic, and he died of them. The panel deeply regret that the responses of the services were not sufficiently effective in protecting him or his siblings [REDACTED]. The panel and those independent consultants who contributed to the review have done everything they can to identify the lessons which they believe will significantly reduce the possibility of a similar case happening again. The managers and staff of the agencies involved are fully committed to implementing those lessons.

5. RECOMMENDATIONS

- 5.1 The LSCB and the Partnership must ensure that staff in the four protecting professions – doctors, lawyers, police and social workers – are appropriately trained, individually and together, in the principles of authoritative practice described in this Serious Case Review.
- 5.2 The LSCB and the Partnership must ensure that staff working as 'safeguarders' - the universal services provided by health, education, early years provision and the police – are appropriately trained, individually and together, to recognise the authority in their role and to use it to safeguard children.
- 5.3 The Partnership should give active consideration to the creation of an 'expert pool' from the four protecting agencies. This pool, both virtual and real, will be trained to ensure authoritative knowledge of assessment and intervention. It will be a source of learning, advice and support to ensure effective multi-agency working.
- 5.4 The LSCB will ensure that all agencies fulfil their legal or moral duty to safeguard and promote the welfare of children under s.11 Children Act 2004, and train all staff who have contact with children in safeguarding awareness. The board must seek reports on progress and publish them in their Annual Report.
- 5.5 The LSCB will ensure that the system by which child protection conferences are conducted is changed in order to address the concerns which have emerged from this Serious Case Review. The LSCB will assure itself that conferences are administered efficiently, attended assiduously, managed authoritatively and produce decisions which are child-focussed, with child protection plans that are purposeful and authoritative. The findings should be reported in the LSCB Annual Report.

- 5.6 The LSCB must ensure that children and young people are effectively protected and safeguarded through the regular multi-agency audit of all child protection and safeguarding interventions. It should make report to the Partnership on the quality of their safeguarding and child protection work, and publish the results in its Annual Report.
- 5.7 The Partnership must communicate its passion for an excellent safeguarding service and provide the means for its staff to deliver it. An agency's vision of itself and its sense of drive and purpose is created by its leadership at every level, from the Leader and elected Members down.
- 5.8 The Partnership must fulfil its duty to ensure early intervention in the lives of vulnerable children by addressing with urgency the development of local delivery teams, the widespread use of the Common Assessment Framework (CAF), and the role of the lead professional. It should make report on progress to LSCB and invite the Board to audit the safeguarding dimension of the delivery of the services.
- 5.9 The Partnership must challenge the low expectations of parental care widely held by services and assure itself immediately, through audit, that all children subject to child protection investigation and planning are properly protected.
- 5.10 The Local Authority should assure itself that all schools are well trained in the practices associated with welfare and child protection and are clear about their responsibilities in relation to Every Child Matters. This recommendation equally applies to early years and other educational providers.
- 5.11 The Local Authority should secure an external audit of resources made available to children's services between 2005 and 2008, to satisfy themselves that their expenditure was sufficient to meet the needs of those services and with a view to establishing the appropriate level of resource to meet the requirements of the JAR Action Plan.
- 5.12 Haringey CYPS will ensure that social workers and their managers are trained, supervised and supported to fulfil their statutory role, with the skills to purposefully and authoritatively drive forward child protection plans with the support of other members of the core group.
- 5.13 Haringey CYPS should immediately review the use of Solution Focussed Brief Therapy in their work with families. While the approach may have value where families have the motivation and capacity to benefit from family support, it is not appropriate for use in s.47 investigations, in initial child protection conferences or with families subject to child protection plans until they are assessed as being able to benefit from family support approaches. Its impact on the present ethos in the department should be checked as a part of the review.

The department should ensure proper processes are in place for the initiation and evaluation of any change in approach to social work practice.

- 5.14 All agencies offering a family support service to children who are the subject of a child protection plan or to parents of such children, should train their staff how to work in a complementary role to the social worker who leads and coordinates the child protection plan. The recommendation applies equally to agencies offering parenting programmes and to adult-focussed services.
- 5.15 Haringey LSCB is required to ensure that any outstanding recommendations arising from the previous Serious Case Review (SCR) are fully implemented in accordance with the Joint Area Review (JAR) Action Plan. The JAR Action Plan will sit alongside and take forward the learning from this Review and the LSCB should scrutinise each development to be assured of its co-ordination, implementation and effectiveness.

To achieve these recommendations, clearly a composite Action Plan will be called for. As the final recommendation makes clear, the necessary actions as caused by the previous Serious Case Review - despite its unsatisfactory nature – are, in the main, appropriate. However, additional actions stem from the recommendations above, both for the LSCB and for other agencies. Furthermore, important actions are detailed in Haringey's response to the Joint Area Review of November 2008. Obviously, there will be a further meeting of the LSCB before publication and if necessary an extraordinary meeting of the Children & Young People's Strategic Partnership, so that an Action Plan that takes account of all the above can be developed in the most expedient way.

GLOSSARY OF TERMS

Family members & significant others	
Child A	Baby P
Ms A	Baby P's mother
Mr A	Baby P's father
Ms AA	Baby P's maternal grandmother
Ms M	Mother's friend and informal carer of child A
Mr H	Ms A's boyfriend
Mr L	Mr H's brother
F	Mr H's 'girlfriend'

Glossary of Terms	
A&E	Accident & Emergency
CAF	Common Assessment Framework
CDC	Child Development Centre
CONEL	College of North East London
CPA	Child Protection Advisor
CPS	Crown Prosecution Service
CYPS	Children & Young People's Service
FWA	Family Welfare Association
GOSH	Great Ormond Street Hospital

HARTS	Haringey Tenancy Support for Families
HtPCT	Haringey Teaching Primary Care Trust
HV	Health Visitor
IMR	Individual Management Review
JAR	Joint Area Review
LAS	London Ambulance Service
LSC	Learning & Skills Council
LSCB	Local Safeguarding Children Board
MPS	Metropolitan Police Service
NHS	National Health Service
NMUH	North Middlesex University Hospital
PCMHW	Primary Care Mental Health Worker
S.47	Section 47, Children Act 1989- child protection investigation
SCR	Serious Case Review
SW	Social Worker
TM	Team Manager
STM	Senior Team Manager
SM	Service Manager
WIC	Walk in Centre