LONDON BOROUGH OF
WANDSWORTH
SAFEGUARDING CHILDREN BOARD
SERIOUS CASE REVIEW
BABY ELIZA

FERGUS SMITH

October 2018
# Contents

1 INTRODUCTION 2
  1.1 Event triggering this serious case review 2
  1.2 Purpose, scope & conduct of the review 3

2 PRE-REVIEW PERIOD FAMILY HISTORY 6
  2.1 Earlier involvement with Police & Children’s Social Care & pregnancies 1 - 4 6
  2.2 Support as a care leaver 13
  2.3 Child protection response / pregnancies 5 & 6 18
  2.4 Legal planning meeting / pre-birth planning & subsequent events 27

3 REVIEW PERIOD 30
  3.1 Delivery & post-natal care at St. George’s Hospital 30
  3.2 Mental health medical review 32
  3.3 Discharge planning meeting & follow-up 33
  3.4 Further mental health medical review 36
  3.5 Child AA’s injuries 37

4 RESPONSES TO TERMS OF REFERENCE 38
  4.1 Introduction 38

5 LEARNING FROM PERIOD OF REVIEW 46

6 RECOMMENDATIONS 47
  6.1 Wandsworth Safeguarding Children Board 47
  6.2 Chelsea & Westminster Hospital 47
  6.3 South West London & St. George’s NHS Mental Health Trust 47
  6.4 Metropolitan Police Service 48
  6.5 CCG &/or GP Service at relevant practice 48
  6.6 Children’s Social Care 49
  6.7 St George’s Hospital 49

7 GLOSSARY: ABBREVIATIONS 50

8 BIBLIOGRAPHY 51

TERMS OF REFERENCE 52
1 INTRODUCTION

1.1 EVENT TRIGGERING THIS SERIOUS CASE REVIEW

1.1.1 Child ‘AA’ (a 4 month old Black British female) had been in the care of her single mother and (to an unknown extent) her birth father. Just before Christmas 2015, Ms. A called an ambulance and her daughter was taken to St. George’s Hospital where a CAT\(^1\) scan revealed unexplained cerebral bleeding thought to have occurred on more than a single occasion.

1.1.2 Child AA remained in hospital for 15 days. Medical opinion is that the cerebral bleeding was non-accidental and may result in long-term adverse consequences. Child AA was subsequently made subject of an interim Care Order and placed with foster carers.

1.1.3 Child AA’s mother (a 25 year old Moslem African-Caribbean and referred to in this report as ‘Ms. A’, had herself been in care when she was 15 and offered support as a ‘care leaver’ thereafter. A previous male child (sib.1) had been removed because of concerns about parental neglect. Pre and post-birth assessments had not raised serious concerns about the risk to child AA and the plan had been that she should be supported as a ‘child in need’\(^2\) and remain in the care of her parents.

1.1.4 In accordance with the Local Safeguarding Children Board Regulations 2006 and local agreed procedures, child AA’s hospitalisation was discussed at the ‘Serious Case, Improvement and Learning Sub-committee in mid-June and again early July 2016.

1.1.5 It was concluded that the primary criterion for initiating a ‘serious case review’ (reproduced in paragraph 1.2.1) was satisfied and a recommendation made to the independent chairperson of Wandsworth’s Safeguarding Children Board that a serious case review be commissioned. The chairperson ratified that recommendation on 06.07.16 and the Department for Education. The regulatory body Ofsted and the ‘National Panel of Independent Experts’ (NPIE) were informed.

1.1.6 This serious case review was undertaken between September 2016 and April 2017 in accordance with the terms of reference appended.

---

1 A CAT makes use of computer-processed combinations of many X-ray images taken from different angles to produce cross-sectional (tomographic) images of specific areas of a scanned object, allowing the user to see inside the object without cutting.

2 A child is defined as ‘in need’ if s/he is unlikely to achieve or maintain, or have the opportunity to so do, a reasonable standard of health or development without provision of services by a local authority, or if her/his health or development is likely to be significantly impaired, or further impaired without such services or s/he is disabled [s.17 Children Act 1989 as amended]
1.2 PURPOSE, SCOPE & CONDUCT OF THE REVIEW

PURPOSE

1.2.1 Regulation 5 Local Safeguarding Children Boards Regulations 2006 requires Safeguarding Children Boards (LSCBs) to undertake reviews of ‘serious cases’ in accordance with procedures in Working Together to Safeguard Children HM Government 2015. A ‘serious case’ is one in which abuse or neglect is known or suspected and the child has died or has [as in this case] been seriously harmed and there is cause for concern as to the way in which the local authority, LSCB partners or other relevant persons have worked together to safeguard the child.

1.2.2 Its purpose is to identify required improvements in service design, policy or practice amongst local or if relevant, national services. A serious case review (SCR) is not concerned with attribution of culpability (a matter for a criminal court), nor (in cases where that is relevant), the cause of death which is the role of a Coroner.

SCOPE

1.2.3 The primary period of review was agreed as being child AA’s birth in early August 2015 to the date of her hospitalisation though agencies possessing relevant material that pre-dated child AA’s birth (records of a disrupted childhood, care and after-care, ante-natal care, removal of sib.1 and Ms. A’s significant mental health history) included it in their submissions.

CONDUCT OF REVIEW

1.2.4 An independent report was commissioned from www.caeuk.org and it was agreed that upon receipt of relevant material, overview author Fergus Smith would:

- Collate and evaluate it
- Develop and conduct consultation / learning events with relevant professionals and
- Develop for consideration by the serious case review panel a narrative of agencies’ involvement and an evaluation of its quality, conclusions and recommendations for action by Wandsworth’s Safeguarding Children Board, member agencies and (if relevant) other local or national agencies
1.2.5 The SCR panel comprised:

- The independent chairperson of Wandsworth Safeguarding
  Children Board (who chaired the review)
- Designated Doctor for Safeguarding Children (Wandsworth
  Clinical Commissioning Group)
- St. George’s University Hospitals NHS Foundation Trust
- Chelsea & Westminster Midwifery Services
- Named GP
- Wandsworth Housing Service representative
- South West London & St George’s NHS Mental Health
  Trust
- London Probation Service representative
- Designated Nurse for Safeguarding Children (Wandsworth
  Clinical Commissioning Group)
- Senior manager from Wandsworth Children’s Social Care
- Head of Safeguarding Standards Wandsworth Children’s
  Social Care
- Metropolitan Police Service representative
- Safeguarding Board Business Manager

1.2.6 The following agencies supplied information to the SCR panel:

- Wandsworth’s Children’s Social Care (Hospital Social
  Work, Care Leaving Services and involved Family Centre)
- Wandsworth Housing Service
- St. George’s University Hospitals NHS Foundation Trust
  (Acute & Community Divisions)
- South West London & St George’s NHS Mental Health
  Trust
- GP Services
- London Probation
- Metropolitan Police Service (MPS)

1.2.7 An early consultation event was held and attended by the majority of
involved professionals. The purpose and process of the review was
explained and the means by which individuals could contribute clarified.
Initial findings were later debated at a second event before presentation to
the Safeguarding Children Board.

1.2.8 Notifications and invitations to contribute were issued to child AA’s parents.
Neither responded.

1.2.9 A copy of this report is being sent to the national panel of independent
experts (NPIE) and to the Department for Education (DfE).
It is thought that in addition to the live births illustrated, Ms. A has in the past 10 years experienced 5 miscarriages / terminations
2 PRE-REVIEW PERIOD FAMILY HISTORY

2.1 EARLIER INVOLVEMENT WITH POLICE & CHILDREN’S SOCIAL CARE & PREGNANCIES 1 - 4

2.1.1 It is understood that Ms. A first entered the UK when of pre-school age and spent some time at ‘address 1’ in the care of her maternal grandmother (i.e. child AA’s maternal great grandmother MGGM) as well as other periods back in Guyana with her birth mother.

Comment: what appears to have been a very disrupted childhood would have rendered it difficult for Ms. A to form secure attachments, receive adequate schooling or form enduring friendships.

INVolVEMENT OF POLICE

Offences committed by Ms. A

2.1.2 The first incident in which Police were involved with Ms. A’s family was in February 2003 when officers were called to address 1 by child AA’s great grandmother). Ms. A (then aged 10) was accused of short-changing her grandmother. No confirmation exists of a notification to Children’s Social Care of this family argument (which at that period would have been a paper ‘form 78’ rather than the current electronic ‘Merlin’ notification).

2.1.3 In August 2003 Ms. A was arrested for shoplifting and later, having admitted the offence, received a formal reprimand.

Ms. A reported as missing

2.1.4 Just over a month later, Ms. A was reported missing having been given permission to visit an ‘aunt’ who lived in the same block of flats. She returned next day but refused to disclose her whereabouts. It is thought likely that a Merlin notification was sent to Children’s Social Care.

2.1.5 In the following Summer (Ms. A aged 11) was reported as missing on 2 occasions, each time returning of her own volition on the same day and refusing to confirm her whereabouts.

2.1.6 In September 2004 (Ms. A then 12) Police were again called as a result of a further argument between her and her grandmother about money. Officers noted that Ms. A manifested ‘anger issues’. On a further occasion in late October, Police and London Ambulance Services were involved when it appeared that Ms. A had become intoxicated by means of consumption of vodka. Grandmother described her as being uncontrollable and she was aggressive and verbally abusive toward officers attending. A notification was sent to Children’s Social Care and an ‘initial assessment’ was completed at the time by the hospital team.
2.1.7 In November 2004 (aged 12) Ms. A was again reported as missing and on this occasion it seems that she had been at a party. At a ‘safe and well' return interview, she alluded to there being ‘a reason' why she went missing but would not describe what it was. Police were called back to the home on the same day and a 15 year old friend passed over to officers the mobile phone number of a 22 year old male whom she reported Ms. A had been with the previous evening (a number with which grandmother was familiar and known to have used by her in attempts to contact her granddaughter).

2.1.8 The record of the above assessment noted that Ms. A had been out of school for some 7 months. It made no mention of her step-grandfather and the worker’s proposed response / plan was limited to the grandmother approaching ‘Social Security' to establish whether they would pay for a one-way trip back for Ms. A to return to Guyana.

Comment: though the ascription of age differed (the informant stated 22 and the man who was to become the father of sib.1 and child AA was then 25) it seems likely that this was the same individual. The proposed plan was optimistic and inadequate.

2.1.9 An ‘agitated, nervous and vulnerable’ Ms. A declined to reveal where or with whom she had been on the nights she was missing. In the knowledge that there may have been a sexual offence committed, the MPS Rape & Serious Sexual Offence (Sapphire) team was allocated to investigate. A prompt visit was made by a specially trained officer but Ms. A appeared composed and made no allegations.

2.1.10 By January 2005 during an investigation of criminal damage to the property of the witness who had assisted in November, officers were told by her paternal step-grandfather that Ms. A was back with her own mother in Guyana. The investigation was concluded on the basis of there being no available evidence.

Ms. A’s allegation of physical assault

2.1.11 Police attended address 1 on 30.07.05 and Ms. A made an allegation that her father (though she denied him this status and referred to him only as an uncle) had physically assaulted her. In an attempt to stop her going out, she alleged that he had punched her in the face and hit her head against the concrete floor. She was treated at A&E and the GP Practice appropriately notified of the incident and of the involvement of Children’s Social Care.

Comment: this incident is the first time that her father’s occasional co-habitation (later characterised as being ‘when he wasn’t in prison’) becomes apparent.

2.1.12 Father was arrested and after an overnight stay in hospital, Ms. A moved in with an unnamed aunt in the block of flats. Grandmother later sought to take responsibility for the assault that officers were sure had been the responsibility of father. Father was subsequently returned to prison for an unrelated offence and because Ms. A (then back home) was declining to complete a video interview, no further action was possible.
2.1.13 There was considerable liaison with named social workers in Wandsworth Children’s Social Care. Recommendations in that agency’s assessment were more robust than in the 2004 predecessor and included a response to the absence of schooling and case allocation to the ‘Child in Need Team’. The assessment also acknowledged the possibility (indicated by her grandmother) that Ms. A was pregnant, but left it for School Health to initiate a ‘confidential discussion’.

PREGNANCY 1 (2005)

2.1.14 The first agency to be told of the first pregnancy of Ms. A (aged 13) was the MPS on 30.09.05. During an investigation of another ‘missing’ episode, her father had reported that his daughter was pregnant though denied knowing how far advanced her gestation was or the identity of the father. He confirmed she had a boyfriend (no age captured) and a Merlin notification was transmitted to Children’s Social Care.

2.1.15 Doctors at the GP Practice became concerned in October 2005 that Ms. A was pregnant and made extensive efforts (including conversations with her father and a home visit) to locate and engage with her. The Medical Defence Union was also consulted. Its advice that ‘every effort should be made to contact patient before sharing information with her [in fact grandmother] …need to assess risk to child / unborn child’ did not offer the doctors sufficient confidence to alert Children’s Social Care or Police.

Comment: confirmation of Ms. A’s first known pregnancy (aged 12) offered clear evidence of statutory rape as defined in the Sexual Offences Act 2003.

2.1.16 Police records indicate that Children’s Social Care was working closely with Ms. A who again reported staying at her grandmother’s home (address 1) only when her father was not there. She was unwilling to make any allegations with respect to her pregnancy and acknowledged only that the baby’s father was an ‘older man’ (this was also reinforced by comments made by a cousin who was distressed that Ms. A had been physically assaulted while pregnant). As on the previous occasion the unwillingness of Ms. A to provide an allegation, absence of medical or other evidence or witnesses led to a ‘no further action’ decision.

2.1.17 2 years later Ms. A revealed to Police that following an assault by her father she had (in her words) ‘miscarried’. Evidence provided to this review indicates that she had complained to her GP of abdominal pain then ignored the advice given to attend hospital. She had later delivered at only 21 weeks into gestation, a baby who survived a few hours. This information (which she reported to the GP months later in February 2006) was captured in child protection notes rather than medical records. The assault to which Ms. A referred had not been reported to Police at the time.

2.1.18 Material found in ‘child protection files’ maintained separately from medical records indicate that Ms. A had been booked in for ‘teenage pregnancy care’ at St. George’s Hospital.

Comment: fragmentation of records renders it more likely that only a partial understanding of any situation will be discerned and adds to existing levels of risk.
2.1.19 A social worker SW1 wrote to the GP in mid-November describing difficulties in reaching Ms. A and encouraging an open channel for communication about child protection-related matters. It seems there were also phone exchanges between SW1 and GPs. In late November Ms. A agreed to GPs sharing news of her condition with her social worker.

2.1.20 At the end of the month a reference (not seen elsewhere) exists in Ms. A’s Teenage Pregnancy Unit notes presumably capturing what she herself had reported. Notes refer to a history of ‘suicide attempts’, ‘physical abuse from partner noted to be of the ‘same age’, a ‘lack of support’ and ‘occasional use of weed’. No specific action seems to have been triggered by these reports. In the event Ms. A mis-carried in mid-January 2006.

2.1.21 Later in February 2006 the GP Practice (with Ms. A’s consent) updated SW1. The Practice was later notified that Children’s Social Care was closing the case because of a ‘lack of engagement’ (Ms. A was still only 14).

Comment: Ms. A had been and was continuing to be sexually exploited and probably also physically and emotionally abused; she was clearly in need of and entitled to services under the Children Act 1989.

2.1.22 Ms. A re-presented to the GP in October 2006 reporting experiences that left her at risk of pregnancy and sexually transmitted diseases. She was not pregnant and was prescribed oral contraception. Her report to the GP was that her sexual partner was of the same age.

PREGNANCY 2 & OTHER EPISODES OF POLICE INVOLVEMENT

2.1.23 In May 2007 the Pupil Referral Unit at which Ms. A (then nearly 15) was nominally a pupil, made a referral to Children’s Social Care. The referral was triggered by Ms. A’s acknowledgement that she was living with a boyfriend and was 8 weeks pregnant. At this time she reported to her GP an assault by unnamed youths. At this consultation Ms. A also reported a ‘regular boyfriend’ whom she said was 18.

Comment: her ‘boyfriend’ was committing an offence under the Sexual Offences Act 2003 that carried a maximum sentence of 14 years’ imprisonment.

2.1.24 Ms. A refused to allow grandmother or father to know of her condition and agreed only that a cousin be contacted. The Medical Defence Union was again consulted by GPs and advised that…‘if potentially hazardous consequences to the patient [are likely?] other agencies can be notified’. More efforts were made by a GP to get Ms. A to engage and he eventually referred her in to the Teenage Pregnancy Unit. His record indicates that Ms. A was ‘Gillick competent’ (and her refusal to notify others, binding).

---

3 A ‘Gillick-competent’ individual is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. In a subsequent Judgment in the House of Lords the ‘Fraser guidelines’ concluded that it is lawful for doctors to provide contraceptive advice and treatment without parental consent providing that:
  - the young person will understand the professional’s advice;
  - the young person cannot be persuaded to inform their parents;
  - the young person is likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment;
  - unless the young person receives contraceptive treatment, their physical or mental health, or both, are likely to suffer
the young person’s best interests require them to receive contraceptive advice or treatment with or without parental consent
2.1.25 A day later father of the unborn child (aged 28) alleged to Police that Ms. A had been assaulted by her intoxicated grandmother who was threatening to kill them both. Ms. A reported being 2 months pregnant and admitted to officers that the man making the allegations was the father of the unborn child i.e. a 28 year old man had impregnated a 14 year old girl.

Comment: her admission could presumably (at the time of her later termination) have been corroborated by DNA testing.

2.1.26 Subsequent efforts by Police and Children's Social Care to locate Ms. A and the father were initially unsuccessful. Within 10 days Ms. A was back home and unwilling to inform a prosecution of her ‘partner’. With no victim or witness willing to make a statement or support prosecution, no further action was taken. A refusal of Ms. A and family to engage with the process rendered the core assessment largely redundant.

Allegation of assault of Ms. A’s father

2.1.27 Toward the end of November 2007 Ms. A’s father alleged to Police that his daughter had tried to stab him. He had a scratch on his neck but there were discrepancies in his account and no corroborating evidence, hence no further action. By then Ms. A had undergone a termination pregnancy.

ALLEGATIONS OF SEXUAL ASSAULT & ENTRY TO CARE

2.1.28 Just before Christmas 2007 Ms. A (aged 15) alleged her step-grandfather had sexually assaulted her that day and often before. She claimed he was the father of her first deceased child and repeated the account of the assault by her father triggering the premature birth. Her account also implicated her grandmother whom she claimed was complicit. A strategy discussion agreed a joint investigation, arrest of grandmother and step-grandfather and accommodation under s.20 Children Act 1989. When police officers called upon address 1, grandmother informed them that Ms. A and her ‘boyfriend’ (aged 28) would often spend the night together.

2.1.29 Following a later arrest by arrangement at the Police station, grandmother denied all charges. She offered an account of Ms. A meeting her 28 year old ‘boyfriend’ 2 years previously when she had felt helpless to prevent their sexual relationship. Her responses implied an acknowledgment that Ms. A’s first pregnancy was a consequence of this relationship. Grandmother was released on bail.

2.1.30 Ms. A completed a video interview and described being sexually abused from the age of 6 to 9 by her step-grandfather on about 4 to 5 occasions a week. Police Powers of Protection were exercised and she was initially placed in a Children’s Home ‘address 2’ though would later be moved back to her grandmother’s home (address 1).
2.1.31 A further strategy discussion was completed to consider Ms. A’s non-compliance with the expectations and threatening manner at the Children’s Home in which she had been placed. Ms. A indicated to a visiting Police investigating officer that she was back in school (having reportedly missed several years of education), had no contact with family but was in regular contact with the man who would later be the father of sib.1 and child AA (she insisted at the time that he was just a friend not an intimate partner). She claimed that him staying overnight was a means of protecting her from abuse by grandparents. Ms. A was adamant that her ‘friend’ was not the father of the foetus terminated in 2007.

2.1.32 The core assessment completed in December 2007 recorded a refusal (not confirmed in GP records) by GP1 to share information without the written consent of his patient (aged 15). The core assessment included in its summary, the following statement with respect to the male that Ms. A described as her source of protection.... ‘questions arise regarding how suitable this relationship is given the age difference’ [father was 28 and Ms. A 15].

Comment: the reported position of GP1 and social worker’s (management-supported) summary suggests insufficient awareness of the Sexual Offences Act 2003 and of the requirements of professionals contained in the then latest edition of statutory guidance - Working Together to Safeguard Children 2006.

2.1.33 Interestingly, the core assessment indicated that Ms. A identified with the Christian tradition whilst her extended family was of the Hindu Faith. In more recent times Ms. A reported that she was a follower of Islam.

2.1.34 In late February 2008 Ms. A provided evidence to Police that her grandmother had offered her money to drop the allegation against her step-grandfather. Following investigation the Crown Prosecution Service concluded that no further action would be taken with respect to an apparent attempt to pervert the course of justice.

2.1.35 During 2008 Ms. A was reported as missing on 61 occasions, the most significant of which were:

- April when arrested in connection with possession of a stolen credit card (a Merlin notification was sent to Children’s Social Care)
- May, when an elderly man admitted paying Ms. A in exchange for sexual services (this was passed on to the specialist MPS for criminal investigation)

---

4 Section 5.25 of Working Together to Safeguard Children 2006 states: ‘Cases involving under-13s should always be discussed with a nominated child protection lead in the organisation. Under the Sexual Offences Act, penetrative sex with a child under 13 is classed as rape. Where the allegation concerns penetrative sex, or other intimate sexual activity occurs, there would always be reasonable cause to suspect that a child, whether girl or boy, is suffering, or is likely to suffer, significant harm. There should be a presumption that the case will be reported to Children’s Social Care and that a strategy discussion will be held in accordance with the guidance set out in paragraph 5.54’ [which describes strategy discussions].
• June (still awaiting the results of her allegations against her step-grandfather and grandmother) when Ms. A was arrested for shoplifting and assault; her grandmother fulfilled the ‘appropriate adult’ role and no further action

• September when MPS officers attended address 1 to which Ms. A had run and were told by a social worker present SW2, that Ms. A was 16 could not be forced to return to her residential unit

Comment: the picture emerging is one of sexual exploitation by strangers as well as family members – whether organised or not is less obvious; given the then unknown result of Ms. A’s allegations against her grandmother, the latter was not a suitable choice of ‘appropriate adult’.

2.2 SUPPORT AS A CARE LEAVER

TRANSFER FROM ‘LOOKED AFTER CHILDREN SERVICE’

2.2.1 In late September 2008 at a looked after child (LAC) review, a move to ‘semi-independent accommodation’ for 16.5 year old Ms. A, was agreed. Case accountability was transferred to SW3 in the Independent Living Service (ILS). A month later Ms. A was formally discharged from s.20 (voluntary) accommodation and a nominal placement at the children’s home terminated because she was not making use of it. Records suggest she was actually staying with her grandmother and/or friends, though maintaining some contact with her allocated worker.

ADDRESS 3 / FURTHER POTENTIAL PREGNANCY

2.2.2 In early December 2008 Ms. A was signed up for a tenancy provided by Shaftesbury Housing at ‘address 3’. Within days a visit by SW4 revealed she had ceased to make use of it and had left it in an untidy and unhygienic. Ms. A later claimed to have returned to the property just before Christmas.

2.2.3 Ms. A consulted her GP again in December, confirmed her termination of pregnancy over the Summer and completed a further (negative) pregnancy test. She was asked to attend Family Planning for suitable contraception.

Comment: the termination of pregnancy was not captured in the medical notes implying that the clinic at which it had been carried out failed to notify the GP; a recommendation to address what is understood to be a not unusual systemic weakness is included in section 6 of this report.

2.2.4 At a further LAC review in March 2009 which Ms. A failed to attend, a plan was made to link payments to her with attending meetings. Efforts were also to be made to assist her use of a source of support for survivors of sexual abuse and to encourage a GP consultation. It seems Ms. A had been living with her grandmother for 9 months. Records capture, but do not elaborate upon grandmother’s disapproval of a ‘boyfriend’ (deduced to be the father of sib.1 and child AA).
Further domestic abuse incident

2.2.5 On a date in mid-April 2009 Police were called to address 1 by Ms. A’s grandmother who alleged that father was assaulting Ms. A. They both admitted arguing but denied any violence. A week later Ms. A was again notified to Police as a missing person. At an office visit a few days later mother denied that she was living with her grandmother and claimed she would return to her allocated tenancy.

2.2.6 Police officers subsequently visited grandmother when she denied that her granddaughter was staying with her. At a visit 2 days later by SW3 she admitted that Ms. A was staying there. The view was formed that although Ms. A was failing to engage with relevant professionals she could no longer be regarded as ‘missing’ and Police were duly notified.

Comment: the account of Ms. A’s early behaviours (and those of her grandmother) illustrate her partial or disguised compliances which came to characterise responses to services offered.

Further domestic abuse incident

2.2.7 Police again attended address 1 in late May 2009 when grandmother feared that Ms. A might stab her. On attendance, no allegations of crime were made and it was agreed that Ms. A (for whom and presumably unknown to officers, semi-independent accommodation was being paid for by Children’s Social Care) would go and stay with a friend in the same block of flats.

Comment: whist the actions of officers on this occasion and the one in April were correct, they should have recorded them on the Crime Report Information System (CRIS) as a non-crime domestic abuse (DA) entry.

2.2.8 In late 2009 records indicate efforts made by a Connexions worker to assist Ms. A find work. In February 2010 at a meeting with SW1 Ms. A referred to ‘getting rid of dogs’ to which she attributed some of her (unspecified) difficulties. Ms. A was supported to complete an application for independent accommodation.

2.2.9 At a meeting with SW3 in May 2010 Ms. A was told that the team had become aware of her domestic abuse and that a place in a refuge was available. She acknowledged the abuse, which she reported was worsening, but felt unable to leave her dogs behind. Maintaining contact continued to be a major challenge for SW3.

Comment: no details of the abuse referred to has been provided nor what potential initiatives on behalf of Ms. A were considered.

5 Disguised compliance involves a parent or carer giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention - the term is attributed to Peter Reder, Sylvia Duncan and Moira Gray who outlined this type of behaviour in their book ‘Beyond Blame: Child Abuse Tragedies Revisited’.
ADDRESS 4

2.2.10 Children’s Social Care had nominated Ms. A as a care leaver and in late June 2010 she moved to a new ‘address 4’ provided by Wandsworth Housing. Ms. A reported that she had latterly been staying with a friend where she ‘felt safe’. The reference to fear appears to relate to her being punched in the face by a named ex-boyfriend though she was unwilling to report the alleged assault to Police.

2.2.11 Because Ms. A was aged less than 21, a tenancy support officer (TSO) from the Tenancy Support Service (TSS) was allocated. A TSO initiated contact with the Children’s Social Care ‘Independent Living Service’ (ILS) a month later when it was agreed that the latter would alert the TSO if the need arose. Ms. A’s ongoing arrears of rent and other charges prompted liaison between the TSS and the Rental Collection Service (RCS). Further efforts by the TSO to engage with Ms. A proved unsuccessful and in late 2011 the case was closed.

PREGNANCY 3

2.2.12 In August 2010 Ms. A (aged 18) self-presented at the Early Pregnancy Unit at St. George’s Hospital and was confirmed to be pregnant at 6 weeks gestation. Next day her GP acceded to her request and referred to a clinic with a view to termination of pregnancy.

2.2.13 Ms. A informed a duty worker at the ILS that the father was a violent ex-boyfriend (presumed to be the same individual to whom she had referred in June). Ms. A alleged that she had been raped by this man and was advised to call the Police. She discussed the possibility of a termination though her GP had already made a referral by then. Ms. A later phoned to confirm completion of the procedure and subsequently failed to attend proposed GP follow-ups later that year or in early 2011.

POLICE RAID / COURT APPEARANCE

2.2.14 In April 2011 a raid was completed by officers responding to reports of dangerous dogs kept for fighting by her ‘boyfriend’ (father of sib.1 and child AA). Ms. A claimed the 4 dogs (one a ‘Pitbull type’) were hers. A later written attempt by Housing to seek from Ms. A’s GP Practice, confirmation of her mental capacity failed because no response was received. GP records make no reference to that request nor why it was overlooked.

2.2.15 Following a further raid on her property in August, Ms. A and boyfriend appeared in court to face a number of charges of dishonesty, assault and possession of class B drugs. Ms. A was cautioned and fined for some offences; others relating to dangerous dogs were dropped.
2.2.16 At an unannounced home visit by an unnamed 'personal adviser' (PA) it was learned that as a result of keeping dangerous dogs in the flat and rent arrears of nearly £2,000, Ms. A had been issued with a notice seeking repossession. Ms. A was in arrears throughout her tenancy and over 200 communications had been sent pursuing the debt. In spite of the above legal proceedings, she remained in the flat.

Further episode of domestic abuse

2.2.17 In mid-February 2012 a neighbour called Police to address 6 to report a violent domestic dispute. Neither Ms. A or father would allow officers to enter. Ms. A was offered standard advice and a ‘victim card’. At a later return visit the flat was in darkness and seemingly unoccupied.

Comment: though recorded as a domestic abuse incident, the fact that 2 previous attendances had not been captured as such, denied these officers the ability to contextualise the incident; all such incidents should be recorded as a non-crime DA entry.

2.2.18 In late March 2012 Ms. A self-presented to her GP and her 4th pregnancy (of about 7 weeks gestation) was confirmed. She disclosed significant domestic abuse (punches to the face and kicking in the abdomen by her partner in an attempt to trigger a spontaneous abortion). She said though, that she wished to continue with the pregnancy.

2.2.19 Ms. A was referred to the Early Pregnancy Unit and asked to report her boyfriend to Police. She later claimed (inaccurately) to have done so. Though apparently ambivalent, she began to engage with ante-natal care and was seen by the GP at 24 and 30 weeks gestation. At her re-consultation in early July she sought a termination, citing a breakdown of her relationship, associated low mood, poor sleep and isolation. Ms. A was referred to ‘Talking Therapies’ though it is thought that she did not make use of that option. The pregnancy continued.

Comment: the boyfriend’s conduct was evidence of coercive control in addition to the previously described physical assaults.

2.2.20 At her first scan in May 2012 Ms. A (aged 20) was offered but failed to take up a parenting group place. In spite of reminders, she appears also to have missed a substantial proportion of ante-natal appointments and accessed ante-natal care only at 32 weeks gestation.

---

6 Under the Children (Leaving Care) Act 2000 and Care Planning, Placement and Case Review (England) Regulations 2010 and Care Leavers (England) Regulations 2010, each local authority has a duty to appoint for each relevant or former relevant young person a ‘personal adviser to help draw up and support ‘pathway plans’ and to keep in touch with those individuals
2.2.21 The Housing Service had liaised with the ILS worker and Police so as to ensure that its proposed possession proceedings were justified. A view of Ms. A’s mental capacity was sought from GP and Children’s Social Care. The former failed to respond and the latter offered the view that Ms. A was capable of understand her situation. The conduct and outcome of the court hearing which was delayed by over a year, are described below.

Comment: the efforts made by Housing were in the author’s view, commendably sensitive and thorough; the GP Practice had a professional obligation to respond to the enquiry.

PRE-BIRTH ASSESSMENT / BIRTH OF SIB.1

2.2.22 A pre-birth assessment meeting was held on 22.10.12. Present were Ms. A, health visitor HV2 and social work team manager TM1 from St. George’s Hospital. Ms. A’s pregnancy was said (whether by her or a midwife is unclear) to be progressing well and Ms. A reported being ‘mentally ready’. She was prepared to return 1 of what she claimed to be only 2 dogs to the breeder.

Comment: it is not entirely clear how many dogs there may have been, whether some were of a breed banned by law or why Ms. A’s assurances about removing a dog was trusted.

2.2.23 In early November 2012 (at 37 weeks gestation) Ms. A gave birth to her son (referred to in this report as sib.1). She refused to discuss the risk posed by her dogs to the new baby and focused only her grievances about her flat. She agreed that an inspection could be made and that boyfriend would contain the dogs [plural; i.e. there remained more than 1 in spite of her promise in October] during such a visit.

Comment: the serious case review group has been informed that DNA tests confirm that the same male is the father of sib.1 and child AA.

2.2.24 Records indicate that Ms. A planned to move out of her flat to friends whilst remedial work was completed. Her plan was reportedly known to and agreed by TM1. Ms. A claimed that her grandmother would keep 1 dog and she would retain the other (implying once again there a total of 2, though by January 2013 there were 9).

2.2.25 No evidence has been found in Ms. A’s medical records of any post-natal check by the GP, nor of any correspondence about a discharge planning meeting.

2.2.26 On 06.11.12 HV2 made an unannounced home visit and was told by an unidentified male that Ms. A and baby were still in hospital and fine. HV2 made a further unsuccessful attempt on 14.11.12 to locate Ms. A and baby. On 07.11.12 a social work visit was completed and 5 puppies (claimed to belong to father) and 2 other dogs seen.

Comment: the identity of the male should have been captured; the unremarkable environment contrasted with the serious concerns about home conditions in Ms. A’s own home described below.
2.2.27 A phone call initiated by Ms. A reported that she and her baby were temporarily living with an aunt in SW19 due to ‘damp in her own accommodation’. A call to the aunt prompted a denial that Ms. A was still living there. It is unclear whether a planned call to Children’s Social Care was made. A new birth visit was finally made on 19.11.12 and triggered no concerns about mother or baby, their interactions or the environment at address 5 (a cousin’s home).

2.3 CHILD PROTECTION RESPONSE / PREGNANCIES 5 & 6

INITIAL CHILD PROTECTION CONFERENCE

2.3.1 In mid-December 2012 a decision was reached to make sib.1 (then 6 weeks old) subject of a child protection plan under the category of neglect. The issues of concern remained the state of her home, the dogs and choice of relationship. Ms. A claimed to have micro-chipped her dogs (one of several conditions sought by the Housing Service) but no evidence to confirm this was provided in spite of correspondence with her solicitor.

Comment: agencies must make use of all such opportunities to evaluate the extent of genuine compliance with ‘agreements’; input from GPs should have been sought for this and subsequent multi-agency forums.

2.3.2 HV2 received ‘safeguarding supervision’ which reinforced her existing attempts to engage with Ms. A and contribute to the imminent conference. At a clinic visit sib.1 was gaining weight and was on 25th centile. Ms. A was seen to handle the baby well and her current ‘address 6’ was noted.

2.3.3 What is presumed to have been intended to be a core group meeting (though described by some agencies as a ‘team around the child’ TAC) was held in early January 2013. The whereabouts of Ms. A and sib. 1 were apparently uncertain.

Comment: it would help reduce uncertainty and thus enhance confidence if such meetings were described in a manner consistent with statutory guidance i.e. core group (reserving the TAC abbreviation for meetings of a team around the child in early intervention by local agencies).

REMOVAL OF SIB.1 & SELF-REPORTING OF (TERMINATED) PREGNANCY 5

2.3.4 An unannounced visit by SW5 and a colleague was attempted next day initially to the address where mother and baby was claimed to be living address 6 (with the great grandmother) and then on to address 4.

2.3.5 Ms. A refused to answer the door and a smell of cannabis was detected. Police were called and her partner set his fighting dogs on officers attending. Tear gas was used to complete an arrest. Housing Services records of this event refer to 2 adults dogs and 6 puppies (plus Ms. A, sib.1 and partner) living in very unhygienic conditions. A Police record had also alerted officers to the presence of a large Bull Mastiff dog some 2 months earlier.
2.3.6 Following the exercise of Police Powers of Protection, (s.46 Children Act 1989) sib.1 was made subject of an interim Care Order and fostered. The possibility of care by his paternal grandmother was explored though it is understood the child was eventually made subject of a ‘Special Guardianship Order’ made in favour of his paternal aunt.

2.3.7 A formal complaint about MPS actions was made, investigated and not upheld by the MPS Directorate of Professional Standards.

2.3.8 In January 2013 Ms. A again presented at the GP Practice, referred to the fact that sib.1 had been removed and sought a termination of her 5th pregnancy. A referral was made by the GP but the clinic involved has confirmed that a termination was not completed until July. Thereafter, the GP had no further contact with Ms. A for some 2 years.

Comment: assuming that there had been no further (unreported) pregnancy, her termination was completed very close to the 24 week lawful limit.

2.3.9 Within Housing Services, doubts about Ms. A’s capacity to understand what was required of her again prompted staff to seek an informed view, this time from Children’s Social Care. The allocated social worker responded to the request and reported that Ms. A did have capacity.

Comment: it is commendable that Housing Services staff had recognised the possibility that she lacked mental capacity and had twice raised this, though the initial child protection conference should have addressed this issue.

ASSAULT OF MATERNAL GREAT-GRANDMOTHER (MGGM)

2.3.10 In mid-March 2013 Ms. A was arrested for an alleged assault of her grandmother apparently triggered by an argument over a dog. She and her partner were later charged with actual bodily harm (ABH).

2.3.11 At what was described as a Team around the Child (TAC) (more generally known as a core group) meeting on 09.04.13 with SW6 Ms. A and the father accepted that she was unable to care for sib.1. Father asked to undertake a parenting assessment (the assessment of the paternal grandmother having by then concluded that she could not provide suitable long-term care).

2.3.12 In May 2013 Ms. A reported that her father (child AA’s maternal grandfather) had died and used that event to explain her disorganisation at that time. It appears that Ms. A was then having supervised contact with her son. Her contention was that the man then assumed [it is now known accurately] to be the father was no longer in a relationship with her. He was reportedly demanding a DNA test and threatening to prevent her seeing her son again if approved as the long-term carer.

---

7 A ‘Special Guardianship Order (SGO) is a private law order introduced by the Adoption and Children Act 2002 and made under the Children Act 1989; it is intended for those children who cannot live with their birth parents and who would benefit from a legally secure placement; a parent cannot apply to discharge it unless they have the permission of the court to do so; though it is less secure than an Adoption Order because it does not end the legal relationship between the child and birth parents.
OBTENTION OF POSSESSION ORDER

2.3.13 Liaison in early June between the Rent Collection Service, ILS worker and Housing Management led to an agreement the latter would lead on the proposed eviction with anti-social behaviour the main ground. A District Judge heard and rejected Ms. A’s counter-claim that her flat was in disrepair. The court concluded it was Ms. A’s failure to co-operate and enable access which had prevented the completion of specified repairs. The Judge made an Order for outright possession within 28 days and an appeal was unsuccessful.

2.3.14 By June 2013 the dogs still resided in the flat and a Possession Order was issued by the court that gave Ms. A 28 days in which to vacate. Adoption Proceedings had been initiated by Children’s Social Care, though she was also being assessed in terms of her potential to offer ‘good enough care’. Housing records indicate that the RSPCA had a court date for a case against Ms. A for neglect of some of her dogs. In July 2013 TM1 was contacted by the ILS to report that Ms. A might once more be pregnant. It is now known that she underwent a termination of pregnancy in July 2013.

CASE CLOSURE TO ILS

2.3.15 The case was closed to ILS in late July 2013 because Ms. A was by then 21 and not in education or training, hence no longer eligible for its services. In August, she took a dog to Battersea Dogs’ home claiming to have found it. The address given was that of child AA’s father. Ms. A later changed her story to claim that the dog belonged to her brother (it remains unknown whether Ms. A has a brother).

POLICE SEARCH FOR MS. A

2.3.16 Though not included in its chronology of agency involvement, in September 2013 a Police search was initiated for Ms. A in the mistaken belief that she was a missing, vulnerable pregnant woman apparently not engaging with ante-natal care. It was later confirmed by the relevant clinic that her pregnancy had been terminated in July.

2.3.17 An invitation to the GP to contribute to a review child protection conference in late September 2013 was received only 2 days before the event.

Comment: though insufficient notice had been given the GP, the Practice should anyway have responded and provided some form of update and opinion.

2.3.18 Nearby tenants reported conduct by Ms. A and her boyfriend in late 2013 of sufficient seriousness to result in a recommendation by Housing officers to alert the Police. In mid-October officers attended the home in response to a report of concerns for a ‘recently born child’ child (probably but not confirmed to be sib.1) and arrested the boyfriend for obstruction.
2.3.19 A statement made to Police by the paternal great grandmother of sib.1 and child AA claimed that sib.1 was living in a room at her home (presumably in the knowledge of the court which had made the SGO in favour of her granddaughter / the child’s paternal aunt). Efforts to achieve an eviction were continuing at this time. Liaison between Housing and Children’s Social Care confirmed that in the context of the ongoing Care Proceedings, Ms. A was no longer being considered as a long-term carer for sib.1.

EVICITION & CONVICTION

2.3.20 In November 2013 Ms. A’s eviction was finally completed. Arrears by then totalled over £4,000. In February 2014 she approached the ‘Housing Options and Assessment Team’ (HOAT). She claimed to have been living with a friend in Kent, then a cousin in Southfield (who had just left the UK). An ex-neighbour was temporarily allowing her to stay.

2.3.21 In early December 2013 Ms. A appeared at a Magistrates’ court to answer charges relating to her neglect of the dogs in January that year. She was fined and banned from having custody of a dog for 10 years.

MENTAL ILL-HEALTH & HOSPITALISATION

2.3.22 In June 2014 members of the public reported their concerns about Ms. A who was seen on a roof fighting with or being abducted by, 2 men (it was unclear which). When she tried to jump, officers exercised their powers under s.136 Mental Health Act 1983 and took her to Springfield Psychiatric Hospital.

2.3.23 Ms. A claimed to be ‘possessed’ and in need of exorcism. Having provided a reasonably accurate personal history (including the removal of sib.1), she indicated that she often visited her mother in Guyana and referred to what appears to have been sexual abuse when she was only 6 as well as further episodes as a young teenager. The accuracy of her account of having some employment is uncertain. The assessment concluded she had no acute mental illness though had ‘possible ongoing psychological stressors’. She was discharged to GP care.

2.3.24 In July 2014 the GP received a call from child AA’s MGGM reporting her granddaughter was ‘having a nervous breakdown’ and smoking ‘weed’. The advice to come to the Practice to discuss the problem was turned down.

2.3.25 At a later contact with the Housing Department in August 2014 (for which she had made no appointment) Ms. A named a current boyfriend. Her behaviour was of concern to the interviewing officer e.g. she would jump up and leave the room as if expecting someone, rambled and digressed if asked a direct question and failed to answer anything coherently. This same man was named as Ms. A’s ‘next of kin’ in a letter she sent to the GP Practice in late August.

---

8 S.136 authorises Police to remove a person from a public place to a place of safety in order to allow an assessment of a person’s mental health.
SECTIONING OF MS. A

2.3.26 In mid-August 2014, having run out of the A&E Department at St. George’s Hospital, (to which she had been brought by her grandmother) Ms. A was taken to Queen Mary Hospital (QMH) under s.136 Mental Health Act 1983 and sectioned under s.2. There was liaison between the hospitals and an acknowledgment of safeguarding children concerns (though Ms. A’s sib. 1 was nominally living with a paternal aunt).

2.3.27 Her case history also captured her acknowledged cannabis misuse, an inability to eat or sleep, a ‘grandiose presentation with pressure of speech’ and a lack of insight into her condition. Her diagnosis was ‘unspecified non-organic psychosis with possible manic features’. The GP was appropriately notified of these events.

2.3.28 The report supplied by the South West London & St. George’s NHS Trust refers to Ms. A returning in early September from agreed ward leave and reporting an assault by the man she described as ‘ex-partner’ and father of sib.1. She also referred to having been forced to remain in a relationship with him for 5 years and being raped, though because ‘married’ to him [no record of a lawful marriage has been located] she did not regard this as rape. She also alleged that she had been forced to undergo 3 abortions.

2.3.29 Police were informed on 04.09.14 that Ms. A had failed to return from unescorted leave. It was reported that without her anti-psychotic medication, she would become aggressive and argumentative. She was rated ‘medium risk’ and upon her voluntary return declined to pursue claims that she had been beaten up by her ‘ex-husband’ (it is not possible to be certain to whom she was referring).

POLICE & A ‘MARAC’ REFERRAL

2.3.30 Ms. A’s allegations of abuse and her so-called ‘ex-partner’s’ involvement in gang-related activities were reported to Police and a commendable MARAC referral initiated by consultant psychiatrist 1. No record of community health staff or Children’s Social Care captured that referral (Housing records did so). The referral had under the ‘professional judgment’ criteria noted:

- Ms. A’s diagnosis of ‘psychotic illness with manic features’
- That she was currently of no fixed abode
- Her claim of being assaulted several times by ‘partner / ex-partner and his links to named local gang

---

10 S.2 authorises the assessment deemed necessary and lasts up to 28 days.
11 A MARAC (Multi-Agency Risk Assessment Conference) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, ‘independent domestic violence advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.
2.3.31 Consequent investigations failed to confirm a gang connection and investigation of the other allegations led to no further action. By mid-September, the s.2 Order was rescinded and Ms. A agreed to remain as a voluntary patient with a diagnosis of ‘psychotic illness with manic features exacerbated by cannabis use’. A women’s refuge outside the area was apparently sought though not used.

**DISCHARGE FROM HOSPITAL**

2.3.32 Toward the end of the month she failed to return from planned leave and (though no longer a detained person under mental health law) was reported to the Police as a missing person (the GP having provided known contact details). By late October 2014 Ms. A’s whereabouts remained unknown and she was discharged in her absence.

2.3.33 The plan was that her support would be taken over by Wandsworth Early Intervention in Psychosis Service (EIS)\(^\text{12}\) as when she could be located. It is known that the MARAC lead for the Health Trust and the EIS team manager continued efforts to trace her.

2.3.34 In early November 2014 Ms. A contacted the EIS and reported that she had been to South America to attend the funeral of an uncle and was currently now staying with an aunt in Yorkshire. She was offered an appointment and Police were informed of her return to the UK. At a subsequent phone contact next day, Ms. A reported that she was living in Streatham and the impression gained and recorded was that she was of no fixed abode.

2.3.35 At her first face to face meeting with EIS, Ms. A acknowledged (according to that agency’s records) that her son (sib.1) was living with his father’s ‘grandmother’ (where it is deduced that the paternal aunt lived). A medical assessment was scheduled and later deferred at her request.

2.3.36 During November 2014 Ms. A informed Housing of her recent hospitalisation and reported that she was now staying with a friend. She was again asked to produce standard documentation. Pending further enquiries, Ms. A was provided with bed & breakfast accommodation.

2.3.37 By January 2015 when Ms. A was seen by a Community Mental Health Team (CMHT) co-ordinator, she claimed the friend (possibly uncle) with whom she had lived since November 2014 had asked to leave. This friend was contacted and confirmed his wish that Ms. A leave. Ms. A was booked into emergency bed and breakfast accommodation in the borough while her application was being assessed.

2.3.38 In the period January to March 2015 the EIS experience of Ms. A’s (intermittent engagement) was comparable to that of others agencies. Not until mid-April 2015 did an unidentified member of the EIS succeed in re-establishing contact by means of an unannounced visit.

---

\(^\text{12}\) Wandsworth EIS works with adult service users and their carers who have experienced a first episode of psychosis.
SELF-REPORTING OF PREGNANCY 6

2.3.39 In April 2015 Ms. A attended her GP Practice again and (at an estimated 9 weeks gestation) sought a referral for a termination. She referred to her recent psychiatric ill-health which prompted a phone conversation with an unnamed mental health worker. The identity or age of the father was not noted. A second GP initiated the referral for a termination a week later. Ms. A (still pregnant) consulted GPs again at 15 and 20 weeks’ gestation and remained uncertain about her wishes with respect to termination.

2.3.40 In late April at a pre-arranged meeting at the HOAT with mental health co-ordinator present, Ms. A claimed to have no knowledge of rent arrears at her last tenancy. She confirmed the court’s removal of sib.1, reported she was 13 weeks pregnant and was uncertain whether she would seek a termination. She complained of having no support from any agency.

Comment: self-evidently, Ms. A had been fully aware of her history of rent arrears, her failure to settle them and the court hearing leading to eviction.

2.3.41 Ms. A was advised to obtain medical confirmation of pregnancy and present evidence of post-eviction accommodation. When she did so, she was transferred into self-contained accommodation at address 8. Efforts were made by the Housing caseworker in late May 2015 to confirm with Children’s Social Care why sib.1 had been removed. The response prompted a favourable decision with respect to ‘intentional homelessness’ and based on her composite vulnerability, a full housing duty was accepted

2.3.42 At some point in May Ms. A decided to continue her pregnancy.

PERI-NATAL MENTAL HEALTH ASSESSMENT

2.3.43 The EIS consultant psychiatrist initiated a referral to colleagues in the ‘Perinatal Service’ where it was concluded Ms. A might have suffered a ‘depressive episode’ following the birth of sib.1. Risks to mother and baby were assessed as ‘low’ though a prophylactic course of an anti-psychotic medication to which Ms. A agreed, was recommended. The consultant liaised with the Midwifery Service in Chelsea and Westminster Hospital. Ms. A confirmed that the father of sib.1 was also father of her expected child and characterised the relationship as offering support and money though no romance.

2.3.44 At no time during its extensive involvement with Ms. A did the HOAT staff have any safeguarding concerns arising from information provided by others or their own limited observations. Within 2 weeks of moving in, neighbours complained of the smell of cannabis at or around the flat. There was uncertainty about the identity of the cannabis smoker and only a warning letter was sent.
2.3.45 In late May 2015 father attended the HOAT. He explained that his son was living with his paternal aunt having been removed from his mother in January 2013. Father reported that he was allowed contact but would need to obtain accommodation before he could apply for residency. He denied knowing Ms. A’s whereabouts or that he had ever lived with her.

2.3.46 The fact that his name was on the child’s birth certificate was confirmed and he was advised that although not a priority need, if he obtained a Residence Order he should return for assistance with accommodation.

ANTE-NATAL CARE OF CHILD ‘AA’ AT CHELSEA & WESTMINSTER HOSPITAL & PRE-BIRTH PLANNING

2.3.47 Also in late May the Health Visiting Service (by means of the routine monthly GP liaison meeting) became aware of Ms. A’s latest pregnancy. Its records capture the lengthy history of non-engagement with professionals, previous involvement with Children’s Social Care including substitute care of sib.1, domestic abuse and provision of stress-related mental health services from Springfield Psychiatric Hospital. GPs were at that time uncertain of the gestation of the pregnancy. On the same date a standard ante-natal referral letter was received at the Chelsea & Westminster Hospital from Ms. A’s GP.

2.3.48 HV1 subsequently phoned HV6 (the geographically attached health visitor) to provide a handover. HV6 in turn linked with a GP and was told Ms. A had been seen the previous week and had moved to a ‘hostel’ in Balham.

Comment: address 8 is standard local authority accommodation (sometimes called a 'hostel' because of an on-site warden who deals with emergency repairs); this misinformation was carried forward and influenced an assumption later made by medical staff. All professional records need to be accurate.

2.3.49 HV6 phoned SW7 who was ‘not available’ and a message was left seeking a briefing. HV6 also made contact with the Chelsea and Westminster Hospital Maternity Services to see whether Ms. A had booked for ante-natal care. SW7 responded to the message and she and HV6 discussed the case. HV6 was able to share Ms. A’s current address and mobile phone number. In accordance with Health Trust policy, family records were transferred by HV6 to the homeless team HV1.

2.3.50 In mid-June an email was received from SW7 based at St. George’s Hospital who had been allocated to safeguard the unborn baby. She sought and was given details of Ms. A’s appointments. In late May 2015 the unnamed mental health worker at a visit to the new accommodation was told that she had decided to continue with her pregnancy. In early June EIS contacted Children’s Social Care to alert it and a meeting to plan a pre-birth assessment was agreed. GPs provided routine ante-natal care in June. GPs were also notified of an A&E presentation when Ms. A presented with an ankle injury incurred by a ‘fall on a bus’. It remains uncertain whether medical staff considered domestic abuse as an alternative explanation.
2.3.51 Prior to the meeting between mental health and social care staff, a mental health medical review with consultant and care co-ordinator was completed. Ms. A reported historical sexual abuse by the partner of her grandmother (about which she said the Police were already aware). She referred also to some physical altercations with one of her partners (himself reportedly involved in gangs).

2.3.52 Ms. A’s account indicated that the father of the child was the father of sib.1 and that he had a 13 year old daughter by another woman. Ms. A appeared stable, denied substance misuse and no evidence to the contrary was apparent. A week later a joint assessment (EIS and Children’s Social Care) was completed. Child AA’s father was present and expressed concerns about previous experience of the latter agency.

2.3.53 In late June 2015 whilst still awaiting permanent housing, Police were called by a neighbour concerned by an argument at Ms. A’s temporary property and presence of a small child. A similar situation was reported a week later. On both occasions, a smell of cannabis was noted.

Comment: the identity of the child remains unknown and may have been sib.1; A Merlin notification should have been initiated.

2.3.54 The estimated date of delivery (EDD) for the 6th pregnancy was the end of October. Ms. A attended her 1st ultrasound scan in late June (the day Police attended her property) and was sufficiently late for a further ante-natal appointment to require it to be postponed. The hospital’s ‘safeguarding lead’ notified SW7 that she had missed her appointment and was informed that concerns existed because:

- Ms. A had been a ‘looked after’ child
- Her first child had been placed with a relative under the terms of a ‘Special Guardianship Order’
- There was professional concern about cleanliness of her home, cannabis use and the number of dogs
- Ms. A refused to engage with involved professionals

Comment: hospital records indicate Ms. A initially reported this to be her first not 6th pregnancy though later acknowledged the birth of a son in 2012.

2.3.55 When Ms. A again failed to appear for her scheduled appointment the midwife left a message for SW3 and checked contact details with GPs. A message left on the home phone prompted a response and re-scheduled appointment was agreed. Ms. A claimed not to have been informed of her missed appointments though when checked the address held by the hospital was correct (a further example of avoidant conduct).
2.3.56 Ms. A failed to attend 2 subsequent appointments though at a home visit in early July 2015 was described as ‘settled’ in appearance. Ms. A kept an appointment with a perinatal consultant psychiatrist and the information derived was shared with EIS, Children’s Social Care, GP as well as the specialist midwife and perinatal services.

2.3.57 The appointment identified a possible depressive episode after birth of sib.1 when she has been prescribed an anti-psychotic medicine for possible post-natal depression or bi-polar disorder. Ms. A cited partner, his mother and a cousin as sources of support.

2.3.58 The risks to herself and the unborn child AA were evaluated as ‘low’ with no safeguarding concerns. The consultant recommended further use of the anti-psychotic medication and it is known that a prescription for it was made out on 11.08.15 to reduce risk of a relapse. Ms. A supported this approach.

2.4 **LEGAL PLANNING MEETING / PRE-BIRTH PLANNING & SUBSEQUENT EVENTS**

**LEGAL PLANNING MEETING**

2.4.1 A legal planning meeting was convened in mid-July 2015 attended by a local authority solicitor, SW7 and team manager TM1. On the grounds of the previous removal of sib.1 and current concerns, it was agreed that:

- S.47 enquiries should be initiated and if the threshold was reached, a pre-birth child protection conference be convened
- A family group conference be offered
- A community-based parenting assessment be completed
- A report should be sought from the hospital that had provided psychiatric help
- The midwife be asked to complete a toxicology test on Ms. A
- A ‘Pre-proceedings letter’ be issued to the parents and a meeting with them be arranged

Comment: the above elements constituted a comprehensive and proportionate response to the known facts and the agreed action was consistent with the London child protection procedures.

**CHANGE OF PLAN**

2.4.2 Less than a week later TM1 held a strategy discussion with a DS1. No ‘agreed notes’ have been located. The MPS records of this important exchange emphasise only a limited range of concerns (cleanliness of the home and dogs, heightened by a previous failure to keep appointments). MPS notes do not cite the history of domestic abuse (itself under-reported in its records) and nor did Ms. A’s significant mental health difficulties appear prominent in notes of the discussion.
2.4.3 The apparently agreed result of this phone discussion was that Children’s Social Care would proceed with a s.17 assessment which could be re-considered if either parent withdrew their co-operation.

2.4.4 The position adopted by MPS (as captured by Children’s Social Care) was that because the parents were co-operating with Children’s Social Care, the MPS was declining the option of a joint investigation. That understanding of the Police view was not challenged. A further consequence was that the plan laid out at the legal planning meeting was set aside i.e. no single agency s.47 enquiry was conducted.

2.4.5 Feedback from involved Children’s Social Care staff has suggested that this incident was not the only example of a Police perspective dominating and serving (unintentionally) to divert implementation of social work plans. That view is though strongly refuted by the ex-head of service who contributed to this review.

Comment: failure to complete all the tasks agreed at the legal planning meeting (or to alert the Legal Department to that position) was a significant missed opportunity; single agency enquiries under s.47 should have been undertaken.

2.4.6 The policy in Children’s Social Care was and remains, that such decisions are reserved to a service manager or head of service. ‘Outposted’ services such as teams in a hospital have fewer practice opportunities to reinforce that appropriate and cautious policy position.

CHELSEA & WESTMINSTER HOSPITAL ANTE-NATAL APPOINTMENT

2.4.7 At the re-scheduled appointment Ms. A told midwife 1 that sib.1’s father was her partner and father of the unborn child. His (separate) address was provided. Because father was present (predominantly using his phone), gathering information about the couple’s needs was constrained and domestic abuse screening not attempted.

Comment: it is understood that this hospital has now introduced a commendable expectation that all women will be offered a 10 minute 1:1 consultation within the booking process, thus providing the opportunity to confidentially disclose domestic abuse.

2.4.8 The GP had provided the hospital with minimal information with respect to obstetric, mental and general medical health and nothing about domestic abuse or Ms. A’s care history, though had indicated that she was known to Children’s Social Care. Staff were aware (presumably from hospital records) that Ms. A had been a looked after child with a history of substance misuse and a home rendered unsafe because of dogs.

2.4.9 Ms. A was noted to be hostile throughout her appointment and shared none of the concerns that existed about her ability to safely care for a baby. She denied any current or previous misuse of drugs, though when challenged said ‘..oh yeah that was ages ago….’. She declined to provide a urine sample for toxicology and denied any involvement with Children’s Social Care until reminded of SW7’s name.
2.4.10 The midwife completed a health visitor referral, added Ms. A’s name to the ‘vulnerable women’s folder’ and informed the lead midwife for safeguarding. She also made a routine follow-up appointment, though Ms. A had delivered her baby before the date offered. The midwife subsequently updated SW6 on the above and was told of a key-worker 1 supporting Ms. A who was then understood (inaccurately) to be living in a ‘hostel’ awaiting re-housing.

Comment: the midwife’s responses were all consistent with best practice; the misinformed presumption that Ms. A was receiving support as a function of her latest address was unhelpful.

2.4.11 The above event was the only face to face midwifery appointment at this hospital because when Ms. A entered premature labour about a month later, she attended St. George’s Hospital. Ms. A was sent a further warning letter by the Housing Department. This was triggered by complaints of shouting and arguments at her temporary accommodation. The Housing report for this serious case review refers to emailed exchanges in the period from August to November between Housing and Children’s Social Care, about a variety of concerns including further use of cannabis

2.4.12 HV1 undertook an opportunistic ante-natal visit in late July 2015 having been emailed by Housing about the argument some days previously. Father’s presence prevented any significant exploration of domestic abuse. HV1 made 3 further unsuccessful home visits. Though not documented, an interview during this review indicates that the case management was informally reviewed with a senior team member.

Comment: HV1’s persistence was commendable.

2.4.13 By late July 2015 the ‘care programme approach’ (CPA) was to:

- Seek a summary of involvement from her GP
- Advise Ms. A to bring maternity records to appointments
- Complete a joint review with the perinatal nurse and EIS
- Draw up a ‘pre-birth plan’ with Chelsea and Westminster Hospital
- Await confirmation from Children’s Social Care that pre-birth child protection was considered necessary
- Offer support to the father of child AA

2.4.14 It was also noted that Ms. A had met with a vocational adviser and ‘was working on accessing peer support training’. Later correspondence to the GP Practice recommended careful peri-natal planning (the elements of which had been identified as described above).

2.4.15 With Ms A’s permission, the Rent Collection Service liaised with the mental health worker to devise a payment scheme for outstanding arrears. She failed though, to honour agreements made.

2.4.16 The following section 3 described and comments on events, judgments and decisions made during the period under review.
3 REVIEW PERIOD

3.1 DELIVERY & POST-NATAL CARE AT ST. GEORGE’S HOSPITAL

BIRTH

3.1.1 In early August 2015 Ms. A contacted ‘Maternity Urgent Care’ and described symptoms requiring urgent admission. Staff were obliged to respond to her immediate needs without the benefit of medical records. Ms. A delivered child AA next day. When Chelsea and Westminster Hospital was informed of the event, its safeguarding lead tried to contact with SW7 who was on leave. A SW8 confirmed the team was already aware that Ms. A had given birth at 27 weeks gestation.

3.1.2 Child AA was admitted to the neonatal unit (NNU) and was given standard medical treatment for 4 days on the intensive care unit, 28 days in the high dependency unit and 38 further days in the special care baby unit. Given the concerns about the child’s social situation, there was to be a discharge-planning meeting and a ‘community parenting assessment’ was anticipated. Health staff provided responses to Ms. A’s questions and concerns about the treatment required by child AA and she appeared reassured.

3.1.3 In response to a request by unit staff for an account from Children’s Social Care of its level of involvement and plans, SW7 provided a letter outlining concerns about unsuitable housing, cannabis use, dogs and neglect of sib.1 leading to alternative care arrangements. The letter did not refer to Ms. A having herself been in care, nor to her history of domestic abuse and mental ill-health.

3.1.4 The Health Visiting Service was notified of the birth by email on following a ‘vulnerable women’s forum’ meeting at the hospital (normally new birth notifications are sent to the Child Health team by the Maternity Unit and then sent by means of Rio (the relevant database) to the health visiting cluster based upon a patient’s address).

3.1.5 Ms. A was reported to be unwilling to seek more appropriate accommodation and to have resisted engagement with the department prior to the birth of child AA. The correspondence confirmed an intention that a ‘community parenting assessment’ would be completed at a named Family Centre.

3.1.6 The parents and other (unidentified) relatives visited when child AA was 4 days old and the parents maintained contact and visits over the next few days when Ms. A read to and played with her baby. It appears that the Early Intervention in Psychosis Service (EIS) had not been informed of the birth of child AA and learned of the event only when a call was made to the child’s father. A prescription for her prophylactic anti-psychotic medication was completed on 11.08.15 and it is thought on a number of subsequent occasions.

Comment: hospital staff remained unaware of the involvement of EIS.
3.1.7 On 11.08.15 Ms. A’s community psychiatric nurse attended and spoke with her at the bedside. The purpose or content of that contact was not shared with hospital staff. Housing records indicate a request by a social worker to allow child AA’s father to stay and offer support to Ms. A when she was discharged. The ‘property management officer’ was uncomfortable about this prospect because of the history of domestic abuse. Further exchanges between the agencies reveal Ms. A denying all complaints and warning letters sent by Housing.

Comment: *given a serious and prolonged history of domestic abuse by this and previous partners, the caution of the Housing Service was justified; Ms A’s denials of recorded facts were consistent with previous misleading responses.*

3.1.8 Apparently prompted by housing colleagues, SW7 checked out with Police on 13.08.15, reports of officers attending Ms. A’s home and sib.1 being present, though theoretically in the care of a ‘maternal’ [actually paternal] aunt. No confirmation was obtained.

3.1.9 On 13.08.15 observations of child AA’s condition justified a step-down to the special care baby unit (SCBU) which (because of the urgent need for an intensive care bed was completed before the parents could be forewarned). A senior nurse later offered the parents an explanation and appropriate reassurance. By 18.08.15 the plan remained to hold a discharge planning meeting with a view to discussing and organising a community parenting assessment. All staff were asked to carefully document parental interactions (anyway considered standard practice).

**DOMESTIC INCIDENT 1**

3.1.10 When Ms. A failed to visit for 2 days a health care assistant phoned and was told she had lost her keys and had been housebound. She promised to visit later that day and did so. On this occasion, the nurse in charge investigated a report by the receptionist of shouting in the ward bathroom. She heard voices and what sounded like 2 slaps. When Ms. A opened the door she was seen to have a red mark on her left cheek. She reassured the nurse that all was OK and was advised that she could speak with a nurse in private if she wished to do so.

Comment: *this event might have been interpreted differently had staff been briefed more comprehensively about Ms. A’s history of being victimised.*

3.1.11 Ms A visited on several more occasions over the next few weeks and spent considerable time with and caring for her child. On a couple of occasions child AA’s grandmother (whether maternal or paternal was not recorded, but presumably the latter as Ms. A’s mother is understood to live in Guyana or be deceased) visited.

3.1.12 At a visit by an unidentified member of EIS on 26.08.15 Ms. A admitted an argument with her partner about paternity which she claimed was resolved. She was noted to be ‘compliant with medication’.

Comment: *it is unclear how compliance was evaluated.*
3.1.13 Ms. A initiated contact with the Rent Collection Service on 01.09.15 entered a repayment agreement and did manage over the coming months to significantly reduce her rent-related debts.

**ALLEGED DOMESTIC DISPUTE**

3.1.14 Police received a report on 03.09.15 alleging use of cannabis at Ms A’s home and male on female abuse. The informant also expressed concern about a small child at the location. Efforts to meet the informant and to make contact with the occupants over the next few days were unsuccessful and no further action was taken.

Comment: *it appears that sib.1 was spending significant amounts of time in the care of his mother / father rather than the paternal aunt in whose favour a Special Guardianship Order had been made.*

3.1.15 A further call to Police from the same informant on 04.09.15 referred to an overnight male visitor dropping keys down to a ‘drug dealer’. The informant failed to keep an appointment made and this incident was simply logged in an intelligence report.

3.1.16 On a ward visit by SW7 on 03.09.15 staff had been asked in particular to document father’s interaction with child AA. According to Ms. A her partner had expressed anger that child AA had temporarily swollen legs (which rapidly resolved when name bands were removed). HV1 made telephone contact with Ms. A on 07.09.15 who confirmed that her baby was still hospitalised and that she had seen the cards left at her home address. A home visit was agreed for 16.09.15 though no record exist to confirm that it took place.

3.1.17 Best practice would have been for the health visitor to meet with Ms. A on the neonatal ward (which would have provided an opportunity for her to seek more information) but no such contact occurred.

**3.2 MENTAL HEALTH MEDICAL REVIEW**

3.2.1 On 16.09.15 a review was completed though Ms. A failed to attend. The Care Plan became a medical review by means of a home visit on 15.10.15, liaison with the perinatal team and allocated social worker as well as ‘consideration’ of a urine drug screen. No evidence of the completion of a urine test has been provided.

Comment: *the results of the contemplated test of urine might have offered professionals some reliable evidence from which to inform their judgments.*

3.2.2 Observations of neither parent prompted any recorded concerns. On 17.09.15 SW7 informed medical staff about the time and date of the discharge planning meeting. She also agreed to inform the health visitor HV1 and key worker 1.
3.2.3 On 17.09.15 Ms. A phoned the unit to report being unwell. She and the father dropped off some clothes and were told supplies of expressed breast milk were low. They brought more next day. On 23.09.15 a visit was made by parents, sib.1 and AA’s paternal aunt with whom he lived. Ms. A said she would attend the scheduled meeting next day but that her partner had to be at work.

DOMESTIC INCIDENT 2

3.2.4 An incident occurred on 23.09.15 in which in response to Ms. A expressing anxiety about the way father was holding the baby, he became upset. She became tearful and couple did not speak again for the rest of the visit. Ms. A later called to apologise. A further verbal altercation was observed next day when Ms. A attributed responsibility for tension between her and child AA’s father to his mother.

3.3 DISCHARGE PLANNING MEETING & FOLLOW-UP

3.3.1 At the meeting convened on 24.09.15 ward staff reported on how active and involved Ms. A was with child AA. Concerns were though expressed about the parental relationship. Ms. A’s view was that a DNA test would clarify paternity and enable an appropriate birth certificate to be issued. This meeting was attended by both parents and a local paternal uncle of child AA who was seen as a source of support.

3.3.2 There was no representation of the (at the time understaffed) Health Visiting Service. Hospital records indicate that SW7 had undertaken to invite a health visitor. In consequence, there was initially insufficient awareness in that service of Ms. A’s social or mental health issues. A week later it was agreed that the perinatal team could now discharge Ms. A and that community colleagues would offer support. A home visit by EIS on 09.10.15 identified no concerns. Ms. A reported taking her prescribed medication and experiencing no adverse effects.

FURTHER PLANNING MEETING IN CHILDREN’S SOCIAL CARE

3.3.3 Erroneously entitled a ‘legal planning review’ (no solicitor was present) a further meeting was held on 07.10.15. Present according to records were TM1, the then head of service and an unnamed service manager. Brief notes of the meeting have been evaluated by the author of the Children’s Social Care report as ‘quite woolly’. When contacted, the ex-head of service was able to recall the case but not the meeting.

3.3.4 The parents were apparently to be given the benefit of the doubt unless / until evidence to the contrary emerged. This may have been linked to a view in Children’s Social Care that sib.1’s removal might perhaps been an over-reaction and a wish to avoid repeating such a response.

Comment: all the reassuring observations about parental care had been in the context of a supportive hospital ward and without awareness of the history of domestic abuse or mental ill-health. The parental capacity to keep the child safe in the community was un-tested and a formal change of plan should have re-involved the Legal Department.
3.3.5 The above meeting also agreed that SW7 would remain allocated pending completion of the Family Centre assessment (beginning on 19.10.15) and an anticipated ‘step-down’ to ‘child in need status’.

3.3.6 Meanwhile, a new birth visit was completed on 07.10.15 and both parents seen by HV1. This visit had of necessity, been delayed until child AA was discharged at 11 weeks. Both parents appeared ‘warm and friendly’ though father’s presence precluded exploration of recent reported domestic incidents.

3.3.7 In the light of what was captured in the chronology made available to the serious case review as Ms. A’s ‘depression’, temporary accommodation and the previous removal of sib.1, HV1 decided to provide a ‘Universal Plus’ Service. A follow-up visit by HV1 on generated no concerns about the home and Ms. A reported that she was successfully breast-feeding. Child AA was seen asleep and noted to be dressed appropriately.

Comment: Ms. A’s diagnoses by the EIS and perinatal consultants had been more elaborate than the term ‘depression’ implies; extensive and complex needs represented a substantial challenge for all involved professionals.

3.3.8 A ‘neonatal discharge summary’ was received at the GP Practice on 15.10.15. Aside from medical information consistent with the child’s premature delivery and a reference to Ms. A’s anti-psychotic medication, it reported that she was living in a ‘mother and baby unit’ [the address is ordinary self-contained local authority accommodation] and made no reference to drug misuse or domestic violence about which nothing was known by the hospital.

Comment: any potential impact of the insufficiency of information provided was offset because GPs had been told by Ms. A of her domestic abuse and the EIS assessment of August 2015 had made the link between use of cannabis and her mental health.

DOMESTIC INCIDENT 3

3.3.9 On 21.10.15, having failed to elicit a response to phone calls over the previous week the care co-ordinator CC1 made an unannounced home visit. She noted large dark bruises on Ms. A’s left arm. The explanation offered was credible but doubted. Ms. A denied that her partner had ever been physically violent toward her (directly contradicting accounts previously shared with mental health professionals).

Comment: the observations and a note of the need for close monitoring, represented good practice; she would have been justified in seeking further advice about her concerns.

13 Health visiting services are provided at one of 3 levels: ‘Universal’, ‘Universal Plus’ and ‘Universal Partnership Plus’ (according to the assessed level of need / involvement of other agencies)
DOMESTIC INCIDENT 4 & FURTHER EFFORTS BY HV1

3.3.10 On 13.11.15 a neighbour reported witnessing a further dispute (details not supplied) between Ms. A and partner and a few days later there were renewed complaints about loud music and a smell of cannabis in her accommodation. Further exchanges of emails between Housing and Children’s Social Care included a reference to planned ‘support’ (its nature was unspecified) from a Children’s Centre.

3.3.11 During November, HV1 had made several unsuccessful attempts to make contact by phone or in person. On 18.11.15 Ms. A reported in a phone call to the EIS that a neighbour was making unfounded allegations about the use of cannabis and that Police had been called.

3.3.12 In this instance Ms. A’s report has been confirmed by information provided by Police to the serious case review. The same neighbour who had raised concerns twice before had phoned Police and expressed concern on this occasion about a baby at the premises (presumably child AA) and an un-named male (thought to be father). The couple were allegedly smoking cannabis and shouting at each other a lot.

3.3.13 Officers spoke with a colleague of SW7 and attended the location. The neighbour acknowledged her long-running dispute and anxiety about the impact on her own and Ms. A’s baby, of extensive cannabis use. The warden was alerted and this as well as several other recent incident were passed over to Children’s Social Care.

3.3.14 On 23.11.15 a pre-arranged and agreed home visit was attempted by HV1 and CNN1. The aim had been to assess maternal mood and well-being and the development of child AA. During a doorstep-only contact, Ms. A introduced these professionals to a young boy described as her son (sib.1). She claimed to be in a hurry to attend a GP appointment and sought an alternative time for contact.

Comment: material supplied to this serious case review has not confirmed any such GP appointment (a further example of avoidant conduct).

3.3.15 HV1 left messages for the allocated social worker to raise the issue of sib.1 being in the care of Ms. A and partner. No response was received and HV1 did not escalate her concerns.

Comment: the initial response of HV1 was commendably cautious; this apparent failure to respond to a message was an example of poor practice comparable to examples cited earlier by the GP Practice; an escalation of HV1’s quite proper concern would have been justified but was reportedly overlooked as a consequence of other priorities.
CONCLUSION OF FAMILY CENTRE ASSESSMENT

3.3.16 The assessment completed by the Family Centre on 25.11.15 has been described as positive with respect to Ms. A’s engagement with staff and care of child AA. Staff there found her easy to talk with and positively motivated. This contrasted sharply with the experience of SW7 and others in previous months and years.

Comment: the sharply diverging experiences of SW7 and the more widespread and extensive experiences of SW9 and other professionals justified further exploration; in addition it seems that the assessment took little account of Ms. A’s social care or mental health history (crucial factors in risk-assessing future behaviours).

3.3.17 The issue of what the Family Centre had been asked to do was explored in the later stages of this serious case review and the ‘letter of instruction’ sent to the Centre by SW7 provided. The letter focused primarily on establishing parental perceptions, plans, sources of support and their willingness to seek help if required. At no point in the letter was the term ‘risk’ employed nor did it commission any exploration of what the respective parental developmental experiences might mean for their capacity together or singly to care safely for a child.

Comment: given the parameters established in the ‘letter of instruction’ the focus on the present noted by the independent author providing a report about the Children’s Social Care services is unsurprising. What was missing and required was an evaluation of the parental capacity to provide safe and good enough parenting.

3.3.18 On 30.11.15 HV1 saw Ms. A and child A at the clinic and was told that she was exclusively breast-feeding. At a visit by the community nursery nurse a week later, Ms. A told her that she was awaiting a visit from a community mental health nurse. Next day, she claimed in a phone conversation with her EIS worker to have called Police about her neighbour who was continuing to shout and be abusive toward her. Material supplied by the MPS confirms that Ms. A had initiated a complaint to Police on 25.11.15 but failed to attend an appointment made for her. No record has been found of any further action on the part of Ms. A or Police.

3.3.19 Ms. A’s allegation of being unfairly picked on / racially abused by her became within days a dispute about the return of some (unspecified) goods. Attempts to engage Ms. A via her mobile, home visits and letters all failed and no subsequent action was taken by Police.

3.4 FURTHER MENTAL HEALTH MEDICAL REVIEW

3.4.1 On 03.12.15 a review with EIS consultant and care co-ordinator noted Ms. A’s unremarkable mood state but identified these ‘stressors’:

- Relationship with her baby’s father
- Disputes with neighbours
- Financial pressures
3.4.2 The review noted that Ms. A had not acted impulsively in response to the above stressors and that the health visitor was not concerned. Ms. A was regarded as having developed a good bond with her daughter who was noted to be ‘flourishing’. The care plan became:

- Arranging a blood test and electrocardiogram (ECG)
- A further review of the use of anti-psychotic medication
- Monitoring of weight
- Support with obtaining a birth certificate and Benefits
- Smoking cessation / lifestyle advice

3.4.3 The GP received correspondence during December that indicated that Ms. A was doing well in spite of the stressors of relationship strain, housing and financial pressures.

3.4.4 A planned meeting about housing-related difficulties with Ms. A, Police and EIS on 03.12.15 failed because of some confusion about dates / times. Ms. A then failed to response to calls or messages left during the remainder of December.

3.4.5 EIS tried without success during December to make contact. At a team discussion on 22.12.15 the main identified concerns centred around Benefits. A further visit was planned for Christmas Eve. No response was obtained at that visit and a card was left. During late November and December efforts by others e.g. SW7 to contact Ms. A also failed (by chance SW7 was also on leave for 2 weeks in December). Ms. A was once again dis-engaging from support services.

Comment: had child AA been subject of a child protection plan (and the evidence available at the time of the strategy discussion suggests an initial conference would have been justified and a decision to formulate such a plan, likely), a greater sense of purpose and urgency would have been likely.

3.5 CHILD AA’S INJURIES

3.5.1 Police were notified by phone at 14.40 on 29.12.15 that child AA had been transported by ambulance to hospital on 24.12.15. A strategy discussion between TM1 and DC1 agreed the need for a joint investigation and a strategy meeting when medical results were available. Meanwhile the hospital staff would supervise parental visiting. 2 officers attended the hospital and were given Ms. A’s account of the circumstances preceding her calling for an ambulance.

3.5.2 At a second strategy meeting on 05.01.16 when the injuries were concluded to be non-accidental, a decision was made to initiate Care Proceedings.
4 RESPONSES TO TERMS OF REFERENCE

4.1 INTRODUCTION

4.1.1 The comments made below relate to professional practice during the period under review. They offer a response to the majority of the narrow elements of the agreed terms of reference and refer only to those agencies about which the question is relevant. Broader points of learning are summarised in section 5 before a number of practical recommendations for service improvements are provided in section 6.

WERE PRACTITIONERS AWARE OF & SENSITIVE TO THE NEEDS OF THE CHILD IN THEIR WORK?

4.1.2 Whilst apparently patient with and well disposed toward Ms. A, the responses of the involved GPs suggests gaps in their knowledge base with respect to the expectations of contemporary safeguarding practice. The independent report provided by the named GP has identified the implied training needs, which are reflected in this report’s recommendations.

4.1.3 The Housing Service acted efficiently at all times and showed a welcome flexibility of response and a sensitivity toward the needs of Ms. A and sib.1 and later child AA.

4.1.4 Chelsea and Westminster’s involvement was limited and unremarkable. The responses of the acute services at St. George’s (liaising with Children’s Social Care) generally indicated appropriate awareness of and sensitivity toward child AA’s needs. The observed and recorded argument and slap might usefully have been shared with SW7 though staff were operating without knowledge of Ms. A’s history of abuse.

4.1.5 Though denied the opportunity of participation in the discharge planning meeting HV1 (in a service which was at the time overloaded) showed commendable commitment to Ms. A and child AA. She might usefully have sought from GP and Mental Health colleagues, more information about Ms. A’s mental health so as to consider its possible impact on apparently good enough care of child AA. A more comprehensive understanding of Ms. A’s situation would probably have led to a ‘Universal Partnership Plus’ level of service.

4.1.6 The intention of HV1 to discuss with SW7 the issue of sib.1’s presence at Ms. A’s address showed commendable sensitivity but the potential value of her initiative was lost when the latter failed to response and HV1 did not escalate the issue.

4.1.7 SW7 and her manager TM1 were insufficiently child-centred when they decided to set aside the well-evidenced plan formulated at the legal planning meeting. Knowledge within the EIS of Ms A’s history including removal of sib.1 usefully prompted the team to engage the Perinatal Service where staff made observed of reassuring interactions between Ms. A and child AA.
WERE THEY KNOWLEDGEABLE ABOUT THE POTENTIAL INDICATORS OF ABUSE OR NEGLECT & ABOUT WHAT TO DO IF THEY HAD CONCERNS ABOUT A CHILD’S WELFARE?, WAS SUFFICIENT ATTENTION & ANALYSIS PAID THE IMPACT OF PARENTAL MENTAL HEALTH, ALLEGED DRUG USE & DOMESTIC ABUSE IN RELATION TO THE SAFETY & WELL-BEING OF A PRE VERBAL, NON-MOBILE BABY WHO HAD BEEN BORN PREMATURELY?

4.1.8 The GP Practice (in consequence partly of mis-coding, partly a lack of inquiry) was not factoring into its contacts with Ms. A, the long-standing history of domestic abuse or reported cannabis use.

4.1.9 The reluctance of the property management office to allow father to stay in Ms. A’s temporary accommodation after the birth of child AA was, given the agency’s experience of domestic abuse and cannabis misuse a well-informed and cautious response. Children’s Social Care was kept well informed by that agency of the various complaints / incidents reported by neighbours. The report provided by Housing offers a convincing account of the usefulness of its current procedures and training programmes for staff.

4.1.10 Because the GP referral was incomplete, Chelsea and Westminster Midwifery Service did not receive the ‘whole story’ and was thus denied the opportunity to evaluate the implications for the then unborn child AA. Similarly, the information provided to St. George’s Hospital’s medical staff by Children’s Social Care omitted some important facts such as Ms. A having been in care herself, the removal of sib.1 or Ms. A’s current involvement with mental health services.

4.1.11 The allocated health visitor HV1 was very attentive though could usefully have taken more account of Ms. A’s mental ill-health, father having been found unsuitable to care for sib.1 (as well as the couple’s sexual relationship having begun well before father’s actions were lawful).

4.1.12 It may be that some optimism within Children’s Social Care was rooted in a sense of injustice with respect to the substitute care of sib.1 and reinforced by the largely positive observations of others such as the Family Centre assessors.

4.1.13 The involvement of the Perinatal Mental Health Service and the willingness of EIS to share information suggests that there was a sound understanding, based on known clinical history and current observations of both Ms. A’s needs and those of her new-born baby.
WERE AGENCIES AWARE OF THE NEEDS OF BOTH PARENTS & THE SIGNIFICANCE OF MS. A’s MENTAL HEALTH, HER OWN HISTORY INCLUDING HER EXPERIENCE AS A CHILD LOOKED AFTER WHEN MAKING ASSESSMENTS?

4.1.14 Some GPs may have been unaware that Ms. A had been in care and later in receipt of care leaving support. At least 1 GP knew of the removal of sib.1 but a failure to code such information into medical records may have meant that others were not as aware.

4.1.15 In its assessment of Ms. A’s homelessness application in 2015 staff took full account of her care history and her mental health. In consequence a full duty to assist with housing under Part VII Housing Act 1996 was accepted.

4.1.16 Health records from either hospital or community staff include little information about father beyond the age differential, a history of offending and that he had not been considered suitable to care for his son sib.1. The detail of Ms. A’s mental health diagnosis was not provided to or sought by the health visitor.

4.1.17 Children’s Social Care possessed all relevant information but hospital team staff and to an even greater extent, those completing the community assessment focused only on the presenting features rather than the cumulative picture that was available within agencies’ records.

4.1.18 Whilst the EIS was cognisant of the risks associated with Ms. A’s history and mental health, there was further potential for a more collaborative approach and perhaps some joint visits by its staff and the allocated social worker.

DID AGENCIES TAKE SUFFICIENT ACCOUNT OF THE ROLE OF AA’s FATHER IN HER LIFE & THE RELATIONSHIP BETWEEN THE PARENTS?

4.1.19 As well as the numerous crises within their relationship (including intermittent violence) it is clear that both parents sought to limit what any professional really knew about their ongoing relationship.

4.1.20 At times Ms. A diverted professional enquiry by claiming she and her partner had split up. At others times his existence was rendered less obvious by claims of him working away. On one occasion at an ante-natal consultation, father avoided any enquiry by the midwife by remaining throughout engrossed in a mobile phone conversation.

4.1.21 The involved GP Practice knew a good deal about Ms. A’s historical and current needs but very little about her partner who was not registered at that the same surgery.
4.1.22 The Housing Service’s knowledge of father was limited to knowing that he represented a threat to Ms. A and on that basis appropriately resisted his suggestion of joining Ms. A in her temporary accommodation.

4.1.23 St. George’s Health Trust staff knew relatively little about father and remained dependent upon others for information and advice about his significance to child AA.

4.1.24 Within the records of Children’s Social Care there existed a good deal of information about the father of child AA, little of it offering reassurance about his conduct as a partner or parent. It seems however that his presentation to professionals was sufficiently reassuring for that history to be set aside and for judgements to be made on the basis of the ‘here and now’.

4.1.25 For example, the commissioned community assessment focused more on Ms. A (and had not sought to explore the significance of her past experiences and behaviours). The report provided by the independent author indicates that the significance of child AA’s father himself or the likely impact of the couple’s co-parenting remained unexplored.

4.1.26 The Mental Health Trust EIS and ward showed commendable sensitivity to the significance of father when it made a referral to MARAC and Police and followed this up when Ms. A failed to return from ward leave. Underpinning the concern felt was a sensitivity to her vulnerability, an awareness of the removal of the couple’s previous child and the risk of dangerous dogs in the house.

WERE AGENCIES AWARE OF THE SIGNIFICANCE OF THE REMOVAL & PERMANENT PLACEMENT OF SIB.1 WHEN MAKING ASSESSMENTS

4.1.27 Most agencies were aware of the fact, if not the significance, of the removal of sib.1 and his substitute care. For example whilst Ms. A made no secret of what had happened to sib.1 at the Practice, the GP’s referral for ante-natal care at Chelsea and Westminster Hospital in 2015 included no reference to this important historical fact..

4.1.28 Chelsea and Westminster staff were briefed by Children’s Social Care about the removal of sib.1 but their involvement was too limited for that information to inform any professional decision making. Ward staff at St. George’s had also been alerted to sib.1’s removal and consequently maintained a log of parental interactions. They were not comparably briefed about Ms. A’s current mental health difficulties and worked under the mistaken impression that she was being discharged to a ‘mother and baby unit’ (where support could be assumed).

4.1.29 The fact of sib.1’s removal was known to the Health Visiting Service but the nature or seriousness of Ms. A’s mental health needs and the implications for child AA of being parented by the same conflicted parents could have been further explored, perhaps in supervision.
4.1.30 The fact of sib.1’s removal was of course known to Children’s Social Care where such action had been initiated. Paradoxically, it may have served, in consequence of misplaced sympathy, to have reduced the level of concern about the ability of a very damaged individual to cope with (ongoing) domestic abuse and the demands of a new baby.

4.1.31 Mental Health Trust staff were aware of sib.1’s removal and of Ms. A’s stated determination that she be allowed to care for child AA. No detail of the evidence justifying the court’s decision was shared with the Mental Health Trust or other health agencies. A complete exchange of information at the discharge meeting was desirable.

**WHEN AND IN WHAT WAY, WERE THE CHILD’S WISHES & FEELINGS ASCERTAINED & TAKEN ACCOUNT OF WHEN MAKING DECISIONS ABOUT SERVICE PROVISION? WAS THIS INFORMATION RECORDED?**

4.1.32 By virtue of her age, any view of child AA’s feelings were of necessity a function of informed observation. Though registered at the Practice child AA was never presented there e.g. for a post-natal check. GPs had not been invited to the discharge meeting in September. A level of (mistaken) reassurance was offered in the discharge summary with its erroneous reference to Ms. A being in a ‘mother and baby unit’.

4.1.33 Housing had when Ms. A’s pregnancy became known, acted in accordance with procedures and for the benefit of the then unborn child AA, by moving her from B&B to suitable self-contained accommodation.

4.1.34 Hospital staff maintained careful and sensitive records of child AA’s development and how Ms. A (and father) interacted with her. There appears to have been some uncertainty about seeking from Children’s Social Care additional information. The named nurse who provided a report to this review has reassured those staff that such challenge is to be welcomed and offers an additional safeguard.

4.1.35 The Health Visiting Service was disadvantaged by not being involved in the discharge meeting (HV1 was unaware of events whilst child AA remained in hospital). Neither mental health professionals or those from the Family Centre observed anything but positive mother-child interactions. However, Ms. A substantially dis-engaged during December and this may have been associated with a deterioration in her ability to cope with the challenge of caring her baby.
DID THE ORGANISATION HAVE IN PLACE POLICIES & PROCEDURES FOR SAFEGUARDING & PROMOTING THE WELFARE OF UNBORN CHILDREN/ INFANTS & ACTING ON CONCERNS?

4.1.36 The report evaluating the GP service identified a number of procedural improvements required at the Practice in question and her recommendations have been carried forward into this overview.

4.1.37 All other agencies are committed to working in accordance with the London Child Protection Procedures (latest edition 2015) and broadly-speaking (with the exception of the set aside pre-birth plan), did so. In addition the Housing report refers to some robust internal procedures in the Housing and Rent Collection Services respectively that are reviewed annually. Though HV1 demonstrated considerable commitment to her support of the family, she did not make use of the existing ‘escalation policy’ to follow up and challenge a lack of response by Children’s Social Care to her justifiable concerns.

WHAT WERE THE KEY RELEVANT POINTS / OPPORTUNITIES FOR ASSESSMENT & DECISION MAKING IN THIS CASE IN RELATION TO THE CHILD & FAMILY? DO ASSESSMENTS & DECISIONS APPEAR TO HAVE BEEN REACHED IN AN INFORMED & PROFESSIONAL WAY?

4.1.38 In relation to the fairly short period from awareness of Ms. A’s 7th pregnancy through to child AA’s injuries, the decisions and assessments that (with hindsight) might have made a difference to child AA’s life chances were:

- The legal planning meeting which, if its agreed plan had been followed would in all probability led to child AA being made subject of a protection plan and (less assuredly) placed the case before a court
- The reported refusal of Police to conduct a joint investigation (and Children’s Social Care subsequent decision not to complete single agency s.47 enquiries)
- The abandonment in October 2015 of all remaining elements of the plan agreed at the legal planning meeting
- The discharge planning meeting of late September (when neither GP or Health Visiting Services were represented and Ms. A’s mental health needs were insufficiently shared)
- The EIS medical reviews potentially provided a formal opportunity to share and evaluate all relevant information (in spite of collaboration across agencies by practitioners, no multi-agency view of needs and risks was completed)
- Children’s Social Care’s community based assessment (which as instructed, focused largely on parental perceptions and presentation, as opposed to developmental history and its implications)
WAS CONSIDERATION GIVEN TO THE IMPACT OF CULTURAL / IDENTITY & OTHER EQUALITIES ISSUES IN ANY ASSESSMENTS?

4.1.39 Ms. A’s ethnicity was captured by most agencies. Her religious affiliation (if any) was variously described e.g. ’Christian’, ’of Hindu origins’, ’Muslim’ or ’no religious beliefs’ (which may of course have reflected differing responses offered by her to different agencies).

4.1.40 The significance of these issues (and in practical terms the connection she still felt or had still with relatives in her country of origin) are not apparent from agency records, with the exception of the mental health professionals who did seem to explore early childhood (some traumatic) memories.

4.1.41 Father’s ethnicity was captured by some agencies as being ‘African Caribbean’ but the centrality of that identity to his day to day life, his religious beliefs remain unknown or how he might reconcile those with his reported sexual and physical assaults of the mother of his children remain unknown.

DID ACTIONS ACCORD WITH ASSESSMENTS & DECISIONS MADE? WERE APPROPRIATE SERVICES OFFERED/PROVIDED OR RELEVANT ENQUIRES MADE, IN LIGHT OF ASSESSMENTS? WERE RECORDS SYSTEMATICALLY REVIEWS TO EVALUATE AND ASSESS RISK?

4.1.42 The Housing report confirms that the Property Management Team acted upon neighbours’ complaints e.g. the smell of cannabis and parental arguments.

4.1.43 HV1 reported that her service was under considerable pressure at the time. Therefore they were unable to review all available historical records and relied upon information from the GP Practice or social worker to evaluate risk.

4.1.44 As previously described, the decision in early October within Children’s Social Care to abandon the plan agreed at July’s legal planning meeting offers the most significant example of an unjustified change of plan.

WERE SENIOR MANAGERS OR OTHER ORGANISATIONS & PROFESSIONALS INVOLVED AT POINTS IN THE CASE WHERE THEY SHOULD HAVE BEEN?

4.1.45 GPs appropriately sought safeguarding-related advice from their Medical Defence Union at the time of Ms. A’s first pregnancy. The author of the report evaluating their professional responses to Ms. A confirms that arrangements are currently in place to enable the provision of any required advice. There are several examples in the records of Housing Services that provide evidence of officers seeking advice from the agency’s medical adviser as well as involved others such as Ms. A’s GP and EIS care co-ordinator.
4.1.46 The Health Visiting Service was not aware of the totality of available evidence about the parents and its implications for safe or good enough parenting. HV1 would have been justified in escalating her wish to be more fully briefed by Children’s Social Care following several failed attempts to make contact with Ms. A in Autumn 2015.

4.1.47 The decision made to review and abandon the plan formulated at the July legal planning meeting was reportedly signed off by the then head of service (who has though, no recall of such a decision).

4.1.48 Within the EIS decisions were made and actions taken by both the team manager and the consultant psychiatrist.

**WAS THE WORK IN THIS CASE CONSISTENT WITH WORKING TOGETHER TO SAFEGUARD CHILDREN 2015 AND THE LONDON CHILD PROTECTION PROCEDURES & WITH WIDER PROFESSIONAL STANDARDS?**

4.1.49 The extent to which professional actions across the network were complaint with statutory guidance and London-wide procedures is sufficiently covered above.

**WERE THERE ORGANISATIONAL DIFFICULTIES BEING EXPERIENCED WITHIN OR BETWEEN AGENCIES? WERE THESE DUE TO A LACK OF CAPACITY IN ONE OR MORE ORGANISATION? WAS THERE AN ADEQUATE NUMBER OF STAFF IN POST? DID ANY RESOURCING ISSUES SUCH AS VACANT POSTS OR STAFF ON SICK LEAVE IMPACT ON THE CASE**

4.1.50 Only the report of the Health Visiting Service identified as a contributory factor a staffing shortfall during the relevant period. This was a function of vacancies and staff illness combined. The Homeless Team is now reported to be fully staffed.

4.1.51 Though described by some staff as contributing to existing difficulties, it seems unlikely that the coincidental presence of regulator Ofsted in Children Social Care during November / December (at which time child AA was at home with her parents) in any way influenced the more strategic assessments and decisions previously made.
5 LEARNING FROM PERIOD OF REVIEW

5.1.1 There was insufficient appreciation of the implications for parenting of:

- Ms. A’s very troubled history (with her grandmother, in care and as a care leaver), vulnerability to domestic abuse, disguised compliance, and uncertain mental health
- Ms. A’s proven neglect of animals (research suggests a correlation between cruelty to animals and child abuse\(^{14}\)) and violence toward a human e.g. her grandmother
- Father’s extensive record of sexual abuse of underage Ms. A and ongoing episodic physical violence toward her
- Ms. A’s lifelong raised vulnerability to victimisation\(^{15}\)
- Possible mis-placed sympathy amongst some, for Ms. A because of sib.1’s removal from her care

5.1.2 There were a number of agency-specific missed opportunities for best practice / compliance with established procedures:

- The GP hospital referral should have reflected concerns about mental ill-health, domestic abuse, removal of sib.1 and Ms. A being a Children’s Social Care case
- The coding of patient-related data by GPs should have better facilitated access to relevant information
- Health visitors and GPs should have been involved in the pre-discharge meeting at St. George’s Hospital
- The formal plan agreed at a legal planning meeting in early Autumn 2015 should not have been abandoned without due process being followed
- Initiation of s.47 enquiries is the responsibility of the local authority and is not dependent upon a Police perspective
- The commissioning of the 2015 assessment needed to be contextualised by reference to personal history rather than depending only upon presentation and observations
- There was considerable scope for greater professional enquiry about men (resident or not) whose relationship and conduct had impacted on Ms. A and her children

5.1.3 The Trust must ensure an effective system for highlighting cases requiring ‘safeguarding supervision’ (not all health visitors are as perceptive as HV1).

---

\(^{14}\) Animal abuse and child maltreatment: A review of the literature and findings from a UK study Executive Summary October 2007- Simon Hackett, School of Applied Social Sciences, Durham University Emma Uprichard, Department of Sociology, University of York

\(^{15}\) Domestic violence, lifetime trauma and psychological health of childbearing women (200 women in South London): Gillian Mezey, Loraine Bacchus, Susan Bewley, Sarah White: conclusion ‘traumatic events are under-recognised risk factors in the development of depressive and post-traumatic stress symptoms in childbearing women; childhood abuse creates a vulnerability to re-traumatisation in adulthood; awareness of the impact of trauma and abuse on psychological health may enable more appropriate targeting of clinical services and support for women receiving maternity care - see bibliography for full reference
6 RECOMMENDATIONS

6.1 Wandsworth Safeguarding Children Board

6.1.1 This case should be used for the purpose of multi-agency training and the following learning points emphasised:

- The need for constant ‘professional curiosity’, ‘respectful uncertainty’ and full information sharing
- A recognition that mental ill-health, substance misuse and domestic violence have an impact on capacity to parent that must be acknowledged so as to inform a risk assessment for a vulnerable child, not diminished in consequence of sympathy for a vulnerable parent
- The benefit of precision in professional exchanges e.g. status of a service user’s given address and commonality of terms (core group v team around the child)
- Persistence in encouraging full involvement of GPs
- A willingness within and across agencies to challenge perceived errors of others’ professional judgements

6.1.2 The LSCB should urge NHS England to take measures to ensure that clinics performing terminations inform the patient’s GP so that s/he is more able to form a more complete view of medical needs and better able to recognise exploitation of that patient or risk to a dependent child.

6.2 Chelsea & Westminster Hospital

6.2.1 Managers of the Midwifery Service should take all required steps (e.g. reviewing / amending policy, procedure, training and practice) to maximise the extent to which:

- A GP referral indicating a complex medical or social history and appearing incomplete, is followed up, if necessary via managers or the Safeguarding Children Team
- ‘Did not appear’ (DNAs) [more accurately in the case of children ‘was not brought’ (WNBs)] are followed up and challenged

6.3 South West London & St. George’s NHS Mental Health Trust

6.3.1 All patients known to the Mental Health Trust and who require assessment by the Perinatal Mental Health Team should be escalated to the named professional for safeguarding children (this would be reported by means of the Trust’s incident reporting system).
6.4 METROPOLITAN POLICE SERVICE

6.4.1 Wandsworth BOCU Senior Leadership Team should ensure that a record is created of the 2 allegations made by Ms. A on 30.05.09 and 14.09.09 respectively.

6.5 CCG &/OR GP SERVICE AT RELEVANT PRACTICE

CCG

6.5.1 The CCG should include in its communication with local GP Practices a reminder of the relevant guidance in ‘Information Sharing: Advice for Practitioners Providing Safeguarding Services to Children, Young People, Parents and their Carers’ DfE March 2015 Ref: DFE-00128-2015 at https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

RELEVANT GP PRACTICE

6.5.2 All correspondence, including sensitive or child protection material, relating to a registered patient, must be filed and stored in the medical records as per standard NHS policies for storage of patient information.

6.5.3 Practitioners must be encouraged to code clinical and risk information in patient records, without fear of potential implications.

6.5.4 The policy for registering new-born children and facilitating engagement with postnatal checks at the relevant Practice must be updated immediately and incorporate pro-active recall of children and safety netting to detect non-attendance or engagement.

6.5.5 GPs should have a recognised way of proactively identifying children and families for whom there are safeguarding concerns. These families should be discussed at regular intervals amongst practice staff and any ongoing safeguarding concerns risk stratified and acted on.

6.5.6 To facilitate adequate reflection and action on the issues raised in this review it is recommended that the involved Practice, based upon the evidence emerging from this case, complete a formal ‘Significant Event Analysis’ for submission to NHS England and the Care Quality Commission (CQC).
6.6 CHILDREN’S SOCIAL CARE

6.6.1 All managers should be reminded that:

- Formal case plans are determined at and may only be abandoned or significantly amended by, formal processes / procedures e.g. at arenas such as legal planning meetings, strategy meetings, child protection conferences or (for looked after children) at s.26 reviews
- The London Child Protection Procedures (regional) and Wandsworth Safeguarding Children Board (local) provide a ‘Pre-birth Protocol’ that must be followed

6.6.2 To avoid confusion amongst partner agencies multi-agency fora with parents of children subject to a protection plan should be referred to as ‘core groups’ rather than ‘team around the child’ (TAC) (generally reserved to describe a response when families are in receipt of ‘Early Help’).

6.6.3 Expectations of and methodologies currently being adopted by Family Centres in undertaking ‘community assessments’ should be reviewed.

6.7 ST GEORGE’S HOSPITAL

6.7.1 Managers of the neonatal unit need to act (e.g. review / amend policy, procedure, training and practice) to maximise the extent to which:

**Acute Services**

- If a parent is known to another agency or discipline (or booked at another hospital), staff ascertain why and ensure that this information is included in the notes
- If a baby is admitted with a (pre-birth) protection plan to discharge to a mother and baby or other safeguarding establishment, there needs to be a multi-disciplinary information-sharing meeting to which the safeguarding team should be invited
- Information about babies discussed in the weekly ‘psychosocial meeting should be filed in in the child’s own notes, thus ensuring that all staff have access
- Staff inform (and document their action) a baby’s allocated social worker if an argument between parents is observed or other concerns about their communication emerge
- Staff inform the safeguarding children team of all babies known to Children’s Social Care or when there are safeguarding concerns
- Safeguarding children team members attend weekly psychosocial or other meetings when safeguarding concerns have been identified

**Community Services**

- Criteria should be developed to assist identification of cases requiring safeguarding supervision
### 7 GLOSSARY: ABBREVIATIONS

<table>
<thead>
<tr>
<th>Agency Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency Department</td>
</tr>
<tr>
<td>CDOP</td>
<td>Child Death Overview Panel</td>
</tr>
<tr>
<td>CMHT</td>
<td>Community Mental Health Team</td>
</tr>
<tr>
<td>ILS</td>
<td>Independent Living Scheme (Leaving Care Service)</td>
</tr>
<tr>
<td>HOAT</td>
<td>Housing Options and Assessment Team</td>
</tr>
<tr>
<td>LSCB</td>
<td>Local Safeguarding Children Board</td>
</tr>
<tr>
<td>NPIE</td>
<td>National Panel of Independent Experts</td>
</tr>
<tr>
<td>RCS</td>
<td>Rent Collection Service</td>
</tr>
<tr>
<td>SCIL</td>
<td>Serious Case, Improvement and Learning Sub-committee</td>
</tr>
<tr>
<td>SCR</td>
<td>Serious Case Review</td>
</tr>
</tbody>
</table>
8 BIBLIOGRAPHY

- Improving safeguarding practice, Study of Serious Case Reviews, 2001-2003 Wendy Rose & Julia Barnes DCSF 2008
- Learning Lessons, Taking Action: Ofsted’s evaluations of serious case reviews 1April 2007 to 31 March 2008 Published December 2008
- The Child’s World Jan Horwarth Jessica Kingsley 2008
- Learning Together to Safeguard Children: A ‘Systems’ Model for Case Reviews March 2009 SCIE
- Healthy Child Programme DH 2009
- A Study of Recommendations Arising from Serious Case Reviews 2009-2010 M Brandon, P Sidebotham, S Bailey, P Belderson University of East Anglia & University of Warwick
- Understanding Serious Case Reviews and their Impact a Biennial Analysis of Serious Case Reviews 2005-07 Brandon, Bailey, Belderson, Gardner, Sidebotham, Dodsworth, Warren & Black DCSF 2009
- Ages of Concern: learning lessons from serious case reviews: a thematic report of Ofsted’s evaluation of serious case reviews from 1 April 2007 to 31 March 2011
- Munro Review of Child Protection: A Child-Centred System TSO www.tsoshop.co.uk Professor Munro 2011
- Learning together to safeguard children: a systems model for case reviews SCIE January 2012
- New learning from serious case reviews: Marian Brandon et al RR226 DfE 2012
- Improving the Quality of Children’s Serious Case Reviews Through Support & Training@ NSPCC, Sequili, Action for Children; DfE 2013 (revised Feb. 2014)
- Serious case review: ‘Ben’: Gloucestershire Local Safeguarding Children Board 2016 (comparable features)
- Domestic violence, lifetime trauma and psychological health of childbearing women; Gillian Mezey, Loraine Bacchus, Susan Bewley Sarah White
TERMS OF REFERENCE

SCOPE OF THE REVIEW

Chronologies and IMR are required to start from 3rd August 2015 if agencies hold records on the parents of AA, which would be useful as background information to the SCR. This is particularly significant as AA’s mother was a previously looked after child. Otherwise chronologies to be completed from agency records from the birth of AA to the incident on 24th December 2015. Where agencies had involvement in the life of the older sibling SAG IMRs should include this information. An IMR from Children’s Services involvement with AA’s mother as a looked after child and care leaver will be required.

METHODOLOGY

A hybrid model of SCR will be undertaken, combining elements of the ‘Learning Together’ methodology promoted by Social Care Institute for Excellence (SCIE), as well as the traditional method of undertaking SCRs, to achieve a proportionate response to the case. This combined methodology being used for the SCR enables discussion of learning points as part of an on-going process.

We will require agencies to produce Individual Management Reviews (IMRs). Actions identified for each agency should be undertaken immediately. To enable publication of the report, it will be written with this intention. The anticipated completion of the SCR will be…???, but publication will be determined by any possible criminal trial.

Family involvement

AA’s parents will be informed of and invited to contribute to the process. Other family members will be invited to contribute as appropriate.

Staff involvement

Practitioners and line managers, who were directly involved with the family, will be met with either individually or as part of a group to share and understand practice. Staff will have access to necessary staff counselling services, if necessary. This may take the form of a multi-agency practitioner’s event to promote reflective learning.
PANEL MEMBERSHIP

- Chair of Panel – Nicky Pace (Independent Chair WSCB)
- Independent Author of SCR – Fergus Smith
- Representative from Children Services
- Representative from Community Services, St George’s Healthcare NHS Trust
- Representative from Police
- Named GP for Safeguarding.
- Representative from Midwifery Services at Chelsea and Westminster Hospital.
- Representative from Adult Mental Health
- Representative from Wandsworth Housing
- Representative from Wandsworth CCG
- Representative from London Probation
- Principal Social Worker
- Head of Safeguarding Standards Service
- WSCB Business Manager

AGENCIES TO COMPLETE IMRS

- Wandsworth Children’s Services; St Georges Social Work team, Care Leavers Service, Woking Close Family Centre
- Adult Mental Health Service
- Wandsworth Housing
- St George’s Healthcare NHS Trust
- Named GP for Safeguarding
- London Probation Service
- Metropolitan Police Service - Child Abuse Investigation Team (CAIT)

ANALYSIS OF INVOLVEMENT

The individual management reviews need to consider the events that occurred, the decisions made, and the actions taken, which indicate that practice or management could be improved. Consideration should be given to not only what happened but why something did or did not happen. Consider the following areas:

- Were practitioners aware of and sensitive to the needs of the child in their work?
- Were they knowledgeable about the potential indicators of abuse or neglect and about what to do if they had concerns about a child’s welfare?, was sufficient attention and analysis paid the impact of parental mental health, alleged drug use and domestic abuse in relation to the safety and wellbeing of a pre verbal, non-mobile baby who had been born prematurely?
• Were agencies aware of the needs of both parents and the significance of the Ms. A’s mental health, her own history including her experience as a child looked after when making assessments?

• Did agencies take sufficient account of the role of AA’s father in her life and the relationship between the parents?

• Were agencies aware of the significance of the removal and permanent placement of SAG, the older full sibling of AA when making assessments?

• When and in what way, were the child’s wishes and feelings ascertained and taken account of when making decisions about the provision of services? Was this information recorded?

• Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of unborn children/infants and acting on concerns?

• What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?

• Was consideration given to the impact of cultural/identity and other equalities issues in any assessments?

• Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquires made, in light of assessments? Were records systematically reviewed to evaluate and assess risk?

• This case did not meet the criteria for services from a number of key agencies, if information had been shared about this case, would this have met criteria and services provided or risk assessment made?

• Were senior managers or other organisations and professionals involved at points in the case where they should have been?

• Was the work in this case consistent with Working Together to Safeguard Children 2015 and the London Child Protection Procedures and with wider professional standards?

• Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisation? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave impact on the case?

• Was there sufficient management accountability for decision making?

• Was consideration given to the escalation of the lack of response to immunisation and development assessment opportunities?
• Are there lessons from this case for the way in which organisations work to safeguard and promote the welfare of children? Is there good practice to highlight, as well as ways practice could be improved? Are there implications for ways of working; training - both single and multiagency - management and supervision; working in partnership with other organisations; resources; are there implications for current policy and practice?