For: **HAVERING LSCB**

June 2011

Overview Report

Case of Child E

Alyson Leslie

Contents

OVERVIEW REPORT - CASE OF CHILD E

Summary Details

Child Details		
Designation of Child	**Child E**	
DOB	**3.11.2009**	
Date of Death	**6.1.2011**	
Gender	Male	
Nature of Incident	Sudden death from significant trauma to abdomen	
Ethnic Origin	White British (English)	
Legal Status Prior to Death	None. Living in family home with parents, Mr G and Ms H and sibling Child F.	
Dates of CP Registration	None	
Siblings	**Child F (7.9.2007)**	
Sibling legal status - previous	None. Living in family home with parents, Mr G and Ms H and sibling Child E.	
Sibling legal status - current	Interim Care Order	
SCR Details		
Responsible Authority	**Havering Local Safeguarding Children Board (Havering LSCB)**	
Contact Person	**Alice Peatling, Business Manager** (tel: 01708 433528)	
Factors Leading to SCR	Suspicious, sudden death of 14 month old boy. Injuries inconsistent with father's account of immediate prior history.	
Other Key Issues	Ongoing criminal investigation. Child's father, Mr G in custody awaiting trial on charges of murder.	
Overview Writer	**Alyson Leslie**	
Overview Writer Status	Independent Researcher.	
Date SCR Initiated	10 January 2011	
Date TOR Agreed	17 January 2011	
Timescale of Review	Submission to Department of Education by 8 July 2011	
IMRs Details	**Provided by**	***Role***
Health Overview	**Havering Primary Care NHS Trust (PCT)**	*Commissioner Health Care Services*
GP and Health Visiting Services	**NHS Havering and Outer North East London Community Services (ONEL)**	*GP to Mr G, Ms H, Health Visiting Services to Child F and Child E*
Midwifery and Obstetric Services	**Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)**	*Antenatal/perinatal services to Ms H during both pregnancies*

Housing	**London Borough of Havering – Housing and Public Protection (Housing / HPP)**	*Provided tenancy of house leased from private sector landlord*
Police	**Metropolitan Police Service (MPS)**	*Emergency Protection Order (EPO) Ms H (aged 15)15) Investigation of Child E's death*
Ambulance	**London Ambulance Services NHS Trust (LAS)**	*Paramedical and ambulance services on day of Child E's death*
Education	**London Borough of Havering Social Care and Learning – Learning and Achievement (Education)**	*Ms H was a student at School 1, including during her pregnancy with Child F*
Children's Social Services	**London Borough of Havering Social Care and Learning – Children and Young People Services (CYPS)**	*Accommodated Ms H briefly when pregnant aged 15. EPO and Interim Care Order in relation to Child F after his brother's death.*
Additional Material		
Clinic A	*Information was sought and obtained clarifying circumstances in which Clinic 1 had contact with Ms H and with agencies seeking information about her.*	
Potential Contributors to SCR	***Response to invitation to participate in SCR process***	
Ms H (Mother)	**Interviewed on 18 April 2011**	
Mr and Mrs H (Maternal Grandparents)	**Interviewed on 18 April 2011**	
Mr G (Father)	**Declined on legal advice to participate**	
Mrs Z (Paternal Grandmother)	**Interviewed on 10 June 2011**	
Mr Z (Paternal Grandfather)	**Interviewed on 10 June 2011**	

Background

1 On 6 January 2011 Child E, aged 14 months, died in Hospital 1 at 13.30 hrs, 30 minutes after he had been admitted unconscious by ambulance following a reported drowning accident in the bath at home. The explanation given by Mr G, Child E's father, for the condition of and injuries to his son was deemed by both paramedical and medical staff in attendance to be inconsistent with the medical evidence. Child E was noted to have:

- numerous bruises on both sides of his face and head
- a 1cm lacerated mark on the left upper shoulder
- a linear lacerated mark on the right shoulder just lateral to the right nipple
- bruises along the middle of the spine extending from top to lower spine
- multiple small injuries to the anus and genital area including possible indications of anal bleeding.

2 Mr G was arrested at the hospital and subsequently charged with murder. At the time of the completion of this report he is in custody awaiting trial and has entered a plea of not guilty.

3 A post mortem conducted on 8 January 2011 reported in May 2011 findings of:

- Twenty-six bruises of differing colouration (red, brown, blue) and age, varying in size from 4cm to 0.2 cm including, multiple fingertip sized fresh bruising to face, neck and trunk
- Twenty abrasions ranging in size from a 4.5 x 4 cm serpiginous (creeping) lesion to tiny punctuate, superficial abrasions
- Anterior healing fractures of the left 6th and 7th ribs of 2-3 weeks duration, along with evidence of recent trauma to the area around the time of death
- An incomplete fracture of the left 8th rib consistent with an injury immediately before death
- Extensive eczema-type nappy rash, with the anal margin particularly inflamed
- Evidence of extensive fresh internal bleeding, total volume approx 150ml
- No convincing evidence of drowning
- No evidence of sexual abuse
- Child E's injuries were not the result of resuscitation efforts
- The most likely cause of death was a blunt force injury to the abdomen, typically such injury being caused by a punch or kick.

4 Prior to his death, Child E had lived all his life with his brother Child F (aged 3) and their parents, Mr G (26) and Ms H (19) at Address 3. Child E and Child F were known only to universal health services (Health Visitor, GP). Their mother, Ms H had short-term contact with CYPS four years previously when pregnant with Child F. Mr G and Ms H were unmarried but had been in a relationship for four and a half years.

5 Both sets of grandparents, Mr and Mrs H and Mr and Mrs Z lived locally. Neither set of grandparents had any concerns about the couple's parenting of the children and indeed all commended Ms H and Mr G as good parents. Mr and Mrs H saw their daughter and her children very regularly. They provided financial support, for the couple to furnish their home.

6 For most of the first two years of Child F's live, Mr and Mrs Z had lived outside the local area, but Mr G and Ms H had visited them and stayed with them. Subsequently, Ms H had refused to allow Mr and Mrs Z to see the children after a dispute around three years ago. Mr and Mrs Z had very little contact with their grandchildren, though would have wanted much more and always provided gifts for birthdays, Christmas and special occasions. They very occasionally saw the children if they met them with Mr G. Mr G continued to visit his family home alone.

Reason for, and Purpose of, Serious Case Review

7 This case was considered immediately to have met the threshold for a serious case review since it involved a non-accidental child fatality where there were indications of possible physical abuse prior to death.[i] The Serious Case Review (SCR) Panel of Havering Local Safeguarding Children Board (HLSCB) was concerned to establish whether anything known about the family had raised or should have raised child protection concerns.

8 The purpose of any Serious Case Review is to:

- Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
- Identify clearly what those lessons are, how they will be acted on, and what is expected to change
- Improve inter-agency working
- Better safeguard and promote the welfare of children.

It is important to note that Serious Case Reviews are not a part of any disciplinary process.

9 The **Full Terms of Reference** (TOR) for this SCR is set out at **Appendix 1.** The TOR explains the parameters and focus of the SCR and identifies the agencies which were required to provide Individual Management Reviews (IMRs). **Comments on the IMRs** and on the SCR process are provided at **Appendix 2.**

10 Further background details are provided as follows:

- A **Glossary** of terms and abbreviations is set out in **Appendix 3**
- A **Genogram** of Child E's family relationships is provided at **Appendix 4**
- A **Key to Anonymisation Details** is provided at **Appendix 5**
- An **Integrated Chronology of Events and Contacts** is provided at **Appendix 6**
- A **Full Set of Recommendations** is provided at **Appendix 7**

Overview Report Author

11 I am an independent researcher and reviewer with 18 years experience of inquiries and reviews in the various jurisdictions across the British Isles, and a further 14 years experience as a social worker and social work manager. I have chaired Fitness to Practise Panels at the General Medical Council (GMC) for 8 years and, relevant to one aspect of this SCR, I have previously undertaken a short interim manager role as Director of Regulation at the Human Fertilisation and Embryology Authority (HFEA). I hold the post of Lecturer at the University of Dundee in the College of Arts and Social Sciences.

12 I have no prior connection with Havering LSCB. I have previously co-investigated, with another independent researcher, a complaint made by a former member of staff of the London Borough of Havering against a former colleague. The complaint related to events in 1996-98 and the investigation was commissioned by the Chief Executive's Office. In the course of that exercise, I had no contact with any staff, teams or service users who are mentioned in this report or in the IMRs. My main contact with the Council at that time was the current Legal Services representative on the SCR Panel.

13 I have no prior connection with any of the Health agencies mentioned in this report or in the IMRs. I have previously compiled Overview Reports for other LSCBs in London which have included IMRs from Metropolitan Police Service and London Ambulance Service. I have previously met the writer of the MPS IMR in this regard, and have also had contact with one of the investigating officers from MPS in respect of arranging access to Police files in another case in another borough. I have no prior connection with or knowledge of Child E's family, or with the families or associates of his parents Ms H and Mr G.

Individual Management Reviews

14 The Individual Management Reviews (IMRs) of the participating agencies were all completed by staff with no current or previous direct contact with the family, or line management responsibilities for services provided to Ms H, Mr G or their children**.**

Family Involvement in the Serious Case Review

15 Both parents of Child E were invited to participate in the review. Mr G, who was on remand in custody, was invited through his solicitor to participate. No response was received. It subsequently emerged from contact with Mrs Z, Mr G's mother that Mr G had not been made aware by his solicitor of the invitation and was keen to participate. Further contact was made with his solicitor who was advised Mr G could also make a written contribution, approved by his solicitor, to the review. The solicitor subsequently advised the LSCB that Mr G would not participate. No adverse inference is drawn from this decision.

16 Ms H's father, Mr H responded on her behalf and arranged for Ms H to be interviewed by the Overview Report Author in the company of her parents at their home. A note of the interview was taken by the Business Manager of the LSCB and agreed. Although talking about her son

was upsetting for her, Ms H participated freely in the discussions which covered the events of her first pregnancy, the contact she had with health professionals during and after the birth of her sons and contact between the family and CYPS after the death of Child E. When Ms H had to leave, the discussion continued with Mr and Mrs H.

17 Mr and Mrs Z were interviewed in their home. A note of the interview was again taken by the LSCB Business Manager. Mr and Mrs Z answered questions about their knowledge of their son's relationship with Ms H and the contact they had with the family over the last 5 years.

18 The Independent Chair of the SCR Panel will discuss the findings and outcome of the review with the families in due course.

Structure of the Report

19 This report summarises family details, discusses the approach to material falling outwith the terms of reference then looks at the facts of the case as they emerged in relation to different time periods. Each time period narrative is followed by analysis and discussion of professional involvement and of the issues relating to the terms of reference which arose in that period. Conclusions, further discussion of the terms of reference and lessons to be learned are then discussed. The content of appendices is set out in paragraph 10.

Summary of Key Family Details

20 At the time of Child E's death his key family members were:

Name	Household	M/F	DOB	Relationship	Ethnicity
Child E	Lived with Ms H, Mr G and Child F	M	03/11/09	Subject [Deceased]	White, British / English
Child F	Lived with Ms H, Mr G and Child E	M	07/09/07	Brother	White, British / English
Ms H	Lived with, Mr G Child E and Child F	F	10/07/91	Mother	White, British / English
Mr G	Lived with, Ms H Child E and Child F	M	07/10/84	Father	White, British / English
Mr H	Lived with Mrs H	M	21/02/65	Maternal Grandfather	White, British / English
Mrs H	Lived with Mr H	F	12/08/62	Maternal Grandmother	White, British / English
Mr Z	Lived with Mrs Z Child X, Child Y	M		Paternal Step-Grandfather	White, British / English
Mrs Z	Lived with Mr Z, Child X, Child Y	F		Paternal Grandmother	White, British / English
Child X	Lived with Mr and Mrs Z and Child Y	M	Aged 13	Paternal Uncle	White, British / English
Child Y	Lived with Mr and Mrs Z and Child X	M	Aged 9	Paternal Uncle	White, British / English

Issues of Ethnicity and Diversity

21 Child E's family are white British and would identify themselves as English. It is noted that a core assessment undertaken by CYPS in 2007 specifically considered Ms. H's ethnicity, age, religion, and gender and sought to establish whether there were particular issues of disability or diversity. No issues of this nature emerged. Health services recognised Ms H's particular vulnerability because of her age and she was given support tailored to teenage mothers during her pregnancies.

Scope of SCR and Approach to Emerging Issues

22 The SCR was established with clearly defined parameters including a starting point of January 2007. Early in the SCR process it emerged that the household in which Child E was living had received only regular, universal child support services. The care of Child E and his brother Child F had never presented any cause for concern to the universal service professionals - GPs, midwives and health visitors - who had been involved with the family in the four years since the birth of Child F. Ms H, the mother of Child E and Child F had accessed medical help for her children appropriately. Her attendance at clinics and for appointments had been good. Contact with the family by professional services had been minimal because of the lack of concern and perceived stability of the family situation.

23 It was therefore considered appropriate to approach the review of the contact between services and the family by ascertaining if at all stages proper procedures and good practice had been followed, and by determining whether there were any indications suggestive of the need for more intervention or different forms of intervention or support during professional contact with the family.

24 It emerged that Ms H, then aged 15, had been temporarily accommodated by the local authority in 2007, shortly after she became pregnant, with Child F. The accounts of this intervention raised a number of questions of policy and practice and it was agreed to explore this period in detail in order to:

- Establish the facts
- Identify any areas of good practice and poor practice
- Identify any lessons to be learned, systems to be strengthened or practice to be improved

25 It also emerged that information was held by CYPS and by Education relating to events in Ms H's family which occurred intermittently between 1986 and 2006. Although this information fell outwith the time parameters of the SCR, it was accepted that consideration would have to be given to whether this information was used appropriately by staff in assessing and responding to Ms H's needs when she sought assistance in 2007. Accordingly, this information was reviewed by the relevant IMR writers.

26 In the course of the SCR process, information giving cause for concern emerged in relation to three aspects of the management of information in the aftermath of Child E's death:

- Difficulties reported by the Metropolitan Police Service in securing access to CYPS files relating to Ms H and her family.
- Information about an unrelated family, Mr and Mrs Q, was wrongfully identified as pertaining to Mr and Mrs H, and included in an assessment report, presented to the Court, about their suitability to have interim custody of Child F following Child E's death. (The report erroneously claimed Mr and Mrs H had two school-age children and had been implicated in the sexual abuse of children).
- Attempts were initiated by the Legal Services Department of Havering Council to delay the funeral of Child E on the that grounds further forensic examination may be required. It was alleged this was against the advice of the Coroner, MPS and senior Children's Services Managers in the Council.

27 These matters were raised in the Police IMR and by Police in discussion and the latter two matters were also raised by the family of Ms H during interview.

28 Subsequently the SCR Panel determined to recommend to the LSCB:

> *"…all agency actions following the death of Child E would be independently reviewed. However it was agreed that this review would not form part of the serious case review but take the form of a further independent report into the issues arising following the death of Child E. (Draft Minute of SCR Panel 20 May 2011)".*

29 These matters are commented on further in Appendix 2 and are the subject of an over-arching recommendation from this review. They are also being investigated in parallel processes following complaints by the H family.

The Facts of the Case: Events prior to and during 11 - 15 March 2007

30 Around December 2006, Ms H, then 15 years old became pregnant by her boyfriend, Mr G, then 22 years old. Ms H and Mr G had attended the same school but not at the same time. Ms H was the youngest of 5 children born to Mr and Mrs H. She did not immediately tell her parents about her pregnancy.

31 Ms H had a chequered history at School 1. She was considered by staff an able, intelligent and often hard-working pupil who did not realise her potential. Her strong personality, sense of justice and protectiveness of people she felt close to at times brought her into conflict with peers and staff. She had been implicated in the bullying of younger pupils and received 8 formal warnings about her behaviour.

32 Ms H was a strong character who had responded well to some teachers while causing difficulty for others. She responded particularly well to a mentoring programme in her penultimate year in school. Her attendance in her final year of schooling was poor. In

October 2006 Ms H had attended her Year 11 interview with Connexions (a career support service). Ms H expressed an interest in working in the travel industry, either by attending a training course or taking a job.

33 Ms H's family had a long history of contact with the school. Mr H was known to be both volatile and fiercely protective of his family. He had allegedly threatened school staff whom he believed had treated members of his family unfairly. Some members of staff reported feeling intimidated and anxious about contact with Mr H.

34 Mr H had acquired ten criminal convictions between the ages of 15 and 21 but had not been arrested for, nor convicted of, any offences for over 20 years. Notwithstanding this, there was a settled belief in the local community he presented a genuine threat to anyone challenging his family and that he could act with impunity.

35 Mr G was reported by the school to have been bright and popular with his peers. Teachers were aware that Mr G's father was imprisoned for a violent offence, and that Mr G lived with his mother and a step-father, with whom he was sometimes in conflict. This relationship has changed as Mr G grew up and the family are close.

36 By 2007 Mr G had a history of two convictions and two cautions for offences, including two incidents of assault in March 2004 and July 2006 involving two different girlfriends.

37 When he began a relationship with Ms H, Mr G was living in the family home with Mr and Mrs Z and their children, his two younger half-brothers, Child X and Child Y. Mrs Z describes him as an affectionate, easy-going young man of whom Child X and Child Y were very fond. When they learned of it, Mr and Mrs Z did not approve of his relationship with Ms H and cautioned him not to get involved with her.

38 Ms H's parents disapproved strongly of her relationship with Mr G. In January 2007, Mr H reported to the Police that Ms H had gone missing from home following an argument where he expressed his disapproval of her relationship with Mr G. Ms H returned home the following day and Police involvement ceased. Around this time Ms H had learned from a home pregnancy-testing kit that she was pregnant, but had not told her parents.

39 At the end of January 2007, Ms H was placed on a reduced timetable at school (unrelated to her pregnancy) in an attempt to manage her attendance and a final warning regarding her attendance was also issued to her parents.

40 Early in March, Ms H's parents discovered she was pregnant by Mr G and insisted she terminate the pregnancy. An appointment was made with her GP on 11th March 2007. She was seen at the practice, in the presence of her mother, by a locum doctor who noted Ms H was "uncooperative" but went ahead and made a referral to a private clinic for Ms H to be further assessed with a view to terminating her pregnancy.

41 On 12 March Mr H went to the Police to report his 15 year old daughter was with Mr G (then 23) and advised he was going to Mr G's house to get her back. Mr H says he wanted Mr G prosecuted for having sex with a minor. According to Police records of the time Mr H did not

report Ms H's pregnancy at this time and did not want Police to search for her but was advising that he intended to remove her from Mr G's home and influence.

42 Later the same day, Mr G contacted the Police in an emotional state, threatening to harm himself. He alleged Mr H and others persons had armed themselves and appeared at his home where they threatened him about his relationship with Ms H. He claimed he had not known she was under-age and believed her to be 17. Again no reference was made to her pregnancy. Police did not respond immediately to either of these reports because of a number of serious incidents happening in the area at the same time.

43 Mr G was living locally, on his own, at this time. Around this period, his family moved away from the area.

44 Ms H was seen at the Clinic on 13 March 2007. The counsellor at the Clinic made a point of seeing Ms H alone. Ms H was ambivalent about terminating the pregnancy but felt her family would not support her to continue. The counsellor made it clear to Ms H that the decision was hers and that could not be forced to terminate the pregnancy against her will. Ms H was accompanied by a parent for the remainder of her assessment at the clinic and an appointment was made for the procedure on 15 March 2007.

45 The next day, 14 March 2007, Ms H attended the Police Station. She explained that she was pregnant and that her family were making arrangements to have the pregnancy terminated against her wishes by booking her in for an abortion. She said that her father had threatened to "put a knife so far up...and cut the baby out" if she did not go through with the termination. She also stated her mother had said Mr H would "beat it out of her". She believed that she and her unborn child were at risk. Police Officers took these threats seriously and contacted CYPS. The CYPS response at that stage was to indicate that help could not be provided with rehousing Ms H until her account had been verified.

46 A Police Officer contacted Mr H by telephone to check Ms H's account. Mr H was angry and became abusive when the Officer stated that Ms H could not be forced to have a termination against her wishes. Ms H meanwhile had left the Police station. The Officer then alerted Clinic 1 to the concerns and asked for the time of Ms H's appointment so officers could attend to ensure she was safe and not under duress. The Clinic asked for a faxed letter from the Police before they could disclose patient information: this was promptly provided. On receipt of the fax, the Clinic Manager alerted the Clinic Client Liaison Officer and the organisation's Safeguarding Officer.

47 Ms H had told officers she was staying with friends that night. Unsuccessful attempts were made to contact Ms H after she left the Police Station, using the details she had given. It was not until the next day that she was found at Mr G's flat and, given the level of concern about her vulnerability and the possible risk to her and her unborn child, she was taken into protective police custody. Ms H was taken to by Police to CYPS and interviewed there by SW1.

48 Two separate strands of Police activity were now pursued. The CAIT team took up the referral by Mr H regarding Mr G having sex with a minor while DC1 liaised with Social Services (CYPS) about the concerns raised by Ms H that she would be forced to terminate her pregnancy. Ms

H told CYPS she was determined to have her baby. She said she would move in with Mr G. She believed the threats of harm to her and her child from her father were genuine having witnessed her father's aggression and violence previously (although not towards her). CYPS contacted Ms H's family to discuss the situation. Mrs H refused to engage in discussion. She considered the exploitation of her daughter by Mr G as "rape". It was decided by CYPS to continue to attempt to discuss the situation with the family with a view to negotiating her eventual return home

49 Later that day, 15 March 2007, Ms H was accommodated under Section 20 of The Children Act 1989 and taken to a foster placement. The Clinic notified Police later that day that Ms H had not attended the termination of pregnancy appointment. The Clinic was advised by Police and was in agreement that no information would be disclosed to Ms H's family without her consent.

Comment on Events 11-15 March 2007

Issues of consent to medical procedures

50 At the time she attended the GP surgery in March 2007, Ms H was 15 years and 5 months old. Ms H was accompanied by her mother to the consultation. She was not interviewed alone. Following the House of Lords ruling in the case of Gillick, the law was clarified as *"any competent young person, regardless of age, can give valid consent to medical treatment"*[ii] The test of legal competence in this instance is that the young person has *"sufficient understanding and intelligence to enable him or her to understand fully what is proposed."* [iii]

51 The GMC has summarised criteria for valid consent as:

- the woman must have sufficient capacity to understand the procedure and its alternatives
- the consent must be voluntary
- The decision must be based on sufficient and accurate information.[iv]

52 The BMA[v] has summarised the test for assessing capacity to consent to or refuse medical treatment, applicable to both adults and minors, as the patient having the ability:

- to understand the information relevant to the decision
- to retain the information relevant to the decision
- to use or weigh the information
- to communicate the decision (by any means)

53 A competent child who wishes treatment cannot have their wishes over-ridden by a parent. In England, a parent can override the decision of a competent child to refuse treatment if the treatment is deemed to be in the child's best interests. However, this provision is generally

invoked in life-threatening situations and it is unlikely this justification would apply in the case of a competent 15 year-old refusing a termination of pregnancy where there is no overt risk to her or to her unborn child. Where the 15 year-old was not in agreement with her parents on this matter, her wishes would generally prevail, or a court could be asked to make a ruling.

54 No competent woman, particularly one of 15, should be coerced by a parent, guardian, or any other person either to undergo an abortion or to continue a pregnancy. Anyone threatened with such coercion can apply to a court for relief, or as in this case voluntarily place themselves under the protection of the State.

55 Ms H was a strong, able, determined young woman who reasoned that the Police were best able to help and protect her and her unborn child. Other young women in such circumstances might not have the strength of character, knowledge, confidence or opportunity to take such a drastic step, particularly knowing the implications it would have for a woman's relationship with her family. The onus of safeguarding mother and unborn child in such situations does not rest solely on the young woman, rather it is a fundamental duty of professionals managing the care of pregnant young women to be satisfied that any decisions regarding pregnancy are freely made and are fully considered. In this respect, Ms H was given good care by the counsellor at Clinic 1.

56 It has not been possible to interview the locum GP who saw Ms H on 11 March 2007. However, it is undisputed that the GP in this case should have been the first source of support for this young woman. Good practice dictates that an assessment should have been made in the first instance as to whether Ms H was Gillick competent and that she should have been interviewed alone. This was the practice followed at Clinic 1, where Ms H was able to voice her concerns in a one-to-one consultation and was given supportive advice by Clinic 1.

57 This issue and the following related issue have been covered in some detail because of their seriousness: the events of 11-15 March 2007 highlight not only some shortcomings in safeguarding practice but also potential failures to follow regulatory and legal requirements.

Issues of Assessment - Regulations of the Abortion Act 1967

58 For a Termination of Pregnancy (TOP) to be legal two doctors have to agree that a pregnancy is associated with factors satisfying one of the five grounds for legal abortion set out in Regulations of the Abortion Act 1967 and in Section 37 of the Human Fertilisation and Embryology Act 1990. In this case of Ms H the legal ground would have been, that:

> "*The pregnancy has not exceeded its 24th week and the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman*"[vi]

59 The determination of whether there is risk to the mother that would satisfy the statutory requirements for an abortion of necessity requires an assessment. The RCOG (Royal College of Obstetricians and Gynaecologists) Guidelines [vii](2004) state:

"*Clinicians caring for women requesting abortion should try to identify those who require more support in decision making than can be provided in the routine clinic setting (such as those with a psychiatric history, poor social support or evidence of coercion). Care pathways for additional support, including access to social services, should be available"*

and

"…there must be factors that would involve risk to her mental health if the pregnancy were to continue… the abortion is not carried out for social reasons, although a woman's social circumstances may be taken into account in assessing the risks to her health"

60 The RCOG guidelines state that *"Doctors providing abortion care are bound by the same duties of a doctor, as laid down by the GMC, as for all other aspects of their clinical practice."* These include:

- make the care of your patient your first concern
- listen to patients and respect their views
- give patients information in a way they can understand
- respect the right of patients to be fully involved in decisions about their care
- work with colleagues in the ways that best serve patients' interests.[viii]

In relation to a termination of pregnancy good practice includes:

"Careful assessment of the adolescent's ability to make decisions and an assessment of her independence from parental coercion must be performed[ix]

61 The Royal College of Nursing (RCN)[x] guidance for pre-abortion assessment is more explicit than the RCOG guidance but derives from the same principles which underpin good medical practice[xi]. It states:

"Because this[assessment] consultation is a sensitive one, it is good practice to see the woman (regardless of her age) on her own initially, so that she can give accurate answers and express her thoughts and feelings freely without being inhibited by the presence of other family members/partners.

The role of pre-abortion assessment is holistic and multi-faceted. It should include:

1. *Developing a full picture of the circumstances leading up to the woman's request for an abortion…*
2. *A detailed medical assessment…*
3. *A detailed physical assessment…*"

62 The RCN guidance emphasises that: "*While the opinion and feelings of others will often form part of the picture for each woman, the decision remains hers alone…".*

63 The RCN guidance indicates that the assessment of a young person seeking a termination should be sufficiently thorough to allow consideration of issues of child harm and states: *"If there are concerns regarding child protection, sexual abuse or exploitation then the case should be discussed or referred to the designated person for safeguarding children.".*

64 Given that Ms H was described as "uncooperative" at the GP consultation in March 2007, and that she was not interviewed alone, it is difficult to envisage how an appropriate assessment could have taken place or how it could have been concluded the statutory requirements for a termination of pregnancy were fulfilled.

65 The Health Overview also points out that: "*The termination form (HSA1) was completed but the rationale for the decision was not documented.".* The form, Form HSA1 for the termination of pregnancy must be signed by two doctors for girls under 16 years of age. A second signature would have been required by another doctor at the private clinic, Clinic 1, to which Ms H was referred.

66 Ms H's subsequent expression of ambivalence at Clinic 1 (which was properly managed) and her actions in seeking Police protection to avoid the termination of her pregnancy demonstrate that she clearly saw no risk to her mental health in the continuation of the pregnancy. She was given no suitable opportunity to express this view at the GP consultation. Listening to young people in health care setting involves creating the conditions which enable them to feel safe articulating their thoughts and feelings.[xii]

The response to Mr G's request for protection

67 Mr H's stated intention to Police of visiting Mr G's house to look for his daughter had the potential to provoke confrontation. It is not clear whether he was discouraged from doing so until Police were available to go with him. Where advice of this nature is given, it should be recorded.

68 The Police IMR suggests that the incident was appropriately prioritised in the light of other demands on the service at the time in the light of other operational demands.

The response to Ms H's request for protection

69 The Police response to Ms H's complaint was swift, thorough and well-managed and the decision to take her into protective custody was keeping with good safeguarding practice. Although Ms H had chosen to leave the Police station when CYPS had asked Police to verify her story, her vulnerability was recognised, contact details were taken and when these proved to be unreliable, efforts were made to trace her. Clinic 1 was also alerted to the potential safeguarding issues to ensure that the termination of pregnancy would not go ahead without further assessment by the Clinic and further investigation by Police of the circumstances.

70 Clinic 1's response to the Police contact was also in keeping with good safeguarding practice, information was provided, internal safeguarding processes were initiated and further advice was later taken from the Police.

71 CYPS, however, responded in a service-driven rather than needs-led approach. The first Police contact was viewed as a request to find housing for Ms H (something that would not have been possible as she was only 15 years old, the minimum age for having a tenancy being 16 years old). This resulted in an inadequate assessment of the situation. From the nature of the threats reported by Ms H, the vulnerability of Ms H and her unborn child, the uncertainty about whether she needed ante-natal care and the fact that was being apparently being coerced into an abortion, it would have been immediately apparent that this was potentially a situation of considerable risk and uncertainty which required immediate response and assessment. The proper response should have been to initiate a Section 47 investigation while making immediate arrangements to ensure the safety of Ms H.

72 The request to Police to verify the details of Ms H's claim was not appropriate - immediate contact with the family risked exacerbating the situation. Rather there should have been a properly considered and planned joint approach to the investigation initiated that day.

73 There is no doubt that once Ms H was brought to CYPS, SW1 put considerable effort into finding a safe place for her to be accommodated. Once Ms H's safety had been assured, it was appropriate to contact her family. However, the indication in the notes at this early stage that the long-term plan would be for her to return home was inappropriate given that no assessment had been made of the situation.

74 This pre-emptive view possibly prevented proper consideration being given, as events unfolded, to calling a Child Protection Conference to pool information, discuss risks and options and make a plan for Ms H and her child. Such an approach would have ensured all the information held by different agencies was shared and that there was an integrated approach to Ms H's care.

The Facts of the Case: Events 16 March - 3 April 2007

75 Following the placement of Ms H in foster care, there is no record of contact with Ms H or with any of her family until almost a week later when Mr and Mrs H visited the CYPS office on 22 March 2007.

76 The social worker recorded *" Mr H very angry towards Ms H's boyfriend, Mr H refutes making the statement to harm Ms H and her unborn child, but accepts that he made an appointment for a termination. Mr H has called the father of Ms H's baby a 'paedophile' and has likened the unborn child to a 'rape child'. Mrs H states that she could not bear to have Ms H at home seeing her pregnant with that 'thing' growing inside of her. Mr H and Mrs H are further concerned that Ms H continues to see the father of the child and is continuing to have unlawful sex with him. "Mr* H also expressed concern that Mr G dealt in drugs and had been violent to Ms H. This information was passed on to Police by the social worker.

77 The same day the social worker phoned the foster carer to check on Ms H and was told she was leaving home at 9am and not returning until 10pm. She had not seen a GP for ante-natal care. The Easter holidays were approaching and the foster carer was due to be away on holiday the coming weekend and then for two weeks and Ms H was refusing to go with the family.

78 The social worker met the next day with Ms H and the foster carer. The social worker negotiated a contract with MS H whereby she would:

- attend GP appointments
- access ante natal care
- attend school
- give the foster carer addresses and details of who she visited during the day
- spend 2 hours a day in placement to build relationships
- sleep at the placement every night.

79 It was explained to Ms H that if she did not comply with this programme, CYPS would consider initiating Child Protection Procedures in relation to the unborn baby.

80 In respect of the holiday arrangements, the social worker properly sought the consent of Mr and Mrs H for Ms H's proposal which was to stay with friends. When this option was refused by Mr and Mrs H, an approach was made to Ms H's sister who refused to accommodate her because of Ms H's attitude. Faced with moving to an alternative foster placement, Ms H left the building. The social worker later visited the foster carer at her home with paperwork for the placement and belongings she had collected from Ms H's home. Ms H rang the foster carer during the social worker's visit, but hung up the phone on her. Thereafter contact was lost with Ms H for 5 days.

81 On Friday 23 March 2007, the day after Ms H ran away, Police were informed and over the weekend visited addresses Ms H was known to frequent before establishing she was with a paternal aunt.

82 From their account, during the days Ms H was "missing" her parents had approached Mr H's sister in this period and she had agreed to accommodate her niece. Ms H also in this period made an appointment to see a GP and was immediately referred into the ante-natal care system. The GP was aware Ms H was staying with her aunt, Ms D, and was aware that Ms H was in foster care. The GP recorded that Ms H had said the baby's father was 18 and that she was in a stable relationship.

83 Notwithstanding that Ms H's whereabouts were still unknown to CYPS and she had been missing from the foster carer's home for 5 days, a LAC Placement Planning Meeting was held on 27 March. It was attended by the social worker, senior practitioner, and foster carer, supervising social worker, school teacher/child protection advisor and home school support

worker. At this meeting the school confirmed that they had never had child protection concerns regarding the family. The outcome of this meeting was a decision the placement would continue.

84 CYPS were unaware of Ms H's whereabouts until 28 March 2007 when Ms H's sister, Ms L contacted the office with an address. On learning from Ms L that Ms H was with her Aunt, Mrs D, SW2 arranged for a police check to be made in respect of Mrs D. The check being satisfactory, it was decided that CYPS involvement would cease, a core assessment having been completed. Ms H was given a copy of the assessment. It was noted that Mrs D undertook to ensure Ms H was encouraged to attend the school (or a Tuition Centre which was being arranged), that she attended ante-natal care and that she ate meals at home, and that Mr and Mrs H agreed to this arrangement. SW2 also noted that Mrs D was prepared to provide this support up until Ms H's 16th birthday (which was then 4 months away).

85 All these checks and arrangements were undertaken and confirmed within a 24 hour period. Information was received from the Police CAIT team in the same period that no action was being taken in respect of the unlawful sexual intercourse issue as Ms H did not want to pursue this. SW2 contacted the Teenage Pregnancy Midwife and advised her of Ms H's background. SW2 then closed the case on 30 March 2007.

86 Ms H shared with her parents the copy of the core assessment she had been provided with by SW2. Mr H promptly contacted CYPS to object to the accuracy of factual data within it. He initiated a Freedom of Information (FOI) request. This related to information alleging Mr H's involvement of acts of violence. Mr H claimed he had no convictions since 1992[1] and that the information alleging violent propensities was unfounded and untrue. Following the receipt of the Freedom of Information request from Mr H, in line with standard procedure a written request was made by CYPS to the Metropolitan Police Service requesting that the Merlin Reports be disclosed to Mr H. There is no record of a response being received from the MPS. However a social services manager agreed that the documents held by C&YPS could be copied and sent to Mr H. Mr H was also advised of contact details of persons within the Council to whom he could make a complaint.

87 At the start of April there was a routine meeting between Havering Police, Missing Person Unit (MPU) and CYPS. These meetings discussed the preceding month's missing person reports and identified any actions to be taken. The process was an important safeguard for ensuring young people going missing were not overlooked or lost to the system. The general rule was that a Strategy Meeting (SM) would be called if the person went missing on three separate occasions. Ms H's case was discussed. Two reports (in January and March 2007) had been received in respect of Ms H. CYPS reported that whilst missing Ms H kept a GP appointment for ante-natal care which "showed she was caring for herself during her pregnancy". The Police understood SW2 remained involved in the case and so it was decided a strategy meeting would not be called.

[1] In fact Mr H's last recorded conviction was in 1986

Comment on Events 16 March - 3 April 2007

Issue of Lost Momentum

88 The delay in the follow-up of Ms H after she was accommodated is inexplicable. The delay allowed Ms H to disengage from the foster placement. Momentum was lost in building a relationship with Ms H which could have paved the way for more meaningful contact with her later. Momentum was also lost in assessing the potential risks to Ms H, given the allegations she had made in relation to threats from her parents, and the risks to her unborn child. There was no assessment of Mr G, despite the concerns which had been expressed over unlawful sexual intercourse and despite the fact Ms H was known to be in contact with him. While an assessment might later have concluded that there was no risk of actual physical harm to Ms H from her parents, this could not be assumed at this stage.

Issues of Inter-Agency Co-ordination of Information, Assessment and Planning

89 During Ms H's "missing period, her GP knew Ms H's whereabouts 4 days before CYPS. The GP's assessment had focused on getting Ms H into ante-natal care and planning. Despite being given indications of a troubled background, the GP took at face value Ms H's account of her circumstances and understood her boyfriend to be 18 years old.

90 Although there was telephone contact between the social worker and the GP on the 26th and 27th March, neither professional learned the full extent of the other's knowledge of Ms H: the social worker remained unaware that Ms H was living with her aunt, knowledge which the GP had. The GP was unaware that Ms H had been missing from her placement for 5 days or that the father of her baby was 22 years old. Thus the discussion between the GP and social worker was based on a confused understanding of the situation and a failure to appreciate the incomplete information on which each was making an assessment of the situation.

91 The GP advised SW2 that there were no concerns regarding the pregnancy. This assessment was based on Ms H's self-reported information and took no account of the uncertainties and risks in Ms H's situation, her vulnerability in terms of absenting herself for 5 nights from her foster accommodation or her likely capacity to care for her child.

92 As a result of the discussion with the GP, the social worker was reassured and imported this reassurance into the overall assessment of the situation. Research over many years [xiii] has shown the dangers of optimism bias, when professionals under pressure accept unchallenged a positive view of a situation, rather than questioning the basis for this assumption. The antidote to the loss of objectivity this causes is good professional supervision:

> *" …so that when the social worker reports that the marital relationship has improved enormously, it will be the job of the supervisor to say "where is the evidence for this?" He must compel the front line social workers to examine their judgements in a critical way…'* (Blom-Cooper 217)[xiv]

93 In this case there appears to have been insufficient challenge to the social worker's perception and under-responsiveness, despite there remaining several unresolved questions and considerable uncertainties in the case.

94 The most overt example of unjustified optimism was in the placement planning meeting. The meeting went ahead despite Ms H's whereabouts being unknown at the time and plans were made on the basis of an unrealistic hope Ms H would return and comply with the "contract" which SW2 had agreed with her. Everything that had happened in the previous 3 weeks should have alerted CYPS to the fact that even if she returned to the foster carer's home, Ms H was likely to take off again.

95 It was now clear Ms H was a strong-willed, independent young woman who was unlikely to cooperate with any care arrangements devised around her foster placement. What was unclear was the extent of her vulnerability, the seriousness and nature of any risks in her situation and her capacity to manage her pregnancy and care for her child, and who she was living and associating with. In the light of these uncertainties, her lack of compliance and the responsibility of care the local authority had towards Ms H, CYPS should have followed through on the conditions of the agreement that had been made with Ms H, and in the light of her failure to fulfil the requirements of her placement, a CPC conference should have been convened.

96 A CPC this stage would have been able to consider the situation of both Ms H and her unborn child and to formulate a multi-agency plan either in the context of CP or Child In Need provisions. At the very least this action would have allowed the pooling of information and the clarification of information amongst professionals.

97 The assessment which was produced appears to have been considered as an end in itself rather than a tool to inform decisions and plans. Its weaknesses were:

- it was descriptive of events rather than analytical of issues
- it did not use historic information about family members in a way that informed the current context
- it did not address some of the complexities of the situation, for example the expressions of Mr H's extreme anger towards his daughter alongside some very forceful efforts he made to protect her; the determination of Ms H to protect her unborn child alongside her immature responses when crossed
- there were no attempts to anticipate how events might develop and what inputs or interventions might facilitate or mitigate different scenarios
- there was no attempt to anticipate or plan for long term needs
- issues of the degree and nature of risk of physical harm, emotional harm and vulnerability were not adequately addressed

- School 1 had not shared information about Mr H or about Ms H's personal qualities, or how Ms H and her family were viewed by both staff and teachers which, as the Education IMR points out, would have enabled a more informed assessment of vulnerability and capacity to have been made.

98 The above shortcomings are suggestive of an approach that has emphasised completing the requirements of the assessment process and form rather than understanding the narrative and using it to form conclusions and inform decisions. There was a failure in the assessment process to obtain a clear history and to contextualise the information. Research by SCIE has shown that:

"*The key [to assessment] is narrative knowledge …understanding what has led up to this point, the context in which events have taken place, how factors have changed, are changing, and are likely to change. " (Bostock)* [xv]

99 The CYPS IMR highlights the consideration that should have been given at this stage to commencing a risk assessment of the unborn child and convening a pre-birth child protection conference, pointing out that such assessments would have given a clearer picture of the risks in the situation including "the impact of all adults involved with Ms H on the unborn child including Mr G, Mr and Mrs H and Ms D [and] any risks associated with Ms H's failure to fully engage with arrangements to safeguard her unborn child."

100 It is worth noting that the process of assessment did ensure Ms H was seen alone and given opportunity to voice her concerns and wishes and that Mr and Mrs H were contacted and their views sought.

101 As the ONEL IMR points out, the GP and midwifery notes in relation to contact with the social worker are poor, failing to detail key aspects of the discussion. As the Health Overview points out: *"There was no indication that her social circumstances were assessed or even considered by health professionals in primary care services and a general acceptance that she was being well supported was being upheld."*

<u>The lack of engagement by School 1</u>

102 Although SW1 had contacted the school with information about Ms H's pregnancy and recent events, this information is nowhere recorded in available school records. There was an Education representative at the Placement Planning Meeting in March 2007 but there appears to have been no formal planning or response within school to identify or respond to Ms H's needs, including health and safety issues.

103 The Education IMR points out the discrepancy between the positive impression of the stability of Ms H's background conveyed at the meeting by the Education representative and what was actually known by School 1 about Ms H, commenting "*It is also hard to imagine, given the family history, that the school felt that Ms H would be supported by her family throughout her pregnancy*". The IMR considers this a *"strange omission given that the school held a wealth of information about Ms H and her family that could have usefully informed the Core Assessment.*

The information received from the school on the following issues could have provided insight into Ms H's parenting capacity:

- *Ms H's personality*
- *Ms H's propensity for physical violence and verbal bullying*
- *The school's experiences of threats of violence from other family members*
- *The H family's attitude towards education*
- *Information about Mr G"*

104 The Education IMR also points out "School 1 does not seem to have considered that Ms H's pregnancy may have made her vulnerable". The Education IMR has also identified that the "flexibility" that schools have in respect of meeting the needs of pregnant students can *"…cause confusion in cases in which there may be concerns but staff are unsure of their right to intervene. In terms of Working Together guidance and the safeguarding of children there tend to be better outcomes when all agencies are clear of the procedures to be followed in relation to a situation."*

105 Opportunities to engage with Ms H or obtain support for her were missed by the school which failed to inform Education Welfare Service, CYPS of the pregnancy and the concerns about Ms H's vulnerability. Additionally the school nurse was never alerted to the pregnancy despite the key role she should have played in supporting Ms H in school.

106 The Education IMR suggests there were a number of possible reasons for the School's seeming unresponsiveness:

- A failure to perceive Ms H as vulnerable because of her strength of character and because she had been implicated in bullying. *"It may have been difficult for staff members to change their perceptions of Ms H from being, at times, something of a bully, to seeing her as a vulnerable young woman who, alongside her unborn child was in need of protection."*
- Members of her family were often seen as the aggressors in disputes and staff at School 1 may have feared repercussions from the H family if they were seen to intervene in what they might consider to be a private family matter.

107 The Education IMR does not find that any of the possible reasons suggested justify the failures to seek to ensure there was an adequate system of support in place for Ms H.

108 This case has highlighted, however, the need for a robust system to provide guidance and support to school staff who feel intimidated by parents or others and which ensures children are not disadvantaged in learning opportunities because of such difficulties.

<u>The closure of the case by CYPS</u>

109 The closure of the case by CYPS in late March 2007 was premature in the light of

- Mrs D's statement that she would only accommodate her niece until her 16h birthday (which would fall, before the birth of the baby).

- The unassessed risks in the situation. No proper assessment had been made of Ms H and her capacity to care for her unborn child, nor had the issue of her allegations about threats made by her parents been addressed.

110 The assessment of Mrs D was cursory, given the role she was being asked to take on. As the CYPS IMR points out "a detailed viability assessment should have been undertaken of Ms D's capability to safeguard and meet the needs of Ms H and her unborn child". The implications of the time-limited nature of the arrangement were not considered. No assessment or checks were undertaken in respect of Mr D, Mrs D's husband who was also living in the home where Ms H would be accommodated.

111 Although SW2 could properly be reassured by Mr and Mrs H's willingness to allow Ms H to stay with her aunt and uncle, having previously vetoed unsuitable informal arrangements with friends, the failure to check Mr D's background or to more thoroughly appraise the situation was unsatisfactory and potentially unsafe practice. Given the uncertainties in the situation and its potential for instability, further monitoring was required.

112 While benefit of hindsight, and a review of past family history, would suggest Mr H's volatility and anger never translated into actual harm of his children, this had not been established by the end of March 2007. Even if this was becoming clear, Ms H had, by her own account, been traumatised by the threats which at least merited consideration as emotional abuse.

113 The poor quality of information sharing meant than when the case was closed by CYPS, other professionals, Police at the Missing Persons (Misper) meeting, the GP, midwife and later health visitors assumed that a social worker was involved.

114 No professional should have proceeded on the basis of an assumption but should have followed through and confirmed whether a social worker was involved and, if so, what their role was and what contact with and updating of them was necessary. In situations of risk and uncertainty assumptions are potentially dangerous as they introduce more uncertainty. As the Climbie inquiry found: *"Assumptions made about Victoria diverted caring people from… acting" (Laming 2003)*

115 The Health Overview Report comments on the problems of assumptions leading to poor safeguarding practice:

> "*Health practitioners were aware that Ms H had been placed into foster care with her aunt, but follow up with social care was not instigated. The GP records make reference "that Ms H is now staying with aunt/foster carer and that Ms H has made contact with social services and that all is OK". There is no written evidence of ongoing planning or further liaison with the social worker in any of the health records in light of the issues surrounding her own family circumstances.".*

116 Further, the ONEL IMR points out, having been alerted to safeguarding concerns, the health professionals should have been undertaking and noting ongoing assessment of risks and vulnerabilities in the situation. Given Ms H was at school, there should have been liaison with the school nurse to ensure continuity of care and support in the school environment.

117 The Health Overview draws attention to the Care Quality Commission review of the Baby P case (CQC, 2009) where poor communication between health professionals and other agencies was evident, and notes the gaps in communication among health organisations in this case: *"GP2 did contact the social worker on 27.03.2007 but there is no recording of the content of the discussion or any sharing of social/environmental information. Whilst written communications between different health and other personnel occurred, medical and nursing staff rarely talked directly to each other."*

Issue of Unlawful Sexual Intercourse

118 The failure to pursue the unlawful sexual intercourse as a child protection issue was a flawed decision. The Police investigation was a criminal investigation and despite the pregnancy and Mr H's complaint, in the absence of Ms H's cooperation it was determined that there was insufficient evidence to pursue this as a criminal investigation.

119 This decision, however, did not preclude separate consideration of the issue as a strand of a child protection investigation. While the evidence in a case may be insufficient to support a criminal prosecution, it may still raise concerns sufficiently serious to warrant investigation of the risks to, and vulnerability of, a young person.

120 The fact that a criminal investigation in respect of safeguarding issues is concluded because of insufficient evidence is never cause to cease or fail to initiate a S47 investigation in respect of the same allegation, because evidence which does not support a criminal investigation may still provide sufficient grounds for a safeguarding intervention. Further at that stage it had never been formally determined whether Ms H was someone at risk of exploitation by older men or whether Mr G's behaviour was cause for concern in relation to the exploitation of young teenage girls.

121 The consent of a child victim is not a perquisite for launching such an investigation. The principle exists because consent may not be possible for example when a victim is an infant or has learning difficulties. While a child's views will be considered, statutory agencies have a wider duty of public protection which meant ensuring Mr G did not pose a risk to other vulnerable girls.

Issues of Access to Information

122 CYPS had sought information from Police to help assess the risk to Ms H in the light of the threats she reported her father had made against her and her unborn child. The status of the various pieces of information provided by the Police was not clarified. The Core Assessment in which it appeared was given to Ms H on completion but there is no indication that information within it was:

- checked with her or her family
- agreed for release to Ms H and her family by the MPS.

123 Mr and Mrs H have also since complained that information about previous family member contact with Social Services, including information about their relationship, which they did not want shared with their children, has been made available to Ms H without their consent.

124 It appears several breaches of good practice occurred in the handling of confidential third party information:

- the core assessment should have been shared with Ms H and checked for accuracy in its preparation and, only once a risk assessment had been undertaken, shared with her family
- third party information, i.e. information provided in confidence by Police should not have been disclosed to Ms H or anyone else without the consent of the MPS
- care should have been taken to ensure Ms H was not given access to information relating to other family members and their contact with CYPS
- the status of information from third parties i.e. Police should have been clarified and proper weight accorded to it and proper caution taken in its use and dissemination

125 The copying and provision of third party information to Mr H was done with the best intentions of ensuring transparency. However, the material should not have provided in the absence of explicit permission from the Police. CYPS had not received a response from the Police about their request to disclose this material under FOI. It was not appreciated that actual consent was required from the Police before disclosure and that in the absence of a response, no action could be taken. FOI requests involving third party information are complex matters and in cases involving general, background information provided by the Police, best practice would be for managers to discuss the issue with the Police and with Legal Services in order to ensure both law and best practice were being followed. This is a specialist area with which frontline staff and their managers will not necessarily be familiar and it is recommended that good practice guidance is drawn up and training provided.

126 Failings in the management of confidential and personal information are extremely serious as they can put service users at risk, can undermine trust between agencies leading to reluctance to share information and can open staff members up to civil litigation and criminal charges.

The Facts of the Case: Events of July 2007

127 In the next three months after CYPS had closed the case, Ms H attended her ante-natal appointments, where she was supported by the Sure Start Midwife, and her pregnancy progressed normally.

128 Ms H was placed on Registration Code B from April-June 2007, that is "*being educated off-site at a supervised activity approved by the school'* usually with a Home Support Worker (HSW). The HSW recalls that the family situation was 'sensitive' and thinks it was therefore unlikely that he took school work to the family home. The HSW remembers Ms H because she was a 'larger than life' character but does not recall any direct contact with her.

129 Although she did not attend school, Ms H sat her GCSEs achieving a pass in English.

130 In July 2007, on the day before her 16th birthday, Ms H and Mr G attended at CYPS. Ms H had a letter from her aunt saying she would no longer accommodate her. She was advised to visit the Housing Offices and to take along with her the copy of the Core Assessment completed in March. No further assistance was offered.

131 Ms H went to the Housing (PASC) team on 10 July 2007. There she completed an application form for priority housing. The Housing Officer was concerned for Ms H and contacted CYPS to discuss whether Ms H required CYPS support and whether a more appropriate placement would be in a supported Mother and Baby Unit. The social worker discussed the matter with their Team Manager and they concluded that "Ms H had obviously been engaging in ante natal care, as a referral would have been received if not". It was noted that she was still in a relationship with the father of the expected child and it was assumed she had support from her aunt and other family members. On this basis Housing officers were advised that Ms H did not require a supported placement.

132 The same day Ms H and Mr G Ms H attended the Connexions office. She explained that she was 32 weeks pregnant and homeless. Ms H explained to staff that she had 'fallen out' with her parents in March and moved into a foster home. Recently she had been staying with her aunt but this was temporary measure until she turned 16 and could apply for housing. Ms H completed a Learning Focused Interview (LFI) which she was to take to the Young Person Advisor at the Job Centre. An appointment was made for 13 July 2007 at 10am.

133 As Ms H had described having had a CYPS assessment and seemed to have had family support, Connexions did not think it was necessary to make a referral to CYPS. Ms H was encouraged to return to Connexions for help finding work/training once the baby was born and her situation was more settled.

134 Soon afterwards Ms H was rapidly placed by Housing in a Homeless Unit where she stayed, seemingly unsupported for the remainder of her pregnancy. She returned to that accommodation after the birth of her first son, Child F, on 7 September 2007.

Comment on Events of July 2007

135 The response to Ms H by CYPS was inadequate and inappropriate. She was barely 16 years old, 7 months pregnant, homeless for the second time in 4 months and having to set up home for herself. No assessment was made of her situation or of the support available from other sources including Mr G. In the light of the recent involvement of CYPS, further assessment should have been undertaken. The suggestion of taking the Core Assessment to Housing was

inappropriate. The circumstances it had been based on had clearly changed as Ms H appeared no longer to have family support. Additionally, given the third party information and personal health information relating to Ms H that it contained, it was unsuitable for sharing in this manner. Core assessments are not documents created to support housing applications and they contain information which may not be appropriate to share without necessary permissions. In fact, Ms H subsequently explained, she no longer had the document.

136 The response of CYPS when Housing officers sought a view on her needs and vulnerability was also inadequate and inaccurate, and was based on assumption and surmise and an outdated understanding of her circumstances. A change in circumstances since March 2007 had prompted the re-referral yet CYPS staff recommended Housing officers rely on an assessment of a situation that no longer existed. Further the assumption that Ms H had the support of her aunt when the referral had been prompted by her aunt making her homeless was irrational. The response to Housing was thus based on CYPS guesswork.

137 At the very least an initial assessment should have been carried out and leading to consideration of what longer term support might be necessary. Aged 16, Ms H could have been considered as a Child in Need and a plan of support devised.

138 The dangers of professionals working on the basis of assumption rather than fact were discussed above.

139 The Housing Officer who interviewed Ms H clearly had some concern about her vulnerability given her age and advanced stage of pregnancy. While the HO was justified in relying on the judgement of CYPS regarding Ms H's needs, it is worth remembering that under S17 of the Children Act 1989, any agency can call a Child in Need (CIN) meeting in order to share and gather further information regarding any concerns in relation to the safeguarding of children.

140 An assumption was made by Connexions that Ms H had support because she had had contact with CYPS and had stayed previously with an aunt. Good safeguarding practice does not rely on assumptions but establishes the factual position. Assumptions, as discussed previously, are dangerous when dealing with vulnerable young people because they introduce more uncertainty into an already uncertain and potentially unstable situation. Good practice would have been for Connexions to contact CYPS to check the position.

The Facts of the Case: July 2007-October 2007

141 During the latter stages of her pregnancy Ms H was diligent in attending ante-natal care appointments and in seeking medical advice when she was worried. Her relationship with Mr G continued.

142 Little is known of Mr G in this period. He was seen by GP4 in August 2007 who recorded that Mr G was stressed " because of a new baby " (although Ms H had not yet given birth) and because he did not have any work. In September 2007, just prior to the birth of Child E, Mr G saw GP3. He said that sometime in the summer he broke his hand "punching" someone or something. There is no history of the circumstances of the injury in his medical notes.

143 Ms H gave birth to Child F on 7 September 2007. She returned to the Homeless Unit on discharge from hospital. She was seen there first by the community midwives and then responsibility for her care transferred to HV1.

144 HV1's first visit had to be rescheduled as Ms H had advised she would not be available for a planned visit because of a trip out of town to see Mr G's family.

145 When HV1 saw Child F, she reported him to be well-cared for and although thin, was gaining weight appropriately. The only note of concern was the two injuries HV1 noticed on Ms H's face on successive weeks. The first, a bruise above her eye, Ms H explained had been caused while playing with her boyfriend's nephews, while the second, an injury to her nose, she said had been caused by a fall in the shower. The injuries were minor but significant enough to have been recorded by HV1.

146 A week later Ms H moved into permanent accommodation. HV1 only discovered this on a visit, when she found Ms H was no longer living in the Unit. On establishing Ms H's whereabouts, HV1 transferred responsibility for Ms H's follow-up to HV2 who covered that area.

Comment on Events July 2007-October 2007

147 No follow-up was undertaken by the GP of Mr G's reports of stress. The Health Overview points out, *"this was an opportunity to liaise the vulnerability issues with the midwife or health visitor."* The Health Overview report goes on to conclude: "*Mr. G was not included in any assessments and appeared to be "invisible" to practitioners which is a common finding in child protection systems. Research has established the importance of including and working with fathers and the related impact on the assessment of the family and subsequent service provision (Ryan, 2000)".*

148 The medical notes relating to the origin of Mr G's hand injury are inadequate. The circumstances of the injury should have been recorded in the light of the "punching" description.

149 HV1 knew that Ms H was barely 16 years old and living alone in a Homeless Accommodation. She knew from the information passed on by the Community Midwife that Ms H had contact with a social worker. She had sufficient unease about two injuries to Ms H to note them. These factors should have prompted HV1 to raise the case in a supervision session. Working Together to Safeguard Children (HM Govt, 2006), states that *"effective supervision is important to promoting good standards of practice and to support individual staff members. Supervision should……help ensure that practice is soundly based and consistent with organisational procedures (para 5.61)".*

150 A health visitor encountering bruising of this nature in a young woman may have two possible explanations in mind, self-harm and domestic violence. She would have had no evidence of either at this stage but would be concerned to monitor the situation.

151 Self-harm is not uncommon amongst teenagers, with the more reliable studies finding up to 35% of young people reporting an incident of deliberate self harm.[xvi] Self-injury through hitting, particularly of the face, is one of the rarer presentations of self-harm [xvii] in teenage girls and would be unlikely to occur to a health visitor as a possible explanation for Ms H's bruising, particularly as there was suggestion of any previous history of self-harm. Self-harming behaviour of this nature can be linked to a number of factors including being a domestic violence,[xviii] low self-esteem and childhood trauma.[xix]

152 A health visitor would more likely have had in mind the possibility of domestic violence injuries, which would not have been an unreasonable view. It would have been important for a health visitor with any concerns of this nature to have ensured a thorough assessment was carried out and that information and concerns were properly passed on to colleagues in any handover.

153 In the case of uncertainty or concern about Ms H's background and support, there was no reason, as the ONEL IMR indicates, that HV1 herself could not have carried out a fuller assessment of the situation, holistic assessment has always been at the core of the role of health visitors.[xx] Such an assessment would have involved learning about Ms H's background, her experience of being parented, her vulnerability, what was known about her partner. This might have indicated whether a referral to another agency for support was required or whether an enhanced level of HV contact was needed.

154 As discussed above in relation to Housing staff, Health Visitors can call a Child in Need meeting to promote the sharing of information and co-ordinate inter-agency planning, in any case where they have concerns. This could have been an option following a supervision session.

155 The Health Overview Report notes of this period that although Ms H was seen in this period by GP, Health Visitor, and Midwives*, "During the pregnancy with Child F, Ms H was living in a homeless hostel, there was no professional curiosity noted to ascertain the circumstances"*

156 In the circumstances of the transfer of responsibility to an incoming Health Visitor, HV2, the information transferred should have been sufficiently detailed to lead HV2 to the same conclusion, that discussion with the Designated Nurse or supervision discussion was required. It is unclear in the absence of adequate notes what information was transmitted.

The Facts of the Case: October 2007-January 2011

157 When HV2 visited Ms H in her new home on 18 October 2007, she and Mr G were living together. HV2 noted good interaction between the parents and child. This was the only time HV2 saw the family at home. HV2 later invited Ms H to bring Child F to the clinic for weighing. HV2 had no more contact with Ms H. Over the following months, Ms H attended all Child F's clinic and GP appointments for screenings and immunisations. Ms H attended her GP with Child F three times during the rest of that year in relation to a persisting oral thrush problem, not uncommon in babies.

158 In January 2008, Ms H took Child F to the GP suffering from a respiratory infection which she thought was related to the dampness and mould in her home, problems of which she had already complained twice to the Housing Department. The GP offered to write a supporting letter about the effects of the damp on Child F if required

159 On 8 January Ms H was visited by a Housing Officer regarding the complaints she had made about dampness three weeks previously. She was advised the private landlord of the property would be asked to make repairs. The landlord was contacted the same day by the Public Sector Leasing Team and acknowledged the request a week later. There is no record of the repairs being carried out. Almost 2 years later, in December 2009, Ms H was again reporting mould problems.

160 In the first three months of 2008, Ms H took Child F to the GP four times for respiratory complaints and dermatitis (nappy rash). Some of the latter complaint may have been attributable to side effects of treatment for the respiratory infections. Two appointments were also missed but it is not clear which family member (Ms H or Child F) they related to. On 16 May 2008 Ms H took Child F for a clinic appointment. HV3 arranged for the GP to see Child F for nappy rash.

161 Two days later, when the problem appeared to be worsening over a weekend, Ms H took Child F to an out-of-hours clinic for emergency treatment. In June, July, September, October and November Ms H took Child F to the GP with respiratory infections. She also attended for immunisations.

162 In February 2009, Ms H became pregnant with her second child. On 24 February 2009, Child F was admitted overnight to hospital following attendance and A&E with a two day history of vomiting, diarrhoea and a rash. The hospital became concerned when Ms H and Mr G took child F home instead of waiting for an x-ray as requested. The family were contacted and Ms H returned with Child F. She explained she had gone home for nappies and had also been upset as she thought a nurse was accusing her of being a poor mother. Child F's illness proved to be a viral gastroenteritis. He was noted to be happy and responsive in the ward with his mother.

163 Child F was followed up by the GP a few days later and was noted to be well apart from nappy rash. He kept well for the rest of the year. Ms H's pregnancy was uneventful and she was referred to the Teenage Pregnancy Midwife (TPM) and attended all appointments.

164 Child E was born on 3rd November 2010. Ms H was discharged home with him later the same day and visits by the TPM team recorded no concerns. Responsibility for follow-up was transferred to HV4 who visited on 16 November and noted Child E was progressing well. Child F was a little unsettled and prone to temper tantrums following the arrival of the baby and strategies for managing this were discussed with his parents.

165 On a follow-up visit on 30 November 2010, HV4 recorded that Ms H was "coping well". She noted that she had heard no vocalising of sound from Child F then 2 years old. She properly initiated a referral to audiology and speech and language therapy services for assessment and also encouraged Ms H to attend Mother and Toddler groups with Child F. Ms H did not attend

the appointments. Ms H had wrongly felt the referral was a criticism of her parenting. She has since explained that she was not concerned about Child F being slow to speak as this had been the pattern with her siblings. She explained she had also spoken with her GP and was reassured that some children did develop speech later. When the GP practice and HV4 were advised that Ms H had not attended the speech development assessment, no action was taken as there were no concerns otherwise about Child F's care.

166 Between January and March 2010 reviews and immunisation appointments confirmed both children were progressing well, although Child F's poor speech was again noted and a pack of information to help parents encourage speech was sent to Ms H. Child F was twice taken to the GP by Ms H for respiratory illness in this three month period. In May 2007 Child F was seen with a one week history of diarrhoea (no vomiting) and Ms H was advised to remove dairy products from his diet.

167 On 27 July 2010 Ms H took Child F to the out-of-hours clinic with a painful groin. He was sent to A&E where a urinary infection was diagnosed and he was discharged with antibiotics. A request was sent to the GP to make a referral for assessment of a possible undescended testicle. The GP did not refer Child F but, according to Ms H, he reassured her that the referral would be best delayed until Child F was a little older, as the problem might yet resolve itself.

168 Child F was seen by the GP in August 2010 for constipation and Ms H was again given dietary advice. Child E was seen for immunisation on 10 November 2010 but did not attend for either a follow-up immunisation on 3 December or a one year review screening on 8 December 2010. These missed appointments occurred in a period of extreme weather conditions when heavy snow made journeys in the borough difficult and during which many patients missed appointments. In these circumstances, the missed appointments did not trigger any concerns. There was no further contact with the family by any health professionals until 6 January 2011.

169 Sometime during the week that included Christmas in December 2010, Child E suffered an injury serious enough to break two ribs. No treatment was sought. It is known from family accounts that both children were ill with diarrhoea around this time, although again there was no contact with health services. In this 2-3 week lead-up to 6 January 2011, Child E must have suffered a number of minor injuries at different times which resulted in the 26 bruises and 20 abrasions of different colouration and age that were apparent on post mortem.

Comment on Events October 2007 - January 2011

170 HV2 was introduced to a couple with a stable relationship whose interactions Child F in her one visit to the family home gave her no cause for concern. While professionals always need to be cautious of forming judgments about the quality of parenting on the basis of one "snapshot" visit, HV" was likely to be further reassured when Ms H proved diligent in attending appointments at clinic and in seeking GP and out-of-hours treatment for Child F if she had any concerns. There was nothing in Child F's history in the period between 2007 and 2011 that would have prompted designating the situation "cause for concern" and increasing the frequency of contact.

171 Mrs H has explained that while she and her husband had been extremely unhappy about Ms H's pregnancy, after Child F was born, they loved him and accepted him as their grandson. Ms H thus had family support in raising Child F and in her second pregnancy.

172 HV4's initial contacts with the family dealt with appropriate matters and her referral of Child F for speech assessment was appropriate. Despite her youth, Ms H was a caring and protective mother. Her protectiveness on a small number of occasions caused her to be overly sensitive to professionals' comments or suggestions, seeing, for example, the referral made by HV4 as a criticism of her parenting, when no such inference is apparent in HV4's notes or referrals. Indeed because the family situation was viewed as stable and the children were developing satisfactorily, there was only minimal contact from the health visiting service.

173 The downside of this situation was that there was no opportunity for Ms H to build a relationship of trust with the health visitor, whom she considered not to be very approachable and of whom she was wary because of what she saw was unjustified criticism. There was nothing in the family situation between October 2007 and January 2011 to have caused any of the professionals who met the family to have any concern and nothing which would have given any indication or warning of the tragedy of 6 January 2011.

174 It is now evident that over a two-three week period immediately prior to 6 January 2011, Child E had acquired a number of bruises and abrasions and had suffered injury severe enough to break two ribs. There is no evidence before this review of any injuries which would be evident before a period starting sometime in the week that included Christmas. In the light of these details which emerged in late May from the post-mortem, it may now be appropriate for a joint strategy meeting to be called to consider the safeguarding implications of the earlier injuries. Part of that consideration will require access to specialist medical advice on the extent to which injuries would be evident to anyone seeing or caring for Child E and the likely effect of the injuries on Child E over that two-three week period.

Housing Issues in the period 2007-2011

175 It is clear the family experienced difficulties in relation repairs to the property. The family lived in Private Sector Leased (PSL) accommodation provided and managed by HPP, and not in mainstream council property managed by Homes in Havering (HiH). Apart from the problem of persistent dampness and mould highlighted above, the family were 12 days without hot water during December 2009. In June 2008 Ms H reported defective patio doors. She reported this problem again in August 2008 and in September 2008 an order for repairs was raised. The request to the landlord to carry out the repairs was not sent until May 2009. An email from the landlord outlining progress on the matter was received in June 2009, almost a year after the problem was reported. The Council explained that*: "The mould growth was investigated and the cause found to be a lack of ventilation caused by the way the home was used by the family rather than any defect in the building. Advice was given on how to avoid such problems. She reported the same problem again in 2009, and this time the owner fitted two new airbricks to improve ventilation, and renewed draughty patio doors at the same time."*

176 Rent arrears first surfaced as a problem for the family in October 2009 when Ms H was served notice to quit with rent arrears of £5329. This appears to have been resolved with an adjustment of her housing benefit but further concerns arose in April 2010 when the arrears totalled £4662. Again this appears to have been resolved when more information was provided to the Housing Benefit section. In November 2010, a further letter was sent to Ms H about arrears of £5015. There appears to have been a further adjustment made around this time to her housing benefit but on 17 December 2010, Ms H was sent a notice to quit the tenancy on the basis of rent arrears totalling £5273.

177 Ms H indicated that arrears were a problem and Mr H explained that difficulties arose repeatedly as Mr G worked on short-term contracts and his income and eligibility for Housing Benefit varied. There were delays each time in Housing Benefit administration catching up with the changes in circumstance. Mr H indicated that he and his wife were unaware of the arrears until after Child E's death. They had previously helped Ms H and Mr G financially and had furnished the home for them.

Comment on Housing Issues 2007-2011

178 The response to the repair requests appears to have been inconsistent at times and was complicated by the housing team having to contact the property landlord and sometimes delays occurring in the landlord's response. It also appears that Ms H was not always co-operative with the advice given. The matters reported were serious ones which had implications for the health (mould and persistent dampness, lack of hot water in winter) and for the safety of young children (defective external door).

179 While the owner from whom the property is leased is responsible for the repairs specified by Section 11 of the Landlord and Tenant Act 1985, the owner can agree to the Council carrying out repairs and having the money deducted from rent money due to them. The process in place in Havering is that: *"Following referral, the PSL team checks that the owner has completed repairs and if not, carries out the work on his/her behalf, deducting the cost from the rent. The PSL [Private Sector Leasing] team generally pass minor repair requests to HiH [Homes in Havering] to order. High priority is given to repairs which could be injurious to residents (whether they are children or adults). The PSL team has the ability to bypass HiH and place orders directly with contractors in exceptional circumstances, and would do so if this was necessary to avoid a continuing risk to a child. They would also do so if a property owner failed to complete repairs promptly. The Council has the ability place orders directly with contractors in exceptional circumstances, and would do so if this was necessary to avoid a continuing risk to a child. They would also do so if a property owner failed to complete repairs promptly".*

180 There is no indication such an intervention was considered in this case, even during the 12 day winter period without hot water in 2009. This is unusual given Housing's firm commitment to intervene to ensure work is carried out where there is risk to children when repairs are delayed. It is therefore recommended that Housing review arrangements or criteria for identifying such situations and expediting repairs.

181 Ms H was not always responsive to contact by Housing officials and on at least one occasion refused a property inspection because of her perception of the attitude of the housing officer. Lack of engagement may have prevented earlier resolution of some of the problems.

182 Housing Benefit is a complex system whose operation is bound by national rules, limiting the scope of response of the Housing team. However, in response to this SCR, Housing have determined that: *"...the PSL team should check that all evictions involving rent arrears in the last year were authorised only after action was taken to make sure the tenant was claiming all the HB to which they were entitled".*

183 Ms H and her parents have commented positively on the response they have received from Housing Officers following the death of Child E. They appreciated greatly that they had been treated with sensitivity and compassion.

The Facts of the Case: Events of 6 January 2011

184 On morning of 6 January 2011 Ms H changed both children first thing and then showered and got ready to go out while they played in her bedroom. She went to nearby shops in her car and on her return at about 11.15 gave both children a cookie. She left the house about 10 minutes later for her father's shop.

185 While there her sister received a text from Mr G saying Ms H had to return home. She rang him but could not ascertain what the problem was. She drove home and found the doors of the house open and Mr G frantic, saying he thought Child E was dead. Mr G then phoned 999 at 12.43pm and the couple in turns administered CPR as instructed by LAS until the first, Fast Responder paramedic arrived at 12.49 pm. Two ambulances arrived one minute and four minutes later, respectively and Child E was taken in under 10 minutes to Hospital 1, where a doctor and medical team had been alerted. Unfortunately, Child E could not be revived and was pronounced dead 30 minutes after arrival.

Comment on Events of 6 January 2011

186 The response of the LAS service was swift and exemplary. The call was given immediate priority and in addition advice was given to Mr G on commencing CPR. By the time Child E arrived at hospital a medical team was on hand to respond immediately. While responding with all the appropriate emergency life supporting measures, the Fast Responder who was first on the scene was alert to anomalies between the presentation of Child E and Mr G's account of events. The paramedic observed bruising on the child and possible signs of anal bleeding. The officer took care to ensure that these observations were recorded and were passed on promptly to the hospital staff, recognising that these may have been indications of abuse. This was commendable safeguarding practice.

CONCLUSIONS and SUMMARY OF FINDINGS

General Issues Relating to Safeguarding and Contact with Child E

187 The conclusions and findings in relation to general issues are:

a) The death of Child E could not have been anticipated by any of the statutory agencies;

b) The records of contact with the family set out by Health Visitor and GP show nothing that would have precipitated a more intensive level of contact from health agencies or referral to Children's Services from October 2007 onwards;

c) At the time of Child E's death the family were in contact with health visiting and GP services and all treatment and actions received from these services were appropriate;

d) Ms H's engagement with services had been good and she had appropriately sought advice and treatment during her pregnancies and when she had concerns about her sons, including seeking emergency treatment twice for Child F;

e) While Ms H experienced three sets of problems with unnecessary delays in essential repairs and received three threats of eviction due to rent arrears, subsequently deferred by Housing Benefit level changes, there were no indications to Housing staff of any safeguarding issues in the household;

f) Ms H communicated to professionals that she was in a stable, supportive relationship with Mr G and she readily left him alone to care for the children as necessary;

g) In the few opportunities professionals had to see the couple or Mrs H with the children, they commented positively on the interaction amongst the family;

h) Following the birth of Child F, Ms H who had been estranged from her family had renewed contact with and support from them.

Safeguarding and Contact Issues January-September 2007

188 The conclusions and findings in relation to safeguarding and contact issues January-September 2007 are:

a) Mr and Mrs H arranged for a termination of Ms H's first pregnancy against her wishes. While proper procedures in relation to assessment of and support for Ms H were followed by Clinic 1, her GP did not undertake the assessment for TOP in line with statutory requirements or regulatory and practice guidance. Additionally by failing to ascertain Ms H's feelings and wishes the GP did not follow best practice;

b) The Police response to the alleged threats to Ms H and her unborn child in March 2007 was prompt, thorough and exemplary and her safety was secured by taking her into protective custody;

c) The initial response of CYPS to the presenting situation was slow and unsatisfactory and delayed by a day, securing the welfare of Ms H at a time when she believed she and her child were in danger;

d) A S47 strategy meeting should have been convened in respect of Ms H and her child in March 2007 followed by an assessment of her history, needs, vulnerability and risks to her and her unborn child;

e) Although the accommodation of Ms H in foster care was appropriate, momentum was lost in the assessment of risks to her and her child and the passage of a week without contact after her accommodation resulted in poor engagement with Ms H;

f) Ms H's age and vulnerability and her refusal to comply with the agreed arrangements for her accommodation should have prompted a CPC in respect of both her and her unborn child;

g) Communication and information sharing amongst agencies following Ms H's accommodation was poor and led to a view of her situation which was both inadequate and over-optimistic;

h) A Placement Planning Meeting held in respect of Ms H's temporary foster placement did not result in an effective pooling of information and the decision to proceed with the placement in the light of Ms H's refusal to live there, was illogical and unsustainable;

i) There was no effective risk assessment undertaken and the core assessment process was flawed;

j) The case was closed prematurely by CYPS and required further monitoring in the light of the short-term nature of her living arrangements;

k) Third party information and information about Ms H's family was shared inappropriately and without consent in the core assessment;

l) Ms H's relationship with Mr G should have been considered at least initially as a child protection matter and an assessment of the circumstances made, notwithstanding the decision not to bring criminal charges;

m) When Ms H was made homeless on her 16th birthday, while 7 months pregnant, not only was an opportunity to re-assess the situation missed by CYPS, but also an opinion of her support needs provided to Housing was ill-informed and outdated;

n) Further opportunities were missed to consider whether a fuller assessment of Ms H's situation was required when first the Sure Start midwife and then a health visitor became aware Ms H was living unsupported in homeless accommodation before and immediately after the birth of her son;

o) No assessment was ever undertaken in relation to Mr G.

Safeguarding and Contact Issues throughout the Children's Lives

189 The conclusions and findings in relation to safeguarding and contact issues throughout the children's lives are:

a) Systems of liaison between secondary and primary care and between primary care disciplines were ineffective at key points in the lives of Child E and his family;

b) A pattern emerges across of professionals across all agencies relying on assumptions about each other's involvement rather than establishing facts and coordinating information;

c) There was also, as the Health Overview describes, 'silo practice' where agencies *"worked in isolation with very limited discussion and information sharing, most critically between health services";*

d) There were poor recording practices across professions - records were unclear, unsigned, incomplete or inaccurate and key aspects of assessments were not recorded;

e) Electronic record systems within different health agencies do not 'talk' to each other;

f) Although the Framework for the Assessment of Need was introduced into health services supervision tools and health visiting in 2000 to provide a systematic way of professionals analysing, understanding and recording what was happening to children and young people within their families and the wider context of the community in which they live *" there is no reference made within records as to how this model was implemented nor consideration applied to assessment of the domains of the environment or parenting and the impact on the children's needs. (Health Overview)";*

g) The Health Overview Report notes that despite ongoing training, sharing of information between professionals remains a concern as liaison systems appear to be fragmented and health practitioners in different disciplines still tend to work separately.

190 None of these matters outlined above had a direct bearing on Child E's death. They represent, however, missed opportunities to understand fully and manage the risks in a complex situation, to deliver best practice in safeguarding to Ms H and her child and to build relationship with Ms H.

Improvements since 2007

191 Some developments in children's services and health services since 2007, following on from another SCR, have addressed some of the shortcomings identified by IMR writers in the response to Ms H's situation during her pregnancy. These are:

- Following Serious Case Reviews 2009 and 2010 action was taken in relation to record keeping and sharing of information between acute midwifery services, GPs and health visitors: a senior manager who is a health visitor from community provider services attends the midwifery liaison group to facilitate information sharing and GPs were given training by the safeguarding team including the sharing of information between GPs and Health Visitors

- A discharge summary form between midwifery and health visiting was revised and is now implemented as was the antenatal booking form to include vulnerability factors
- Training has been provided to GPs, midwives and community health staff in addition to LSCB serious case review dissemination of learning events
- Midwifery antenatal booking forms and HV Liaison forms have now been revised and implemented since a previous case review
- GPs have been sent revised lists of allocated health visitors and school nurses
- A senior manager who is a health visitor from ONEL CS (Havering) attends the midwifery liaison group to improve information sharing and coordination of response to vulnerable young women
- GPs have had training by the safeguarding team including the sharing of information between GPs and Health Visitors
- ONEL and NHS Havering have made it clear in their policies that 16 and 17 year olds should be considered as children in terms of their vulnerability, needs and with regard to safeguarding issues and responses
- Service Standards for social work staff in regard to child protection and looked after children were revised to better reflect legislation, statutory guidance and regulation
- Pre-birth referrals were not being handled in accordance with the London Child Protection Procedures in 2007; there are new systems in place, the threshold has been tightened up and greater input is sought from other agencies in assessment and decision making.
- Joint training of police officers and social workers working in child protection has been undertaken to ensure compliance with London Child Protection Procedures in relation to Section 46 and to improve professional decision making by social workers.
- The problem of seconded social workers being unfamiliar with systems has been addressed through formal induction processes
- Managers decisions were not always evidenced electronically; systems are now in place to ensure that all decisions are entered on to the electronic database and monitored in supervision at all levels
- A Think Father Strategy has been developed to highlight the need to include fathers in all assessments and there is an advocacy service to help men to engage with the assessment process in order to secure better outcomes for children.
- It was recognised that the joint protocol with Housing was in place but not consistently implemented by staff in both agencies. New guidance states that the needs of 16 and 17 year olds for accommodation should be assessed in the context of their relationship with any partner and advises that it is good practice for an assessment to be conducted jointly by Children's Services and Housing

which will lead to a joint understanding of vulnerability issues. A new protocol will reflect this.

Some Examples of Good Practice

192 Any retrospective scrutiny of professional activity will inevitably highlight shortcomings particularly when concerned to identify any practice or systemic failings that may have missed signs of a family under stress or a child at risk. While shortcomings have been identified by the IMRs and in this Overview Report, it is important also to acknowledge and promote the evidenced areas of good practice. These include:

- The mentoring support provided to Ms H during her schooling
- The assessment and safeguarding practice of Clinic 1
- The response of the MPS to Ms H's request for protection
- The contract SW2 drew up with Ms H for her foster care placement
- The prompt response by Housing to Ms H's accommodation needs in July 2007 and the recognition of her vulnerability
- The treatment and advice given to and in respect of Child E and Child F by Health professionals
- The response of LAS to Mr G's call on 6 January 2011 and the observations and response of the Fast Responder paramedic in respect of safeguarding issues.

193 In highlighting commendable action, the response of Ms H to the threats and coercion by her parents should be mentioned. It took considerable courage and thoughtfulness to resist the pressure and to seek Police protection for herself and her child, knowing the implications that defiance of her parents' wishes would have for her family relationships.

Questions Posed by Terms of Reference

194 The findings of this SCR can be further summarised in relation to the Terms of Reference as follows:

QUESTION	**FINDING**
At all times did professionals held the child's needs as the paramount consideration within any assessment undertaken and decisions made?	The most obvious omission in this respect was the failure of a GP to elicit Ms H's views on a TOP when she was competent to give them. This potentially put her at risk of coercion into a termination she did not want. Also Ms H's needs and those of her child were not fully analysed, anticipated and addressed in the core assessment of March 2007.
Identified parental vulnerability	In the early stages of Ms H's first pregnancy, professionals

and its impact on parenting capacity?	were impressed by Ms H's strength of character but did not properly consider her vulnerability. However, given her behaviour in her foster care placement, assessment of her maturity and need for support in parenting should have been undertaken. The Health Overview Report notes that missed opportunities arose in liaison and follow up between acute and primary care around the vulnerability issues, social care involvement, homelessness and family history. It is agreed by all agencies now that fuller assessment should have been undertaken during her first pregnancy and immediately after the birth of Child F given her homeless state and her age. Issues of possible domestic abuse were hinted at in two notes of Ms H having facial bruising soon after the birth of Child F. There was no follow-up of this concern.
Identified whether there were family pressures that should have alerted agencies to potential risk?	There were no pressures identified in relation to the household of Ms H and Mr G aside from ongoing rent arrears. These arrears were in part due to variations in housing benefit payments reflecting Mr G's intermittent employment status.
Identified and shared information between agencies appropriately?	It is agreed by all agencies that information around the incidents and events of 11-15 March was poorly communicated and shared, particularly between health and social services and amongst health professionals. This resulted in a less than satisfactory assessment of and response to Ms H's needs. Additionally, poor sharing of information by and with education services resulted in other agencies being unaware of information and concerns school had about Ms H and her background and to a failure to secure a properly supportive educational environment for her during her pregnancy. Deficiencies in information sharing within health services were in part a consequence of poor record-keeping by some professionals.
Responded appropriately to referrals received?	The response of Housing, Police and LAS was prompt and thorough. Both CYPS' initial response to Ms H's situation and the response in July 2007 were inadequate. The CYPS IMR attributes this to a lack of consistent management oversight of the case.

Had appropriate knowledge/skills to identify safeguarding concerns and follow the common assessment framework process to provide an integrated and co-ordinated response to identified need?	The Health Framework for Assessment was not activated - and should have been. Some good safeguarding examples were identified. In other areas, problems arose from over-optimism, under-responsiveness, a failure to identify the need for S47 discussions or pre-birth CPC. Ms H's circumstances should have prompted further inquiry / supervision request by a health visitor and community midwife. Agencies other than CYPS can initiate CIN meeting.
Had appropriate knowledge/skills to identify a child at risk?	Areas for ongoing training identified in the recommendations. Some good practice evident particularly in the Police and LAS responses in March 2007 and January 2011 respectively.
Failed to identify or respond to child protection concerns?	CYPS was slow to respond to the initial referral regarding Ms H in March 2007 and did not respond adequately to Housing request for opinion in July 2007
Issues of diversity identified?	School noted Ms H's behaviour very much influenced by the culture of a local area with which she identified. Proper consideration was given to identifying issues of diversity by all agencies.
Was the family engaged with / known to agencies other than statutory partners?	Clinic 1 - details obtained for SCR. Ms H attended Clinic 1 in March 2007
Was the family known to statutory partners or agencies other than statutory partners elsewhere than in the London Borough of Havering?	Thorough checks made by Education and Health. No other links identified.

Learning Lessons

195 The important learning which emerges from this SCR derives mainly from the period of Ms H's contact with services between March and September 2007. Some of the issues, as the IMRs identify have since been identified and addressed. Others matters can predominantly be addressed by training or by review of specific areas of practice. They are:

a) The necessity of seeing assessment as a tool to achieving outcomes and meeting needs and not an end in itself

b) Ensuring assessments are focussed on identifying and managing risks, identifying needs, anticipating developments and geared towards desired outcomes

c) The importance of ensuring relevant information is sought from and communicated to fellow professionals rather than making assumptions in already uncertain situations

d) The need to recognise the limitations of self-reported information

e) Understanding how young parents' experiences of being parented impacts on their capacity to nurture and care for their own children

f) The need to put the assessment of fathers at the heart of good assessment practice

g) The need for challenging supervision to offset the potential bias towards optimism in assessment

h) Recognition of the vulnerability of pregnant teenagers and the need for an integrated approach and plan for their support, including offering all pregnant teenagers an assessment of needs under the Common Assessment Framework.

i) Understanding and complying with the statutory and good (and safe) practice requirements of information management, the status of third party information and the disclosure of confidential information, particularly in assessment documents

j) The need for GPs to understand and comply with the legal and regulatory requirements around issues of consent by children and young adults and around assessment for termination of pregnancy

k) Improving responsiveness to essential housing repairs which affect the health and safety of children.

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Overarching Recommendations

A full set of recommendations from all the IMRs and the Overview Report are provided at Appendix 7

Recommendation 1

Issue: The need for a series of training programme for professionals will be devised, linked to CPD requirements, which will address potential skill and knowledge gaps identified through this SCR. The methods of delivery should be selected to ensure wide participation and may include online modules.

Training Programmes to be Delivered				
Theme	**Target Group**	**Timescale**	**Desired Outcomes**	**Evaluation Method**
Consent and Children - Legal and regulatory issues and good practice	**GPs**	**12 months**	**Target percentage of GPs attend.** **Increased familiarity with legal and regulatory requirements.**	**Monitored by Trust** **Monitored through GP appraisers**
Assessment for TOP - Legal, regulatory issues and good practice	**GPs**	**9 months**	**Participation of agreed percentage of GPs. (Target to be set by ONEL in consultation with local Deanery).** **Increased familiarity with legal and regulatory requirements.**	**Uptake monitored through GP appraisers**

Disclosure of information, handling third party information - the law and good practice **Good practice guidance to be developed**	**CYPS managers, team leaders and staff**	**Commence within 3 months**	**Increased familiarity and compliance legal and good practice requirements.** **Reduced risk inappropriate disclosure and litigation.**	**Feedback from training** **Senior Manager / Legal Services joint case audit of 20 files for compliance in 12 months**
Managing and supporting teenage pregnancy	**Multi-disciplinary - Community Midwives, Teenage Pregnancy Midwives, Health Visitors, Social Workers, Educational Welfare Officers and Teachers with Safeguarding responsibility, School Nurses**	**6 months**	**Building of relationships between different professionals.** **Closer interagency liaison on teenage pregnancies where risks are identified.** **Better understanding of good practice and of risks and needs around pregnant teenagers.**	**Joint audit by 2 teams of 3 frontline-professionals (each from different professional background) of relevant agencies' files, of 10 teenage pregnancies - 12 months after training events**
Managing optimism bias through effective supervision	**Team Managers CYPS, Supervisors of health visitors and midwives**	**9 months**	**Supervisors have more confidence and a range of tools for considering and monitoring team member decisions.**	**Feedback on training from supervisors** **Feedback on supervision from frontline staff**
Assessment as a means not an end - including identifying and managing risk, engaging fathers in assessment, evaluating information and avoiding assumptions	**CYPS, Health Visitors**	**9 months**	**Renewed understanding of purpose and skills of assessment.** **Greater confidence shown by staff and more focussed analytical reports.**	**Senior Manager / Legal Services joint case audit of 20 files for compliance in 12 months**

Recommendation 2

Issues: The difficulties faced by school staff who feel intimidated by parents and the potential adverse consequences for children where there is no engagement between school and home because of such tensions.

Recommendation	Agency	Timescale	Desired Outcomes	Evaluation Method
Working Group to be established to consider the development of guidance and systems to support individual teachers and staff groups who feel intimidated by aggressive parental behaviour and to ensure young people are not educationally disadvantaged when such situations arise	**Learning and Achievement**	**12 months to completion**	**Straightforward guidance and an inventory of resources to support schools and staff.** **Identification of good practice in this area and plans to promote this.**	**Progress Report to LSCB within 3 months and full report within 12 months.**

Recommendation 3

Issue: Closer liaison required between education and health staff to provide optimal support for pregnant teenagers in education.

Recommendation	Agency	Timescale	Desired Outcomes	Evaluation Method
A protocol to be put in place to ensure school nurses are alerted by GP and community midwife of pregnancy of any girl in their school and that a care plan for the pupil in school be developed	**ONEL**	**9 months**	**Closer liaison between professionals and continuity of care for pregnant teenagers.**	**Joint audit by 2 teams of 3 frontline-professionals (each from different professional background) of relevant agencies' files, of 10 teen pregnancies - 12 months after protocol in place**

Recommendation 4

Issue: Improving assessment of pregnant teenagers' parenting capacity to help early identification of young parents needing additional support.

Recommendation	Agency	Timescale	Desired Outcomes	Evaluation Method
Pilot programme to be developed for assessment of pregnant teenagers' parenting capacity based on their own experiences, with a view if successful to expanding the programme **to all new parents**	**ONEL / BRUHT / Children's Centres**	**12 months**	**Early identification of families which may need additional support.**	**Evaluation method to be built into pilot development. Report on proposed form of evaluation to LSCB in 12 months.**

Recommendations 5a, 5b and 5c

Issue: Housing related issues with a bearing on safeguarding such as essential repairs to homes with young children, families at risk of eviction.

Recommendation 5a	Agency	Timescale	Desired Outcomes	Evaluation Method
A review be undertaken of the extent to which evictions from tenancies because of housing arrears also have unresolved housing benefit issues	**Housing**	**18 months**	**A system that improves arrangements for resolving Housing Benefit issues which might otherwise jeopardise continuation of a tenancy.**	**Report to LSCB n 18 months**
Recommendation 5b	**Agency**	**Timescale**	**Desired Outcomes**	**Evaluation Method**
A review be undertaken of arrangements for identifying and completing essential housing repairs to the stock of Private Sector Leased homes with a view to expediting repairs effecting the well-being or safety of children	**Housing**	**12 months**	**A system that identifies repairs which may impact on the well-being of children if delayed and expedites them.**	**Report in 12 months to LSCB**
Recommendation 5c	**Agency**	**Timescale**	**Desired Outcomes**	**Evaluation Method**
The Joint Protocol on 16 and 17 year olds to be implemented and monitored	**Housing**	**6 months**	**A system that promotes effective joint working and reflects the CYPS responsibilities under part 3 of the Children Act 1989 and Housing's under part 7 of the Housing Act 1996**	**Report in 6 months to LSCB**

Recommendation 6a

Issue: The need to learn from difficulties encountered and errors made in the handling of events after the death of Child E.

Recommendation	Agency	Timescale	Desired Outcomes	Evaluation Method
A Serious Case Review be undertaken into inter-agency working between Police, Legal Services and CYPS in relation to child protection matters from the time of Child E's death until Child F's placement with Mr K.	**Legal Service, MPS, CYPS**	**6 months**	**Shared and owned understanding of why problems arose. Development of action plans to address any deficiencies is systems or practice.**	**Ofsted**

OR

Recommendation 6b

Recommendation	Agency	Timescale	Desired Outcomes	Evaluation Method
It is recommended that an independent review be undertaken into inter-agency working between Police, Legal Services and CYPS in relation to child protection matters from the time of Child E's death until Child F's placement with Mr K. The findings of this review would be published.	**LSCB**	**6 months**	**Shared and owned understanding of why problems arose. Development of action plans to address any deficiencies is systems or practice.**	**LSCB**

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