For: **HAVERING LSCB**

April 2011

Summary Report

Case of Child E

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Safeguarding Children

SUMMARY REPORT - CASE OF CHILD E

Background

1 Child E, aged 14 months died in Hospital on 6 January 2011. The explanation given by Mr G, Child E's father, for the condition and injuries of his son was deemed by the medical staff in attendance to be inconsistent with the medical evidence. Mr G was arrested at the hospital and subsequently charged with murder. On 8 December 2011, Mr G, was found not guilty of the murder of Child E, but was jailed for 9 years following an earlier guilty plea to the offence of manslaughter

2 Child E and his older brother Child F (aged 3) were known only to universal health services (Health Visitor, GP). Their mother, Ms H, aged 19, had limited contact with CYPS four years previously when first pregnant with Child F.

3 Havering LSCB SCR Panel was concerned to establish whether anything known about the family had raised or should have raised child protection concerns and commissioned a Serious Case Review to establish the facts of professional contact with the family, consider the performance of agencies and learn lessons to improve inter-agency working and better safeguard and promote the welfare of children.

History of the Case

4 Ms H became pregnant at 15 with her first child, Child F, by Mr G. Ms H's family strongly opposed the relationship and initially did not support her wish to have and raise a child. To her parents' concern, this dispute led to Ms H leaving her family home. She was taken into protective Police custody in March 2007 and then accommodated with a foster carer (voluntarily under S20) by social workers from the LB of Havering Children's Services (CYPS).

5 Ms H did not settle in the foster carer's home and spent her time with friends and with Mr G. She did not return to the placement after a disagreement with a social worker and instead, with her parents' agreement, went to stay with an aunt. CYPS closed the case.

6 On her 16th birthday Ms H was made homeless and was quickly accommodated in a Homeless Unit from where she was admitted to hospital to give birth to Child F in September 2007. She returned to the Unit after the birth of Child F and from there was allocated a privately leased house into which she moved with Mr G in October 2007.

5 Over the next three years Ms H regularly attended clinic and GP appointments with Child F and was prompt in seeking treatment for him when unwell. She attended all her ante-natal appointments when pregnant with Child E, who was born in November 2009, and took him for immunisation and review appointments as necessary.

7 The family appeared to be stable and coping. They now had support from Mrs H's family. The medical and health visitor personnel who had contact with them had no cause for concern. Consequently, the family were classed as requiring only the minimum level of contact with health visiting services they were seen as coping well and had demonstrated they were able to obtain additional help if necessary.

8 Ms H unusually missed two clinic appointments in December 2010. These fell during heavy snowfall so no adverse inference was taken - many other appointments were cancelled by families at that time.

9 By December 2010, Ms H had received notification to quit the property she rented because of rent arrears of over £5000. This was the third time she had been under threat of eviction for rent arrears. On the two previous occasions resolution of outstanding Housing Benefit issues had quickly and substantially reduced the arrears.

10 Ms H raised three matters relating to repairs and one relating to harassment by neighbours during her tenancy. The response to these issues was slow and not always satisfactory.

11 Ms H was in her father's shop on the morning of 6 January when Mr G contacted her and told her to return immediately. It was not unusual for her to have left the children with Mr G. She arrived to find him frantically trying to revive Child E. An ambulance was called and Child E was rapidly transferred to hospital, where sadly he died 30 minutes later. The cause of death is thought to be a blunt trauma injury consistent with a kick or punch.

Analysis and Conclusions

12 Child E's death could not have been anticipated by any family member or by any professional.

13 None of the early contacts with Ms H or the later contacts with universal health services had any bearing on Child E's death.

14 The contacts with universal health services from July 2007 onwards were timely and appropriate and the treatment and advice given was appropriate. No professional noted any cause for concern in the care of Child E or Child F.

15 Ms H was prompt in seeking treatment for her sons and diligent in keeping appointments. She conveyed she was in a stable relationship and had no concerns about leaving the children with their father.

16 In the early stages of Ms H's first pregnancy, there was a prompt response by Police to the perceived vulnerability of her situation and subsequently an appropriate decision was made by CYPS to accommodate her in a foster placement. However, a S47 strategy meeting should have been held to plan an investigation of potential risks to Ms H and her unborn child in order to identify what level of support would be needed for her over the coming months.

17 Delays in engaging with Ms H may have contributed to the failure of the foster placement. As the situation again deteriorated a further opportunity was lost to initiate formal inter-agency

assessment through a pre-birth CPC, which would have helped also to co-ordinate the input of professionals and ensure information about Ms H's background and needs were shared appropriately.

18 The assessment of Ms H's aunt as a suitable carer was not sufficiently comprehensive and the decision to close the case was premature in the light of the uncertainties in the situation.

19 Another opportunity was missed to assess Ms H's vulnerability and needs in July 2007 when she became homeless on her 16th birthday. Housing Officers responded promptly to her needs, had regard to potential safeguarding issues and were diligent in making CYPS aware of the situation. An opportunity was missed by CYPS to reassess the situation in order to determine whether Ms H required additional support in the light of her potential vulnerability and the imminent birth of her child.

20 Health care staff became aware Ms H was living in Homeless Persons Accommodation, first in the latter stages of her pregnancy and then with a new-born child. Opportunities were not taken by the midwife or health visitor to clarify Ms H's background or to assess if additional support was required.

21 None of the shortcomings in the response to Ms H's needs and circumstances in 2007 had any direct bearing on the later tragedy.

22 The poor experience of CYPS Ms H had in her first pregnancy resulted in her viewing Children's Services as ineffectual and she would not have looked to that agency as a source of assistance.

23 Ms H was particularly sensitive to any perceived criticism of her care of her children. On one occasion she believed her health visitor was criticising her parenting, when this was far from the case. Ms H was comfortable raising concerns about her children with her GP. However, she saw health visitors as not very approachable, because of her perception of the health visitor's motives in suggesting additional support for Child F's speech development.

Lessons to be Learned

24 Following on from another, unrelated, developments in children's services and health services since 2007 have addressed some of the shortcomings in the response to Ms H's situation during her pregnancy.

- 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. 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.

25 Other lessons learned from the review of this case include:

- The need to ensure assessments are focussed on identifying and managing risks, identifying needs, anticipating developments and geared towards desired outcomes
- The importance of ensuring relevant information is sought from and communicated to fellow professionals rather than making assumptions in already uncertain situations
- The need to recognise the limitations of self-reported information
- 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
- 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
- Improving responsiveness to essential housing repairs which affect the health and safety of children

Recommendations

26 This SCR recommends that the improvements outlined above continue to be progressed and monitored. It also recommends that additional training is made available in areas of assessment, information management, confidentiality and managing teenage pregnancies. It also recommends a review of Housing processes for prioritising repairs which have health or safety implications and a review of the links between housing benefit issues and terminations of tenancy for rent arrears. An action plan has been developed.