Kevin
Harrington
Associates
Limited

CHILD D

A SERIOUS CASE REVIEW

Kevin Harrington JP, BA, MSc, CQSW

On behalf of the Havering Local Safeguarding Children Board
Completed 25th January 2010

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1. INTRODUCTION

1.1 The London Ambulance Service was called to an address in the London Borough of Havering in July 2010, in the early hours of the morning. They found Child D, who was nearly 6 months old, showing no signs of life. There were indications that he had been dead for some hours. His father, Mr E, had just returned from work. His mother, Ms F, was under the influence of alcohol. She was subsequently detained in hospital under section 2 of the Mental Health Act 1983.

1.2 The circumstances of the death of Child D led the Havering Safeguarding Children Board (HSCB) to conduct a Serious Case Review (SCR) in line with statutory requirements, as set out in the government's guidance[1]. This is the Overview Report from that Review.

2. FAMILY COMPOSITION

2.1 A genogram is attached at Appendix A. The composition of the family is as follows.

Name	Age (at July 2010)	Ethnicity
Child D	6 months	White British
Ms F	38	White British
Mr E	30	White British

3. DECISION TO CONDUCT THIS SERIOUS CASE REVIEW

3.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires Safeguarding Boards to undertake reviews of serious cases. The Regulation defines a serious case as one where
(a) abuse or neglect of a child is known or suspected; and
(b) either –
(i) the child has died; or
(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

3.2 In this case, the decision to conduct a SCR was based on the death of a child in circumstances giving cause for concern that he had been neglected. That decision was taken by the Chair of the HSCB on 6th August 2010, on receipt of a recommendation to that effect from the HSCB Serious Case Review Working Group. The Working Group had met on 20th July 2010 to consider the circumstances of the case. The key issues identified by the Working Group as indicating that a SCR was necessary were:

- the period of time that elapsed before emergency services were contacted.

[1] Working Together to Safeguard Children (2010) – referred to in this report as "Working Together"

- the presentation of the child when found by emergency services.
- the presentation of the mother when emergency services attended.
- there had been significant contact between the family and some local services before the death of Child D.

4. SERIOUS CASE REVIEW PROCESS

4.1 The purposes of SCRs are set out in "Working Together" (Para 8.5). They are to

- *establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;*
- *identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and*
- *improve intra- and inter-agency working and better safeguard and promote the welfare of children.*

4.2 It was determined that the following agencies should contribute to the Review:

AGENCY	**NATURE OF CONTRIBUTION**
Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT)	Individual Management Review
North East London NHS Foundation Trust (NELFT)	Individual Management Review
Outer North East London Community Service (ONEL CS)	Individual Management Review
London Ambulance Services NHS Trust (LAS)	Individual Management Review
London Borough of Havering, Social Care and Learning – Children and Young People Services (CYPS)	Individual Management Review
Metropolitan Police Service (MPS)	Individual Management Review
NHS Havering	Health Overview Report[2]

4.3 Individual Management Reviews (IMRs) and the Health Overview Report were drawn up by officers who had had no previous involvement in the case.

4.4 A SCR Panel was established to manage and assure the quality of the review process. In order to provide impartial leadership and appropriate challenge, the Panel was chaired by Ms Sue Dunstall. Ms Dunstall formerly chaired Northamptonshire Area Child Protection Committee. She was a non-executive director of Northampton General Hospital Acute Trust (1997-2005);

[2] "Working Together", Para 8.30, requires that all SCRs should include "an integrated health chronology and a health overview report focusing on how health organisations have interacted together".

and an elected member of Northampton Borough Council (1995-1999) and Northamptonshire County Council (1997-2001). She currently holds a substantive part-time post as policy advisor with the NSPCC, alongside which she acts in an independent capacity as Chairperson of the Havering LSCB.

4.5 The composition of the Panel was as follows:

Name / Designation	**Organisation**	**Role**
Ms Sue Dunstall	Independent	Independent Chair
Service Manager	North East London Foundation Trust	Panel Member
Interim Assistant Director of Non-acute Commissioning	NHS Havering	Panel Member
Designated Nurse Consultant	NHS Havering	Panel Member
Service Manager Safeguarding and Service Standards	L B Havering Children's Social Care and Learning	Panel Member
Head of Patient Experiences	London Ambulance Service	Panel Member
DI Child Abuse Investigation Team	Metropolitan Police service	Panel Member
Director of Nursing	Barking, Havering and Redbridge University Trust	Panel Member
Head Nurse Safeguarding	Barking, Havering and Redbridge University Trust	Panel Member
Additional Educational Needs Services Manager	Children Social Care and Learning	Panel Member
Commissioning Manager[3]	NHS Havering	Panel Member
Legal Services Manager	L B Havering	Legal Advisor

4.6 Kevin Harrington was appointed to draw up an integrated chronology of events during the period under review and to produce this Overview Report, with an accompanying Executive Summary and an Action Plan, integrated across services. Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has a particular interest in Serious Case Reviews, in respect of children and vulnerable adults, and has worked on more than 30 such reviews. Mr Harrington is also involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council. He has served as a magistrate in the criminal courts in East London for 15 years

[3] This officer was unwell and did not attend any Panel meetings, but was represented by a number of deputies.

4.7 The Terms of Reference for the Review are attached at Appendix B of this report. The SCR Panel determined that agencies should provide detailed accounts and analysis of their contact with the family from May 2009, when Ms F became pregnant with Child D, until his death, and should provide summary accounts of any relevant contact outside that period.

4.8 Agencies were asked to address in their reports all the issues detailed in the government's guidance[4], namely:

- Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child?
- Did your organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?
- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about children's services. Was this information recorded?
- Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?
- Were more senior managers or other organisations and professionals involved at points where they should have been?
- Was the work in this case consistent with your organisation's and the London Child Protection Committee policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?

4.9 Agencies were further asked to consider issues identified at this stage as specific to this case, namely, whether the services:

- At all times held the child's needs as the paramount consideration within any assessment undertaken and decisions made.
- Identified parental vulnerability and its impact on parenting capacity. The review will take account of any relevant medical history relating to the parents of Child D
- Identified and understood the significance of contextual factors including mental health, alcohol dependency, social isolation, the use of prescribed medication, which may have impacted on parenting capacity.

[4] Working Together Paragraph 8.39

- Provided quality referrals within and between agencies that shared accurate and appropriate information in a timely manner to ensure appropriate assessments were undertaken.
- Responded appropriately to referrals received.
- Held consistent information in relation to the family and were fully aware of mother's disclosure regarding her alcohol dependency and mental health.
- 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.
- Had appropriate knowledge/skills to identify a child at risk.
- Failed to identify or respond to child protection concerns.

4.10 In line with "Working Together's" guidance that
"SCRs should be completed within six months from the date of the decision to proceed"
a timetable was agreed leading to the submission of all reports to a meeting of the full HSCB on 25th January 2011, when all reports were agreed.

5. PARALLEL PROCESSES

5.1 The death of Child D has also been considered by the Coroner – to establish cause of death, and the police – to consider whether a crime may have been committed. The Metropolitan Police Service representative on the SCR Panel acted as the link between this Review and coronial and criminal investigations.

5.2 NHS agencies are required to carry out reviews of "Serious Untoward Incidents" (SUIs). For the NHS agencies involved, that requirement was met by the conduct of this Review.

6. METHODOLOGY USED TO DRAW UP THIS REPORT

6.1 This Overview Report is based principally on the agency IMRs. The structure of the report has been discussed previously between the author and OFSTED. It consists of

- A factual context and chronology.
- Commentary on the family situation and their input to the SCR.
- Analysis of the part played by of each agency, and of their IMR, summarising their response to the "standard" Working Together issues detailed above.
- Closer analysis of the specific issues identified in the Terms of Reference, detailed in paragraph 4.9 above.
- An account of other issues arising from an overview of the case.
- Conclusions and recommendations.

7. NARRATIVE CHRONOLOGY

7.1 Introduction

7.1.1 Each of the agencies submitted a detailed chronology, in tabular form, of their involvement with the family in the period under review. Those submissions have been co-ordinated into an integrated chronology of all involvement with the family during the period under review.

7.1.2 This section of this report aims to summarise, in an accessible way, key events and issues emerging in the period covered by the SCR. It does not include every contact, or failed contact, and does not provide a detailed account of all the work carried out.

7.2 January 2005 to March 2009

7.2.1 This precedes the period covered in detail in this report but, during this time, Ms F's problems with alcohol first became known. She saw her GP about this for the first time in January 2005. She reported depression, had attempted suicide some six months previously and said she was drinking four bottles of wine daily. She received anti-depressant medication throughout 2005 and was involved with an alcohol outreach service in south London, where she was living at the time.

7.2.2 Ms F continued to receive out-patient treatment from her GP for depression in 2006 and in 2007. In November 2007 she told her GP that she was planning to move to Romford with her fiancée and was now determined to conquer her difficulties with alcohol. She transferred to a GP in the area to which she had moved.

7.3 April 2009 to January 2010: the pregnancy

7.3.1 Ms F's pregnancy with Child D was confirmed in April 2009 by her new GP. She next saw her GP, a locum on this occasion, in June. The GP's recording of her presenting problems is described in the IMR as "limited" but the action taken was a referral to the Mental Health Initial Assessment Team (MHIAT). The faxed referral, dated 16th June, and subsequently confirmed with a formal letter, gave the following information:
"Problem situation 8 weeks pregnant. She has had problems with alcohol in past very vulnerable at the moment feels well but concerned if needs help what to do. Not suicidal. Plan. Refer to MHIAT"

7.3.2 Ms F, who was working as a civilian for the Metropolitan Police Service also informed her employers of her pregnancy. She was referred by them to their Occupational Health service, where she was seen the following day by an Occupational Health Adviser, OHA1, with whom she discussed her misuse of alcohol. She told OHA1 that she was committed to a "substance misuse contract". OHA1 advised Ms F's managers to carry out a Pregnancy Risk Assessment (PRA) and adjust her working arrangements as necessary.

OHA1 also obtained Ms F's consent to discuss her situation with a medical professional.

7.3.3 The MHIAT tried to contact Ms F by telephone on the 18th and 19th June, and then wrote to her. She responded on 25th June, contacting a duty officer, MH1, who conducted a "telephone assessment". Ms F reported that she had been trying to cut down drinking and commit to her work. She said that she had no psychotic disturbance and had no suicidal or self harming feelings. She denied using illicit drugs but confirmed taking alcohol in excess. She said that she lived alone (which was not accurate) and worked full time night shifts, but that her sleep pattern and appetite were satisfactory. She was not at this time taking any prescribed medication. She mentioned her pregnancy and that she had an appointment for a scan in July. The duty worker gave Ms F contact details for the Community Drug and Alcohol Service and advised her to contact them if she felt this would be helpful. The case was then closed by MHIAT, who informed the GP of the contact.

7.3.4 The following day Ms F was referred to her Occupational Health service because of "sickness absence secondary to alcohol addiction". She had been sent home from work due to being under the influence of alcohol on one occasion. She signed a "alcohol/substance misuse agreement/contract" which was subsequently sent, with her consent, to her GP, who was informed that she had spoken of being addicted to alcohol. The letter to the GP also refers to her having previously participated in some private treatment for addiction to alcohol.

7.3.5 Ms F attended her first ante-natal appointment on 7th July 2009. She spoke of being depressed and previously addicted to alcohol, although she claimed now to be drinking only 5 units of alcohol weekly. It is recorded that she spoke of being well supported but this is not explained further. An appointment was made for her to see the lead Consultant Obstetrician for mental health some six weeks later.

7.3.6 OHA1 reviewed Ms F on 16th July. Ms F told her that the pregnancy was proceeding well, although she had taken a couple of days pregnancy related sickness absence. She said that she had arranged but not yet started treatment for her alcohol addiction. OHA1's report spoke of concerns that Ms F was still drinking – she was flushed and bleary eyed in appearance - though her work was reportedly of a good standard. Ms F subsequently emailed OHA1 to advise that she had arranged OHA1's access to the medical records held by her GP, and told her of her appointment with the Consultant Obstetrician. OHA1 arranged for her to see a doctor through the Occupational Health service.

7.3.7 Ms F saw the Occupational Health Doctor, Dr H, on 1st September. Dr H put it to her that her managers had concerns that she was still drinking alcohol but she denied this. She also said that her partner was being supportive. Dr H subsequently reported back to Ms F's managers that Ms F claimed to have stopped drinking alcohol since her first scan. Dr H, in her report, asked managers to continue to be as supportive as possible, while reminding them

that the substance misuse "contract" she had signed did allow for unannounced testing in some circumstances.

7.3.8 On 2nd September the Occupational Health Service received a response from Ms F's GP to their initial enquiries in June. The GP confirmed the background, concluding that it was not possible to assess the level of dependency, but that he was optimistic about the prognosis if Ms F engaged with the appropriate services.

7.3.9 The following day Ms F had her first appointment with the Consultant Obstetrician, CO1, who noted a
"history of depression due to problems with relationship but now…stable".
The obstetrician concluded that Ms F was able to ask for help if necessary and did not require consultant care. She did not refer her to any mental health services.

7.3.10 On 24th September Ms F met with OHA2, a counsellor for the police occupational health service. Ms F said that her situation had improved after having counselling sessions elsewhere. There were no details of who was said to be providing this counselling, and it has not been corroborated in the process of this Review. She declined any further contact with OHA2 and in due course she was removed from his list and her file was closed. On 28th September the Occupational Health Service wrote to CO1, explaining the nature of their involvement and requesting a Consultant Obstetrician's report on Ms F's current condition.

7.3.11 Ms F was seen by a Community Midwife on 9th November. She was "small for her dates" and was transferred to a high risk care programme. She was then seen at a review meeting by OHA1 on 12th November. She said that she was continuing to abstain from alcohol and explained that she had declined continuing contact with OHA2. OHA1 thought it was appropriate to terminate her involvement at this stage, as Ms F would soon be starting maternity leave, except that she was still awaiting a reply from CO1 to her letter of 28th September.

7.3.12 CO1 saw Ms F the following week and judged that the high risk care programme should continue. She was seen by CO1 again two weeks later and, the following day, had a scan. The baby was small – below the third centile – but maintaining growth velocity. Ms F had a couple of days sickness absence from work around this time and then started her maternity leave.

7.3.13 On 8th December OHA1 chased up the lack of response from CO1 to her letter of 28th September. CO1's secretary said this had not been received but told OHA1 that the history of contact was as follows:

- 03/09/09 - new patient contact.
- 11/11/09 - Ms F missed appointment.
- 18/11/09 - Ms F missed appointment.
- 15/12/09 - scan booked.

It is not clear that the information about missed appointments is correct but CO1 confirmed this in writing on Christmas Eve and Ms F was subsequently discharged from contact with the Occupational Health service.

7.3.14 Ms F's scan in December raised no concerns. There were further scans on 5th January 2010, and 12th January, which found that Child D had not grown and was now well below the 3rd centile. Ms F was admitted to hospital. She reported a three day history of vomiting, which ceased on admission. She was discharged, to return the following day to be admitted for induction of labour. In fact, because the maternity wards were so busy, she could not be admitted until a few days later when induced labour commenced.

7.4 January 2010 to April 2010

7.4.1 Child D was born late the following afternoon, well and weighing below the 0.4th centile . He was healthy and by the following day was bottle feeding well. There was a recorded decision to alert mental health services on discharge, because of Ms F's history, but it appears that this did not happen. Mother and baby were both judged to be well and were discharged on 19th January. A Community Midwife visited the following day, and had no concerns, and again on 22nd January, when the baby had slight jaundice but was generally well. They were discharged from the care of the midwives on 26th January. The Health Visitor, HV1, made her New Birth Visit two days later. She had not been made aware of Ms F's history of mental ill health and alcohol misuse, but recorded that Ms F spoke of a family history of mental ill health. HV1 had no concerns and arranged to return in a week.

7.4.2 On that occasion Ms F was in a better mood and said her eating and sleeping had improved. Ms F also said she was feeling more confident in handling Child D. However, she spoke again about having a "history of depression" and HV1 planned to return in a week to carry out the Edinburgh Post Natal Depression (EPND) tests[5]. She noted that there was a half-full glass of wine in the kitchen, the home smelt of cigarette smoke and was less tidy than when she had visited before. Ms F also told her that she had lost a tooth and needed to go to the dentist. HV1 did not pursue any of these matters directly with Ms F but did call the midwife who had been visiting. She told HV1 that she had not felt concerned about the family

7.4.3 When HV1 returned the following week, Ms F's presentation was much better, and she spoke of becoming more confident as a mother. However, Child D's weight gain was slow and HV1 arranged for them to be seen by the GP the following day. The GP carried out a full assessment of the child but no action was necessary, except that HV1 should keep him under review, and they should come back in 2 weeks.

7.4.4 HV1 visited again a week later and carried out the EPND test which did not give cause for concern. Ms F also seemed well and the flat was tidier than when she had last visited. The GP saw them again as arranged, noting some

[5] A simple screening tool for postnatal depression, widely used by primary care professionals

improvement in Child F's weight, which had further improved by 2nd March when he was weighed at clinic. Ms F was pleased and rang HV1 to inform her. Ms F herself attended the GP on 8th March for her routine postnatal check. She reported that she was coping well, with help, did not feel depressed and was managing some occasional episodes of feeling "down".

7.4.5 Child D was not brought to a GP appointment on 18th March but was brought on 26th March when his 8 week check was carried out, without raising any concerns, and his first immunisations were given. He was then seen at clinic on 6th April, and on 20th April and attended for his second primary immunisations on 28th April.

7.5 May 2010

7.5.1 On 4th May, just after midnight, emergency services were called to a domestic disturbance involving Ms F and Mr E. Ms F had contacted emergency services, stating she was outside their home, unable to gain access, and was concerned that Mr E may have become unwell. Police and the London Ambulance Service (LAS) attended, finding Ms F outside the flat.

7.5.2 It transpired that Mr E, who was inside with the baby, had come home from visiting his parents with Child D, to find Ms F extremely drunk. He had eventually removed her from the home and given her a credit card, telling her to stay in a hotel. She had not left the scene but called the LAS, who attended and in turn called police. Police officers took Ms F to a local hotel to stay overnight. Mr E told police that he believed that his partner required help with a drink problem but that she was unwilling to admit this and seek support. Child D was described to be well looked after, in a clean and secure environment, and there were no immediate concerns for his safety.

7.5.3 This attendance was routinely notified by police to Havering Children & Young People's Services (CYPS) on 5th May by way of police Form 78, usually now referred to as a MERLIN[6]. This was reviewed by a manager who detailed a Family Support Worker, FSW1, to undertake a home visit to

- *"speak with mother / father*
- *obtain consent to complete checks / share information with the health visitor*
- *clarify extended family support*
- *sign post to alcohol services*
- *discuss a Children Centre referral*
- *feedback to the duty Senior Practitioner if concerns were noted following the home visit. so that a social work assessment could be undertaken".*

[6] The Metropolitan Police Service routinely notifies local authorities of all incidents where a child comes to police attention in circumstances which may give cause for concern. These notifications are referred to as "MERLINs".

7.5.4 The Family Support Worker made an unannounced visit, accompanied by a student social worker, on 10th May. They saw Ms F who told them that she had consumed two bottles of wine whilst out with friends on 4th May but denied being drunk. She said that she had contacted the LAS due to genuine concerns for her partner's health and not in order to gain access to the flat. Ms F told the two workers that she had previously had a drink problem, "*approximately one to two years ago*", and had sought help with this through specialist alcohol services and counselling. She said that she had not taken alcohol during pregnancy but did now drink socially and might drink in excess of two bottles of wine at a time. She stated that once she had started to drink she could not stop at one drink. She also said that she was aware of the risks posed to Child D and that she might stay elsewhere following an evening out in the future. She said she had support from both maternal and paternal grandparents and from her sister. However she acknowledged feeling low and isolated, with no friends in the local area, and was home alone a great deal because Mr E worked six days each week.

7.5.5 FSW1 described the flat as warm, clean and tidy with appropriate toys for Child D, but noted that Ms F 'looked' stressed and had been tearful at times during the visit. Ms F agreed to a referral to a Children's Centre and was particularly interested in baby massage. She agreed to allow information to be shared with the Health Visitor, and appeared interested when it was mentioned that the Health Visitor held a group for women with post natal depression. FSW1 subsequently left a message for HV1 to contact her.

7.5.6 Before FSW1 and HV1 spoke, Child D was taken by Ms F for a routine clinic appointment, where he was seen by a different Health Visitor. He was "snuffly" and had a cough and Ms F was advised to bring him to the GP if this did not improve. The following day FSW1 and HV1 discussed the situation. FSW1 explained the background to her involvement and said that she remained concerned that Ms F was low in mood. She told HV1 that Ms F had spoken about previous misuse of alcohol – the first time HV1 had been made aware of this. HV1 said that she had been concerned about Ms F but had concluded that she was just extremely tired. She explained that she had completed the EPDS assessment which had not given cause for concern, but agreed to visit and carry this assessment out again.

7.5.7 FSW1 then telephoned the home and spoke with both Mr E and Ms F. Mr E said that he remained concerned about Ms F's drinking. He wondered if she had indeed been out with friends as she claimed, or whether she had been drinking alone at home. He also queried whether she might be suffering from post-natal depression and said that he was doubtful that Ms F would access support services to help her overcome the alcohol problem. Ms F became tearful and sounded angry during the phone call. When it was suggested that she and her partner should talk things through, FSW1 noted that she responded 'sarcastically' that it was all her fault and they could talk about that. FSW1 suggested seeking support from RELATE[7] but Ms F said that she did not believe the service would be helpful.

[7] A large voluntary organisation offering a wide range of counselling services

7.5.8 HV1 visited the following day, 14th May. Ms F told her she was feeling very low in mood, apathetic and lacking in enthusiasm. Ms F also reported difficulties in sleeping and feelings of anxiety. She now shared with HV1 her history of alcohol misuse which she said was associated with depressive illness. The EPDS assessment was completed again and Ms F now returned a higher, more worrying "score" of 18. HV1 advised that she would discuss the situation with the GP and subsequently arranged a GP appointment for Ms F 4 days later. She also made a Children's Centre referral for baby massage, mentioning that Ms F was low in mood but not detailing concerns about misuse of alcohol.

7.5.9 Meanwhile CYPS had decided to terminate their involvement following FSW1's assessment, and formally did so on 14th May. On the same day police contacted the family, as they would routinely do, in following up all possible domestic violence matters. They spoke with Ms F who said that she and Mr E were now working through their difficulties together. It was suggested that she could contact the MPS Occupational Health Service for assistance but she declined to do so. Police terminated their involvement at this point.

7.5.10 Ms F did not attend the appointment that had been arranged with the GP on 18th May. GP1 contacted HV1 and asked her to follow this up. HV1 was off duty so she asked her colleague, HV2, to follow up. She contacted Ms F who said she had overslept and the appointment was re-arranged for 16th June.

7.5.11 HV1 visited Ms F on 21st May. Ms F reported feeling very tired and depressed, and also now admitted "binge drinking" but said she wanted to be sober to care for her baby. HV1 felt that Ms F did not look well and noted her "dry cracked lips". They discussed the possibility of referral to peri-natal mental health services and / or alcohol support services, but no action arose from this. A referral to a Children's Centre was completed, copied to CYPS, and arrangements were made for HV1 to visit again in 1 week. The referral described Ms F as isolated but made no reference to alcohol.

7.6 June and July 2010

7.6.1 Child D was brought to clinic on 1st June and his weight was found to be improving. On 3rd June he had his third immunisations. On 7th June the Children's Family Centre received the Health Visitor's referral and allocated the case to a Family Support Worker, FSW2, who advised HV1 of her intention to carry out an initial assessment[8] of need to establish the most appropriate support arrangements for the family.

[8] This was a local Children Centre initial assessment and not an initial assessment under the National Assessment Framework for Children in Need and their Families.

7.6.2 Ms F saw her GP on 11th June, not 16th June as had been arranged by HV2. The GP carried out a very full review of Ms F's situation and on 15th June referred her by fax to the MHIAT, as follows:
"Poor self esteem, feeling of worthlessness. Past history of depression and binge drinking. Agitated and isolated. Started Citalopram and Diazepam today will review in 2 weeks. Urgent assessment please."

7.6.3 In response to this referral MHIAT sought to contact the Health Visitors, leaving messages for HV1 twice on 16th June, before successfully contacting her on 17th June. MHIAT asked HV1 to complete a "peri-natal mental health" referral She agreed to do so and MHIAT took no further action in response to the GP's referral, other than to write to the GP describing what they had asked the Health Visitor to do.

7.6.4 HV1 accordingly visited Ms F the same day, accompanied by FSW2. Ms F reported no further incidents of drinking alcohol and no ongoing problems between Mr E and herself. Ms F also reported that she felt well supported by both Mr E and her mother who visited weekly, travelling from the Essex coast. The paternal grandparents were also supportive and lived locally. However, Ms F said that she felt isolated and would like to attend baby groups and baby massage but did not drive and would have to use public transport. Ms F spoke of feeling anxious about returning to work later in the year and having to learn new skills. FSW2 agreed to obtain information about local childminders and to support Ms F to attend a baby group with Child D by accompanying her to the first meeting

7.6.5 HV1 confirmed that she had already made a referral for baby massage and would now make a referral to peri-natal mental health services. She did so that day, giving the reason for referral as "post natal depression with anxiety and apathy" and stating that there was a "history" of binge drinking. She did not use the word "urgent" in the referral, as the GP had done.

7.6.6 Ms F saw her GP again on 23rd June as she was dissatisfied with the anti-depressant medication prescribed at the previous consultation. A different anti-depressant was prescribed. She told the GP that she was expecting a visit from the perinatal team. In fact, on the same day as this GP consultation, the perinatal team recorded receipt of the referral faxed by the Health Visitor on 17th June. The referral was then discussed at a perinatal service team meeting on 28th June and a letter was sent to Ms F, inviting her to attend an appointment with a psychiatrist at Goodmayes Hospital on 26th July.

7.6.7 FSW2 continued to make arrangements for baby massage and to accompany Ms F to a mother and baby group and kept in touch with HV1. She spoke to Ms F on 5th July, noting that she sounded happier than previously and that Ms F had said 'it was getting easier with Child D. He was seen at clinic routinely on 6th July and satisfactory weight gain was noted.

7.6.8 At 23:13 that day Mr E called police from a train whilst travelling home. He had been called by a neighbour after Ms F had knocked on the neighbour's door, asking if they had her baby. Police contacted the neighbour,

who confirmed the above and told them that Ms F was drunk. Police attended, arriving at around the same time as Mr E. Child D was found in the family home, lying between a wardrobe and other furniture. The home was in disarray – presumably because Ms F had been anxiously looking for the baby. Police were performing cardiopulmonary resuscitation (CPR) when ambulance staff first arrived at 23:31.

7.6.9 Ambulance staff have documented that Child D was in cardiac arrest, showing no signs of life and was beyond resuscitation. He was judged to have been dead for several hours. The ambulance crew have further documented that the bedroom was in a state of disarray.

7.6.10 Child D was conveyed to Queens Hospital, Romford. The ambulance left the scene at 23:48 and arrived at the hospital at 23:51. The hospital has documented that on arrival Child D, who was unclothed, showed no sign of life. CPR was discontinued shortly after arrival and death was certified at 23.53. At 01:10 on 7th July staff at the hospital informed the Children's Services Emergency Duty (out of hours) Team of what had happened. Mr E's employers, the City of London police service, were informed of these events by MPS officers.

7.6.11 Ms F was arrested and taken to a police station at 01:48. She was seen at 03:30 by a Forensic Medical Examiner who judged that she was too drunk for interview but fit to be detained, and recommended the presence of an Appropriate Adult when Ms F was interviewed under the Police and Criminal Evidence (PACE) Act 1984. However, on the same day, she was assessed and detained under Section 2 of the Mental Health Act 1983, and bailed by the Metropolitan Police Service to reside at a psychiatric hospital.

7.6.12 A post - mortem was conducted on 8th July 2010 finding that:

- cause of death was unascertainable
- there was no evidence of injuries indicating abuse
- there was no evidence of disease, infection or illness found

7.6.13 On 20th July there was an Extraordinary Meeting of the Havering LSCB Screening and Serious Case Review Group to consider whether this case met the threshold for a Serious Case Review. This meeting noted the government's guidance[9] that
" When a child dies……..and abuse or neglect is known or suspected to be a factor……the LSCB should always conduct a SCR……".
The group agreed that as neglect was suspected the case met the threshold. to require that a SCR be held and a formal decision to that effect was taken by the LSCB Chair on 6th August.

7.6.14 On 6th October 2010 Ms F was charged with one count of neglect. She appeared before magistrates on 17th November 2010 and pleaded guilty. The magistrates took the view that their sentencing powers might be insufficient and committed her to the Crown Court for sentence. She was to appear on 7th

[9] Working Together 2010, Paragraph 8.9

January 2011 but was unwell. The case was further adjourned and finally progressed to sentence in April 2011. Ms F received a sentence of two years in prison.

8. THE FAMILY

8.1 The SCR Panel considered the issue of family involvement at all meetings. The Panel took advice from agencies currently involved with the family. It was judged that there were no issues of faith, culture, language or ethnicity which would prevent their contributing, or which needed to be addressed in order to facilitate their involvement.

8.2 The Independent Panel Chair wrote to Ms F and Mr E, explaining the purpose of this review, and why families are encouraged to contribute. They were invited, separately or together, to meet her and the author of this report. They did not reply. The letter had also been sent to Ms F's legal representatives, who did not reply.

8.3 As no response was received from the parents of Child D, it was judged inappropriate to contact any members of the extended family. It is perhaps not surprising, in the context of a continuing criminal investigation, that no response was received. It is disappointing that no family input to this Review has been achieved but it was judged that no further action was likely to achieve that input at this stage. This will be kept under review as the coronial and criminal investigations take their course.

9. THE AGENCIES

9.1 Introduction

This section of the report considers the Individual Management Reviews (IMRs) submitted by each agency, summarising and commenting on both the agency's involvement and the quality of the IMR.

9.2 The General Practitioners

9.2.1 The review of GP services has been completed by an experienced GP, working elsewhere in London, who has previously undertaken IMRs in several other cases. He has no connection with any of the organisations involved in providing clinical care to Child D or his parents. It is right to acknowledge at the outset that his IMR explicitly confirms that
"There are no concerns about the clinical care provided to Child D".

9.2.2 However, the IMR raises a number of concerns about the GPs' management of Ms F, particularly in the ante-natal period, when, it concludes, *"Ms F's mental health problems, alcohol dependency and social isolation were not effectively considered by the GP practice".*

9.2.3 The IMR notes that, when initially referring Ms F to maternity services on 4th June 2009, the GP failed to refer to her previous history of being treated for mental ill health, including abuse of alcohol, for an extended period from 2005. This was a missed opportunity to highlight her fragility to maternity services, where, although she disclosed treatment for mental ill health, she

minimised her misuse of alcohol. Furthermore, the GP failed to explore any current mental ill health or use of alcohol.

9.2.4 Ms F then came back to the GP two weeks later, seeing a locum on this occasion. She was now explicitly seeking help because of her mental health and specifically referred to her misuse of alcohol. Although this doctor made a referral to mental health services, it does not appear that Ms F's previous history was explored and the IMR judges that the referral made by this GP was of an "*unacceptably low quality*", in failing to investigate the scale or extent of the presenting problem. This Overview Report does not accept that the response of the mental health services to this referral was adequate (see Section 9.5), but it is also right to recognise the weaknesses in the referral from the GP to the mental health services.

9.2.5 The IMR goes on to consider the exchange of information between the GPs and Ms F's employers' Occupational Health Service, which had, with her permission, approached the GPs for information. The GP advised Occupational Health, in a letter dated 14th July, that Ms F had been referred to specialist alcohol services and was "under their care" which, as the IMR points out, is an assumption (and an incorrect one) rather than a fact. Overall, the Occupational Health Service was given a misleading impression of someone actively engaged in tackling an alcohol problem, which was not the case. This was a missed opportunity for the GPs to note the appropriate concerns of the Occupational Health Service and respond proactively by contacting Ms F and exploring these issues further.

9.2.6 The IMR identifies no other major concerns about the input from GPs to the management of this case, although it does question the thoroughness of the supervision provided to GP1, who was a GP in training at the time, and, further, notes some weaknesses in the management of clinical records. The report also identifies good practice in the GP's assessments of Ms F post-natally and comments on the good relationships between GPs and Health Visitors (which also comes across in the ONEL CS review).

9.2.7 Perhaps the key issue, from this IMR and others, is the failure to focus on Ms F's misuse of alcohol and its potential consequences, particularly in respect of her ability to provide adequate care for her child. As the IMR comments

"…at no point in the clinical records is there a formal assessment of her alcohol consumption and its effect on her physical and mental health. There is no record of Ms F's daily consumption of alcohol or the pattern of her drinking. There is no assessment of the presence or absence of physical symptoms that may result from alcohol dependence".

9.2.8 So, to quote this IMR directly again,
"There is no evidence that the (GP) practice failed to identify or respond to child protection concerns. However there is clear evidence that the evident risks in Ms D's past medical history were not effectively considered".

9.2.9 This IMR makes recommendations to the GP practice under review and draws out broader recommendations to NHS Havering, all detailed at Section 14.1 below.

9.3 Barking, Havering and Redbridge University Hospitals NHS Trust

9.3.1 The IMR submitted by this organisation deals principally with the health care services provided to Ms F in pregnancy and immediately after the birth of Child D.

9.3.2 The IMR notes that, at her first ante-natal appointment, despite the fact that her GP had failed to advise of this, concerns arose about Ms F's use of alcohol. Ms F told the midwife (CM1) that she had been treated with medication for depression in 2005 and was now well, but also said that she was having counselling through her employers, the MPS, because of problems with alcohol in the past. CM1 advised her that she would like to make a referral to the consultant obstetric lead for perinatal mental health (CO1) and Ms F agreed to this. However, as the IMR notes, having done well to pick this issue up, the midwife could have gone further and explored Ms F's use of alcohol in more detail. One of the recurring features of this review is that, unlike many people who misuse alcohol, Ms F did not consistently deny that she had a problem – she was clearly at times "asking for help".

9.3.3 However, 2 months passed before Ms F was accordingly reviewed by CO1. The consultant offered counselling due to the problems with alcohol in the past but this was declined. It was noted that Ms F had a history of depression due to "relationship problems" but that she was now stable. CO1 did not apparently make any further enquiries. This was a disappointingly thin "specialist" assessment.

9.3.4 There seems to have been an acceptance of Ms F's reassurance that she was no longer misusing alcohol. As the IMR states
"Clarification on this point was important, as, according to Perinatal Substance Misuse Guidelines (2007) if alcohol misuse is recent (within one year or less) blood should be taken for Gamma Glutamile Transferase (GGT) and liver function (LFT). If the results of these tests are negative, no further action is necessary. However, if the levels are raised the mother would be referred to the Lead Midwife for Substance Abuse for further consideration of needs and of risks to the unborn".

9.3.5 No such tests appear to have been carried out. The IMR further points out that, even on receipt of subsequent correspondence from the occupational health service of Ms F's employers, referring specifically to alcohol misuse, concerns were not raised and investigations triggered. Then, soon after Child D was born, an appropriate recommendation to refer to the Perinatal Mental Health Service, because of "previous" misuse of alcohol, was either ignored or overturned.

9.3.6 In all other respects the care provided to Ms F and Child D at BHRUT was good. However, there were a number of missed opportunities to ensure

that the issue of alcohol misuse was given appropriate priority in the pregnancy and immediate post-natal period. As a further consequence this area of potential risk was not identified when the midwives transferred responsibility to the Health Visitors.

9.3.7 The IMR gives some important information about the organisational context, stating that
"…there were often capacity issues in the clinic with an increasing number of mental health and substance abuse referrals… the need for additional staffing was recognised (and when)… a new consultant obstetrician was appointed to the Trust in July 2010, the decision was made that she would also provide cover in a combined mental health and substance abuse clinic once a week, and an additional whole time equivalent mental health / substance abuse midwife was also recruited to the team".

9.3.8 The only other involvement from this agency was on 6th July 2010, when Child D was brought to hospital by ambulance. There were no signs of life and he was pronounced dead just before midnight.

9.3.9 The IMR is comprehensive and addresses all the key issues, identifying a limited number of appropriate recommendations.

9.4 Outer North East London Community Services, Havering

9.4.1 Outer North East London Community Services, Havering, (ONELCS) is the local provider of community health services, including the Health Visiting service, the subject of this IMR. There were changes in key personnel during the process of this review, so that the report submitted was the work of more than one person.

9.4.2 When Child D was 11 days old HV1 visited the family for a New Birth Visit, where an assessment was made of family and child health needs. Although there were no particular concerns about the child Ms F told HV1 that she had previously been treated for depression. She did not disclose any misuse of alcohol. HV1 did not follow up the issue of previous depressive illness and the IMR suggests that this might indicate a lack of "professional curiosity". This is probably correct, although it is right to note, as the IMR does, that the HV had not been made aware, by either the GP or maternity services, of Ms F's previous mental ill health.

9.4.3 HV1 visited again a week later and Ms F spoke about being tired and lethargic, but said that she was not depressed. She mentioned that she had lost a tooth. HV1 noticed a glass of wine (the visit was at 10:00am) but did not pursue that, or how she had lost her tooth, with Ms F. However, following the visit she contacted the midwife,CM1, to ask whether she had been concerned for Ms F's health and was told that CM1 had seen nothing to cause particular concern. This is characteristic of HV1's actions in this case – she responded promptly and intuitively to concerns but that response is undermined by a lack of thoroughness. As the IMR points out

"this was a missed opportunity for a more holistic and comprehensive assessment and inter professional liaison between HV1 and the GP".

9.4.4 HV1 continued to visit and carried out an assessment using the Edinburgh Post Natal Depression tool, the results of which did not give cause for concern. There were similarly no issues of particular concern in respect of Child D, who was brought routinely by Ms F to the child health clinic.

9.4.5 On 12th May HV1 learned from FSW1 about the events of 4th May, when emergency services had attended the family home. HV1 visited the next day, again carrying out an assessment using the Edinburgh Post Natal Depression tool. The results of this were of slightly greater concern than when previously administered, and Ms F spoke of feeling low in mood, anxious, lacking enthusiasm and having difficulty in sleeping. She also now disclosed that she had a history of alcohol misuse associated with a previous depressive illness.

9.4.6 HV1 appropriately liaised with the GP who made an appointment to see Ms F on 18th May. Ms F did not keep that appointment and HV1 visited her on 21st May. She subsequently noted that Ms F looked unwell and close to tears, and reported feeling very tired and depressed. She told HV1 that she had been "binge drinking". HV1 noted that a referral to the Perinatal Mental Health Service might be necessary if Ms F did not improve. The IMR comments, and I agree, that it was now clear that more specialist support was indicated. However, the reasons for that specialist referral not being made by HV1 are not explored in any depth in the IMR.

9.4.7 HV1 continued to keep in touch with Ms F, by telephone on 2nd June and visiting on 17th June. By this time Ms F had seen her GP, was taking medication for depression and the process of referral to the Perinatal Mental Health Service had been initiated by the GP. As discussed below, HV1 then contacted the MHIAT and was also, unnecessarily, asked to make a referral which she did, on 17th June. HV1 continued to liaise with other services and, on 6th July, Child D was brought to clinic, where his health and development were satisfactory. There was then no further contact with the Health Visiting service before the death of Child D.

9.4.8 The IMR is thorough and identifies a number of weaknesses in the Health Visiting input to the management of this case. These are reflected in the IMR recommendations, detailed at Section 14 of this report. As the IMR points out, this should be seen in the light of the input from other services, perhaps particularly the failure of the GP and maternity services to share their knowledge of Ms F's previous history of mental ill health and treatment. A specific consequence of this was that the Health Visitors did not become involved or alerted ante-natally, as they might have done. More broadly this may have led to HV1 demonstrating "greater professional curiosity" throughout her involvement.

9.4.9 It is clear that HV1 did recognise that Ms F might be vulnerable and, indeed, responded promptly to specific evidence of concerns and the risk of post-natal depression. However, a key weakness in her input, which the IMR

pinpoints, was a failure to identify the "multiple risk factors" of post-natal depression and alcohol misuse. The use of the Common Assessment Framework is discussed specifically below but, as the IMR states,
"there were no Common Assessment Framework or pre-assessment checklists in the records provided for this review. Full exploration of these areas within a CAF would have informed the HV's understanding of the needs of both Ms F and Child D and it is an expectation of the HV service that it would be completed in such circumstances".

9.4.10 The IMR also appropriately identifies the evidence of HV1 failing to give adequate emphasis to the child protection issues in the case. She was not alone in this, and it has been a frequent finding of SCRs that professionals and services have concentrated their efforts on the problems experienced by adults rather than the potential impact of those problems on the adults' parenting capacity. Ultimately, as the IMR states
"throughout the time period of the review , the recorded assessments made by HV1 did not explicitly hold the child's needs as paramount ".

9.4.11 The IMR notes that arrangements in Havering were such that identification of parental mental ill health did not automatically lead to the development of a care plan for the child. This is an important issue and the recommendation of the IMR is echoed in a recommendation from this Overview Report.

9.4.12 The IMR properly identifies some individual and structural failings in record-keeping, and some weaknesses in information sharing, which were less significant than those highlighted above. The IMR also notes that the following issues arising from this SCR had been identified in a previous review in Havering[10] (Child B,2009):

- lack of awareness of previous mental health history
- incomplete obstetric & medical history
- ineffective liaison between community midwives and health visitors
- lack of access to GP records by midwife and sharing of information
- ineffective implementation of Edinburgh Postnatal Depression Scale

While some actions had been recommended and followed up from the previous review, it is clearly a matter of concern that similar concerns should recur. The issues are dealt with in this IMR but this must also give rise to a broader recommendation from this Overview Report.

9.4.13 The completion and submission of this IMR to agreed timescales was hampered by changes in personnel during the review process, and the author of the final IMR makes a number of references to this, pointing up weaknesses in the work carried out by her predecessor. It may be appropriate to recognise this but the SCR Panel emphasised that it was the responsibility of each agency to make a submission with which they were satisfied.

[10] http://www.havering.gov.uk/lscb

9.5 North East London Foundation Trust

9.5.1 The North East London Foundation Trust (NELFT) provides healthcare services, including specialist mental health services, across 4 north-east London local authority areas, including Havering. The IMR submitted by NELFT considers the two referrals they received, in June 2009 and, almost exactly a year later, in June 2010, and the input from the Perinatal Mental Health Service. The IMR does not systematically go through the issues to be considered in all SCRs, only those specific to this Review.

9.5.2 On 17th June 2009 Ms F's GP sent a fax to the Mental Health Initial Assessment Team (MHIAT) which stated:
"Problem situation 8 weeks pregnant. She has had problems with alcohol in the past very vulnerable at the moment feels well but concerned if needs help what to do. Not suicidal."

9.5.3 MHIAT followed this up without delay, telephoning and writing to Ms F and on 25th June MH1 successfully telephoned Ms F and carried out an "initial telephone assessment". Ms F confirmed excessive use of alcohol but denied the use of illicit drugs. She said that she had not had previous contact with psychiatric services (which was not questioned but was not true). She told MH1 that she had been trying to reduce her use of alcohol and commit herself to her work. MH1 recorded that
"She said that she was not experiencing psychotic features in the form of hallucinations or delusional ideation…(and) had no suicidal or self harming intent".
On the basis of this exchange MH1 advised Ms F to contact local alcohol services, advised the referring GP of this and NELFT took no further action.

9.5.4 This telephone conversation effectively added nothing to the referral from the GP, who, in a sense, might as well have directly advised Ms F to contact local alcohol services. More specifically, the account of how the referral was dealt with does not indicate any awareness of the particular issues arising in connection with Ms F's pregnancy and use of alcohol. By terminating their involvement at this point, NELFT could not follow up and monitor whether Ms F did contact specialist services, and, if so, to what effect. The SCR Panel did not accept that this was a sufficiently thorough response. It did not take any account of the unborn child.

9.5.5 The second contact with NELFT again arose from a GP referral, 5 months after the birth of Child D. The referral, marked "urgent" was specific:
"Postnatal Depression… Poor self esteem, feeling of worthlessness. Past history of depression and binge drinking. Agitated and isolated…Will review in two weeks".
The referral was faxed on Friday 11th June and noted as received on Tuesday 15th June. There was then liaison between the MHIAT and the Health Visitor, as a result of which the MHIAT asked the Health Visitor to make a further referral directly to the Perinatal Mental Health Service (PMHS). This is a specialist team dealing with the care and treatment of women with mental

health problems during and after pregnancy. The Health Visitor did so by fax on 17th June and the referral was noted as received at the PMHS on 23rd June. After a screening process, on 28th June Ms F was offered an appointment with the PMHS on 26th July, which turned out to be some three weeks after Child D's death.

9.5.6 There are a number of weaknesses in the management of this referral by mental health services, and this is accepted in the IMR.

9.5.7 Firstly, the MHIAT made no attempt to assess Ms F but asked the Health Visitor to make a further referral to a specialist service. Services responsible for "initial assessment" will inevitably end up referring some cases on but here there simply was no initial mental health assessment over and above what the GP and Health Visitor had done. Given that this was a second referral to MHIAT, marked "urgent" by the GP, and that there was now a vulnerable child in the family, it was a very significant error that MHIAT did not become directly involved and bring their specialist knowledge to the management of the case. That error of judgment was then compounded by their requiring the Health Visitor effectively to start again from scratch and make a referral to the PMHS.

9.5.8 The IMR explains that the PMHS is a small specialist team, covering a wide geographical area, and details the internal processes leading to Ms F being offered an appointment with a psychiatrist on 26th July. The SCR Panel again accepted the need to be realistic about how promptly such a service might respond to referrals, but, ultimately, found that this was not an adequate response to the presenting situation. The GP had viewed the situation as "urgent" but that requirement for urgency was lost in the response across mental health services, which were both insufficiently thorough and unnecessarily bureaucratic.

9.5.9 The IMR is not entirely clear about this but there is an indication that the MHIAT was routinely referring all cases involving post-natal depression to the PMHS, which was consequently becoming bogged down. This organisational issue raises broader concerns, echoed in the MHIAT response to the first referral, about the quality and usefulness of the work of the MHIAT. The team has the difficult task of pinpointing the most urgent referrals and it may be that they could be doing this more thoroughly. This leads to a recommendation from this Overview Report.

9.5.10 The IMR also helpfully points up some contextual issues

- The PMHS service was at this time unable to arrange urgent appointments with doctors due to lack of capacity
- There are problems arising from the geographical location of the PMHS service, covering 4 London boroughs, particularly for mothers and babies using public transport

9.5.11 The conclusions and recommendations in the IMR do capture key issues in the involvement of NELFT in this case but that is not adequately

supported by the body of the report, which was seen as insufficiently thorough and self-critical.

9.6 Metropolitan Police Service

9.6.1 The Metropolitan Police Service is routinely involved in all SCRs carried out in London but, unusually, is also involved here as the employer of Ms F. The IMR submitted by the MPS contains information and analysis in respect of both aspects of their involvement. Information has been provided by the MPS Human Resources Department and Health & Wellbeing (H&W) Department (Occupational Health) in line with their professional boundaries and guidelines.

9.6.2 Ms F has no criminal record and, before the death of Child D, has come to police attention on only one occasion. This was, as detailed above, on 4th May 2010 when police were called to the family home following an argument between Ms F and Mr E. Police attended without delay, satisfied themselves that Child D was well and unharmed and assisted Ms F to spend the night elsewhere. A MERLIN report was completed and routinely shared with Havering Children and Young People's Services the following day via a secure email system.

9.6.3 On 5th May, the Havering Police Community Safety Unit (CSU) investigated the matter further and spoke with Mr E to confirm the circumstances. Ten days later they made contact with Ms F and discussed the incident. This was routine follow-up to an incident which might indicate concerns about domestic violence. Having satisfied themselves there had been no, or no further domestic violence issues, a letter was sent to both parties providing CSU contact details.

9.6.4 As the Police IMR states
"The … incident was the only contact police had with this family as a unit and was dealt with correctly"
Police involvement in this incident was thorough and appropriate and raises no matters for further consideration here.

9.6.5 Ms F has worked for the MPS since 2004 in the service which deals with telephone contacts, both emergency and non-emergency, from members of the public. She had an extended absence from work in 2005, with a diagnosis of depression, treated with medication. In January 2006 she was on one occasion believed to be drunk at work. She was otherwise doing well at work but had admitted to a problem of addiction to alcohol. At this time she was already receiving support through the MPS occupational health service, the Health & Wellbeing (H&W) Department. She also claimed to be in touch with other agencies about this problem. She was warned about her conduct and no further action was taken.

9.6.6 However, by September 2008, there was evidence of a continuing problem. In May 2009 she was formally issued with a written Final Stage

Warning. A Substance Misuse Contract (SMC)[11] was agreed, as was an action plan with managers and H&W. Soon after that Ms F advised her employers that she was pregnant. This led to a routine referral back to H&W, where she was seen by an Occupational Health Adviser, OHA1, who, with Ms F's consent, wrote to her GP highlighting the concern about her use of alcohol.

9.6.7 In September Ms F was routinely reviewed by an MPS Consultant Occupational Physician, Dr H, who had been informed by Ms F's managers of concerns that misuse of alcohol was continuing. Dr H confronted Ms F with this but she denied it. Dr H appears to have been sceptical and in her report reminded local management of the Substance Misuse Contract and that they could test Ms F for alcohol use. Soon after this, as discussed above, Ms F's GP responded to the contact from OHA1 in June, advising that Ms F's misuse of alcohol was known and that she had been referred to community alcohol services.

9.6.8 Later in September Ms F was seen by a Counsellor, to whom she had been referred by H&W. This was an assessment meeting and Ms F said that her misuse of alcohol had improved after having external counselling sessions. She was now five months pregnant and said that this would affect her ability to attend any future regular sessions with the Counsellor (although she continued to go to work until early December). She made no further contact and, in due course, he formally terminated his involvement.

9.6.9 On 28th September OHA1 also initiated contact with the obstetricians overseeing Ms F's pregnancy. They responded to advise that there were no particular concerns about the pregnancy although the baby was slightly small. By the time this response was received Ms F had started her maternity leave and H & W now terminated their involvement.

9.6.10 The thoroughness and commitment displayed by the H & W service (and OHA1 in particular) was impressive. This might perhaps be expected from an organisation, whose employees are more than usually likely to need occupational health support, because of the nature of their work. Nonetheless, it is worthy of comment.

9.6.11 However, despite their own continuing concerns and prompting by Dr H, local managers found themselves unable to make use of the compulsory testing arrangements available. This is dealt with in the police IMR, which states that

[11] This supports the Health and Safety at Work Act 1974, aiming to assist the employer to ensure the health, safety and welfare at work of employees. Police Regulations allow substance testing and Home Office Circular 45/2005 supports the provision for compulsory testing. The SMC is also aimed at supporting individuals who may have an addiction. It allows managers in conjunction with the individual and HS&W to enter into a contractual agreement to have regular testing to demonstrate they are compliant with Standard Operating Procedures (SOPs).

"Tests are conducted ***when there is information or intelligence to suggest that the contract has been broken*** *(*my emphasis*) and an employee is drunk or drinking whilst at work …there is no suggestion to indicate that anyone noted drink on her breath whilst at work. Consequently, there appears to have been no necessity for the management to complete a SMC test".*

9.6.12 This was a safeguarding issue, as the subsequent tragic events have shown. There is no criticism of the individuals involved but the limitations of the current arrangements should be highlighted as a lesson learned from this analysis.

9.6.13 Finally, I think it is right to state that there is no indication that police involvement was in any way influenced by Mr E being a police officer, or by Ms F's employment by the MPS. The officers dealing with the incident on 4th May did so in a thorough and sensible manner. The IMR itself is similarly thorough, and gives full consideration to both the "one off" operational involvement on 4th May 2010 and the continuing involvement as employers. The report makes no recommendations.

9.7 London Borough of Havering, Children and Young People's Services

9.7.1 CYPS involvement in this case was triggered by the police MERLIN submitted to CYPS following the incident on 4th May 2010. The MERLIN was considered by a Senior Practitioner, SP2, who set out the following plan in response:
"Action

- *Family support worker to complete a home visit to speak to Ms F and Mr E and signpost to alcohol services*
- *Clarify extended family support*
- *Discuss Children's Centre referral with family*
- *Obtain consent to complete checks and share information with the health visitor*
- *If concerning, feed back to senior practitioner for social work assessment*
- *Administrator to log as a referral and pass to the family support worker"*

9.7.2 FSW2 followed this up by carrying out an unannounced home visit, accompanied, as an observer, by a student social worker on 10th May 2010. They saw Ms F but not Mr E, although they learned, on leaving, that he was in the flat, and was said to be asleep. Ms F denied having been drunk on 4th May. She claimed to have been genuinely concerned that Mr E was unwell, and might need emergency assistance. She said that she had experienced problems with alcohol some years previously and had received specialist support from alcohol addiction services. She also said that that she still drank "socially" and might drink more than two bottles at a time (presumably of wine – there is no recent reference to Ms F using any other sort of alcohol). She also said that once she started drinking she could not stop at one drink.

9.7.3 FSW2's case notes recorded Ms F as having support from paternal grandparents, who lived locally, and her mother who visited weekly. There was no reference to her sister. Ms F did not have any local friends as she was relatively new to Havering. Ms F said she felt isolated as Mr E worked shifts six days a week and she was mostly on her own. She presented as tearful and stressed during the visit. She acknowledged feeling low and not getting enough sleep.

9.7.4 The family lived in a small, fourth floor property. Ms F complained about the flat being small and that the lift was often broken. However, during this visit the flat was clean, warm and tidy with evidence of age appropriate toys. Ms F agreed to a referral being made to a Children's Centre and for information to be shared with the health visitor. She was informed that CYPS might not take any further action but this decision would be made by a more senior officer.

9.7.5 The senior practitioner, SP2, considered FSW2's case recording and asked that the situation be discussed with both Mr E and the Health Visitor, HV1. In the event, FSW2 spoke to both of them on the same day, 12th May. HV1 confirmed that she had undertaken a couple of visits to Ms F and Child D, and had been concerned by Ms F's behaviour. She had put this down to extreme tiredness. She said that the Edinburgh Postnatal Depression Scale had been completed and no concerns about Ms F's mental health had been highlighted by this.

9.7.6 Mr E said that he and Ms F were on bad terms and not speaking to each other. He expressed concern about her use of alcohol and wondered whether she might be clinically depressed but said that he was not concerned about her care of Child D. FSW2 then spoke with Ms F to reiterate that Child D's safety was of primary importance. Ms F was tearful and sounded angry during this conversation and made what was recorded as a "sarcastic" comment about the difficulties being her fault. She was advised to seek support from alcohol services.

9.7.7 FSW2 made a record of these contacts which was considered by the manager, SP2. SP2 decided that the family situation did not meet the threshold for the completion of a formal assessment by CYPS but that the family should be referred to a Children's Centre for family support services. That referral had already been made on the 10th May 2010 and the analysis of risk level was recorded on the referral form as low. The case was formally closed by the Assessment Team on 14th May.

9.7.8 The response of CYPS to the MERLIN was well-intentioned but not well thought through. It was "neither one thing nor the other" - not a formal assessment by an appropriately qualified officer but an intervention which effectively served as an assessment, on the basis of which SP2 decided to take no further action.

9.7.9 To put this in context, many Children's Services Departments would take less or no action in response to a MERLIN describing a situation in which

- a family had come to police attention for the first time.
- no-one had been harmed.
- there were no immediate concerns for the welfare of the child.

A more usual response might be to ensure that primary health care services were aware of the issue and, perhaps, to contact the family to offer assistance. However, having become directly involved, CYPS had to ensure that their involvement was appropriate and thorough. Unfortunately, as they fully accept in their IMR, they did not achieve this. There was no delay but the agency inappropriately used an unqualified officer and failed to draw together all the relevant information to make a fully informed decision.

9.7.10 It is right to question, as the IMR does, the decision that was made, as well as the decision-making process. When CYPS terminated their involvement, although they did not have all the relevant information, they did know that

- Ms F had a history of alcohol problems for which she had received services.
- The health visitor had continuing concerns about the situation.
- Mr E felt that Ms F might be suffering from post natal depression and was not sure if she would seek further support from specialist alcohol services.

In those circumstances, as the IMR correctly concludes, rather than taking no further action,
"the case should have been referred to another agency for a Common Assessment to be conducted or allocated to a social worker to complete an Initial Assessment".

9.7.11 The action that was taken was slow. The referral to the Children's Centre was made on 10th May – before the "assessment" was even concluded - but processing that referral took far too long and it was not till 17th June that a Family Support Worker made a visit to the family, accompanied by the Health Visitor, HV1. They saw Ms F who described an improved relationship with Mr E, although she was now taking anti-depressant medication and feeling low and isolated. Child D was asleep at first but woke during the visit, and was fed by Ms F. The flat was described as
"very child centred, with clothes drying and a clay hand print of Child D …in evidence".
Plans were in place for FSW to accompany Ms F to a "mother and baby group" on 7th July, after Ms F had apparently spent a week away with her mother, but Child D died before the planned visit.

9.7.12 The services to be provided via the Children's Centre were not urgent but there was avoidable delay and unnecessary bureaucracy in assisting the family, which is recognised in the IMR and its recommendations.

9.7.13 Given the limited involvement of CYPS, the IMR is extremely thorough and detailed. The report makes a number of recommendations, detailed below.

9.8 London Ambulance Service

9.8.1 The involvement of the London Ambulance Service (LAS) in this matter consists only of their response to the incident on 4th May, when Ms F was excluded from the home by Mr E, and their response to the call on 6th July when Child D died.

9.8.2 On 4th May 2010 the call from Ms F was appropriately given priority status and a Fast Response Unit (FRU) and an ambulance arrived within five minutes. On arrival they found Ms F pounding the door, trying to gain access to the premises. They appropriately liaised with the MPS, concluded correctly that ambulance resources were not required, and they left.

9.8.3 The IMR appropriately points out that a safeguarding referral should have been considered following this incident. Guidance to staff is that they should not rely on other agencies to report concerns of this nature. In the event the incident was reported by the MPS to the local authority Children's and Young People's Services, but LAS staff should not have relied on this.

9.8.4 The only other involvement by the LAS was their attendance on 6th July, following which Child D's death was confirmed. The LAS attended promptly and transferred Child D to hospital without delay. There are no matters arising in respect of this contact.

9.8.5 The IMR submitted by the LAS reflects their limited involvement in this matter and appropriately identifies the only learning point, the failure to make a safeguarding referral on 4th May.

9.9 Health Overview Report: NHS Havering

9.9.1 The government's most recent guidance on the conduct of SCRs requires (Paragraph 8.30) that a "Health Overview" report be drawn up and considered as part of the overall exercise:
"Designated safeguarding health professionals, on behalf of the PCT(s) as commissioners, should review and evaluate the practice of all involved health professionals, including GPs and providers commissioned by the PCT area. …This may involve reviewing the involvement of individual practitioners and NHS Trusts, and advising named professionals and managers who are compiling reports for the review. The designated professionals should produce an integrated health chronology and a health overview report focusing on how health organisations have interacted together. This may generate additional recommendations for health organisations. The health overview report will constitute the IMR for the PCTs as commissioners".

9.9.2 The Health Overview report in this review was drawn up by the Designated Nurse Consultant Safeguarding Children, NHS Havering (commissioning organisation) and considers the IMRs submitted by

- NHS Havering GP services
- Barking, Havering & Redbridge University Hospital Trust (BHRUT)
- Outer North East London Community Services (ONEL CS)
- North East London Foundation Trust (NELFT)

- London Ambulance Service (LAS)

9.9.3 The report adopts a particular theoretical approach, as required by NHS London, Root Cause Analysis
"The Health Overview critical analysis has been undertaken through the application of a root cause analysis (RCA) which is a systematic process. RCA assumes that systems and events are interrelated. As an analytical tool, RCA within the NHS is a technique for undertaking a systematic investigation that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened (NPSA 2004)".

9.9.4 The Health Overview report highlights particular issues for NHS Havering to consider as commissioners of health services:

- substance misuse in pregnancy
- implementation of the Common Assessment Framework
- referral processes and record keeping arrangements
- communications and effective information sharing between health services
- the ability and capacity for local health organisations to comply with the requirements of any future SCR

9.9.5 The report largely echoes the themes and findings set out throughout this Overview Report.

10. SPECIFIC ISSUES IDENTIFIED IN THE TERMS OF REFERENCE

10.1 Introduction

10.1.1 The previous section of this report summarises the agencies' response to the "standard" SCR issues, as detailed in the government's guidance, "Working Together". Agencies were further asked to consider issues identified as specific to this case. They have done so to varying extents. The submission from Havering CYPS considers each issue separately and in detail. The MPS report presents a summary view. The reports from the other agencies fall somewhere between these two positions.

10.2 Did agencies at all times hold the child's needs as the paramount consideration within any assessment undertaken and decisions made?

10.2.1 Serious Case Reviews very often find that agencies have become over-involved with parents and not kept the welfare of the child at the centre of their planning and activity[12]. In this SCR most of the agencies have judged in their IMRs that this was not the case, and that their perspective on the child was appropriate.

10.2.2 However, CYPS judge in their IMR that
"Child D's needs were taken into account (but)… a more holistic approach would have focussed more specifically on Child D's needs".
Similarly ONELCS comment that
"The assessment … appeared to focus on the needs of Ms F and there was not evidence…that the needs of Child D were seen as (the) paramount consideration in the assessment".

10.2.3 There is a danger that agencies involved in SCRs become unrealistic about how cases should have been managed. The points made by CYPS and ONELCS are correct. However, the principal challenge for this family and the agencies was Ms F's use of alcohol and whatever lay behind that. The key criticism of all agencies, is, to quote the CYPS IMR again, that
"the plan of intervention did not focus on Ms F's alcohol use, how this might have impacted on her parenting capacity and present risks of possible harm to Child D".
I think it would be over-critical to conclude that agencies "lost sight" of Child D in their work with this family.

10.3 Did the agencies identify parental vulnerability and its impact on parenting capacity? (The review will take account of any relevant medical history relating to the parents of Child D).

[12] See, for example, the London Safeguarding Children Board's First Annual Report:
"In 56 percent (56%) of the reviews services were provided and considerable attention was given, to the parents at the expense of close scrutiny and prioritisation of protection of the children".

10.3.1 There is no evidence of “parental vulnerability” in respect of Mr E.

10.3.2 There were failures to share information about Ms F’s history of mental ill health which are detailed throughout this report. However, all the relevant agencies, to some extent, recognised that Ms F was “vulnerable”, as a consequence of her mental ill health and the “contextual” factors detailed in Section 10.4 below. Agencies then failed to give adequate weight to the potential impact of those vulnerabilities on the parenting capacity of Ms F. The detail of those failures is set out throughout this report and summarised in the conclusions.

10.4 Did the agencies identify and understand the significance of contextual factors including mental health, alcohol dependency, social isolation, the use of prescribed medication, which may have impacted on parenting capacity?

10.4.1 This question is again addressed throughout this report. To varying extents all the agencies took account of these “contextual factors”, some of which had more significance for parenting capacity than others. The use of prescribed medication was significant only in that Ms F reacted badly to medication prescribed for her in June, 2010, but this was addressed without delay by her GPs. There was undoubtedly a degree of “social isolation”, as Ms F had moved across London, but she was not without access to local family support. Plans made by CYPS and the Health Visiting Service to involve her in child-centred local activities were appropriate. But all agencies failed to understand and respond, with appropriate urgency and determination, to the extent of Ms F’s mental ill health, evidenced principally in her misuse of alcohol.

10.4.2 The “contextual factor” which is not specified here is the extent to which Ms F was supported by her partner and family or, conversely, the extent to which those around her closed their eyes to what Ms F was experiencing and its potential consequences for Child D. Without a better understanding of that, our overall analysis of these events is limited. Ms F and Mr E have not responded to invitations to contribute to this Review, and those decisions must be respected. However, there are indications that Ms F saw herself as not adequately supported and, unsurprisingly, indications also that Mr E was angry and frustrated by her conduct. It is disappointing that services did not respond as thoroughly as they might have done to those indications.

10.5 Did the agencies provide quality referrals within and between agencies that shared accurate and appropriate information in a timely manner to ensure appropriate assessments were undertaken?

10.5.1 The term “referral” is considered in this report in a broad way, not confined specifically to requests within and between agencies for assessments or the provision of services. For example, I have regarded the police MERLIN as a referral, although there was no indication that the MPS expected that any particular action would be taken as a result of the

notification. The MERLIN was submitted without delay and contained an appropriate account of events. No issues arise from that.

10.5.2 As employers, the MPS, through their Occupational Health service, liaised appropriately with other agencies. They did not so much make referrals as seek information to ensure that their actions were properly informed. When they did become aware of continuing concerns from Ms F's managers about alcohol misuse, they responded appropriately by feeding that information back to the obstetricians, although, disappointingly, the obstetricians did not take any action in response to that information.

10.5.3 As acknowledged in their IMR, the LAS should have made a safeguarding referral following their attendance on 4th July. There are no other relevant issues for the LAS in this respect.

10.5.4 For CYPS, the only referral made was the internal referral to the Children's Centre. The referral is reasonably full and detailed although, as the IMR comments, it could have contained more direct information about the issue of misuse of alcohol.

10.5.5 The first referral made by a health agency, in the period under review, was the notification from Ms F's GP to maternity services of her pregnancy. As detailed above, that referral signally failed to highlight Ms F's history of mental ill health (although this was picked up anyway by maternity services). Then, a few weeks later, a different GP made a referral to mental health services, when Ms F sought help with her mental state and, specifically, use of alcohol. The IMR describes both these referrals as
"of an unacceptably low quality".

10.5.6 The IMR does not directly spell out the factors contributing to these misjudgements by the GPs. However, the inferences to be drawn from the IMR's recommendations are that they were a consequence of
"a general lack of alertness to psychiatric or emotional problems that may impact on the …ability to be effective parents"
Also, one of the GPs was in training and relatively inexperienced. The IMR's recommendations are appropriate to those weaknesses in the GPs' practice. The SCR Panel accepted the IMR's judgement that referrals made by the GPs after the birth of Child D were satisfactory.

10.5.7 The first midwife, despite the lack of notification from the GP, picked up from Ms F that she had a history of mental ill health and appropriately referred this to the obstetrician with a specialist interest in mental health. There were however weaknesses in the obstetrician's management of that referral, as detailed above.

10.5.8 The knowledge of Ms F's previous mental ill health was not passed from the hospital to the community after the birth of Child D. The hospital IMR comments that

"The transfer of information from the hospital to the community midwifery services did not share the known history of depression and alcohol problems in the past as this was not identified as a concern in the pregnancy"
This implies that there was a deliberate decision not to highlight the history to community services, although I am not sure that this was so. In any case, the information was necessary to the management of the family by community health services and the information should have been shared.

10.5.9 Once mother and baby were back at home, the midwives saw nothing that should have prompted a referral, and passed the case on appropriately to the Health Visitors. HV1 made referrals to the GPs, the Children's Centre and, at the request of the MHIAT, to the specialist mental health service. The IMR appropriately picks up that, although HV1 responded quickly to concerns, her responses were not always sufficiently thorough. In particular, as the IMR points out, there was more than one occasion when her referrals *"did not contain any information regarding concern about alcohol misuse".*

10.5.10 Finally, turning to mental health services, the issue for MHIAT was that they fell at an earlier fence. They failed to become directly involved in the case, as they should have done – certainly in response to the referral in 2010 - and consequently were not in a position to make referrals.

10.6 Did the agencies respond appropriately to referrals received?

10.6.1 "Referrals received" in this case were largely between agencies contributing to this Review. There were no referrals from family, friends, neighbours or members of the public. There were instances of self-referral by Ms F. Some of the referrals were "routine" and would have been made in all cases, such as the GP's notification to maternity services of Ms F's pregnancy, whereas others were specific to the circumstances of this case.

10.6.2 The LAS received two referrals, one when Ms F was excluded from the home by Mr E, and the second when Child D died. They responded promptly and appropriately to both referrals, except that, as noted above, they did not complete a safeguarding referral after their first contact in May.

10.6.3 The MPS, in their role as service provider, received only one referral, again prompted by the events of 4th May. They responded promptly and sensitively, and routinely referred on to CYPS by way of the MERLIN system. The help offered to Ms F by the MPS, as employers, was exemplary.

10.6.4 CYPS received only one referral, the routine MERLIN notification from police of the events of 4th May. As detailed above, their initial response was not "appropriate" in that they effectively used an unqualified officer to carry out an assessment, and did not take full account of that in determining their overall response. The mitigating circumstances are that it is not clear that the information on the MERLIN should have prompted any direct assessment by CYPS. My view is that in many localities no direct assessment would have been carried out. The information from police would more probably have been noted and held against any future re-referral. Nonetheless, the agency

committed itself to an inappropriate course of action and that is recognised in their report and recommendations.

10.6.5 There was then avoidable delay in the follow up action within CYPS, of offering supportive services through the Children's Centre. That is again recognised in the agency's report and recommendations.

10.6.6 The GP IMR appropriately considers the request for information from Ms F's employers as a referral, and judges, bluntly but correctly, that
"The response to this request for information was not appropriate. The report (provided by the GPs to the Occupational Health service*) was inaccurate and misleading".*
Otherwise the referrals to GPs were those from Ms F herself, and the GPs broadly responded appropriately in seeking to establish contact between her and specialist services.

10.6.7 The hospital's response to Ms F being referred for maternity care was satisfactory and the issue of misuse of alcohol was picked up even though it had not been highlighted by the GPs. The weaknesses in the response of the obstetricians to the internal referral about Ms F's use of alcohol have been noted and the hospital IMR also appropriately notes that
"The request for information from Occupational Health should have prompted another appointment with CO1"

10.6.8 The Health Visitor responded without delay to all referrals but that response was not always well thought through. Specifically the IMR points up that when HV1 visited on 13th May, having learned of Ms F coming to police attention, it was documented that Ms F was feeling anxious and having difficulty sleeping, and now admitted a history of abnormal alcohol use associated with previous depressive illness. However, the IMR continues, there was no recording of

- *"Child D's general health and development*
- *Ms F's current alcohol intake – pattern, number of units per day*
- *What was the impact on parenting capacity of possible excessive alcohol intake and concerns regarding maternal mental ill health?*
- *Who was caring for Child D and how his safety was being maintained if she was consuming alcohol?*
- *Any observations of parent child interaction".*

Overall, the IMR adequately demonstrates that the Health Visitor, in her responses to referrals, showed
"a narrow professional focus and limited professional curiosity".

10.6.9 Finally, as stated above, the SCR Panel was concerned that the MHIAT responded weakly to the first referral and entirely inadequately to the second referral they received. In the second instance that was compounded by a slow response from the perinatal service – so that, effectively, when the family was in greatest need of specialist assistance, no such service was provided.

10.7 Did the agencies hold consistent information in relation to the family and were (they) fully aware of mother's disclosure regarding her alcohol dependency and mental health?

10.7.1 There were clearly gaps in the information shared between agencies, so that the full extent of Ms F's history of mental ill health was not known to all agencies. With the exception of the police, each of the agencies can be seen, to different extents, to have failed to share all the information they held about the nature and extent of Ms F's mental ill health and misuse of alcohol.

10.7.2 SCRs commonly identify failures to share information which have had very significant consequences for the way in which the agencies have gone about the task of protecting children. However, in this case, it seems to me that this failure to share information thoroughly was not a key factor. The agencies may not have been as fully informed as possible, and as early as possible, about the nature and extent of Ms F's problems. But each agency had enough information to understand that they were dealing with an inexperienced mother with a history of treatment for mental ill health in which misuse of alcohol featured significantly.

10.7.3 Information could have been shared more thoroughly and consistently but the concerns arising from this SCR are more to do with how the agencies evaluated and responded to the information they did hold. In particular, as discussed below, there was a general lack of alertness to the nature and extent of Ms F's misuse of alcohol and its potential consequences.

10.8 Did the agencies have appropriate knowledge/skills to identify a child at risk? Did the agencies have 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?

10.8.1 There is some repetition in these two questions and they are therefore considered together.

10.8.2 The first consideration is whether agency staff had the appropriate level of knowledge and skill to identify and respond appropriately to a "child at risk". The term "child at risk" is a vague one. All children are at risk in some ways. The Review was clear that, before his death, there was no evidence of any harm to Child D. There was nothing in his presentation, health or development which should have required any protective action by any of the agencies involved. This is reiterated in Section 10.9 below.

10.8.3 The second issue is whether staff responded appropriately to the possibility that Child D might come to harm, and the Review considered the position of each agency separately.

10.8.4 When police were called out on 4th May Mr E was providing adequate care for the child and there is no indication that the officers needed to take any action other than, as they did, submitting their MERLIN.

10.8.5 We have already noted that, in failing to make a safeguarding referral, LAS staff were not sufficiently alert to the needs of the child.

10.8.6 As detailed above, CYPS were wrong to rely on the feedback from FSW2 to determine, effectively, whether Child D was "at risk", and were wrong to have put FSW2, an unqualified officer, in that position. The agency IMR accepts this unequivocally. The IMR also explains, in detail, the arrangements for the management of the case by the Children's Centre and finds that staff were suitably trained and equipped to identify a child "at risk". I think that is correct: FSW1 saw the child once and no matters of concern arose from that contact.

10.8.7 Turning to the health services, the GPs, particularly in the ante-natal period, did not adequately explore and plan for complications which might arise from Ms F's history of mental ill health, as is detailed in Section 9.3 above. There was an insufficient exploration of Ms F's history of mental ill health by the Consultant Obstetrician before Child D was born, and medical tests, which might have thrown light on the current situation, were not carried out. Immediately after his birth there was a plan by maternity services, in view of Ms F's history, to notify the specialist perinatal mental health service. That plan was not followed through and there is no clear explanation for this. After Ms F returned home, HV1 always responded promptly to concerns but those responses did not give adequate weight to the possibility that Child D might come to harm. The MHIAT unnecessarily required HV1 to make a referral to the specialist perinatal service, without carrying out any assessment themselves. The perinatal service, when they did receive the referral, deemed it "routine" although the initial referral from the GP, which the specialist service had not seen, was marked "urgent". It is clear then that, in different ways and to differing extents, the health agencies were all insufficiently alert to the possibility that Child D might come to harm.

10.8.8 The use of the Common Assessment Framework (CAF) is specifically raised here. The CAF was established by the former Department for Children, Schools and Families[13] as
"a standardised approach to conducting assessments of children's additional needs and deciding how these should be met…The CAF promotes more effective, earlier identification of additional needs, particularly in universal services. It aims to provide a simple process for a holistic assessment of children's needs and strengths; taking account of the roles of parents, carers and environmental factors on their development. Practitioners are then better placed to agree with children and families about appropriate modes of support. The CAF also aims to improve integrated working by promoting coordinated service provisions…All LA areas were expected to implement the CAF… between April 2006 and March 2008".

10.8.9 In short, the CAF is the appropriate process to follow where the "universal" agencies identify that a child might have "additional" needs - such

[13] Every Child Matters – DCSF website

as those which might arise from a parent misusing alcohol. Essentially, this was the appropriate inter-agency procedure to be followed to flag up and begin the analysis of the additional needs of Child D which arose from his mother's misuse of alcohol and associated problems. One might have expected the GPs, maternity services and Health Visitor to have made use of this "tool". None of them did so.

10.9 Did the agencies fail to identify or respond to child protection concerns?

10.9.1 As detailed above, there were failures to share information which meant that agencies were unaware of the history and extent of Ms F's mental ill health and, specifically, misuse of alcohol. There were avoidable delays in following up assessments and making services available. In some agencies there was an inappropriate emphasis on Ms F's situation, rather than a focus on the child. Child D should have been seen more clearly as a "child in need".

10.9.2 However, there were never any specific child protection concerns. Child D always appeared to be loved and well cared for by his immediate and extended family. He was growing and developing well. Before his sudden death the agencies saw no evidence of his experiencing harm or neglect. The SCR found that the threshold for providing a "child protection" service was never reached and consequently no agency failed to identify or respond appropriately to child protection concerns.

11. ISSUES ARISING FROM AN OVERVIEW OF THIS CASE

11.1 Ms F's misuse of alcohol

11.1.1 Ms F's misuse of alcohol was like "the elephant in the room"[14] . She disclosed her excessive use of alcohol to professionals from all of the agencies involved in this Review. Like many people who misuse alcohol her disclosures were not consistent, and there were also instances of her denying and minimising the problem. There were weaknesses in transferring information between agencies, as detailed above, so that agencies were not always as fully informed as they might have been and not as thorough in their investigations.

11.1.2 But it is clear that all agencies had enough information, either current, historical or both, to have identified misuse of alcohol as a key presenting problem. The most useful factual information we have comes from the police IMR, which advises that Ms F had a history of alcohol abuse dating back to early 2000, that she drank during pregnancy and drank secretly:
" she would buy little bottles of drink and drink them by the rubbish bin by the flats in order to not be seen".
When examined after Child D's death she was

[14] "an idiom… (commonly used in relation to addiction)… for an obvious problem or risk no-one wants to discuss" (Wikipedia).

"about three times over the drink/drive limit".
The police IMR further advises that a close relative of Ms F had also had a problem with misuse of alcohol in the past. With hindsight, the account of the visit by HV1 on 21st May can particularly be seen to include a "cry for help" from Ms F about this problem.

11.1.3 In trying to develop a comprehensive, integrated response to the overall family situation, the agencies lost sight of the need to develop a speedy, focussed response to this principal area of risk. There is no suggestion that local alcohol misuse services would not have been able to offer appropriate assistance. However, as the case never reached a point where such services were directly involved, there should be some further examination of the availability and appropriateness of local services. This leads to a recommendation from this report.

11.2 Assessment

11.2.1 That failure to target misuse of alcohol is the most important example of a theme running through the analyses of these events – a lack of thoroughness in assessment. This is demonstrated most importantly in

- the response of the MHIAT to the second referral
- the practice of HV1.

The failure to use the Common Assessment Framework (CAF) is discussed above. This is the piece of the "toolkit" which might best have been used to give a shape to an overall assessment of the situation. This report criticises agencies for not using the CAF. Given that Ms F made attempts to secure help with her problems, a well-organised CAF approach may have managed the situation or identified unacceptable risk and arrangements for escalating the agencies' involvement.

11.2.2 In a way, though, this is a symptom of a deeper problem. None of the assessments of the overall situation were sufficiently thorough. For example, the MHIAT assessment in 2009 failed to consider that Ms F was pregnant. The most important learning point is not just about failing to adopt a particular approach but, rather, about emphasising the need for all assessments to be comprehensive.

11.3 issues of diversity which may have a bearing on the review

11.3.1 All those mentioned in this report are white British. There is no firm evidence to indicate that ethnicity, faith, sexual orientation, gender, language or any other issue of diversity had any direct bearing on the events under review. The Panel did consider whether professionals and agencies may have been falsely reassured by Ms F being a young, white woman, with a demanding job, but found no evidence to substantiate this.

11.4 Was the death of Child D preventable?

11.4.1 The regulators, OFSTED, have criticised SCRs for failing explicitly to comment on whether the death of a child was preventable. The author of this

report does not accept that this is necessarily a helpful expectation. It is reasonable to comment on whether different actions might have led to different outcomes, but that commentary is not necessarily improved by focussing on the death rather than the events preceding the death. It is also important that the purposes of this exercise do not get unnecessarily confused with coronial or criminal procedures.

11.4.2 Having said all that, it seems to me that there were clearly missed opportunities to ensure that Child D, an increasingly healthy baby at the time of his death, was safer in the care of his family. The problems of that family were known to a range of professionals. Ms F periodically sought help with those problems. There was assistance available but the agencies failed to ensure that arrangements for accessing that assistance were provided in a way that was efficient and effective.

12. COMMENTS ON SERIOUS CASE REVIEW PROCESS

12.1 Overall process

12.1.1 The decision to conduct a SCR was necessary and appropriate. It was followed up promptly and in line with guidance. The processes for establishing governance arrangements were similarly thorough, with an independently chaired SCR Panel, and an independent Overview Writer. The Overview Writer attended all meetings of the SCR Panel but did not sit as a member of that Panel. The SCR Panel was composed of senior representatives of the appropriate local agencies.

12.1.2 The IMR authors were all appropriately independent of any involvement in the case. The reports submitted were subject to challenge throughout the process. There were no issues arising which required expert or legal opinion.

12.1 3 As discussed in Section 8, arrangements to meet the family and secure a contribution to the Review from them were ultimately unsuccessful. This will be specifically re-considered when criminal proceedings have been concluded, as it may then be possible to enlist the co-operation of some or all of the family members and consequently enhance the learning from this Review. Consideration will be given at that point to re-convening the SCR Panel, again to evaluate whether any further lessons can be learned in the light of the outcome of criminal proceedings.

12.1.4 The SCR was completed within target timescales and published on the Safeguarding Board website. The integrated Action Plan will be monitored by a sub-group of the LSCB.

12.1.5 The LSCB Business Manager has agreed provisional arrangements for the dissemination of lessons learned from this SCR through a programme of multi-agency workshops.

12.1.6 The SCR Panel noted the findings of the most recent biennial review of SCRs that the practitioners who had been directly involved in cases often were unaware of the outcomes of SCRs.
"Few practitioners… had ready access to the overview report or executive summary (and) …would have liked to be debriefed on its content"
Agencies have been asked to ensure that all practitioners involved with the family are appropriately debriefed, outside the general programme of dissemination of lessons learned.

12.2 Consistency of input to the Serious Case Review

12.2.1 Despite the sterling efforts of the LSCB Business Manager and Administration Officer to guide agencies towards submitting reports that were broadly consistent in style and size, there was a marked disparity between the contributions of agencies to this review. The report from ONEL CS runs to 111 pages whereas the submission from NELFT is 41 pages in length. All the reports use different formats. This makes it difficult to cross-check effectively and ensure that agencies have complied with the Terms of Reference for the Review. There is consequently a recommendation to the Safeguarding Board from this Overview Report.

12.3 Good Practice

12.3.1 OFSTED[15] has suggested that the "best" SCRs will identify
"Good practice… with appropriate consideration of its potential for wider implementation".
I have not identified any examples of good practice which quite meet OFSTED's aspirations, in the sense that they can be implemented more widely. However, some of the IMRs in this case do identify examples of individuals working particularly hard and conscientiously, the police Occupational Health Adviser being the most obvious example.

[15] OFSTED SCR Descriptors January 2009

13. CONCLUSIONS: LEARNING POINTS AND MISSED OPPORTUNITIES

13.1 Before his death there had been no evidence that Child D was not being adequately cared for. He was developing normally and the Review found that there were never concerns which should have led to any child protection intervention.

13.2 However, there was a great deal of evidence that his mother was misusing alcohol, including repeated direct requests from her for help with that problem. None of the relevant agencies gave adequate priority to the need to address her misuse of alcohol, and the consequent risks to Child D. There were weaknesses in the sharing of information but all the “treating” agencies had some knowledge of the problem and failed to give it adequate priority.

13.3 Mental health services had a particular responsibility to address this issue but failed adequately to do so. Their response to the referral from primary health care services in June 2010 was disappointingly weak: no mental health assessment was carried out in the community and there was avoidable delay in offering a specialist appointment, in response to a referral the GP had described as “urgent”. There is no evidence that mental health services took any account of there being a vulnerable child in the family.

13.4 Initially the GP failed to ensure that maternity services were aware of Ms F’s history of alcohol misuse. Maternity services picked this up anyway but there were delays and weaknesses in the assessments carried out by obstetricians. Then all the other health services involved failed to ensure that the Health Visitor was aware of the relevant history.

13.5 The Health Visitor only became aware of the issue of alcohol misuse after the one occasion, in May 2010, when Ms F came to the attention of police. Nonetheless, although she was always prompt and sympathetic in her dealings with the family, the Health Visitor still failed to carry out comprehensive assessments and to focus on the misuse of alcohol.

13.6 Children and Young People’s Services were only briefly involved, following up the incident involving police in May. They made errors and demonstrated a lack of thoroughness in deploying an unqualified officer, effectively to carry out an assessment of a child’s safety. There was then avoidable delay in making child-focussed support services available to the family.

13.7 The Common Assessment Framework (CAF) was established as the appropriate process to follow where the “universal” agencies identify that a child might have “additional” needs - such as those which might arise from a parent misusing alcohol. Essentially, this was the appropriate inter-agency procedure to be followed to flag up and begin the analysis of the additional needs of Child D which arose from his mother’s misuse of alcohol and associated problems. One might have expected the GPs, maternity services and Health Visitor to have made use of this “tool”. None of them did so.

13.8 Through her employment Ms F was in touch with impressive occupational health services. However, the contribution from those services was undermined by slow and inconsistent feedback from other health services. There were also limitations on the ability of occupational health services to use compulsory testing for use of alcohol, despite the continuing concerns of managers.

13.9 Agencies have identified that there are a number of similar themes in this Review and a previous Serious Case Review in Havering in 2009. It is consequently necessary to check that lessons learned from that Review have been thoroughly followed up.

13.10 The principal learning point relating to the process of this Review was that some agencies failed to submit reports which were concise, punctual and in the standard format which had been agreed. This meant that the process of analysing and cross-checking those reports was more complicated and time-consuming than necessary.

14. RECOMMENDATIONS FROM INDIVIDUAL MANAGEMENT REVIEWS

This section sets out all the recommendations made in the agencies' Individual Management Reviews. The actions in response to the recommendations are detailed in the integrated Action Plan which accompanies this report.

14.1 The General Practitioners

14.1.1 The Practice needs to ensure that the initial assessments of pregnant women include an assessment of any psychiatric or emotional problems that may impact on the progression of their pregnancy or their ability to be effective parents. This should include ensuring that all referral forms are fully completed and include all relevant historical information.

14.1.2 The Practice should ensure that the supervision arrangements for doctors in training are sufficiently robust and over the course of the training period cover all the aspect of the curriculum described in the RCGP Learning and Teaching Guide.

14.1.3 The Practice needs to review its approach to the management of clinical records and the expected standards for the content and structure of the clinical entries made by the doctors.

14.1.4 The practice should reconsider its approach to records management and ensure that the approach is consistent with best practice.

14.1.5 The Practice should review all the proforma letters it uses to ensure that they are fit for purpose.

14.1.6 The Practice should ensure that all the individuals involved in providing clinical care to Ms F are supported and mentored through the processes that will follow the publication of this report.

14.1.7 NHS Havering needs to ensure that all general practitioners working in its area are familiar with the NICE guidelines on the provision of antenatal care.

14.1.8 NHS Havering needs to ensure that all general practitioners working in its area are aware of the perinatal psychiatry service provided by the NE London NHS Foundation Trust.

14.1.9 NHS Havering should ensure that the proforma referral forms in general use in the area are redesigned so that they are fit for purpose.

14.2 Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT)

14.2.1 The existing discharge information form from the maternity wards should be amended to ensure all significant information is shared with the community midwives (maternity matron and named midwife)

14.2.2 Midwives should be reminded of the need to document detailed information where available about vulnerability factors at booking (consultant midwife in public health)

14.2.3 A review and gap analysis of the services, care pathways and awareness of the needs of pregnant women with complex social factors should be undertaken in line with the recent NICE guidelines (September 2010) – (consultant midwife in public health)

14.2.4 Teaching sessions on alcohol abuse should be arranged for midwives and doctors in maternity (named midwife and maternity education lead)

14.2.5 All maternity staff should be reminded of the importance of adhering to the correct procedure for recording sensitive information in the Maternity Unit – (head of midwifery and divisional director for women & children)

14.2.6 Community midwives should routinely offer all new mothers referral to local Children Centres services and provide details to the Children's Centres, if the mother agrees – (consultant midwife).

14.3 Outer North East London Community Service (ONEL CS)

14.3.1 ONEL CS to be assured that its HV staff are knowledgeable about indicators of abuse and are able to undertake high quality health visiting assessments that identify risk and result in the development of a health care plan in response to identified need.

14.3.2 ONEL CS needs to ensure that its record keeping system is operated so that it effectively safeguards children in its care.

14.3.3 ONEL CS to ensure that its record keeping system is operated in line with Trust policies.

14.3.4 There is a need to improve information sharing and communication both within health and partner agencies.

14.3.5 ONEL CS to ensure that the CAF is appropriately used within the HV service to identify children in need of early intervention.

14.3.6 ONEL CS to be assured that all cases where there are concerns about parenting capacity are discussed within a safeguarding supervisory framework and that there is a care plan in place that is SMART[16]

14.3.7 ONEL CS to ensure that the Edinburgh Post Natal Depression Scale Standard for the Health Visiting service incorporates safeguarding issues

14.4 Recommendations to the North East London Foundation Trust

14.4.1 No referrals to MHIAT which require input from other NELFT services should be referred back to referrer or other professional involved for referral onwards. They should be referred on internally by MHIAT to the appropriate NELFT service including Drug and Alcohol Services.

14.4.2 All referrals to MHIAT with postnatal mental health issues to be assessed face to face (this is to be rolled out to all the Initial Assessment Teams across the other three Boroughs within the NELFT area) with due regard to safeguarding issues.

14.4.3 All referrals for postnatal assessment will go to the Initial Assessment Teams to be assessed and then referred on, if appropriate, to the Perinatal Mental Health Service.

14.4.4 Local Perinatal Mental Health Service clinics to be arranged in Barking and Dagenham and Havering with the provision for urgent appointments with the Doctors.

14.4.5 Training for Initial Assessment Teams on postnatal assessment to be provided by the Perinatal Mental Health Service.

14.4.6 NELFT to ensure Safeguarding Children training is available and relevant teams receive appropriate levels of training according to service type.

14.4.7 NELFT to ensure appropriate staff have received training for CAF.

14.4.8 NELFT Perinatal Mental Health Service to publicise their service again to GP practices and Primary care staff in Havering, to ensure all staff are aware of the service provided and the referral pathway.

14.5 Recommendations to the London Ambulance Service

14.5.1 The Trust should provide feedback to the staff involved.

14.5.2 The Trust should highlight the circumstances in the Trust's internal magazine; personally issued to all Trust staff, so to draw attention to the need to make a referral in these circumstances.

[16] Specific, Measurable, Achievable, Realistic, Time-limited

14.5.3 The Trust should give further consideration to specific reference within the safeguarding guidance available to all staff on the Trust's intranet and internet facilities.

14.6 Recommendations of the Health Overview Report

14.6.1 All health agencies must comply with the local LSCB guidance and the guidance issued by NHS London guidance in 2010 when undertaking serious case reviews.

14.6.2 Commissioners responsible for the commissioning of local antenatal services to include referrals to substance misuse services as a Key Performance Indicator in service specifications.

14.6.3 Inclusion of implementation of the CAF process by provider services must be monitored within relevant service specifications and evidenced as a key performance indicator for 2011.

14.6.4 Commissioners to ensure that communication protocols are in place in provider organisations and assurance provided they are being appropriately operated

14.6.5 The implementation of National Institute of Clinical Excellence (NICE) guidance (2010) on ante-natal care be reviewed across health organisations

14.6.6 SCR single agency action plans must be reported to the LSCB & to internal safeguarding committees

14.7 Recommendations to Havering Children and Young People's Services

14.7.1 The use of unqualified practitioners to carry out roles and functions of qualified social workers should cease with immediate effect.

14.7.2 The role of family support workers should be reviewed and clarified and the results disseminated to all line managers within Children and Young People's Services.

14.7.3 A comprehensive set of policies and procedures including arrangements for staff supervision and allocation of work are to be developed for use within Children's Centres.

14.7.4 The Children's Centre's initial assessment framework should cease to be used and the use of CAF is to be extended and used as the form of assessment by Children's Centres.

14.7.5 Children & Young People Services should ensure that issues of ethnicity and cultural and religious identity are addressed in assessment and direct work with families.

14.8 Recommendations to the Metropolitan Police Service

14.8.1 No recommendations arise from this Management Review

15. RECOMMENDATIONS FROM THIS OVERVIEW REPORT

15.1 Introduction

15.1.1 These recommendations arise from this Overview Report which reflects the views of the SCR Panel and the independent Overview Report author. They may overlap with the recommendations, set out above, made by individual agencies. They are in line with the Government's guidance[17] that Serious Case Reviews should

"focus on a small number of key areas with specific and achievable proposals for change".

The recommendations arise directly from the content of this Serious Case Review. The London Safeguarding Children Board has suggested that Overview Reports from SCRs should consider the relative urgency of recommendations made. These recommendations are all important. However, none of them are so urgent that they require immediate attention. They can be dealt with in the normal course of service planning. Some recommendations give rise to a number of actions, detailed in the accompanying Action Plan. Each recommendation includes in parentheses a date by which the overall objective should have been achieved.

15.2 Recommendations to the Havering Safeguarding Children Board

15.2.1 The Havering Safeguarding Children Board should use this Serious Case Review to highlight to staff across all appropriate agencies the potential consequences of parental misuse of alcohol. (December 2010 and continuing).

15.2.2 The Havering Safeguarding Children Board should review the availability and adequacy of alcohol misuse services, and the extent to which relevant staff are aware of those services. (July 2011).

15.2.3 The Havering Safeguarding Children Board should require all appropriate agencies to ensure that their staff understand how and when to make use of the Common Assessment Framework. (May 2011 and continuing)

15.2.4 The Havering Safeguarding Children Board should consider the findings of this Serious Case Review against the findings of the previous Serious Case Review (Child B, 2009) and ensure that steps have been taken to address any concerns common to both reviews. (March 2011 and continuing).

15.2.5 The Havering Safeguarding Children Board should develop measures to ensure that, in the event of any subsequent Serious Case Review, the

[17] "Working Together" (2006) Paragraph 8.34

contributions from agencies are broadly consistent in style, format and detail. (Immediate).

15.3 Recommendation to all agencies

15.3.1 When working with parents who have mental health, substance abuse or similar problems all agencies must ensure that they specifically take account of and plan for the needs of children.
(Immediate and continuing).

15.4 Recommendations to the North East London Foundation Trust

15.4.1 The North East London Foundation Trust should review the service provided by the Mental Health Initial Assessment Team to ensure that

- thorough assessments are carried out in all appropriate cases
- staff are aware of their responsibilities for the safeguarding of children

(April 2011)

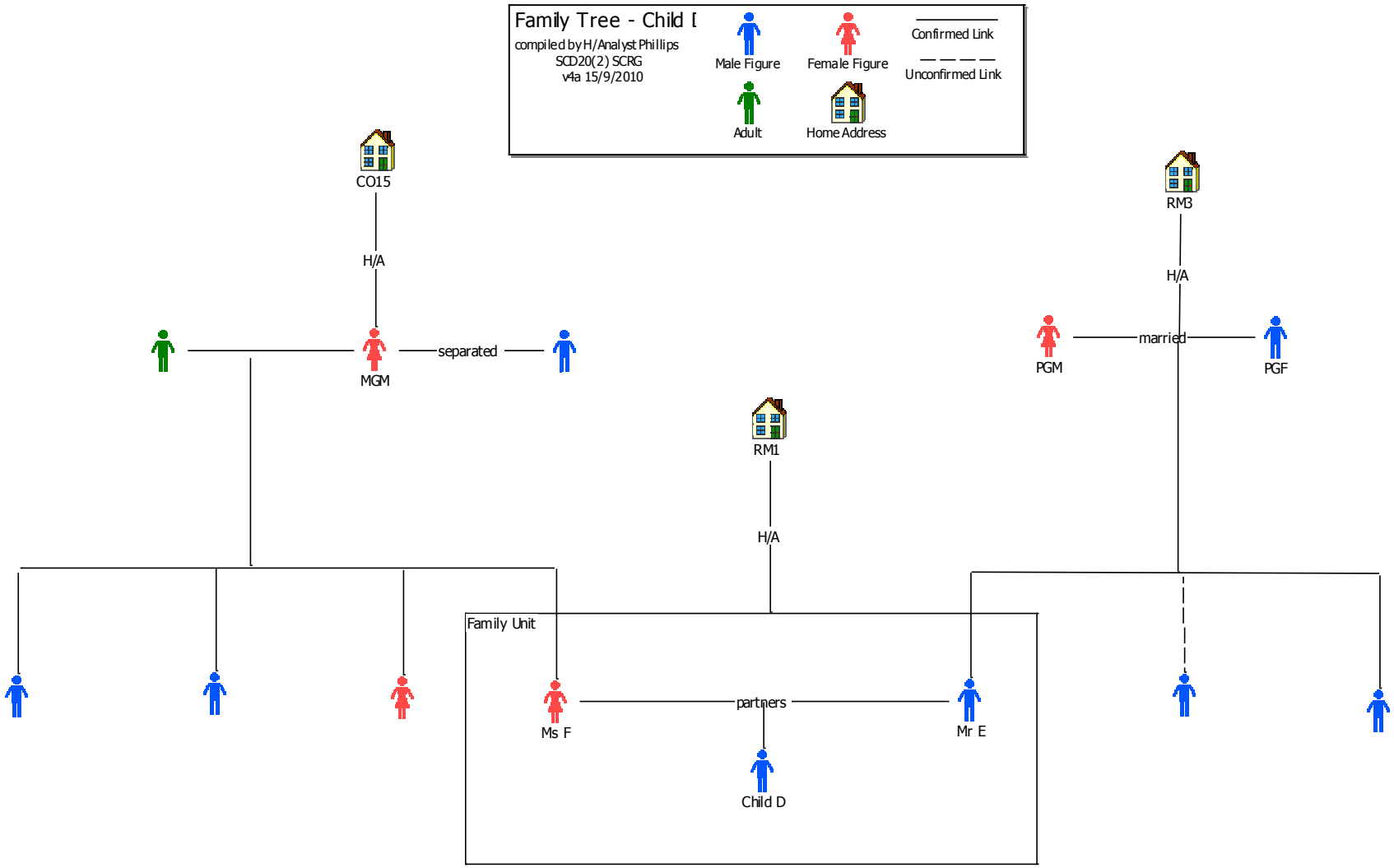
15.4.2 The North East London Foundation Trust should review the arrangements made by the Perinatal Mental Health Service, to ensure that an accessible service is provided, without unnecessary delay, across its catchment area.
(April 2011)

15.5 Recommendation to Havering Children & Young People's Service

15.5.1 Havering Children & Young People's Service should review their arrangements for screening and assessment of new referrals, so that only appropriately qualified staff are deployed to undertake assessments which have potential child protection implications.
(April 2011)

16. APPENDIX A GENOGRAM

The genogram below has been helpfully provided by the Metropolitan Police Service


Family Tree - Child [
compiled by H/Analyst Phillips
SCD20(2) SCRG
v4a 15/9/2010
Male Figure
Female Figure
Confirmed Link
Unconfirmed Link
Adult
Home Address
CO15
H/A
MGM
separated
RM3
H/A
PGM
married
PGF
RM1
H/A
Family Unit
Ms F
partners
Mr E
Child D

APPENDIX B: TERMS OF REFERENCE

The Serious Case Review (SCR) will follow the guidance detailed in Working Together to Safeguard Children (2010). The review will consider how effectively the services involved with the family worked together to meet the needs of Child D and support this family.

In particular the serious case review should consider whether the services:

- At all times held the child's needs as the paramount consideration within any assessment undertaken and decisions made.
- Identified parental vulnerability and its impact on parenting capacity. The review will take account of any relevant medical history relating to the parents of Child D.
- Identified and understood the significance of contextual factors including mental health, alcohol dependency, social isolation, the use of prescribed medication, which may have impacted on parenting capacity.
- Provided quality referrals within and between agencies that shared accurate and appropriate information in a timely manner to ensure appropriate assessments were undertaken.
- Responded appropriately to referrals received.
- Held consistent information in relation to the family and were fully aware of mother's disclosure regarding her alcohol dependency and mental health.
- 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
- Had appropriate knowledge/skills to identify a child at risk.
- Failed to identify or respond to child protection concerns.

<u>Specific considerations</u>
Do any issues concerning diversity emerge in the review, for example

- Ethnicity
- Religion
- Equalities

<u>External links</u>
Was the family engaged with / known to agencies other than statutory partners?

In addition, the review will take account of:

- Other investigations: the review should explicitly incorporate relevant information and recommendations from any parallel process.
- Learning: how the report links to learning from research and other SCRs

<u>Timeline</u>

The SCR will consider in detail the period from when Child D's mother became pregnant to the date of his death

Timescale
In line with the guidance set out in Working Together to Safeguard Children 2010 this SCR, which was formally initiated on 7th August 2010, will be completed by 7th February 2011

Family involvement
The independent author of the Overview Report and a member of the SCR Panel will invite Child D's parents and grandparents to meet with them, so as to contribute to the SCR process.

Organisations and professionals to submit reports / contribute to the SCR

- Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT)
- North East London NHS Foundation Trust (NELFT)
- Outer North East London Community Service (ONEL CS) (To include General Practitioner Services)
- NHS Havering (commissioners) to provide a Health Overview Report
- London Ambulance Services NHS Trust (LAS)
- Metropolitan Police Service
- Metropolitan Police Service, Occupational Health
- London Borough of Havering Social Care and Learning – Children and Young People Services (To include prevention and intervention provision).

Each agency will complete an IMR following the guidance set out in chapter 8 Working Together to Safeguard Children 2010.

Legal Advice
Legal advice, if necessary, will be made available to the SCR Panel by the Safeguarding Board.

The Coroner and the Crown Prosecution Service
The Metropolitan Police Service will liaise with the Coroner and Crown Prosecution Service and feed all relevant information into the SCR process.

Quality Assurance
Explicit arrangements have been made for the quality assurance of reports and the SCR process overall.

Managing family, public and media interest
Havering LSCB will manage family, public and media interest through a clear communication strategy. Family members will be formally notified informed of the process and findings of the SCR following evaluation by OFSTED.

Havering LSCB
18th August 2010

APPENDIX C: REFERENCES

Footnotes have been used to indicate specific quotations from or references to research, practice guidance and other documentation. This Overview Report has been generally informed by the following publications

- Working Together to Safeguard Children,(HM Government 2009)
- The Victoria Climbie Inquiry (Lord Laming 2002)
- The Protection of Children in England: A Progress Report (Lord Laming 2009)
- The Annual Report of Her Majesty's Chief Inspector of Education, Children's Services and Skills 2007/08
- Safeguarding London's Children: Review of London Serious Case Reviews First Annual Report (London SCB 2007)
- Joint Area Review, Haringey Children's Services Authority Area Review of services for children and young people, with particular reference to safeguarding (2008)
- London Child Protection Procedures (3rd edition 2007)
- Improving safeguarding practice, Study of Serious Case Reviews, 2001-2003 Wendy Rose & Julia Barnes DCSF 2008
- Analysing child deaths and serious injury through abuse and neglect: what can we learn – A biennial analysis of serious case reviews 2003-2005
- Understanding Serious Case Reviews and their Impact - a Biennial Analysis of Serious Case Reviews 2005-07 DCSF 2009
- Safeguarding Children a review of the arrangements in the NHS for safeguarding children (CQC July 2009)
- 'What to do if you're worried a child is being abused' DH 2006
- Child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect (Cawson, Wattam, Brooker, Kelly November 2000)
- Review of the involvement and action taken by Health Bodies in relation to the case of Baby P (Care Quality Commission (2009).
- Learning together to safeguard children: developing a multiagency systems approach for case reviews. (Social Care Institute for Excellence 2009)