SERIOUS CASE REVIEW INTO THE DEATH OF CHILD H

OVERVIEW REPORT

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SERIOUS CASE REVIEW INTO THE DEATH OF H

1. SUMMARY OF FINDINGS

1.1 The conclusion of this review is that there is no evidence that the death of H could have been predicted and that the professionals who came into contact with her and her family could not have anticipated, and therefore prevented, the tragic outcome. There was nothing in Mother's Boyfriend's antecedents or known behaviours that indicated that he would perpetrate the level of violence that killed H. He had had a troubled childhood and adolescence but it was not exceptional. Many other young people have similar backgrounds but do not commit such violent acts. Professionals were alert to the changes in the family once he became involved with them and were in the process of acquiring a fuller understanding of his role in the family and its impact on the children's lives when H died. There was nothing to indicate to those professionals that the usual time scales for assessment needed to be accelerated.

1.2 However the window onto the system this review has allowed has identified some learning for the professionals involved, on both an individual and organisational level. While it is recognised that professionals' behaviour and actions which generated this learning did not contribute to H's death nevertheless it is pertinent to reflect on these aspects so that the learning can inform actions taken to ensure the continuous improvement of the multi-agency response to vulnerable children and their families in Cambridgeshire.

2. INTRODUCTION TO THE REVIEW

2.1 Working Together (2013) states that where abuse or neglect of a child is known or suspected and the child has died, then the Local Safeguarding Children Board (LSCB) must initiate a Serious Case Review (SCR). The purpose of a SCR is to enable the professionals and organisations involved with the child and their family to reflect on both their own practice and that of others and to identify improvements that are needed and to consolidate good practice.

2.2 Working Together (2013) also says that SCRs should be conducted in a way that

- recognises the complex circumstances in which professionals work together to safeguard children
- what are the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

This serious case review has been undertaken in a way that ensures these principles have been adhered to.
3. INTRODUCTION TO CASE

3.1 The child who is the subject of the review is referred to in this report as H. Her parents are called Mother and Father. Other family members are referred to by their relationship to H e.g. maternal grandmother. Mother's Boyfriend is referred to in this way as this was the way in which the relationship was described by the children. Agencies were given differing understandings of the relationship between the two adults with them referring to each other at various times as neighbours and partners. A genogram is attached at appendix 1.

3.2 H was 2 years and one month old when she died in November 2013. At about 8.50 am on a day in November 2013, an ambulance was called to the home address where Mother's Boyfriend had been caring for H while Mother took her older sibling to school. Mother's Boyfriend alleged she had sustained a head injury falling off the toilet. H was taken to the City Hospital where she died of her injuries which included a lacerated liver. The post mortem identified that she had other, older injuries, including a broken wrist.

3.3 Mother’s Boyfriend was subsequently convicted of her murder and sentenced to life imprisonment and was told he must serve at least 17 years of his sentence. Mother was acquitted of causing or allowing H's death but admitted two charges of neglect in relation to the older children. She was given a suspended sentence.

3.4 H's two older siblings were accommodated by the Local Authority in November 2013.

4. FAMILY STRUCTURE

4.1 Mother married the Father of Sibling 1 in 2004 (when she was 19) and Sibling 1 was born in 2006. Father of Sibling 1 and Mother separated in late 2006 and Father of Sibling 1 was deported in 2007. In March 2009 Mother met Father of Sibling2, and Sibling 2 was born in March 2010. The current whereabouts of Father of Sibling 2 is not known.

4.2 Mother and Father met in in latter part of 2010 and H was born the following October. They separated in September 2012. Mother was 26 years old when H was born and Father was 23.

4.3 All three fathers are of different ethnicity. Mother’s ethnicity is white British. No information was made available to the review about the religious affiliation of any of the adults except for Father who is an active Christian.

4.4 Mother’s parents are separated. Maternal Grandmother lived comparatively near the family with Mother's half brother who is now aged 18. Maternal grandfather lives in another part of the country.

4.5 Mother’s Boyfriend's 19th birthday was the month before he and Mother met, following the family's move to the house next door to where the father of Mother's Boyfriend lived.

5. TERMS OF REFERENCE

5.1 In order to ensure the process was proportionate to agencies' involvement, agency authors were asked to provide either full reports or background reports detailing historical involvement prior to August 2013. Those that had peripheral involvement were asked to provide a statement of involvement only. The Terms of Reference are attached at appendix 2.
and detail which type of report each agency was asked to provide. The TOR also articulate
the particular issues for consideration the report authors were asked to consider. The format
for agency reports that the authors were given is attached at appendix 3.

5.2 The period of review was originally set as from August 2013, when the family moved to the
property where H died. However, the first drafts of agency reports, considered at the
Authors’ Meeting, confirmed that there was relevant information from the month before the
move, July 2013, and so the period under review was extended back to commence in July
2013.

6. PROCESS

6.1 The LSCB’s SCR sub-group was informed of H’s death on 26th November, and the review was
initiated on 17th December 2013. Draft Terms of Reference were then further scoped at the
SCR sub-group meeting on 28th January which the Reviewer also attended. A meeting for
authors of individual agency reports was held on 4th March 2014 where the review process
and expectations of the agency reports were discussed.

6.2 The LSCB liaised with the Crown Prosecution Service to discuss how staff who had been
involved with the family could participate in a learning event without compromising the
criminal trial. Original time scales were amended when the dates for the criminal trials of
Mother’s Boyfriend and Mother were announced so that a Practitioners’ Event could take
place after the trial had concluded.

6.3 On 20th May the agency report authors met with members of the SCR sub-committee and the
overview report writer to review the reports, to discuss emerging themes and to identify
further information needed to produce a final version of their reports. All participants had
view of all the reports prior to the meeting to ensure everyone attending was able to fully
understand the multi-agency context of the review.

6.4 A full day’s Practitioners’ Event took place on 3rd July. All the agencies who had submitted full
reports were represented as well as some of those who had done only background reports.
Front-line staff and line managers who had been involved with the family during the
reviewed period were invited as were the agency report authors. The Event was very well
attended and enabled a “window on the system” and the discussions and reflections that
emerged informed this report. A further Practitioner Event to share the final report and to
further discuss the learning is planned.

6.5 The draft Overview Report was considered at meetings of the LSCB Serious Case Review Sub-
group on 9th September and 21st October.

6.6 The Overview Report Writer and a representative from LSCB met with Father on 27th August
give him the opportunity to share his views and, where these contribute to learning, they
have been integrated in to this report. Once completed the LSCB Business Manager has
subsequently shared the findings of the review with the Father, and the Overview Report
writer and LSCB Business Manager have met with the mother to share the findings, however
the mother had not felt able to contribute to the Review at an earlier point.
6.7 The Overview Report writer is an independent child protection social work manager and consultant and has no previous connection with Cambridgeshire Local Safeguarding Children Board and its partner agencies.

7. BACKGROUND PRIOR TO THE SCOPED PERIOD

7.1 Mother moved back to Cambridgeshire area from where she had been living with her father very soon after the birth of Sibling 1 in Aug 2006. By the time Sibling 2 was born in March 2010, Sibling 1 had been diagnosed with a learning disability and the family were receiving support from a local Children’s Centre and a Family Worker was briefly involved. Mother was perceived by those professionals working with her at the time as a single mother with a child with special needs who needed extra help but “nothing exceptional”. Her single parent status alluded to the fact that professionals recognised that neither of the two children’s fathers had remained involved although there is no evidence that there was curiosity about the how she had formed these relationships and any consequent implications for her and the children. Sibling 1 started school in September 2011, a year later than her contemporaries, her admission having been deferred because of her special educational needs.

7.2 During 2010 Mother and Father started a relationship and he was part of the household from late 2010 until September 2012 when Mother made an allegation of assault against him. She also cited previous incidents of domestic abuse which were said to have been witnessed by the children. Father was charged in relation to three incidents although these charges were eventually dismissed in court. During this time Mother obtained Prohibited Steps and Residence Orders in relation to H as she reported that Father had threatened to abduct H and take her abroad. Prior to charges being dismissed Mother reported Father for breaching his bail conditions by making indirect contact with her on several occasions.

7.3 Because Mother had made an application for the above orders, and because Father subsequently made an application for a Contact Order, the Children and Family Court Advisory and Support Service (Cafcass) became involved. Pending a Fact Finding hearing, Cafcass recommended that contact between Father and H should be not be allowed until all the data from safeguarding checks had been received and considered. The court subsequently made six findings that Father had physically assaulted Mother and had sought to intimidate her. It also made a finding that they had both argued in front of the children. Cafcass undertook an assessment (which involved telephone only contact with Father) and recommended that, in light of his denial of abuse and “lack of understanding of the need for him to make changes to his behaviour” he should have indirect, letter box, contact four times a year until he showed “some acceptance of his violent behaviour and (of) taking some steps to deal with this”. The court ordered Cafcass to identify a Domestic Abuse Perpetrator Programme (DVPP) to assess Father for his suitability to attend and that in the meantime he was to have indirect contact at six-weekly intervals. Father subsequently attended a DVPP which reported on his regular attendance and progress in its interim report. In October 2013, Cafcass requested an adjournment of the next hearing to enable the final report to be received. This meant that Father’s application for contact with H was still being considered at the time of her death and he had had no direct contact with her since he had left the family home in September 2012.
7.4 There was no information to suggest that Mother’s Boyfriend knew Mother prior to the family moving in to the house next door to his father’s home at the beginning of August 2013. However, by the end of August he was living at his father’s address (although his father had imposed the condition that he was not to be in the house on his own) and the relationship between him and Mother started shortly afterwards. At the time Mother was 28 and he was 19 years old.

7.5 Mother’s Boyfriend had had a troubled childhood and adolescence. At 4 years old he had a serious illness, his parents then separated acrimoniously and he moved between them at various times when his behaviours became too much for one or the other to cope with. He was diagnosed as having hyperactivity and conduct problems and was involved with Child and Adolescent Mental Health Services (CAMHS) for 9 years until he was discharged when he was too old for the service. While he was under the supervision of CAMHS Mother’s Boyfriend was prescribed medication for Attention Deficit Hyperactivity Disorder (ADHD). He had some “planned breaks” from the medication and reported that he preferred being on medication as he felt more impulsive and more likely to get into trouble when not taking it. At the time there was no formalised specialist adult ADHD service and when, at the age of 17 he was discharged to his GP from CAMHS, he did not continue to be prescribed medication. (Even though there is now a service for adults with ADHD within Cambridgeshire mental health services, there is no pathway for young people to transfer from CAMHS to this service and young people continue to be discharged back to their GP. They have to be referred back to the service for adults, placing a barrier in the way of obtaining continuity of treatment for this group of young adults).

7.6 Children’s Social Care services (CSC) had intermittent child in need involvement (under s17 of the Children Act 1989) with Mother’s Boyfriend during his childhood. Their last involvement was in 2012 - just before his 18th birthday - when they were informed that he was homeless. He also acquired a Police record and the Youth Offending Service had been involved with him. The offences for which he was found guilty of were burglary and theft (in 2008 and 2009), a charge of destroying /damaging property in 2009, and of possessing an offensive weapon (a knife) in a public place in 2011. No further action was taken on four other offences spanning 2007-2011 and he was found not guilty of Battery in 2012 (this last incident relating to an incident between Mother’s Boyfriend and his step father when there was a confrontation over money).

8. ANALYSIS OF KEY PRACTICE EPISODES

Key practice episodes are episodes that are judged to be significant to understanding the way that the case developed and was handled. The term ‘key’ emphasises that they do not form a complete history of the case but are a selection of the activity that occurred and include key information to inform the review.

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1 S 17 Children Act 1989 states the duty of Local Authorities to safeguard and promote the welfare of children who are in need.
Key Practice Episode 1 - July and August 2013

8.1 The first key practice episode started in July 2013. During this time the family were preparing, and then moving, to their new home. Staff from the agency that had had the longest involvement with the family – the Health Visiting Service – reflected that this move was seen as a positive development for the family and was “seen to be the answer” to most of the family's presenting problems at that time. These problems included mother's depression – her GP had prescribed antidepressants on 15th July, Sibling 2's “erratic, destructive and disruptive” behaviours reported by mother, the poor condition and unsuitability of the flat they were living in and “issues” with neighbours.

8.2 However, prior to the actual move, on 21st July, a neighbour contacted the Emergency Duty Team (EDT) to make a referral to CSC. The neighbour said she regularly looked after the children for mother and made allegations about the mother’s behaviour whilst looking after the children. This referral was responded to by an (agency) social worker from the Integrated Access Team (IAT) completing a threshold assessment. The purpose of a threshold assessment is to avoid “undue escalation to statutory assessment” (IAT Manual) by gathering further information, which can include seeing the family, to inform decision-making. There was some uncertainty about whether the family had already moved to their new address or not and the efforts to clarify this caused some delay in undertaking the threshold assessment which was eventually completed on 2nd August.

8.3 The social worker who completed the threshold assessment undertook a home visit and also spoke with the Nursery Nurse who was involved with the family at this time. The Nursery Nurse, who is a member of the Health Visiting team, had been asked by the allocated HV to complete a CAF (Common Assessment Framework) assessment. This was because a GP had requested Health Visiting input in regard to Sibling 2 (who was then aged nearly 2½) for sleep and behaviour advice. The Nursery Nurse's assessment noted that Sibling 2's behaviours were reported by mother to include “throwing herself off her bed and cutting herself, eating tissue paper and not sleeping well”.

8.4 The social worker's threshold assessment concluded that no further action was needed as “no safeguarding concerns were identified” and that the family were receiving “relevant support from the children centre”. This was not the case at the time. The children's centre was referred to by name in the assessment and staff at the Practitioner Event pointed out that this children's centre was not in the local area and therefore would have been very unlikely to have been involved. The fact that the social worker was an agency worker and perhaps not familiar with the locality may have contributed to this error, though this does not explain whether the social worker simply made an assumption about the children's centre involvement or was given misinformation when he did the home visit - or why the person signing off the assessment did not recognise that the family were unlikely to be receiving support from a children's centre some 25 miles away.

8.5 The CAF was considered at the August Locality Allocation and Review Meeting (LARM). LARMs are professional meetings used to identify appropriate resources and actions to help children and families who have more complex additional needs but who do not require social work involvement. The chair of the LARM was aware of the referral and threshold
assessment and concluded that the family’s needs “might be higher than suggested by the original CAF” and asked the Locality Social Worker (LSW) to clarify whether CSC were going to transfer the case for a social work assessment. This request is in keeping with the responsibilities of the LSW (who is a senior social worker) which include “supporting the interface of service provision ...between Locality and Social Care”. The LSW confirmed that the referral to IAT had been assessed as not reaching the threshold for children’s social care involvement and confirmed that the children centre team should allocate a Family Worker and proceed with a Team Around the Child (TAC) meeting. As a result a Family Worker from the Children's Centre was allocated on 30th August 2013.

8.6 This is a key episode because Sibling 2's behaviour was noted to be of concern, a first referral was made to CSC and the first LARM was held, offering professionals opportunities to explore what the children's lives were like. It is also the period during which the family moved to their new home. It evidences that some concerns already existed prior to the house move and Mother's Boyfriend becoming involved.

Key Practice Episode 2 – Start of school term (4.9.13) - school referral to CSC (17.10.13)

8.7 Very soon after the start of term school staff started a “diary of concerns” about Sibling 1 as they noted that she was “sad and clingy and not her usual happy self”. Despite the family's move Sibling 1 had been able to continue at the same school she had been attending and at the Practitioners' Event her Teaching Assistant spoke eloquently about the changes she observed, both in Sibling 1 and in Mother, not only as the term progressed but in contrast to her previous experience of them both. Frequent concerns were noted in the diary about Sibling 1’s appearance: “her teeth are dirty and breath smelly” “same dirty clothes on as all week” as well as an observation of Sibling 1 trying to take food off another child. This was a stark contrast with the school's previous experience of Sibling 1 when “she always had everything she needed; she was not hungry and was pristine”.

8.8 The school also formally recorded some concerns in the school's child protection file. A child protection file had been started in 2012 when the school had been informed of two domestic violence incidents. During this key practice episode two incidents were recorded on the child protection file - the fact Sibling 1 had a red mark on her face along with mother's explanation (that it may have been caused by a coat zip) and a further incident, seen outside school, when Sibling 1 was told off by Mother’s Partner and was threatened with no food. Then, on 26th September, after Sibling 1 had spoken of her sister “being bad at bedtime” and that Mother's Boyfriend had “shut the bedroom door hard and the door had hit (Sibling 2) making her nose bleed”, the school had a “What If” conversation with CSC. “What If” conversations are an opportunity for a professional to discuss a concern with a social worker to clarify appropriate action to take.

8.9 The school recorded the outcome of this conversation as being told to monitor. However, CSC had recorded their advice as to make a referral. As is IAT’s routine practice, they sent a letter to the school confirming their advice to make a referral. This letter was sent by IAT on the day following the “What If” conversation (27th September). It was received by the school on 30th September and was reported in the agency report to have been “annotated... to say they were advised to monitor”. The School did not contact IAT to clarify the difference in their
understanding of the outcome of the “What If” conversation. When the school did eventually make a referral to CSC on 17th October, it was in relation to further concerns about Sibling 1 being hungry and not in response to the letter of 27th September from IAT. It has been difficult to understand how such a diametrically different understanding of a conversation can have happened and the use of “What If” conversations gave rise to discussion at the Practitioner Event and is considered further in the analysis section.

8.10 On 30th September a member of staff from Sibling 2's Pre-school observed an incident in the community involving Sibling 2 being roughly handled by a man - assumed to be Mother's Boyfriend. The member of staff was concerned enough to telephone her manager to report what she had seen and subsequently completed a “log of concern”. However this information was not shared with any other professionals working with the family nor was a referral made to CSC. The Agency Report recognised that the Designated Person at the Pre-School was “acting up” as Manager. She continued to cover her substantive post's responsibilities while she was Acting Manager and, although she had completed the Child Protection Designated Person training she had not previously taken an active role as the previous Manager had taken responsibility for safeguarding issues at the Pre-School. This meant that both her capacity and experience was limited.

8.11 The Nursery Nurse's CAF regarding Sibling 2 was again considered at LARMs in September and October 2013. The Family Worker who had been allocated at the end of August (once clarity had been obtained about that CSC were not currently involved) had been asked to arrange a Team Around the Child (TAC) meeting but had not done so as she was about to leave the service. At the September LARM the case was reallocated to another Family Worker who first met the family on 8th October. During this visit the Family Worker met Mother's Boyfriend and was concerned about what she considered his “controlling behaviour” towards Mother. Because she had access to the CSC recording system she was able to establish the fact that the School had had the “What If” conversation and this caused her to take advice from her line manager and to then contact the School. The resultant meeting between the Family Worker and the Special Educational Needs Coordinator (SENCO) took place on the same day as the School made the referral to CSC.

8.12 The only other incident of significance that occurred during this practice episode was contained in the report from the Ambulance Service who noted that on 11th October there was a 999 call from the family home at 00.51am because of a “3 year old feeling faint and dizzy” and suffering from vomiting and diarrhoea. Paramedics attended and gave advice but were not concerned about either the child's health, the carers' (reported to be a man and a woman) behaviour or the home conditions. There is currently no reliable system for notifying other agencies – including GPs – of ambulance call outs that do not result in taking the patient to hospital and so this incident was not known to the professional network around the family. It is not possible to form a view on the significance of this incident but had it been known to the professional network it may have prompted additional curiosity.

8.13 This is a key practice episode because the significant change in Sibling 1's presentation and

2 The role of designated professional lead is “to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect” (Working Together 2013)
behaviour was noted by the professional network then working with the family and linked to Mother’s Partner’s involvement. There was an emerging pattern of concerns for two of the three children in the family but there was delay within the professional network involved at the time, in linking and responding to these concerns and considering the impact on H about whom no specific concerns were being raised.

Key Practice Episode 3 – Start of CSC involvement (17.10.13) – CSC complete initial assessment (31.10.13)

8.14 The referral from the School listed their concerns about the deterioration in Sibling 1’s presentation, her hunger and linking them to Mother’s Boyfriend’s involvement with the family was received by CSC on 17th October and passed from the IAT to a Social Work Unit for assessment. There was a conversation between the Family Worker (who had been copied in to the referral by the School) and the Consultant Social Worker (CSW) and they agreed that the Family Worker’s visit, planned for that day, would go ahead as “no social worker would be available to visit in the next couple of days or so”. It was also agreed that the planned TAC, arranged at the October LARM for 24th October would be held as a Child in Need (CiN) meeting instead of a Team Around the Child (TAC) meeting thus enabling “handover” from the lead professional to the social worker.

8.15 However, after this discussion the CSW decided to allocate the case to a different, more experienced, social worker in recognition that the referral had been categorised as at MOSI level 4, implying that the details contained in the referral gave rise to greater concern than other child in need referrals. The new social worker undertook an unannounced visit to the family on the same day (17th October). At the Practitioner Event the social worker described that, as he was on duty and in the area that afternoon, he “would be pro-active” and call on the family, and, because the concerns from school were “regarding food”, by calling without warning he could clarify “the reality of the situation”. At the Practitioner Event it also became clear that the school had not informed Mother that they had made a referral to CSC (but had tried to contact her by phone), therefore the social worker’s visit would have been a total surprise to Mother. The impact of this is considered further in the analysis section.

8.16 When the Family Worker undertook her planned visit - shortly after the social worker had left - she found the family “very upset” and at the Practitioners’ Event the school recalled how Mother had been “very cross” (with them) the next day. The social worker did another home visit the following day – the primary function of which was to check that food had been obtained as there had been very little in the house the previous day. He took a food parcel with him but there was food in the home and evidence of a food delivery having been arranged. At this visit the social worker gained Mother’s Boyfriend’s permission for Police National Computer (PNC) checks to be done.

8.17 At the conclusion of this second home visit the social worker agreed a verbal “action plan” with the family. It is clear from the social worker’s recording and contribution at the Practice

3 Cambridgeshire’s Model of Staged Intervention (MOSI) provides a framework for developing a common understanding of children’s needs, a shared understanding of the roles and responsibilities of services and aids practitioners in understanding the thresholds of different services. Cases meet MOSI Level 4 if needs are complex and enduring and cross many domains.
Event, from mother’s subsequent actions and from information recalled as being shared at the TAC meeting that took place on 24th October that it was agreed that Mother would take responsibility for taking the children to and from school. The CSC agency report states that it was also agreed that “Mother's Boyfriend would not be left alone with the children, that Mother's Boyfriend would not be involved in the parenting of the children”.

8.18 Between this period of professional activity starting on 17th October and the TAC meeting on 24th October the only incident of note was that H was taken to the GP by Mother with a “bony swelling” on her forearm. H was able to move her wrist and arm without pain and Mother said there was no history of trauma. The GP referred H for an X ray at hospital and asked Mother to call the surgery to discuss the results. H was not taken for the X ray but the GP was not made aware and did not follow this up. The GP Agency Report Author subsequently clarified that the X-ray Department's policy is to only notify GPs of non-attendance after six weeks has lapsed, sadly H died before this. The GP’s surgery were unaware of CSC’s involvement at this time.

8.19 On 24th October the TAC meeting that had been arranged at the October LARM was held at the family home. It was attended by the Family Worker and the Locality SW, the Special Educational Needs Coordinator (SENCO) from the School and the Health Visitor as well as Mother, Mother's Partner and Maternal Grandmother. Crucially, despite the Family Worker having been advised by CSC on 17th October that the arranged TAC should go ahead and become a CiN meeting in order to hand over case responsibility (in line with “step up” process), no one from the Social Work Unit attended. The absence of CSC was caused by the allocated worker taking unavoidable leave and no one else being available to attend.

8.20 The content of the meeting as recorded by the Family Worker was that the SENCO explained the reasons why the school had concerns about Sibling 1 and that Mother “was able to see the concern and agreed that she needs support” and that “we discussed openly the concerns that we all have for Mother and the girls regarding her new partner”. It is clear from Agency Reports that there was uncertainty in the professional network about what limitations of Mother’s Boyfriend’s involvement with the children had been agreed with CSC . In fact it was reported that Mother’s Boyfriend himself that told them that he was not to be left alone with the children.

8.21 On 31st October, the social worker completed writing his initial assessment within the prescribed time-scales which concluded that a CiN meeting should be convened and a core assessment be completed “to further understand the family and the children's world”, recognising that only a limited understanding had been obtained so far. The initial assessment identified that, other than details provided by Mother and her Boyfriend, it was informed by input from the School and the Family Worker. No contact was made with Health Visiting Services or the GP, the assessment simply recording that there were no health concerns, based on the family's information.

8.22 This is a key practice episode because during this time CSC became involved and instituted a

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4 At this time Cambridgeshire were working to the requirements of Working Together 2010 which required initial assessments to be completed within 10 working days from the referral to CSC and core assessments within 35 working days.
verbal agreement that included that Mother was to take the children to and from school and take “full care” of the children.

Key Practice Episode 4 – November 2013

8.23 On 6.11.13 the social worker met with Mother, Mother’s Boyfriend and the children and discussed the information obtained from the PNC check (received by CSC on 25th October). The social worker thought the information it contained to “be concerning…. partially due to the number of entries which (he) felt were significant for a young person”. However, the Reviewer's opinion is that it is not an unusual record for a troubled young man to have and does not contain information that would give immediate safeguarding concerns.

8.24 At this meeting the social worker discussed with Mother’s Boyfriend why the information gave rise to concern and re-iterated to both Mother and Mother’s Boyfriend the need to continue to abide by the verbal action plan, described as a “brief holding plan leading up to the CiN meeting” (CSC Agency Report). By the time of this meeting Mother had been expected to abide by it for 4 weeks.

8.25 On the same day, November 6th, Mother took Sibling1 to the GP having had a telephone conversation with a doctor from the surgery earlier in the day. She told the doctor that the school and the social worker were concerned about Sibling 1’s weight and height and had commented that she “smells”. Mother told the GP about CSC’s involvement and this prompted the GP to both review Sibling 1 a week later (when positive progress in her presentation and weight were noted) and also to contact the school. The doctor did not check Sibling1’s other siblings' records and so did not ascertain that H had not had her X-ray.

8.26 On 14th November, within the locally prescribed time-scales, the first CiN meeting was held at the School. Apart from the family members the only other person there who had been at the TAC was the SENCO. The Health Visitor who came to this meeting was covering for the family’s Health Visitor who was not available to attend. No formal notes of this meeting had been circulated before H’s death, however, all attendees noted down agreements and expectations of their agency. Mother was contacted by her allocated Health Visitor the next day and was reported to “be a little overwhelmed by what is expected of her”.

8.27 On the afternoon of 20th November the Teaching Assistant noticed that Mother did not have the other children with her when she collected Sibling 1 from school. She recorded this in the school’s child protection concern log the next morning but had not passed this information on to CSC before the school were contacted following H being taken to hospital.

8.28 This is a key practice episode as it had been concluded by the initial assessment that there were concerns that needed further assessment and so the children were assessed as being in need of support, the primary focus of which was the verbal agreement to limit Mother Partner’s involvement with the children. H sustained an injury for which she was taken to the GP and which the post mortem has confirmed was non-accidental. Because of limitations within systems, the GP practice were not alerted to the non-attendance and so did not pursue when she was not taken for an X-ray.
9.0 ISSUES IDENTIFIED BY THE KEY PRACTICE EPISODES

9.1 A number of issues were identified in the key practice episodes which warrant further consideration. These are

- the Early Help arrangements (including the CAF, LARM and the role of the locality social worker),
- the use of “What If” conversations and referrals to CSC
- the initial assessment and the verbal agreement with the family.

In addition, as one of the functions of the review to use it as a window on the system, the impact of Cafcass involvement is also considered although it started outside the period of the review.

Early Help arrangements

9.2 The CAF completed on Sibling 2 was initially considered at the August LARM and reviewed at two subsequent LARMs. Although Cambridgeshire CAF arrangements now include the possibility of using an e-form CAF, which can include a number of children's needs on one form, this facility was in the process of being rolled out across Cambridgeshire in July 2013 and was not utilised in this case. Adding this to the fact that LARMs are age-banded and the CAF completed by the Nursery Nurse was presented to a LARM convened to address the needs of 0-5 year olds caused the reviewer to consider whether these arrangements preclude/hinder a holistic approach to families with children of different ages.

9.3 This risk is recognised in the 0-5 LARM Guidance which states that “consideration needs to be given to which LARM a family sits within .... (the) decision should be based on either the complexity of need of the youngest child or the level of need of other siblings, whichever is greater”. The August LARM took place before concerns for Sibling 1 started to develop and, although the CAF initiator, the Nursery Nurse, attended, little information about H seems to have been presented (this “invisibility” of H is considered later in this analysis). Systems in place informed the LARM of CSC’s recent involvement which enabled a “joining up” of this information. The conclusion is that there is no evidence that it was the age-banding of the LARM that prevented a joined up approach and the current development of a paper and electronic Family CAF will support a Think Family approach by Early Help practitioners.

9.4 The CAF (which had been initiated in July) was considered for three consecutive monthly LARM meetings with the Family Worker only making a first home visit to meet with the family the day before the third LARM in October. This is not a timely process although it is recognised that there are several factors contributing to this including the holiday period, staff who had been allocated leaving, the time taken to clarify CSC’s involvement and some difficulty the eventually allocated Family Worker had in arranging a home visit. Nevertheless early help services need to be arranged so that they are responsive and support is provided in a timely way to stop situations deteriorating. However, although there was delay, this did not materially alter the course of events.

5 Early Help refers to services provided by a number of agencies which provide a ‘bridge’ between specialist services such as Social Care and universal services such as schools and the NHS.
9.5 The LARM was unsure whether the Threshold Assessment by the IAT was robust, as one of the rationales for recommending that no CSC involvement was needed was that the family were receiving relevant support from a Children's Centre and they had identified that this was not the case. The Locality Social Worker simply reviewed the CSC electronic case record and confirmed that the case had not met the threshold for social care and therefore advised the children centre that the team should allocate a Family Worker and proceed with the TAC meeting. There was no communication with IAT about the anomaly concerning the Children’s Centre and whether this had any bearing on the assessment’s conclusion that the case did not meet CSC threshold. Cambridgeshire is currently undertaking a Consultation on the Re-commissioning of Early Help Services where the question of what the best arrangements to secure social care input to Locality Teams to support risk management and advice on casework is being considered and this case should be used to inform the decisions made.

“What If” conversations and referrals to CSC

9.6 These types of consultations are provided by CSC duty desks to professionals who want to discuss whether a concern meets the threshold for a referral to CSC or for advice on what further action or information they need to obtain before making a decision about referring. In Cambridgeshire this facility is provided by an IAT duty social worker with calls being put through to them from the Contact Centre. At the Practitioner Event it was clear that the professional network found this opportunity for discussion supportive “(it makes you) feel you are not alone. (You can) share the concern”.

9.7 However, it also emerged at the Practitioner Event that referrers found the system clumsy because if the “What If” discussion concluded that a referral was needed the referrer had to repeat the information they had just shared with the IAT duty worker to someone else in the Contact Centre who would record it as a referral. Referring agencies found this especially frustrating as the IAT workers do also make a record of the “What If” conversations and it does appear to be duplication of effort.

9.8 The IAT’s practice of sending a letter stating the agreed actions following a “What If” conversation provides a system for confirming the outcome of the discussion. However the efficacy of this system is reliant on the recipient both reading the letter and, if it then appears that there is a discrepancy in the in the understanding of what the agreement was, making contact with CSC to clarify. In this case the School did recognise that there was a difference in understanding between themselves and IAT about the outcome of the “What If” conversation of 26th September but they did not contact IAT to obtain clarification which would have been expected practice.

9.9 IAT processes now include routine monitoring of actions agreed in “What If” discussions to ensure that they have been actioned.

Working with families under s17 (Children Act 1989)

9.10 The decision made by IAT once they received the referral from School was that the threshold
for s47 enquiries was not met. The IAT summarised the referral as “worries about mother’s new partner, the impact that this has upon the children, and mother’s ability to be protective. Sibling 1’s appearance has deteriorated, she is hungry and people had witnessed that new partner now collects her and she is shouted at on the way home”. The Agency Report author consulted with a wide range of staff about this decision and there was unanimous agreement that the presenting information warranted a response under s17 rather than a s47 child protection investigation. From the information available this would appear to be an appropriate decision.

9.11 The School had not discussed the fact that they were making a referral to CSC with Mother and at the Practitioner Event confirmed that not to do so was their usual practice. This is not consistent with the Cambridgeshire LSCB procedures which state that, that unless to do so would place a child at increased risk of significant harm, “concerns should be discussed with the child (as appropriate to their age and understanding), and with their parents, and their agreement sought to a referral being made”. Although CSC have an expectation that staff taking the referral will confirm that it has been discussed with the family, this was not done in this case. Mother therefore had no reason to anticipate contact from a social worker.

9.12 Working with families under s17 of the Children Act (1989) is a voluntary arrangement and the family has a choice whether to accept the intervention and support being offered. The initial interaction with the social worker can have a critical impact on any family’s perception of them as a supportive and approachable individual and influence the quality of the relationship and the family’s willingness to accept their advice and support. Given that the social worker’s initial home visit was unexpected - both because the School had not told Mother of their referral as well as because the social worker had called without first making contact, it is unsurprising that the family were “very upset”. Cambridgeshire LSCB procedures state that “Where the referral is Section 17, the allocated worker must contact the family at the point of allocation of the referral. When the case is allocated for Assessment a letter should be sent”.

9.13 At the Practitioner Event it was explained that, as School’s referral had included concerns about Sibling 1 being hungry, an unannounced visit afforded the opportunity to “check the reality of the situation” to see if there was sufficient food in the house. However, even if there had been a well stocked larder, the concerns about Sibling1’s hungry presentation would not have been resolved as other causes, such as the deliberate withholding of food would have needed to be explored. It should also be noted that at about this time there was a lot of national attention on the case of Daniel Pelka and issues about food and the agency report author hypothesised that this may have influenced the approach. In fact, there was very little food in the home and the social worker acted practically by returning with a food parcel the next day.

9.14 It is recognised that the home visit was very timely, being undertaken on the same day as the Unit received the referral. The Unit were “on duty” that week and therefore had responsibility for undertaking assessments on all incoming work and so there would be

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6 Under section 47 (Children Act 1989) an enquiry is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm.
pressure to “pull in” visits if a worker was in the right area. However, the fact that the visit was unannounced had the potential for setting a tone about how social workers engage with families.

9.15 The verbal action plan agreed following the social worker’s second visit was described in interview with agency report author as a “brief holding plan leading up to the CiN meeting”. At the Practitioner Event the social worker spoke articulately about the rationale for suggesting it, explaining that the intended purpose of the agreement was to put some element of distance between Mother's Boyfriend and the children to “eliminate potential risks” while he continued to assess and offer support. However verbal agreements are not an effective way of confirming expectations with families as their status (and content) is ambiguous and open to misinterpretation.

9.16 Although the action plan was stated to be a “brief holding” plan, the CiN meeting on 14th November confirmed that Mother was still being expected to adhere to it some four weeks later. The proportionality - and reasonableness - of the action plan is debatable. There could be a logic in suggesting it (under s17 it could not be a formal requirement) as a very temporary measure to “protect” not only the children but also Mother's Boyfriend (from allegations) but to continue it for so long and to reinforce its importance by asking School to monitor implies that there was a belief that the risk of harm to the children was more significant than the initial assessment implies. Although it is acknowledged that that the initial assessment concluded that a core assessment was needed in order to gain a fuller understanding of what was happening in the children’s lives there was no suggestion that consideration had been given to whether the initial assessment identified that threshold for s47 enquiries was met, which could reasonably be expected, given the conditions of the plan.

9.17 Mother was described as being “a little overwhelmed” by the expectations of her after the CiN meeting. She had three young children (then aged 7, 3 and 2 years old) to cope with and there is no evidence of consideration of the practical implications of the action plan, such as how much support Maternal Grandmother would be able to provide. CiN plans need to be explicit about what it is that needs to change and what help the family are going to get to implement those changes.

Children and Family Court Advisory and Support Service's role

9.18 Cafcass is asked by a court to become involved in private law cases (where arrangements need to be made for children when parents separate) to provide judges with advice, information and recommendations so that they can make a safe decision about children’s future. In this case Cafcass's role was to complete a s7 (Children Act 1989) welfare report into father's request for contact with H. Cafcass's initial advice that, because of the allegation made by Mother that Father had threatened to take H abroad, there should be no direct contact until further assessment of risks was completed was appropriate. However the continued recommendation that contact should be indirect – and the suggested level and type, (four times a year post box contact) raises questions about how this could be meaningful for a child of H's age (she was under a year old when Father left the family home).
9.19 The Cafcass worker who completed the s7 report did not meet father, relying on a telephone discussion and referring in their report to a Police record that the children had appeared “very withdrawn” when they had attended an incident and to Mother's and Maternal Grandmother's assertion that the children were “scared” of Father. There is no evidence of efforts made to contextualise these statements. The worker recognised that supervised contact in a Cafcass centre may have been relatively safe for H in terms of any physical risks she might face. His rationale for not recommending this was that “it would serve little purpose at this stage as it could not move on to unsupervised contact in the community, whilst Father is unable to show any insight into his behaviour”.

9.20 The balancing of the need to ensure that children are not exposed to any additional harm following parental separation that has involved domestic abuse with the need to enable the child to maintain a meaningful relationship with the non-resident parent is complex and requires thoughtful assessment. The Cafcass representative felt that participation in a Domestic Violence Perpetrator Programme was necessary to demonstrate Father’s acceptance of the need to address his behaviours that had been established by the fact finding hearing. However he did not consider that her age meant that indirect contact, via cards and letters would not be meaningful nor whether H could have contact with her father before he completed the program. No plans were made as to how Father's progress on the DVPP was to be monitored and how he was going to assess H's readiness for progression of contact and how this might be introduced.

10. ANALYSIS BY THEME

10.1 There are several themes which pervade the key practice events and which are also reflected in the above analysis. Viewed from a systemic perspective it is apparent how these themes influenced and impacted on each other. The themes are

- professionals seeing the family as individuals
- working with the children and the “invisibility” of H
- working with men
- recording and information sharing

These themes are inextricably linked and they are considered in turn below and the links explored.

Seeing the family as individuals

10.2 There was a pervasive theme, especially in the work prior to the referral to CSC, of professionals seeing the family members as individuals and not recognising the potential impact of the information agencies held, or of their actions, on other members of the family (and other professionals in the family's network). There were some examples of very insightful observations made about Sibling 1 but little of consideration of whether similar concerns might apply to her siblings. Similarly the Pre-school’s record of the incident witnessed by a member of staff involving Sibling 2 was not shared either with CSC, as a potential referral, or with other professionals working with the family and therefore was not available to contribute to an holistic picture of growing concerns. The Practitioner Event
identified that the school’s information system does not collect information on siblings and was a contributory factor in why there was not communication with the Pre-school setting attended by Sibling 2. The agency author explored with the nursery nurse who had initiated the CAF the rationale for the CAF not including information about the other two children (Siblings 1 and H) and established that it was because “no concerns were raised for...(them)...at that time and so a family CAF was not indicated”. The report also noted the limited amount of information that can be recorded on the paper version of the CAF. The e-CAF now available enables a family CAF to be completed and is more supportive of a systemic way of working with families.

10.3 A later example of not joining up concerns occurred when Sibling 1 was taken to the GP. The GP was sufficiently worried by mother’s description about School’s and CSC’s concerns to arrange to review Sibling 1’s progress and also to contact the School but did not review the other children’s records in light of this. If he had done so he would have seen that H had been sent for an X-ray but no results had been returned and he could have followed this up with Mother. The GP practice’s electronic case record system is not linked to the one the Health Visiting Service uses and this adds additional barriers to the GPs being aware of concerns that may surround a family although the system of quarterly meetings has been instituted as a result of this case may ameliorate this.

10.4 Maternal Grandmother’s involvement in the family was peripherally noted throughout the agency reports. She is recorded as being present at most of the professional meetings with the family that took place in their home during the review period. It was assumed that she would support the verbal action plan by assisting mother with child care/school run following the agreement that Mother’s Boyfriend would not be involved. The practical implications of this, of her understanding of the concerns and of her role in the family were not explored. She was not at the CiN meeting (held at the School) and so the actual contribution she was able and willing to make was not specified.

The invisibility of H

10.5 What was striking about the reports and the time lines of significant events that the main agencies involved with the family submitted to the review was the infrequency of H’s name being mentioned. To some extent this is unsurprising given that she did not yet attend any educational setting so reducing her exposure to professional attention but this also had the effect of increasing her vulnerability. This was compounded by professionals who had concerns about one or other of her siblings not explicitly considering how these concerns might also apply to or impact on H.

10.6 H’s age and stage of development meant that obtaining her views and feelings relied heavily on means other than verbal communication. These would include observation of her behaviours and reactions and would be limited by the fact that professionals had been peripheral to her life and so would not have the opportunity to observe the differences that may have been evident once Mother’s Boyfriend became involved with the family. The CSC agency report author identified that the social worker had seen the children a total of five times during the five weeks the case was open to him, which would have allowed him the opportunity to start to become a more familiar figure to H but it remains a challenge for any
worker to gain meaningful impression of a young child’s views and feelings early in their relationship with them. The Cafcass officer had even fewer opportunities to gain an understanding of H’s wishes and feelings having only met her on one occasion.

10.7 As it was, H’s elder sibling, Sibling 1, was the child who may have been able to provide information about what was going on in the children’s lives. The social worker spoke with her alone on at least four occasions and, recognising that he may have needed support with communicating with a child with a diagnosis of autism, also arranged to speak with her in the presence of her Teaching Assistant. This was a very appropriate action but the Teaching Assistant’s subsequent report that she had not been sure that Sibling 1 had understood the questions she was being asked emphasises the responsibilities on professionals to both plan and debrief effectively after such sessions. A 2011 report of Ofsted’s evaluation of serious case reviews identified that “even when practitioners did listen to children and others who represented the voice of the child .. (there were).. difficulties and sometimes (the) shortcomings in interpreting what was seen and heard”.

**Working with men**

10.8 In the same way that H’s name was not very obvious in the reports and the time lines of significant events submitted to the review, there is also little mention of the men in the children’s lives with the notable exception of Mother’s Boyfriend. All three children had different fathers, who also all had different ethnic backgrounds. The fathers of Sibling 1 and Sibling 2 were not part of the children’s lives. This did not prompt much professional curiosity about any vulnerabilities Mother may have had that could impact on the children’s well being. Studies of serious case reviews (Brandon et al 2008,2009) have emphasised the need to understand the role that men play in individual children’s lives and, although in this case, professional attention was quickly alert to Mother’s Boyfriend’s involvement, there was very little consideration of the role of other men, who besides the fathers also included maternal grandfather and uncle, in the children’s lives.

10.9 Cambridgeshire CSC has adopted systemic practice as the under-pinning methodological approach and social work is delivered through Social Work Units. The family were discussed at three Unit meetings where the issues to be explored further were discussed. However there is no evidence that basic systemic tools such as genograms and family history chronologies were utilised by any of the practitioners involved with the family. The use of such tools with families enable discussion to take place about relationships and events which reveal not only underlying patterns of behaviour but also where there are gaps in professional knowledge of the family and where more inquisitiveness is needed.

10.10 The fact that the children’s fathers all had black ethnicity reflects a pattern in the SCRs (and other reviews) completed by the LSCB over the past five years. A high percentage of the subjects of these reviews were children from minority ethnic backgrounds. Studies (Brandon et al 2012) have shown that there is a tendency for children of black/black British ethnicity to be over-represented in serious case reviews but the numbers in Cambridgeshire are noticeably disproportionate to both the general population and to the numbers of children identified as vulnerable (because they are Looked After or are on child protection plans). The reasons for this are not clear and warrant further investigation.
Recording and information sharing

10.11 Most of the full agency reports identified issues where recording could be improved and made recommendations to achieve this. Of particular relevance would be ensuring that agencies do not have (internal) parallel systems for recording concerns. For example the School had a child concerns diary and child protection log and the Pre-School had injury forms and child protection chronologies. This does not facilitate a comprehensive understanding of a child's situation and risks information being missed and patterns not identified. This parallel recording has developed because some recording is done by (more junior) front line staff and the other (the formal child protection record) by more senior members of staff.

10.12 This division was also reflected in this case by the CiN meeting which was attended by professionals representing their agencies who did not know the children on the intimate level some people did. To be meaningful, the people at the CiN meeting needed to have sufficient level of “hands on” knowledge and understanding of family so that an accurate picture of the situation was gained. However it is recognised that there needs to be balance between this requirement and the need for the representatives to be of sufficient seniority to be able to commit their agency to undertake certain actions. It is also acknowledged that there are potential difficulties in providing cover to free up front line staff to attend although there was no evidence that this was the reason the Nursery Nurse (the CAF initiator and someone who had longer term knowledge of the family) or the Teaching Assistant (who knew a lot about Sibling 1’s everyday life) did not attend the CiN meeting.

10.13 Staff at the Practitioner Event staff reflected on the need for professional confidence in both approaching families to ask for permission to gather information as well as in supplying it. The fact that the School did not tell Mother that they had made a referral to CSC – and confirmed at the Practitioner Event that this was their usual practice – reflects this lack of confidence. The recent judgement against Haringey Council (where the local authority was found to have acted unlawfully in its data gathering) was cited by one practitioner as a reason for not seeking permission to talk to the family’s GP. This illustrates how practitioners’ practice and confidence can be influenced by media reporting.

10.14 The dissemination of Police notifications of domestic abuse incidents was reasonably effective with the key agencies having been notified of the incidents involving Father and responding by starting formal child protection files. The exception was the GP's surgery. The surgery have taken subsequent action and set up a system whereby the Health Visiting Team notify them of “families causing concern” which is recorded on children’s and parents’ records.

11. CONCLUSIONS

11.1 This review sought to establish whether those involved with the family were aware of the risks that the children were exposed to and to identify any factors that either promoted or inhibited agencies and individuals to act to ensure the children’s safety. It concludes that there is no evidence that the death of H could have been predicted or prevented because
there was nothing in Mother’s Boyfriend’s antecedents or known behaviours that indicated that he would perpetrate the level of violence that killed H. He had a troubled childhood and adolescence but it was not exceptional. Many other young people have similar backgrounds but do not commit such violent acts. Professionals were alert to the changes in the family once he became involved with them and were in the process of acquiring a fuller understanding of his role in the family and its impact on the children’s lives when H died. There was nothing to indicate to those professionals that the usual time scales for assessment needed to be accelerated. However the process of undertaking the review has allowed a window on the system through which learning can be generated which can contribute to the continuous improvement in the safeguarding of children.

11.2 The review has attempted to avoid hindsight bias which “oversimplifies or trivialises the situation confronting the practitioner and masks the processes affecting practitioner behaviour” (Woods et al 2010). Although there were instances were practitioners could have more effective in sharing information, others where more professional curiosity was called for and examples of not considering the whole family system or intervention not being timely, the review has concluded that there was no evidence that the tragic outcome could have been anticipated. Busy child care professionals work with many families where there are concerns about the risk posed by a new partner entering the family system and it is very difficult to identify the case were the unexpected will occur. Low probability events do occur.

Good practice

11.3 There were examples of strong practice by individuals and by agencies. Of particular note was the work of the school with Sibling 1 and their understanding of her needs arising from her autism. The Nursery Nurse’s consistent involvement with the family was an organisational effort to ameliorate the effect of changes in the actual Health Visitor allocated. CSC’s system of following up “What If” conversations with a letter confirming the outcome of the discussion is good practice. The subsequent development of monitoring to confirm that actions agreed in “What If” conversations have been implemented further strengthens the system. The social worker's involvement was very timely with all expected time scales adhered to.

11.4 There was also evidence that a number of staff did show some professional curiosity when they felt intuitively that something was not right – gut feelings - although they did not always pursue the questions raised to conclusion.

Lessons learnt

11.4 Some actions, such as CSC amending their recording guidelines and the GP practice instituting multi-disciplinary team meeting to discuss families “at risk”, have already been taken by agencies as a result of the lessons learned from this case. The Practitioner Event identified other lessons learnt from undertaking the review and which assumed significance from the inter-agency feedback the event allowed, for example, how the ripple effect of agencies concentrating on individuals contributed to the “invisibility” of H. This reflects the concept that some of the “best learning from serious case reviews may come from the process of carrying out the review” (Brandon et al 2012).

11.5 The importance of all professionals considering the whole family system - and to “Think
Sibling” - in their work is a key lesson from this case. Where there are concerns for one child in a family, practitioners need to think about whether they give rise to concerns for the other children, in particular for pre-school children who have the potential to be less visible to the professional network. Recording systems can mitigate against seeing the family holistically and this can be further impacted on if there are parallel systems within a single agency.

11.6 Unless by doing so, children will be put at further risk of significant harm, agencies need to share their concerns with parents and tell them if a referral to CSC is to be made. CSC need to ensure that their system ensures confirmation with the referrer that the family are aware that the referral is being made and that they behave in a respectful way and communicate their intention to visit the family at home.

11.7 The review has identified the need to clarify when there is an apparent misunderstanding about agreed actions following “What If” conversations and in general, the need for agencies to clarify the status and agreed outcomes of conversations in the context of sharing information and concerns about children.

11.8 The use of verbal agreements and whether they serve a useful function is key learning point identified by this review. Verbal agreements are even less enforceable than written agreements and, by their very nature difficult to ensure are consistently understood by the parties and are open to misinterpretation. If they are to be used, it is important that they are proportionate to the family's identified needs; are shared with other people in the family's network; and are reviewed in a timely way and do not run the risk of unintended consequences.

12. RECOMMENDATIONS

It is recognised that actions have already been made in relation to some of the individual agency's identified learning. In addition, agency reports included a number of recommendations which this review endorses. The purpose of providing additional recommendations is to ensure that all professionals in the partner agencies of the LSCB are confident that the areas identified as of concern in this review are addressed.

**Recommendation 1**

The LSCB’s expectations regarding working in partnership with families are reinforced and that agencies are compliant with the LSCB procedures when sharing information.

**Recommendation 2**

Cafcass to consider how its work on supporting staff to distinguish between coercive and situational couple violence can include consideration of:

a) the different treatment options
b) how safe and beneficial contact can be achieved when the child's age means that indirect contact can not be meaningful.

**Recommendation 3**

LSCB ensures that partners understand the mechanisms of ‘What If’ discussions and checks compliance with the actions agreed

**Recommendation 4**

CSC consider their procedures in regard to verbal agreement and define their expectations...
regarding good practice in their use.

**Recommendation 5**
Education settings review their recording processes and ensure there are not parallel systems which impact on the effectiveness of seeing an holistic picture of the child and their family.

**Recommendation 6**
The LSCB considers how to ensure that the message “Think Sibling” is disseminated.
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