WORCESTERSHIRE SAFEGUARDING CHILDREN BOARD

This is an Independent Overview Report of the Serious Case Review Concerning the Death of Child GW

Date of serious incident: 7 December 2012

This report has been commissioned and prepared on behalf of the Worcestershire Safeguarding Children Board .

Until publication this report is confidential and must not be shared with non relevant parties. References relating to the subject child, family members, organisations professionals and places have been coded and anonymised.

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1 Introduction

1.1 The ambulance service received an emergency phone call from GW's mother in the early afternoon of 7 December 2012. At this time GW was aged three months. The mother described GW as having trouble breathing and described that the child had been ill all morning and had then collapsed.

1.2 On arrival at the family home the mother was found to be carrying out basic life support care, and the attending ambulance crew carried out resuscitation while transporting GW to hospital. Following attempts to revive GW the child was transferred from the accident and emergency department to the children's hospital. Medical examinations revealed head injuries, bleeding in the eyes and some rib and leg fractures, some of which were historic.

1.3 GW's parents were arrested by West Mercia Police on suspicion of grievous bodily harm against GW and subsequently released on bail. GW died on 12 December 2012, and West Mercia Police launched a murder investigation.

1.4 At the time of the child's death, GW was the subject of a Child in Need (CiN) Plan and GW's family had extensive involvement with local agencies.

2 Decision to Undertake a Serious Case Review

2.1 The death of Child GW was notified to Ofsted on 13 December 2012 and the case considered at Worcestershire Safeguarding Children Board's Serious Case Review Sub Group on 21 December 2012.

2.2 The sub group considered the criteria for holding a Serious Case Review (SCR) contained in *Working Together to Safeguard Children. 2010 (Chapter 8)* being the relevant guidance in force at the time of GW's death. Paragraph 8.9 states that: "When a child dies (including death by suspected suicide) **and** abuse or neglect is known or suspected to be a factor in the death, the LSCB should **always** conduct a SCR into the involvement of organisations and professionals in the lives of the child and family. This is irrespective of whether local authority children's social care is, or has been, involved with the child or family. These SCRs should include situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse."

2.3 The Serious Case Review Sub Group considered that the relevant criterion was met for holding a Serious Case Review in order to ascertain if there were lessons to be learnt. This recommendation was made to the Independent Chair of Worcestershire Safeguarding Children Board who agreed that a SCR should be initiated. This decision was notified to Ofsted on 11 January 2013.

3 Membership of the review panel and conduct of the review

3.1 In accordance with guidance contained in *Working Together 2010* a Serious Case Review Panel was established drawn from the relevant agencies involved in the family.

3.2 The aim of the review panel was to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
- Identify clearly what these lessons are, how they will be acted upon, and what is expected as a result.
- Improve inter-agency working, better safeguarding and promoting the welfare of children.

3.3 An independent chair and independent author were appointed to conduct the review.

3.4 The independent chair was Mark Dalton. Mr Dalton is an Independent Social Work Consultant of over thirty years experience in children's services. Mr Dalton was formerly the Area Manager of the NSPCC in an area of the West Midlands and is currently the Independent Chair of the Coventry Safeguarding Children Board Serious Case Review Sub Committee.

3.5 The independent author was Mike Harrison. Mr Harrison is an Independent Safeguarding Consultant with over thirty five years experience in Children's Services having formerly been a senior manager. He is an experienced author and is a former Inspector of Children's Services and HMI with Ofsted, and has been responsible for the evaluation of a large number of serious case reviews while in that role.

3.6 Both the chair and author are independent of the agencies involved in the SCR and had no prior involvement in the case under review.

3.7 The Serious Case Review Panel comprised the following:

- Mark Dalton, Independent Chair
- Integrated Safeguarding Team Manager Worcestershire Health & Care NHS Trust
- Detective Inspector, Public Protection, West Mercia Police
- Named GP for Safeguarding
- Matron (Midwifery) Worcestershire Acute Trust
- Designated Nurse for Safeguarding, Clinical Commissioning Group
- Change Manager Children with Disabilities Transformation (Interim), Children Services

The independent author, Mike Harrison, attended all meetings of the panel but was not a panel member.

3.8 With respect to general safeguarding issues, consideration was given to whether it would be appropriate to appoint an independent expert to provide

specialist advice to the Serious Case Review Panel. However, a decision was made that such an appointment was not required as there was sufficient expertise provided by the chair, the independent author and the panel members to cover the issues likely to be raised in this Serious Case Review.

3.9 However, given that aspects of the case concerned issues regarding the medical examination of GW, and the determination of non accidental injury, the panel sought advice from a the Named Doctor (a practicing consultant paediatrician in the Acute Trust) who attended the panel on two occasions to provide an expert medical opinion.

4 Scope and Terms of Reference

4.1 It was agreed by the Serious Case Review Panel that the scope of the review would cover the approximate date of GW's parents commencing their relationship up until the death of GW. This covered the period between 1 October 2011 and 12 December 2012. It was recognized that some of the agencies involved may have had involvement prior to these dates and it was agreed that a summary reference would be made to that involvement if it was relevant to the serious case review.

4.2 The following Terms of Reference were agreed by the Serious Case Review Panel for this SCR:

Issues to be addressed by all agencies (As outlined in Working Together 2010):

- Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?

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

- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of 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 children 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?

- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?

- Where relevant, were child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?

- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?

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

- Was the work in this case consistent with each organisation's and Worcestershire Safeguarding Children Board's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?

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

- Was there sufficient management accountability for decision making?

- Was specific risk assessment in relation to substance misuse undertaken?

Additional issues for all agencies specific to this SCR:

- At what stage were the parents identified as a vulnerable couple who would need support in preparing and caring for their baby? Was a CAF undertaken?

- What was the quality of the assessments that were made of the parents' capacity to safely care for GW and meet her needs? In particular, what risks were identified and what consideration was given to the following:

    - The mother's family background and the impact of this on her as an adult/parent.

    - The father's family background and the impact of this on him as an adult/parent.

    - The father's learning difficulties and the impact of this on him as an adult/parent.

- Was there any assessment of mother's learning abilities/literacy level?
- The parents' backgrounds and the impact of this on their relationship.
- What was the role of members of the extended family in supporting the parents and caring for GW?

- What consideration was given to the involvement of specialist services to support young and vulnerable parents both pre and post birth?
- How robust was the Child In Need Plan and was this regularly reviewed by the agencies?
- What do we learn from this case?
- Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of children?
- Is there good practice to highlight, as well as ways in which practice can be improved?
- Are there implications for ways of working; training (single and inter-agency); management and supervision; working in partnership with other organisations; resources?
- Are there implications for current policy and practice?

5 Methodology for the Serious Case Review

5.1 In order to provide information to address the terms of reference Individual Management Reviews (IMR) were commissioned from the following agencies that had had involvement with the family:

- West Mercia Police
- Worcestershire Health and Care Trust (Health Visiting and Adult Mental Health Services)
- Worcestershire NHS (GP Involvement)
- Worcestershire Acute Hospitals Trust (Including Midwifery and Neonatal Services)
- West Midlands Ambulance Service
- Worcestershire Children's Services, Safeguarding and Services to Children(Social Work/Family Support)
- Redditch Borough Council (Housing Provider)

5.2 In addition' Worcestershire NHS was asked to provide a Health Overview Report in order to amalgamate the contributions from the individual health agencies from the commissioning perspective.

5.3 The individual management review (IMR) authors were briefed by the chair and the author of the serious care review at a panel meeting on 19 March 2013. The terms of reference and scope of the review were provided to the IMR authors together with a standardised format for the production of the IMR reports. The IMR authors were asked to compile a chronology of their individual agency's involvement with the child or family using both electronic and paper records held by each agency and to comprehensively review that involvement. In doing so the IMR authors conducted personal interviews with the key individuals who had involvement with GW or GW's family.

5.4 The IMR authors were asked to look openly and critically at what happened in the case, to evaluate what actions were taken or not taken and why, to indicate any lessons to be learned for future practice and to make recommendations for action. In completing the individual management review the authors were asked to take cognisance of the relevant guidance on such matters as contained in *Working Together to Safeguard Children* (2010) Paragraph 8.39.

5.5 The IMRs were completed at different stages and were presented to the Serious Case Review Panel at their meetings on 23 April 2013 and 10 May 2013. Panel members and the independent author had the opportunity to debate the issues raised in the IMRs, and to ask further questions resulting in some additions and amendments being made to the final IMRs. All of the final IMRs were certified by senior managers in the agency which produced them as being an accurate reflection of that agency's involvement.

5.6 The overview report author compiled the overview report using the information and evidence gained from the IMRs, Health Overview Report, Serious Case Review Panel discussions and the integrated chronology. The serious case review overview report was presented to the Serious Case Review Panel on 24 June 2013. Following discussions, amendments were made to the overview report which was presented to the Worcestershire Safeguarding Children Board on 29th July 2013.

6 Family Involvement in the Review

6.1 The Serious Case Review Panel discussed the involvement of the family in this review and agreed its preference that family members be fully involved in the review process where appropriate. However, given ongoing police investigations, the police, on advice from the Crown Prosecution Service, advised the panel that such involvement would be potentially prejudicial to future prosecutions. Following discussions, the panel agreed to limit the contact with the family to notifying them of the decision to conduct a serious case review. Further advice will be taken from the police and Crown Prosecution Service by the Serious Case Review Panel in respect of the timing and content of information to be given to the family on the outcome of the review.

7 Parallel Investigations

7.1 As outlined above the West Mercia Police are currently undertaking an investigation into the death of GW. At the time of preparation of this overview report the investigation has yet to be completed. [1]

7.2 Two post mortem examinations were performed on GW and the case is currently subject to a coronial enquiry which is incomplete at the time of preparation of this overview report.

8 Profile of GW

8.1 GW was born to the mother, GW1 and father, GW2. GW was a premature baby having been delivered by Caesarean section at 34 weeks due to placental difficulties. GW was of white British origin.

8.2 GW was three months old at the time of death and was born six weeks prematurely, taking a few weeks to reach a developmental stage normally associated with a full term newborn child. At birth GW was underweight, required some assistance with breathing and was admitted to the Special Care Baby Unit (SCBU). GW2 was present at the birth.

8.3 GW remained on the SCBU for three weeks receiving routine care and monitoring at which time the baby was discharged home to be cared for by the parents with the support of the neo natal outreach nursing team.

Wishes and feelings of GW

8.4 Given that GW was such a young age and the child's life was so short it was not possible to ascertain GW's wishes and feelings. Documented evidence contained in the integrated chronology points to services having been sensitive to the wishes and feelings of the parents, particularly from a cultural and religious perspective. GW was a white British child born of white British parents and therefore language issues appear not to have been problematic in the case. Both parents are thought literate although of limited ability. The evidence suggests that advice on parenting issues was given to the parents both verbally and in writing at appropriate times.

8.5 Family Composition at the time of GW's Death

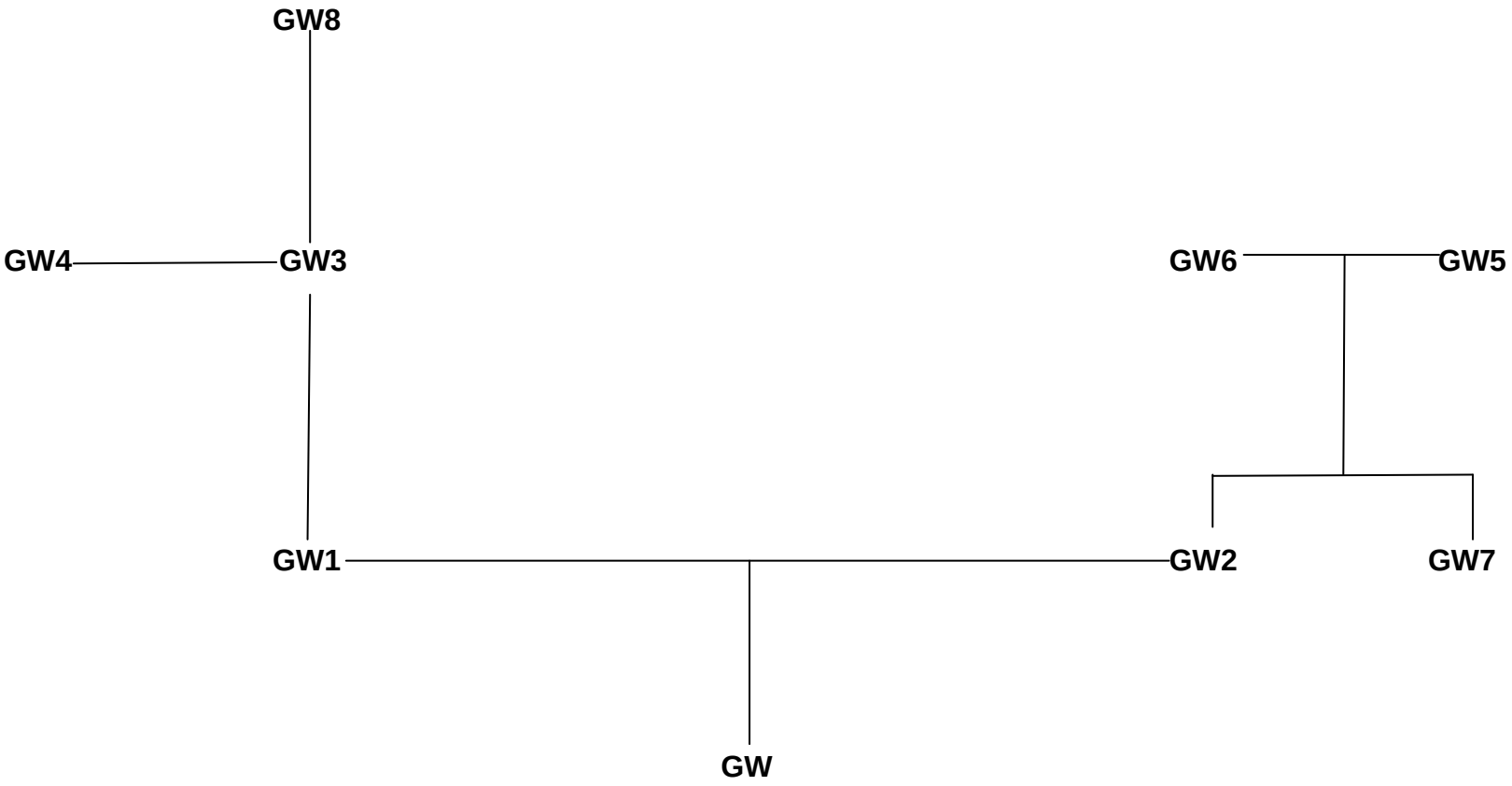
GW Subject of the review 3 Months old

GW1 Mother of GW 18 years old

GW2 Father of GW 19 years old

[1] At the point of publication Criminal Proceedings have concluded

Genogram



9 Background and Summary of Significant Events Prior to the Period Considered by this Review

9.1 The family of GW's mother (GW1) and GW's father (GW2) had been known to local services for a number of years prior to starting their relationship and then the subsequent birth of GW.

9.2 GW1 is part of a large family of which she is the eldest. For a number of years she was seen as the primary carer within the family because of difficulties suffered by her own mother (GW3) and GW1's step father (GW4). These difficulties included ongoing issues of domestic abuse some of which were witnessed by GW1. As a result of a number of recorded violent incidents, GW1 and her siblings were placed on the child protection register in 2006 but subsequently removed three months later in January 2007.

9.3 Contact between Children's Services and GW1's family continued over a lengthy period of time punctuated by case closures, followed by incidents of domestic abuse prompting a reopening of the case. A number of domestic abuse incidents between GW3 and GW4 involving alcohol in January, May and June 2011 again prompted the case to be reopened regarding concerns about conditions in the home and the family's chaotic lifestyle. The case has remained open to Children's Services from this time to the present.

9.4 GW2 comes from a family that had previously been known to Children's Services due to extensive offending, domestic disputes, anti social behaviour and problems caring for GW2 and his sibling. GW2's mother (GW5) and father (GW6) have a record of assaults outside the family. GW2 was also involved in some acts of violence or threats to people outside the family.

9.5 At the age of ten years GW2 was diagnosed as suffering from Attention Deficit Hyperactivity Disorder (ADHD) and Tourettes Syndrome. GW2 was supported by the Child and Adolescent Mental Health Services (CAMHS) for a number of years and prescribed appropriate medication to assist with his conditions, a facet of which were motor and vocal tics, and anger management difficulties.

9.6 CAMHS referred GW2 to Adult Mental Health Services in April 2011 for an assessment of his conditions and to ascertain if they would be able to provide ongoing treatment. Two appointments were offered to GW2 by the Adult Mental Health Service which he failed to attend. Therefore his General Practitioner (GP) was written to saying that they could add nothing further to his care.

9.7 GW1 and GW2 appear to have commenced their relationship in late August 2011. Around this time GW1 was absenting herself from her family home due to arguments with GW3 and GW4 and staying with a variety of friends. At this time GW1 was 17 years of age. It was during this period that GW1 and GW2 were together staying at a friend's house. Children's Services were aware of GW1s situation but closed the case in the belief she was able to meet her own needs

9.8 GW2 was re-referred to the Adult Mental Health Services by another GP in September 2011 requesting psychiatric support for GW2 in relation to anger management. The Adult Psychology Service invited GW2 to complete an "opt in" questionnaire. This invitation was followed by a further two letters neither of which GW2 responded to nor did he fill in the questionnaire.

10 Summary of Events and Agency Involvement between 1st October 2011 and 12th December 2012 being the Timescale Covered by the Scope of the Review

10.1 Records of GW1's whereabouts during the last few months of 2011 and early in 2012 are unclear. GW1 appears to have left the home of GW3 and GW4 following arguments, and Children's Services had taken the decision that GW, having moved out of the family home, was able to meet her own needs based on her age and ability to care for herself. Children's Services believed this was demonstrated by her previous care of her siblings. GW1 was 17 years of age at this time.

10.2 This decision occurred around the same time that GW1's siblings were made the subject of child protection plans. Children's Services had no further contact with either GW1 or GW2 until a referral was made in June 2012 by a social worker involved with GW1's family who was concerned that GW1 was pregnant, vulnerable and could be at risk from her own family members.

10.3 GW2 was residing with his mother GW5 and father GW6 in late 2011 and early 2012. GW2's relationship with his father appears to have been occasionally violent, with GW2 being assaulted by GW6 in December 2011. GW2 was punched in the face by GW6 causing him a lacerated lip. The police recorded the incident as a crime at the time it occurred but as GW2 declined to pursue a complaint, no further action was taken. GW2 is thought to have assaulted his mother around this time but it is unknown if this was the cause of the violence perpetrated by GW6.

10.4 The first contact GW1 had with services in respect of her pregnancy with GW was with a GP in Practice A in early March 2012. GW1 was accompanied by GW2 and his mother (GW5). The GP made a referral to midwifery services. The pregnancy was booked and again GW1 was accompanied by GW2 and his mother. The midwife enquired if a social worker was involved but both parents confirmed there was no involvement. It was not possible for the midwife to see GW1 alone so the midwife was unable to ask the standard required question regarding whether GW1 had any concerns of domestic violence in her relationship.

10.5 During this period of time and up to the birth of GW it would appear that GW1 and GW2 were living with GW2's parents at their home.

10.6 In March 2012 GW2 was seen in the psychiatry clinic The GP records contained a note of this and highlight that he had missed a few previous appointments, was not taking his medication and was having frequent violent

outbursts. At this stage GW2 was attending GP Practice A, the same practice as GW1 was seen for her pregnancy, although GW1 was actually registered at another practice (Practice B) at this time.

10.7 Identifying which GP saw GW1 and GW2 over time has been difficult to discover and complicated to understand. A situation seems to have arisen where both GW1 and GW2 were visiting both GP Practice A and GP Practice B. It appears likely that the couple attended one or other of the GP practices using "temporary residency" arrangements between the two practices. This situation was linked to a number of house moves over the timescale of the review.

10.8 GW1 did not experience an easy pregnancy with GW and suffered abdominal pain, migraine and infection from an early stage.

10.9 Approximately four months into the pregnancy, in early May 2012, GW2 took a deliberate overdose of his Concerta medication together with alcohol which resulted in a psychiatric review. GW2 said the overdose was in response to an argument with GW1 and not a serious attempt at suicide. As part of the psychiatric review GW2 was advised to continue contact with Mental Health Services, avoid alcohol and seek help with anger management difficulties.

10.10 An incident was attended by the police in May 2012 where, following an altercation with one of GW1's siblings, an 11 year old, who had threatened her with a knife, GW2 assaulted the child causing a minor injury. A crime report was not completed by the police in respect of the incident which was downplayed by GW3 at whose house it had occurred. This incident was notified to the police by Children's Services who visited the sibling. GW3 was uncooperative with Children's Services and no further action was taken.

10.11 GW2 was referred to Adult Psychology Services by the consultant psychiatrist to address his anger management issues connected to his frustration in respect of Tourettes symptoms. A letter was sent in early July 2012 which he did not respond to. However, a further follow up letter was sent which he did respond to and he did fill in the "opt in" questionnaire. However he did not then subsequently attend the clinic appointment made for him in October 2012.

10.12 In June 2012 GW1 attended the GP at Practice A suffering with stress, anxiety and low mood related to a variety of issues. GW1 was requesting counselling as she had concerns in respect of her own mother's problems but mentioned that GW2's Tourettes condition was 'irritating'.

10.13 The first referral of GW1 and GW2 to Children's Services occurred in June 2012 when a social worker (SW1) who was working with GW1's mother and family became aware of GW1's pregnancy. Awareness of the family's background, the siblings of GW1 being the subject of child protection plans at the time, together with the possibility of risk presented to GW1 by her siblings, one of whom had punched her in the stomach, were factors which prompted the social worker to make the referral. GW1's mother had also referred to

GW2 as “controlling”, and that he had threatened GW1. An allegation was also made that GW2 had tried to strangle one of GW1’s siblings and had chased two other siblings ‘out of the house with a hammer’.

10.14 SW2 was allocated to the case and asked to complete an initial assessment. This was completed in one visit on 5 July 2012 at the home of GW2’s parents where the couple were living.

10.15 GW2’s parents were assessed as supportive and the home was assessed as suitable for a new born child to live in. GW2’s parents said that the couple could remain in their home for as long as they wished. As part of these enquires SW2 contacted the specialist midwife (SM) knowing that if particular concerns or strengths were known about the family, among midwives, the specialist midwife would be a source of information. SW2 explained in an email that a referral had been made to Children’s Services and that an initial assessment was being carried out. SW2 did not state the nature of the concerns which had led to the referral. The specialist midwife checked with the midwifery team and obtained maternity records, noting that GW1 was the daughter of GW3 who was also pregnant at the time, and about whom a police log had been filed, although they did not live at the same address.

10.16 As no concerns were noted in respect of GW1 or GW2 the specialist midwife replied to the social worker in this vein a few days after their initial contact. SW2 informed SM that the initial assessment was complete and the case would likely be closed. SW2 said that a copy of the assessment would be forwarded to SM although this was never received.

10.17 At this time the specialist midwife considered setting up an ‘alert’ on the information system which would alert other health care professionals to concerns. However, SM was reassured by the social worker saying the case would be closed; therefore the SM did not post an alert.

10.18 SW2 recommended in the initial assessment that there was no role for Children’s Services and the case should be closed. The assessment went to the Team Manager (TM1) who did not accept the conclusion of the assessment. TM1 had been the social worker for GW2 and his sibling in the past and therefore had insight into the prior offending behaviour in the family and its effect on the children. SW2 had been unaware of this further information on the family which was contained in a paper file separate from, and in addition to the information available on the electronic system. This information therefore challenged the conclusion as to how much of a protective factor GW2’s parents would be.

10.19 On the direction of TM1 SW2 began a core assessment which was to include a formal request from West Mercia Police on the offending history of GW5 and GW6 (GW2’s parents). The core assessment was to be a pre-birth assessment. The team manager (TM1) appears to have instructed that the initial assessment be updated to take account of the new information, a referral for family support made, and a formal Child in Need Plan be drawn up. The Children’s Service’s IMR notes that at a meeting with GW1 and GW2

on 6 August 2012 a Child in Need Plan was agreed. There are no records to show the content of the plan or who was to be involved.

10.20 SW2 did not notify the specialist midwife (SM) of the new information who, based on the previous information from SW2 that the case was to be closed thought that it had been closed and therefore there were no concerns.

10.21 SW2 began a core assessment in August 2012 and the Children's Service's IMR notes that a total of five visits were to be made to the family between August and GW's birth in September, most of which were to be pre-planned with one being unannounced. The integrated chronology show some of the visits as abortive due to the family being out and in total three assessment visits were completed, resulting in the assessment being undertaken in the three visits. The assessment was intended to be a pre-birth assessment due for completion in thirty five working days but was not completed until November 2012 (and as GW was born in September it was completed post birth) a total of 65 working days.

10.22 GW5 and GW6 were initially resistant to the assessment as they realised that this would necessitate background police checks on themselves but they did co-operate with the process. Records show that the family were concerned that GW would be removed at birth but SW2 gave an assurance that was not being considered.

10.23 SW2 assessed the relationship between GW1 and GW2, how they were managing disagreements, the preparation for GW's birth and the subsequent care of GW.

10.24 The social worker, SW2, had contact with other professionals involved with GW1 and GW2 although the integrated chronology is unclear about the exact time and nature of some of the contact. SW2 did not contact the GP(s) of either GW1 or GW2 to obtain information when compiling the core assessment nor did SW2 re-contact the specialist midwife or midwife.SW2 did not know that Adult Mental Health Services were involved so did not contact them. No contact was made with the health visitor pre birth.

10.25 GW was born in the middle of September 2012 by caesarean section at 34 weeks gestation due to problems with growth. GW was admitted to the special care baby unit.

10.26 SW2 advised staff on the maternity ward of the ongoing social work involvement due to a core assessment because of a family history of domestic violence and anti social behaviour. This was notified to the specialist midwife by a ward midwife, who up until that time had thought the case to be closed in accordance with the previous social worker contact. There is no record that this information was passed to staff on the special care baby unit, by either the maternity ward staff or the specialist midwife. It is assumed these staff knew of SW2's involvement as they provided feedback to SW2 on GW's progress.

10.27 GW remained in hospital for three weeks following the birth and SW2 contacted the hospital and received regular information from the special care baby unit staff on GW's progress. SW2 did not visit GW in hospital or visit the child's parents GW1 and GW2, in hospital, or at home over a five week period believing they needed time to recover. SW2 received regular updates from staff on the special care baby unit regarding GW's progress.

10.28 The special care baby unit staff noted that GW1 was loving and affectionate with GW, as was GW2, and helped with the care of GW. One minor argument was witnessed between the couple while on the ward which ward staff believed to have been caused by the parent's anxiety regarding GW's discharge home.

10.29 GW was discharged from hospital to the care of the parents on 5 October 2012 who were still living at the home of GW2's parents, GW5 and GW6. The Acute Hospital Trust IMR notes that SW2 was unaware of the discharge and was not involved. The actual date of discharge is confirmed in the integrated chronology (cited from hospital records) as 5 October although this is at variance with the date for discharge cited in the Children's Services IMR which was four days later on 9 October 2012

10.30 The Neonatal nursing outreach service provided care to GW at home initially until it was judged the child was medically fit for discharge to the care of the health visitor and GP. There is no record that information concerning a social worker being involved with the family was passed from the staff on the special care baby unit to the neo-natal outreach nurses. It was later confirmed that they were unaware of Children's Services involvement.

10.31 Contact was made between the neo-natal nurses and the health visitor, and co-ordinated visiting was arranged over the first few days that GW returned home. At each of the first four home visits the neo-natal nurses undressed, assessed and weighed GW finding everything satisfactory.

10.32 SW2 visited the family for the first time after GWs birth on 22 October 2012. The previous evening GW had been taken to the accident and emergency department by the parents as the child was crying and in pain. Accident and emergency staff administered gaviscon for reflux and expressed no concerns about the baby. According to Children's Service's in the integrated chronology, SW2 was informed of the hospital visit by the accident and emergency department on 22 October 2012 although the Children's Services IMR notes that there is no record of a discussion with the parents about it. SW2 noted that the parents of GW gave a lot of emotional warmth to their child and that GW2's parents (GW5 and 6) said the couple could stay with them as long as was necessary and appeared very supportive.

10.33 Post GW's birth, the Children's Services IMR notes that SW2 had a considerable amount of contact with other professionals involved with the family including health visitors and housing. All of these professionals were said to share SW2's view that GW1 and GW2 presented as a doting couple, open and willing to listen to advice and, despite their own childhood

experiences, were able to meet GW's needs. However, for whatever reason some of the health care professionals involved with GW post birth remained unaware of SW2's involvement, notably the neo-natal outreach nurses.

10.34 In respect of GW5 and GW6, SW2 discussed their extensive offending history highlighted in the checks, and accepted the reassurances the couple gave that their past life was behind them.

10.35 On 23 October 2012, the day following SW2's visit to the family the couple were asked to leave the home of GW5 and GW6 following what is documented as a family argument caused by overcrowding. Following these events the couple took GW to stay with GW8 who is GW1's grandmother. GW5 and GW6 did give a commitment to provide general support other than housing. At this time SW2 was not notified by the couple that they had moved and was unaware of the move.

10.36 Also on 23 October 2012 the couple applied to housing services for assistance with housing.

10.37 The health visitor, who had only become aware of SW2's involvement in mid October 2012, informed SW2 that the couple had moved from GW5 and GW6's home.

10.38 On 2 November 2012 the couple were informed by housing services that they were eligible for help due to their vulnerability, albeit that they were deemed as being intentionally homeless having originally left a private rented property prior to moving in with GW5 and GW6. Housing Services nominated the couple for a supported housing project. This action was intended to assist with a planned move to accommodation and did not cover emergency accommodation which GW1 was deemed not entitled to by nature of having previously made herself intentionally homeless.

10.39 GW suffered some difficulties over the following days; at this point the couple had moved to live with GW8, GW1s grandmother. GW was taken by her mother to the GP constantly crying, having a cough and taking less feed. On 4 November 2012 GW was admitted to hospital with bronchiltis and remained in hospital for four days.

10.40 SW2 completed the core assessment on 5 November 2012 and recommended that a multi agency meeting be held to review the core assessment. SW2 was unsure of the role for Children's Services and wanted to explore whether support could be offered by means of the Common Assessment Framework (CAF). SW2's team manager TM1 accepted this recommendation and a meeting was arranged for 13 November 2012.

10.41 GW1 stated that on GW's discharge from hospital the family would be homeless as it was unsuitable to return to GW8's home as she smoked and drank heavily. SW2 was away on training so the case was covered by a duty social worker (SW3). SW3 spoke with GW5, and GW1 and GW2 were advised to contact Housing Services. SW3 advised GW5 that if the couple

were homeless they might need to go to a refuge. The Team Manager (TM2) overheard the conversation and was concerned that the impression was being given that GW might be taken into care. In a subsequent phone call with another social worker (SW4) GW1 was reassured that this was not Children's Services intention.

10.42 Following attempts by SW3 and SW4 to find emergency accommodation for the family it was agreed a return in the short term to the home of GW8 was the only option available. This was recognised as less than ideal given the great grandmothers smoking and drinking issues and that GW3 was temporarily staying with GW8 and her children (GW1's siblings) had only recently been taken into care. GW was discharged to GW8's address on 6 November 2012 with GW1 and GW2.

10.43 On 7 November 2012 interim bed and breakfast accommodation was found for GW, GW1 and GW2 with a transfer to self contained temporary accommodation being made on 8 November 2012. Assistance by Housing Services was provided to the couple to move into and manage the tenancy.

10.44 Throughout the accommodation moves highlighted above, the integrated chronology shows that GW was tracked by the outreach neo-natal nursing team who were making regular visits to the family and the health visitor was in regular contact by telephone giving feeding advice. The health visitor appears not to have told the neo natal outreach team of SW2's involvement.

10.45 A Child in Need Meeting had previously been arranged for 13 November 2012. At this stage the integrated chronology indicates that a child in need plan had not yet been formulated although SW2's team manager (TM1) had noted on the file on 5 November 2012 that such a plan needed to be put in place.

10.46 GW1 and GW2 were reporting difficulties with their temporary accommodation at this time concerning mould in the property. GW1 was concerned about GW's respiratory problems, and the property was inspected by housing staff and advice was given on preventing the mould. Alternative accommodation was offered to the couple but they declined the offer.

10.47 At lunchtime on 13 November 2012, the day planned for the Child in Need Meeting, one of the neo-natal nurses visiting GW in the temporary accommodation was informed by GW1 and GW2 of a mark or bruise on the child's face. They explained that they had noticed it the day before when lifting GW from the cot, and the couple questioned if it could have been caused by the child laying on a dummy or the charm attached to the dummy. The neo-natal nurse examined GW prior to weighing and could see no other injuries. The neo-natal nurse telephoned the health visitor to report the bruise.

10.48 The neo-natal nurse contacted the special care baby unit to ascertain if any underlying condition had been noted when GW was in hospital. Matron 1 and the named doctor for safeguarding were then involved who advised that a child protection medical examination should be called and GW should be

taken to the clinic at 3.30pm that afternoon. The integrated chronology shows no contact was made with SW2, or children's services, until 2.40 pm following the arrangements for the medical having been made.

10.49 GW1 was contacted at around 2.35 pm by the neo-natal nurse with a request to attend the medical but she refused explaining that she and GW2 were due to attend a meeting at 3.30pm (CiN meeting) at which she hoped housing issues would be resolved. It was following this interaction with GW1 that the neo-natal nurses realised that a social worker was involved with the family and contact was made by them with Children's Services.

10.50 As a result of the request by GW1 another appointment was offered for the medical the following day, although meanwhile TM1 had become aware of the situation and was clear that a medical examination should take place that afternoon. SCR Panel discussions indicate that SW2 arrived for the CiN Meeting and was then redirected by TM1 to accompany GW and parents for the medical examination. It was noted by SW2 that the parents chief concern was the cancellation of the CiN meeting which they had hoped would resolve their housing issues.

10.51 The integrated chronology indicates a strategy discussion (probably by telephone although this is unclear) took place prior to the medical examination between children's services and the police)

10.52 SW2 took GW, GW1 and GW2 to the hospital where GW was examined by a consultant paediatrician (CP2). SW2 had examined the bruise before going to the hospital but could see nothing, although on arrival at hospital under direct light did see the bruise. SW2 explained the family background to the paediatrician, and the reason for Children's Services involvement but explained there was no concern as to the parenting of GW by either GW1 or GW2.

10.53 GW was fully physically examined by CP2, who saw the mark on the cheek. The examination included undressing the child and a blood test to rule out certain conditions concerned with bruising. Due to GW being an active baby CP2 was unable to check for haemorrhages at the back of the eyes (a fundal check) which can indicate brain injury due to shaking and while no other injuries were noted CP2 did not carry out a full skeletal examination using x rays.

10.54 CP2 noted that no historical explanation could be given by the parents for the mark and the fact that the baby was two months old and not yet mobile discounted certain types of injuries associated with active or mobile toddlers. CP2 was asked to consider the mark being caused by the child lying on a dummy or charm attached to the dummy but CP2 felt this to be unlikely. CP2 believed that non accidental injury could neither be substantiated, nor ruled out. CP2s conclusion, which was recorded in a letter sent to children's services the following day, stated that "the possibility of the non-accidental nature of this bruise cannot be ruled out".

10.55 TM1 reconvened the earlier strategy discussion with the police and the outcome of the medical examination was discussed. A risk analysis was undertaken by TM1 but on balance it was decided to allow GW to return home with the parents. Records from the strategy discussion note that the concerns were not substantiated although TM1 directed an "immediate safety plan" including the edge of care team to visit 2/3 times weekly including weekends, the social worker to maintain weekly visiting including unannounced visits, the Child in Need Meeting to be reconvened and reviewed on a monthly basis and the core assessment to be updated to reflect the investigation and to evaluate the support package.

10.56 TM1 and SW2 met on 14 November 2012 to discuss the previous day's event in supervision. Both agreed that no grounds for the removal of GW existed but that the level of support and monitoring should increase to further assess whether GW was at risk. Records do not show consideration of a child protection conference at this time. SW2 visited GW on 14 November 2012 and noted the child was seen 'alive, safe and well".

10.57 GP Practice B received a phone call from the consultant paediatrician (CP2) to inform the practice of the examination made on GW. GW was registered with GP practice B at this time. GP4 receiving the information sent out a general non urgent, non flagged email to the other GPs with the note "SEE CONSULT PLEASE". There is no evidence to indicate which GPs read this email or any other related information.

10.58 SW2 visited the family with a family support worker (FS4) on 16 November 2012 and arranged a twice weekly visiting schedule including Sundays. For the second occasion SW2 recording stated that he had seen GW 'safe, well and alive".

10.59 A Child in Need Meeting took place on 20 November 2012 and was attended by GW1, GW2, GW5 and the Health Visitor (HV1). The integrated chronology shows that there was no representation from housing although housing was a major issue for the family at this time. Records do indicate that no invitation was made to housing to come to the Child in Need Meeting and this is detailed in the Housing IMR. It is unclear from records who chaired the meeting but it is likely that it was SW2. Recent events in the case were reviewed but it was concluded that GW1 and GW2's care of GW was good. GW was thought to be developing well and no further significant concerns had been raised since the investigation of the mark/bruise the previous week.

10.60 The Child in Need Meeting participants noted the numerous changes of home address the couple had recently experienced and the difficulties caused by their being deemed intentionally homelessness for leaving a property prior to GWs birth.

10.61 An increased package of support was accepted by GW1 and GW2 at the meeting. The Children's Services IMR notes that the family support worker in the case (FS1) was very experienced and fully concurred with SW2 and other professionals involved, that GW was well cared for by caring concerned

parents who were providing a clean, warm and suitable home for the child. The couple were reported as being very open about their relationship including some tensions due to tiredness.

10.62 The first visit by the edge of care worker took place on 21 November 2012 at which time GW1 and GW2 talked about the strains in their relationship as GW2 felt GW1 was undermining him.

10.63 On 23 November 2012 GW was not brought to GP 5 at the surgery of Practice B for an eight week assessment. The integrated chronology shows no evidence that failure to attend this appointment prompted any action from the GP. At this time GP Practice A did not realise that GP Practice B were involved and vice versa. On this date it had been eight days since the alert had been received by Practice B from the consultant paediatrician regarding GWs visit to the hospital with the facial mark and GP4 had notified the other GPs in the practice.

10.64 The housing situation became more difficult for GW1 and GW2 when they received notice that they would have to leave their property by Christmas, due to the property being damp, which they had complained about. However they had been offered alternative accommodation but had refused it. The couple confided their concerns to the family support worker and records show liaison with the housing service who notified the couple of the right of appeal against a move.

10.65 SW2 rang housing on 23 November and was informed that the couple would be served notice on 30 November from when they would have 28 days to find alternative accommodation, although in subsequent days it becomes clear there is a right of appeal to this decision. The integrated chronology shows frequent negotiation between Children's Services, family support staff, and housing officials attempting to resolve the situation. Housing officers did again offer the couple alternative accommodation but they refused the offer. The reason given by GW1 and GW2 was that there was conflict between those living in the suggested area and GW1's father.

10.66 SW2's last successful visit to GW when GW was seen took place on 30 November 2012 and no concerns were noted. SW2 did make an unannounced visit on 5 December 2012 but could find no one in.

10.67 GW was seen as an outpatient by paediatrician (P2) on 4 December 2012 where GW was undressed, weighed and found fit and well. GW1 explained GW was suffering with vomiting but this was diagnosed as overfeeding and advice was given. A letter containing this information was sent to both the GP and Children's Services.

10.68 The family support worker (FS2) last visited the family on 6 December 2012 as part of the 'edge of care' arrangements. Coincidently the health visitor (HV3) was also present. This was the day before GW's admission to hospital prior to the child's death. Both GW1 and GW2 were at home with GW. The couple's housing situation was discussed and they confirmed they were

considering privately rented properties. Relationship issues between the couple were discussed as there were rumours that GW3 (GW1's mother) had been staying over at the couple's property. The integrated chronology confirms that GW2 gave the worker assurances that GW3 would not be allowed to be alone with GW.

10.69 The health visitor (HV3) weighed and measured GW, noting the child to be happy and smiling and having put on six pounds in weight since birth. The health visitor undertook a standard form of post natal depression questionnaire with GW1 during the visit. GW said that issues in respect of housing were 'getting her down' as they were about to be evicted but said she did not feel depressed. GW1 said she would feel much better when the housing issues were resolved.

10.70 Neither the health visitor nor the family support worker noted any concerns in the records following these visits. Records noted that the home was very clean and tidy.

10.71 On 7 December 2012 the ambulance service received an emergency phone call from GW's mother in the early afternoon. At this time GW was aged three months. GW1 described GW as having trouble breathing and described that the child had been ill all morning and had then collapsed. On arrival at the family home GW1 was found to be carrying out basic life support care and the attending ambulance crew carried out resuscitation while transporting GW to hospital. The ambulance crew reported what appeared to be bruising to the inside of GW's arms.

10.72 A 'grandmother' was said to be accompanying GW. This was thought to be GW3 although none of the individual management reviews are able to identify which grandmother.

10.73 The paediatrician attending GW phoned Children's Services reporting GW's admission in a critical condition and enquiring if there was Children's Services involvement. SW received the phone call from the paediatrician and as TM1 was on leave another team manager (TM2) also spoke with the paediatrician.

10.74 When it was realized that GW3 may be present TM2 raised concerns with both the ambulance service and the hospital of the safeguarding risks GW3 may present and a telephone strategy discussion was held.

10.75 TM2 made a case note that three possibilities existed: GW was having another significant health episode; there might be significant child protection concern if GW3 had been caring for GW or the parents had caused GW to be ill. TM recorded that of these "the third is the most unlikely option".

10.76 TM2 reportedly had considerable difficulties in communicating concerns to members of the hospital staff regarding child protection concerns in respect of GW linked to a report that GW3 had accompanied GW to the hospital and TM2 thought GW might be in danger from GW3.

10.77 A medical examination and CT scan carried out at the hospital revealed subdural bleeding to both sides of GW's brain, retinal hemorrhages in both eyes and several old healing rib fractures. Hospital staff confirmed the injuries as non accidental.

10.78 GW was transferred from the accident and emergency department to the children's hospital that evening. On 10 December 2012 a strategy meeting was held. Information recorded in the Children's Services IMR in respect of information passed to the strategy meeting is inconsistent with the real time events, however it was disclosed at the strategy meeting that it was strongly suspected that the maternal grandparents (GW3 and GW4) were staying at GW1and GW2's property despite assertions otherwise.

10.79 GW was taken off life support systems on 12 December 2012 and died the same day.

11 Analysis

11.1 This analysis is drawn from the information and analysis contained within the individual management reviews, the integrated chronology, together with the benefit of discussion, facts, and opinion expressed in the Serious Case Review Panel Meetings. It is the role of the independent overview author to gather the information, views and analysis, and analyse them from an independent perspective. The following analysis is designed to address the terms of reference set for the review and not only examines what happened, but why it may have happened. In such a complex case rather than addressing the individual terms of reference in isolation, the author has approached the analysis by identifying a number of key themes present in the terms of reference and thereby addressing them under those headings. These are

- Assessment of risk and protective factors
- Recognition of safeguarding concerns and responses to incidents and crises
- Information sharing and multi-agency planning
- Development, implementation and review of safeguarding plans
- Management systems

11.2 Inevitably, given the review is not intended to be a forensic investigation some questions remain unanswered. The author has identified those questions for reflection by the Worcestershire Safeguarding Children Board (WSCB).

11.3 Any investigation and analysis of any past event holds the danger of containing 'hindsight bias'. Dekker (2010) notes that *"hindsight causes us to oversimplify history; relative to how people understood events at the time they were happening".* Shiller (2000) goes further noting that *"Hindsight bias encourages a view of the world as more predictable than it really is"* Bearing this tendency in mind the author has balanced what actually happened in the case with what with the benefit of hindsight arguably should have happened,

taking into account information known to be to available to the professional or agency at the time
Assessment of risk and protective factors

11.4 There were four key opportunities for the assessment of risk and protective factors in the case, in addition to what would be generally considered as routine assessments through contact with universal services. The first was available to the Mental Health Assessment Team in May 2012 in relation to GW2's overdose, two opportunities were available to the Children's Services, firstly through the initial assessment in July 2012, and secondly the core assessment from August 2012 onwards. The fourth opportunity was available to the consultant paediatrician at the hospital in November 2012 when assessing the mark/bruise on Child GW's face. Each of these four opportunities represented a key practice episode in the case where safeguarding opportunities were missed.

Assessment by Mental Health Assessment Team, May 2012

11.5 The first key assessment opportunity arose when GW2 took an overdose of medication along with consuming alcohol in May 2012. Following the overdose GW2 was assessed by RMN1 and assessment records show that key facts were disclosed by GW2 and GW5 to RMN1. GW2 explained he had a pregnant girlfriend with whom he had been living only three weeks and that due to a recent move to live independently with her he felt 'quite stressed'. He stated that he was not always compliant with his medication and GW5, who was with GW2 at the time of the assessment, confided that GW2's behaviour changed when he did not comply with his treatment regime.

11.6 RMN1 did recommend that GW2 continued to see Adult Mental Health Services with whom he had ongoing contact for his Tourettes and ADHD condition, and to attend an anger management programme which was available through psychology services. The health overview report author notes that RMN1 appears not to have considered how the stress of a new baby would impact on an individual already under a number of stresses which the birth of a baby was likely to exacerbate. Contained in the records available to RMN1 at the time of the assessment was information that GW2 had assaulted his mother (GW5) ten months earlier. RMN1 clearly had concerns that anger management was a difficulty for GW2 yet RMN1 did not liaise with other health care professionals to discuss these concerns, or seemingly make the connection that GW2's variable use of medication and anger management problems may have a bearing on his future capability as a parent.

11.7 The health overview author notes that contact with GW2's GP or liaison with midwifery services would have enabled a more informed assessment of GW2's behaviour and would have explicitly alerted both the GP and midwife of the anger management issues which remained hidden from those particular health care professionals. The Social Care Institute for Excellence publication '*Think child, think parent, think family'* (2012) urges practitioners to "*develop a working knowledge about and relationship with other services. This will facilitate joint working, reciprocity and shared case management".* The author

has no evidence as to why RMN1 did not liaise either with other health care professionals or children's services and therefore can only speculate on the reason. In the view of the SCR overview author RMN1 was adult focussed and did not consider what was presented holistically. This represented a missed opportunity to raise awareness of potential future safeguarding issues in respect of the unborn baby and the impact of his possible behaviours. What should have happened is that the assessment should have been shared with children's services and a follow up appointment made with either the psychiatrist or community mental health team rather than await a routine psychiatry appointment, thus enabling a more thorough assessment of risk.

11.8 The lack of communication with the GP caused further problems. GW2 did not respond to the letters sent by Psychology Services inviting him to apply for help with his anger management. When he did eventually respond to the questionnaire sent to him an appointment was made which he did not attend.

11.9 This cycle of events raises issues about how easy it was for GW2 to access anger management help and what action was triggered as a result of not attending the appointment eventually made for him.

11.10 The SCR Panel took the view that issuing a questionnaire in order for patients to 'opt in' for services such as anger management provided a barrier to access to the service. Indeed, the SCR Panel was informed that the service operates in this way explicitly in order that potential users prove their commitment to the service by filling in the questionnaire. The SCR Panel took the view that this potential barrier discouraged GW2 who really needed help from the service despite his reluctance.

11.11 The GP was aware of GW2's missed appointments but did not follow it up by involving Children's Services. All of these events indirectly hampered the safeguarding of GW as GW2's angry outbursts were neither treated nor alerts sent to those who needed to know about them.

Initial Assessment

11.12 When SW2 undertook the initial assessment in July 2012, the referral was originated by a social worker colleague (SW1) working with GW1's family. The overview author has not viewed the initial referral. However, discussion within the Serious Case Review Panel, together with information in respect of the assessment in the Children's Services IMR including detailed discussion with the IMR author lead to a view that it was detailed in its content particularly in respect of GW1's background and life experiences. The potential dangers presented to both GW1 herself, and her unborn baby (GW) by GW3 and GW4 (GW1's parent and step parent), and potentially the older siblings were apparently made clear. The fact that GW1 had been threatened by GW2 and GW2's mother (GW5) and that GW1 had told the referring social worker that GW2 could be 'controlling' were all documented. At the time of the initial referral GW1 was only 17 years of age and pregnant.

11.13 GW2 was known to have ADHD and to be suffering from Tourettes Syndrome

and was himself barely 19 years of age. At the time the referral was received and a request for an initial assessment made, SW2 was under a disadvantage as all of the known information on GW2's family and their offending history was not available on the electronic system. Therefore a background check on the Children' Services information system would have only revealed information post 2006 when the electronic system was implemented.

11.14 From a systems perspective this is clearly a problematic area which the author will reference later in the report.

11.15 SW2 completed the initial assessment following one visit to GW1 and GW2 noting the strengths and probable protective factors provided by GW5 and GW6 (GW2's parents) with whom they were living at the time. A number of questions arise which the author is unable to answer. It is unknown why some form of comprehensive case summary on GW2's family and background of offending was not available on the electronic records system as Children's Services had been involved with the family. If this was impractical, was there a facility on the system to 'flag' the existence of paper based information? If a flagging system does exist why was there no 'flag' put in place to alert users to the location of the paper files in which important information could be found? On allocating the case to SW2, why did TM1 not alert SW2 to the information that was later disclosed after the initial assessment?

11.16 The initial assessment completed by SW2 needed to essentially focus on the future scenario of GW1 and GW2 with their baby (GW) due to be born later that year.

11.17 The author is struck that the temptation for SW2 is likely to have been to concentrate on the adults when completing the initial assessment. Information contained in the initial assessment would suggest that GW1 and GW2 were expressing great happiness at the likelihood of becoming parents and eager to demonstrate their obvious determination to overcome a range of difficulties and vulnerabilities, not least their age. This may have led SW2 away from considering some of the possible safeguarding issues and led to the recommendation to close the case.

11.18 In fact there was a considerable amount of available information at the time which challenged the stable picture presented by the family even at that early stage of initial assessment. Only two months before the initial assessment took place GW2 had himself been violent to GW1's siblings, assaulting one of them and threatening others. GW3 had reported to the referring social worker (SW1) that GW2 was controlling and had threatened GW1 in May 2012. GW6 was recorded by the police as assaulting GW2 in December 2011 causing a facial injury thus demonstrating violent tendencies. This incident occurred only seven months before the assessment was completed. Therefore, even at the stage of the initial assessment evidence was available and known, to challenge the settled picture of GW1 and GW2 at the home of GW5 and GW6 even before TM1 disclosed the information about GW5 and GW6's prior history and directed further checks and a core assessment.

11.19 The issues mentioned above do not seem to have been considered in SW2's initial assessment. The issues of concern that were contained in the original first referral from SW1 which had been the reason for an initial assessment. It is the contention of the author that these incidents illustrated a possible level of risk which required further detailed consideration and multi-agency assessment.

11.20 The case history shows that the conclusion of the initial assessment for case closure was not accepted by the team manager (TM1) and a core assessment requested utilising further pertinent information about GW5 and GW6's prior violent behavior and offending history which TM1 confided in SW2 following the completion of the initial assessment. This direction demonstrated effective management oversight and evidence of an effective supervisory relationship between the team manager and the social worker. Although it would have more effectively assisted SW2 if this information had been made available, by TM1, before commencing the initial assessment.

11.21 However, it is possible that the impression SW2 may have formed from the initial contact with GW1 and GW2 and GW2's family had produced a longer lasting favourable impression of the family which the discovery of further information did little to alter.

11.22 In considering that possibility the author reflected on why that might be the case. The 'Learning Together' model of systems focused Serious Case Reviews developed by the Social Care Institute for Excellence (SCIE) notes a facet of human reasoning that "*once we have formed a view on what is going on there is a surprising tendency to fail to notice or to dismiss evidence that challenges that picture".* In the view of the author there was evidence even at the time of the completion of the initial assessment, prior to further information being available about GW2's family that challenged the satisfactory picture of GW1 and GW2 and their respective families. This evidence appears to have been insufficiently evaluated in conducting the assessment which may have influenced the ongoing risk analysis for GW which needed to be firmly child focused.

11.23 The initial assessment was completed largely as a single agency assessment by Children's Services. SW2 did make checks with the specialist midwife and received no concerning information, although there was a degree of miscommunication between the two which is covered under the *information sharing* section of this report.

Core Assessment

11.24 The second opportunity to assess GW1 and GW2 and their extended family came as part of the compilation of the core assessment by Children's Services.

11.25 Information supplied by the Children's Services IMR author suggests that there was no comprehensive chronology of case events available to the worker when completing this task because the electronic information system

does not provide one. The production of a chronology is a systems issue with which the author will deal with in the *Management Systems* section of this report. Suffice to say that not having a comprehensive chronology of events from each of the family member's files is likely to have made formulating a picture of them more difficult and required the worker to complete one in retrospect. Completing it in retrospect meant that key information was more likely to have been missed.

11.26 The core assessment was commenced on 6 August 2012 and should have taken thirty five working days to complete, in effect by mid September 2012. The assessment was intended to be a pre-birth assessment and therefore needed to have been completed before the birth of GW, the expected date of delivery for whom was the middle of October 2012. GW was born prematurely in mid September 2012 and was discharged from hospital in early October 2012. In any event, if the core assessment had been completed in accordance with the original plan and timescale it would have been completed by the time of GW's, birth, albeit premature. Three of the planned five visits were carried out while compiling the assessment which was delayed and was completed on 5 November 2012. Two further visits were attempted, but these were unsuccessful.

11.27 The core assessment was commissioned as a pre-birth assessment the purpose of which was to ensure that the living circumstances and parenting of GW were safe and suitable for a young baby. A decision in respect of the risks to GW based on the core assessment should have been made prior to GW's birth. The purpose of the assessment was not achieved in as much as it was not completed until GW was nearly two months old and was already living with the parents. It was the view of the SCR Panel that this was an unsatisfactory situation and may have led SW2 and TM1 to view the home situation more positively than it actually was. The purpose of the core assessment appears to have been lost in the 'happenstance' circumstances of GW's birth and placement at home with GW1 and GW2.

11.28 The core assessment was compiled with reference to other professionals, largely after GW's birth, although there were key omissions. SW2 did not make contact with the adult mental health services which GW2 was attending and did not speak with either GW1 or GW2's GP.

11.29 The author has had the opportunity to read the content of the core assessment and has also had the benefit of the Children's Services IMR author's view of it. The core assessment appears to have been largely completed post the birth of GW and contains many of the essential elements required to make an informed risk analysis of the possible risks to GW.

11.30 The core assessment concluded that GW2's medical conditions were well managed through medication and were thought to have little impact upon his parenting capacity. The author would question on what basis that assertion was made given that the professionals managing those conditions, the GP and psychiatrist (Mental Health Services), had not been contacted for information or an opinion and none of the other health care professionals

involved talked to either the GP or the psychiatrist about this nor were they themselves in a position to give an informed view. The conclusion reached by SW2 was therefore based on GW2's self reporting of his condition and its management.

11.31 Evidence from the IMRs case history suggests that GW2 had periods when he did not take his medication, the effect of which manifested in aggressive outbursts. The Health and Care NHS Trust IMR notes that the psychiatrist, if contacted, would likely have expressed the view contained in the records that while GW2's condition was not thought to be a detriment to his parenting ability, GW2 had been referred to an anger management programme at his own request (following a recommendation by RMN1) but which he had not attended. This is an opinion given with the benefit of hindsight because contact was never made and an opinion was never given. However, it is the view of the author that the issue of GW2 not taking his medication consistently, linked to violent outbursts is significant.

11.32 The Children's Services IMR author notes that *" the core assessment does identify most of the potential risk factors…..and addresses these but there is no sense of the scale of these risks (i.e. how big a risk?) and whether or not these had been or could be fully mitigated".* The overview author would agree with that view and add the comment that the core assessment while usefully providing a commentary on the risks presented, insufficiently analysed the significance of these with respect to the safeguarding of GW.

11.33 The information provided in the original referral by SW1, the referring social worker in July 2012, noted above as being insufficiently risk assessed in the initial assessment, appears not to have been sufficiently evaluated in the risk analysis for the core assessment either. The conclusions drawn in the core assessment are, in the author's view, overly optimistic and this will be discussed further in the section of this review dealing with the *Development, Implementation and Review of Safeguarding Plans.*

11.34 The core assessment was supported by the team manager (TM1) who 'signed off' the assessment with a number of comments, which in the view of the author, insufficiently balanced the assessment of risk or built upon it.

11.35 The author believes the importance of high quality assessment is essential in cases such as this and this view is supported by research findings. In a recent DfE publication *'Social work assessment of children in need: what do we know? Messages from research'* (2011) the authors note, 'While it is not always straightforward to show that good outcomes for children necessarily follow from good assessments, there is certainly evidence to support the link and conversely, to demonstrate that bad or inadequate assessments are likely to be associated with worse outcomes'.

11.36 This is not to imply that the assessment of or management of risk in safeguarding cases is an exact science where risk can always be accurately quantified or indeed mitigated. Munro (2011) is clear that there is "sometimes limited understanding amongst the public and policy makers of the

unavoidable degree of uncertainty involved in making child protection decisions, and the impossibility of eradicating that uncertainty".

11.37 Nevertheless, the core assessment could have been enhanced by the use of methodologies designed to assist in the risk analysis process. Methodologies are available such as the 'signs of safety' tool (Turnell. A 1997), which was designed to assist in the quantifying of risk through the use of a questionnaire leading to a numerical score. This approach features as a good practice example in Eileen Munro's recent work (Munro, E, 2011 "The Munro Review of Child Protection: Final Report: A child centred system"). Other tools such as the Resilience/Vulnerability Matrix (Horwarth et al 2000) which provides a graphical matrix approach to risk and safety analysis could also have assisted in more accurately assessing the possible risks to GW.

11.38 The author does recognize that it is particularly difficult to gauge, pre-birth, how parents will react and bond with their child. However, unusually, SW2 did not visit GW or the parents during GW's time on the Special Care Baby Unit. This would seem to be a lost opportunity as it would have allowed SW2 the opportunity to assess the parent's early bonding with the child. In mitigation, there is no evidence that health care professionals on the Special Care Baby Unit were aware of any parenting problems at this stage. However the Children's Services IMR notes, in hindsight, that this was a missed opportunity by the social worker to further assess the parent's interaction with GW. SW2 did receive regular updates from health care professionals at the hospital. It has not been possible to find out definitively if the information was supplied by ward staff or the special care baby unit staff during GW's stay in hospital. SW2 did not visit GW or the family at home until 22 October 2012 which was over two weeks after the child was discharged from hospital and five weeks from last having had contact with the parents immediately prior to GW's birth. While the children's services IMR does not identify any capacity issues for SW2, the author is struck that in being confident that GW was safe in hospital, SW2 may have afforded the case a lower priority for a period of time.

11.39 At the end of the core assessment process the social worker did attempt to consult other colleagues working with the family. However, the Child in Need Meeting, called in mid November 2012 to discuss the core assessment had to be cancelled due to the bruising to GW's face. This Child in Need Meeting was reconvened on 20 November but apart from the family and the social worker only the health visitor was present with apologies received from key professionals involved with the family such as the family support worker and a representative from the children's centre the family were engaging with (although subsequently it was realized there had been no contact). The IMRs from housing and children's social care reflect differences, housing stating they were not invited to the Child in Need Meeting and children's services that they did not attend. There is no record that those not present at the meeting sent written reports. Under these circumstances the assessment was approved by those present at the meeting, without the opportunity for a wider multi-professional discussion.

11.40 At this point challenge and oversight of the assessment and plan for GW would seem to have been crucial and the professional best placed to provide that was the social worker's manager TM1 through the supervisory process. TM1 provided supervision to SW2 at this time and evidence shows a good deal of contact between the social worker and supervisor throughout this period. It was decided by TM1 and SW2 that on balance to "assess and support via a child in need plan" was an appropriate course of action.

11.41 This was a matter of judgment at the time which with hindsight may have been led to a different decision. However, what seems to be crucial is the evidence on which the decisions were made. In the view of the author the challenge to the assessment and plan was inadequate. The absence of a critical risk analysis within the core assessment had a limiting effect on the value of the assessment in informing the development of safeguarding plans for GW. This was made more significant given the unexplained bruise GW had sustained on or around 13 November 2012 which records show raised the anxieties of professionals working with the family.

11.42 Dingwall (1983) highlights a "rule of optimism" where professionals dealing with children and families see situations from an overly optimistic standpoint. What is evident from research is that 35% of babies who were killed or seriously injured were less than one year old at the time. (Ofsted 2011 & NSPCC 2011).The content of the core assessment does reflect an overly optimistic view and in the author's view is insufficiently focused on a risk analysis.

Medical Examination of GW

11.43 The medical examination of GW following the discovery of a mark/bruise to the child's face was a key turning point in the case. The medical examination was arranged when the neo-natal nurse attending GW visiting on 13 November 2012 noticed the mark. The reaction of both the neo-natal nurse, the sister who the nurse contacted (Sister 2), the matron, the named doctor (safeguarding) and the consultant (CP2) was for there to be effectively a safeguarding medical set up immediately. While this reaction was understandable it did not concur with the interagency safeguarding procedures which require the immediate involvement of Children's Services for consideration of a Section 47(Children Act 1989) investigation. Children's Services were not contacted until later in the afternoon albeit before the examination took place. However, contact with Children's Services appears only to have taken place because the neo-natal nurse attending GW realised belatedly that Children's Services were involved with the family.

11.44 Evidence presented to the Serious Case Review Panel suggests that the consultant carrying out the medical examination was aware of some of the case history when the examination was undertaken but that the information given by SW2 to CP2 was minimal. It is unclear why only minimal information passed between these two professionals. However, the SCR Panel was satisfied that the information given to CP2 was of sufficient concern to warrant

the completion of a comprehensive examination.

11.45 The Acute Hospital Trust IMR author was clear, as was the named doctor, (Acute Trust) that the panel called on for advice, that the examination undertaken on GW on 13 November 2012 was thorough in its nature as far as it went. However, it was not comprehensive as key examinations and tests were not completed.

11.46 Both the Acute Hospital Trust IMR author and the named doctor expressed a view that normally it was considered good practice that the examination should include an examination of the fundus (the rear of the eye). In the circumstances outlined in this case where a child may be active at the time of examination, they both expressed a view that the normal course of action would be to wait for the baby to settle at which time that part of the examination could occur. There was also an option for CP2 to have requested an experienced ophthalmologist to look at the eyes. CP2 did neither of these things and an examination of the fundi did not take place. There was no reference made in the records that CP2 made about the results of an examination of the oral frenulum. Such an examination would indicate if the child had been force fed in some way, reporting on which is considered good practice.

11.47 With respect to the carrying out of a full skeletal examination, the panel was told by the named paediatrician that the giving of any examination involving exposure to x rays was a matter of judgment to avoid possible over exposure. However, applicable national guidance from the Royal College of Paediatrics and Child Health found in the Publication '*Child Protection Companion'* (2006) indicates that "skeletal survey should be undertaken where physical abuse is suspected in all children less than 12 months of age".

11.48 The guidance further states that "CT scan (neuroimaging)… for any infant under the age of two years in whom a skeletal survey has been performed for suspected non accidental injury, it is recommended that a CT head scan should also be performed". In this case this examination did not occur.

11.49 Information given to the Serious Case Review Panel given by the named paediatrician indicated that the types of scans and examinations mentioned above do not necessarily provide conclusive evidence of abuse, nor do they discount it. It was also noted by the panel, when hearing expert presentation, that the healing fractures discovered at the time of GW's death may not have been perceptible to the skeletal survey, even if they had been present at that time, had one been carried out.

11.50 CP2 was doubtful as to whether the mark/bruise suffered by GW was in fact non accidental or not. In writing to Children's Services following the examination, CP2 wrote "in the absence of any explanation (no history of fall or injury) the possibility of the non accidental nature of this bruise cannot be ruled out". While the author understands that CP2 felt unable, based on the evidence available, to rule the mark/bruise as accidental or non accidental, all of the objective tests available to CP2 had not been undertaken i.e. the

fundus had not been seen by an examination of the eyes, a full skeletal survey had not been carried out and neither had a CT scan of GW's head.

11.51 The diagnosis of child abuse is a difficult and uncertain area. To assist in overcoming this difficulty, the Acute Hospital Trust IMR author comments that, "when consultants have any difficulty deciding when physical abuse should be suspected they should discuss the case with the named or designated doctor or senior consultant colleague". The overview author would support this viewpoint particularly as the objective and critical challenge by colleagues is a sound basis on which to proceed when considering complex safeguarding situations.

11.52 However, CP2 did not seek the opinion of colleagues in this instance. The author accepts the expert medical opinion as presented to the panel in respect of the uncertainty of the results which may have flowed from carrying out a full skeletal survey or a CT head scan. The expert opinion suggests that it does not necessarily follow that the skeletal survey or CT scan, had they been completed would definitely have indicated abuse had it been present nor completely discounted it. However, the failure of CP2 to carry out these potentially illuminating tests is viewed by the SCR Panel as a significant missed opportunity to either provide or to discount evidence of abuse.

Recognition of safeguarding concerns and responses to incidents and crises

11.53 Following the birth of GW, GW1 and GW2 were staying at the home of GW5 and GW6 who had assured the social worker that the couple could 'stay as long as necessary'. However, the day after this assurance was given; the couple was asked to leave by GW2's parents. GW was only five weeks old at this time.

11.54 This event triggered a housing crisis for the couple which was to last until GW's death. Evidence from the IMRs suggests that the couple's housing difficulties caused a significant amount of stress, particularly for GW1 who confided in her GP that the housing situation was one aspect of her life causing her depression.

11.55 There is evidence in the IMRs that the Housing Service and Children's Services worked well together to try to resolve the various housing crises that occurred between the couple leaving GW2's parents house and GW's death.

11.56 The Housing Service, despite having legitimate concerns that GW1 and GW2 had made themselves intentionally homeless, recognised the vulnerabilities in the family and worked with Children's Services and the family to find suitable accommodation. The SCR Panel has not seen the emergency accommodation in which the family was placed, however information contained in the IMRs suggest damp and mould were a problem in the last property in which the couple were placed. That situation was of concern to the SCR Panel. Given GWs prematurity and breathing difficulties the SCR Panel would question the appropriateness of this choice of accommodation in which to place the family.

11.57 The family was vulnerable throughout the period and their lack of appropriate housing caused a great deal of stress as evidenced when GW1 attended her GP complaining of suffering depression largely linked to the family's housing problems. The family had received an eviction notice in late November 2012 which effectively meant they must move out of their home only a few days following Christmas (28 December). The SCR panel was of the view that this stress factor was a significant in the dynamics of safeguarding GW.

11.58 The SCR Panel acknowledges that offers of other accommodation were made to the couple and they refused them, although this was largely to do with GW1's fears that her father was known in the area of the proposed property and difficulties were likely to arise with local residents. The uncertain housing situation no doubt caused stress and anxiety for the couple and this stress was recognised in the team leader's comments (TM1) when 'signing off' the core assessment. However, there is no evidence that the potential effect this may have had on the couples parenting ability, from a safeguarding perspective, was ever evaluated or the impact of the unsuitable housing on a vulnerable baby.

11.59 The housing situation did have potential safeguarding implications, in particular when GW was admitted to hospital in early November 2012 and the parents explained to staff that on discharge they would be homeless. The duty social worker tried to arrange accommodation on an emergency basis but, because no other solution could be found, GW was discharged to GW8's home with the parents. GW3 was also living with GW8 at this time. GW was not supposed to have unsupervised access to GW3 because GW3 was thought to present possible dangers, although the records are unclear exactly what these were. At this time GW3's children had been taken into care.

11.60 A number of issues flow from this situation. The Children's Services IMR is not clear what exact danger GW3 posed to GW. The author has viewed the core assessment described above which is also unclear as to exactly what danger was thought to be posed by GW3. Evidence given to the SCR panel from the Children's Services IMR author pointed to possible neglect as a cause of concern if GW3 were left alone with the child. However, when it is thought by TM2 that GW3 was accompanying GW in the ambulance on 7 November 2012, great concern was expressed that GW3 may have caused or maybe about to cause GW physical harm. The author finds this situation confusing although it demonstrates an example that some of the professionals involved in the case who were concerned about GW were unclear in either their quantification of concern or which individuals they were concerned about and why.

11.61 The incident of bruising to GW's cheek was a critical decision point and as detailed above, the interagency child protection procedures were not followed by a number of the health care professionals involved with GW on that day. A telephone strategy discussion was convened before the medical examination and reconvened after its completion. A decision was taken not to refer the matter for consideration by case conference and minutes of the strategy

meeting (electronic format) indicate that 'concerns not substantiated'. However, this recording is at odds with the findings of the consultant paediatrician that "the possibility of the non accidental nature of this bruise cannot be ruled out". Minutes of the strategy discussion go on to describe an "immediate safety plan". What is clearly described in the IMRs is a feeling of unease, exemplified by SW2's later recordings in the case. The Children's Services IMR explains that TM1 did not consider calling a child protection conference and felt at the time there would be insufficient consensus regarding the need for one given the safety plan agreed. The calling of a case conference at this time was a matter of judgment and with hindsight the decision may have been different. If TM1's decision was affected by either operational procedures or developed practice in respect of 'thresholds' pointing to only conferencing cases when the likelihood of this leading to the making of a child protection plan was virtually certain would be of concern to the author. If this were the case the consequence would be that that opportunities to discuss difficult cases were effectively being limited. The author has no evidence that this was the case but it is a potential systems issue and may be an aspect of the case on which the LSCB would wish to reflect.

Information sharing and multi agency planning

11.62 Instances of poor communication or miscommunication between agencies are a perennial feature of Serious Case Reviews. While there is some individual evidence of good inter and intra agency communication in this case, the incidence of poor communication is significant. Against a background of a high and increasing workload and decreasing resources the author has empathy with those at the frontline of services involved in multiple complex professional interactions. However, the need for the accurate, relevant and timely communication of facts and a professional analysis of those facts remains an essential component of good safeguarding practice.

11.63 In the process of compiling the initial assessment on GW1 and GW2 in respect of the unborn GW, SW2 did undertake an agency check with the specialist midwife (SM); however a degree of miscommunication was present in their contact. The social worker, while explaining that an initial assessment was being undertaken, was not clear of the referral circumstances which had led to the assessment and the SM had only partial information. On receiving the information that there were no concerns about GW1 or GW2 from SM, SW2 indicated to the SM that the case would be recommended for closure, and that a copy of the assessment would be forwarded to the SM for information. In actual fact the case was not closed due to the intervention of TM1 who asked SW2 to undertake further checks which would cast doubt on the protective nature of GW5 and GW6.

11.64 It is unknown if an original initial assessment or indeed a revised one was ever sent to the SM but if so it was not received, thus leaving the SM with a view that no concern had been found in the case which militated against raising a safeguarding alert on the health system. Had SW2 forwarded by email, properly flagged with a read receipt facility, a copy of the revised initial

assessment giving SM the correct information could been included in the health records which would have been available to the health care professionals who subsequently accessed the records.

11.65 Reeson. J (1990), models an example of a number of slices of Swiss cheese standing together where the random holes in the cheese line up allowing an object (or error) to pass through. This model graphically illustrates how individual system failures such as a piece of miscommunication can become aggregated as information slips through organisational systems.

11.66 In this case the lack of up to date information on the ongoing concerns about GW, GW1 and GW2 not being communicated to the SM formed an information block stretching from early July 2012 when SM was first contacted by SW2, right up until 13 November 2012 when the neo-natal nurses realised Children's Services were involved when the mark/bruise on GWs face was notified.

11.67 As was highlighted in the section on *Assessment* above, there was poor information sharing between RMN1 and other health care professionals. RMN1 did recognise the multiple stress factors that were present for GW2 during the assessment following his overdose. The Health IMR notes that had RMN1 "alerted maternity services to the possibility that the young couple might have additional stresses, the needs previously undisclosed would have been known".

11.68 In respect of information shared with and by the GP's involved with GW, GW1 and GW2 a considerable amount of confusion arose due to the couple moving between GP practices A and B. GW was seen by GP1 at GP Practice A on 15th October 2012 and again at Practice A on 29th October 2012 for a routine 6 week check. At GP Practice B, GW2 attended with GW on 30th October 2012, to register himself and GW as patients. On 1st November 2012, GW1 and GW2 arrived with GW at the GP Practice B reception asking for a prescription for GW.

11.69 The reception staff took details but her parents did not wait for GW to be seen and left the surgery. GW was never seen at GP Practice B by a GP or other health professional. There is no direct evidence to suggest that GW1 and GW2 engineered this confusing picture deliberately although this may have been the case. In the author's view it was more likely to have been due to their frequent accommodation moves.

11.70 Of particular concern to this serious case review is the system by which one GP practice is alerted that a patient has moved from one practice to another. A patient is under no obligation to inform one GP practice that they intend to leave to attend another. The system has been helpfully described as a 'pull' system rather than a 'push system'. In other words a GP practice is unaware that a patient has moved until records are requested by another surgery instigated when a patient registers. When this happens records need to be requested (or pulled) from the previous GP surgery. The situation was complicated in this case. The request from Surgery A to surgery B for records

on GW1 was made in November 2011.The records were not received until August 2012. This is clearly an unacceptable delay and one for which the review team has been unable to find a cause.

11.71 The Health Overview Report author notes that "due to the sheer volume of patients it would be impossible to undertake formal handovers with every patient". However, in this case an information blockage was caused preventing information known about GW1 being available when she booked her pregnancy in March 2012. With respect to the safeguarding of children the opportunity for a parent, either by accident or design, to move between two GP practices potentially concealing background information which could be accessed to safeguard a child is of great concern.

11.72 The Health Overview Report author notes that "the referral letter to the acute trust from the GP requesting maternity services did not give any detail in respect of either the social concerns or medical concerns in respect of GW1 or GW2. The Health Overview Report author states that this was poor practice by the GP making the referral and a missed opportunity for early information sharing".

11.73 With respect to GP Practice B, a GP in the practice had been contacted by the hospital paediatrician (CP2) in respect of the examination of the bruise on GW's cheek in November 2012. This should have resulted in a 'flag' being put on the electronic records system to alert other GP colleagues of ongoing concerns in relation to vulnerability or safeguarding concerns with a child.

11.74 The GP who dealt with the information from the consultant did so by sending an email to colleagues to be aware of the information from the consultant. It is not known who received or read the email and if any other GP acted upon its content. The use of email as a flagging tool for safeguarding between partner GP's who may have contact with vulnerable children leaves the potential for information to be missed. The electronic 'flagging' system in place on the electronic records was designed to provide a consistent solution to this difficulty. The Health Overview Report author notes "This system has been instigated as a County Wide measure following recommendations from a previous serious case".

11.75 It is of concern to this Serious Case Review author that a system has been devised and put in place following a previous serious incident but as evidenced in this case is not consistently being used. The LSCB will wish to consider the implications of this.

11.76 When GW was discharged from hospital a neo-natal nursing team took over GW's care from a health care perspective. Health care professionals on the Special Care Baby Unit should have been aware of the involvement of Children's Services (as SW2 had been in contact with health care professionals at the hospital) but that information did not get passed on to either the neo-natal nursing team or the health visiting service. The Health Overview Report notes "The health visitors were not aware that GW1 and GW2 were a vulnerable couple and did not visit them antenatally" ……"

the health visitors were not contacted by Children's Social Care until 15 October 2012" ……despite otherwise good liaison between the health visitor and the neo-natal outreach nurses, the health visitor did not share with the neo natal outreach nurses (when the HV was informed) that Children's Services were visiting the family. The information should have been shared to enable all practitioners to make an informed assessment."

11.77 The significance of this lack of communication bears reflection. A core assessment was underway at this time which was being undertaken by SW2 with the aim of assessing the parenting capacity of GW1 and GW2 who were known by SW2 to have vulnerabilities by nature of their age, background, health issues and housing difficulties. The input into the assessment by health care professionals such as the neo-natal nurses involved on a daily basis with the family would be essential to the completion of the core assessment. They were neither involved in the assessment or knew one was taking place. When the health visitor belatedly became aware of the Children's Services involvement, that information was still not shared between what were key health care professionals such as between the health visitor and the neo-natal nurses. This lack of information sharing both inter and intra agency is concerning for a number of reasons.

11.78 Had the relevant health care professionals been aware of the core assessment process they could have contributed to it. They would have been alerted to and more attuned toward vulnerability issues that might otherwise appear inconsequential and they could have provided a line of monitoring and feedback on potential vulnerability or safeguarding issues to the SW2. None of these processes were in place. The health care professionals were child focused but were concentrating on, understandably, health issues in respect of GW and the child's health issues following premature birth.

11.79 Assessment processes lead to and inform the planning of how agencies will respond to individual children and families. The national *Framework for the Assessment of Children in Need and their Families(2000)* states 'At the conclusion of this phase of (core) assessment, there should be an analysis of the findings which will provide an understanding of the child's circumstances and inform planning, case objectives and the nature of service provision'. There is an explicit requirement within the assessment framework that assessments are carried out holistically encompassing the views of agencies involved with a child and family. The exclusion of key health care professionals in this case failed to meet this expectation and reflected poor inter-agency planning.

11.80 The rationale for why the communication blocks occurred in this case are not clear but circumstances do indicate both inter and intra agency communication system failure. What is of concern to the author is that a previous SCR case locally (Child AW, March 2012) highlighted the issue in recommendation (ii) as requiring to *"review and evaluate the multi agency processes for information sharing and assessing risks to children (including unborn children) and particularly vulnerable young women in cases of domestic abuse".* This recommendation would seem equally applicable to this

case and the LSCB will want to examine the current position on implementing that recommendation.

Development, implementation and review of safeguarding plans

11.81 A key issue in the SCR is whether or not appropriate plans to safeguard and promote the welfare of GW were developed, implemented and reviewed in a timely way.

11.82 The sections of this overview report dealing *with assessment and information sharing* suggest that information to allow the development of appropriate safeguarding plans was either missing or insufficiently taken account of. It does therefore follow that plans to safeguard GW were potentially flawed for that reason.

11.83 However, the social worker and the health care professionals involved in the care and safeguarding of GW repeatedly saw a young couple, appropriately caring for their baby and actively trying to work with professionals to overcome their difficulties. This led to an optimistic view of the child's safety.

11.84 The Children's Services IMR addressed the issue of whether or not the parents were actively engaged in 'disguised compliance' in an attempt to deceive the professional team working with them. The overview author is satisfied, from the evidence presented in the IMRs that 'disguised compliance' was likely not to be present in respect of GW1 and GW2. However, it is possible that other adults in the extended family, particularly GW3, GW5 and GW6 may (have been involved in that type of deception.)

11.85 The proposal by SW2 to close the case following initial assessment was inappropriate and was countered by the supervisor TM1. This challenge was an example of good management practice. However, evidence suggests that the development of the core assessment drifted and was not completed by the time GW was born. This was significantly problematic as a pre–birth assessment, designed to inform the ability of GW1 and GW2 to safely parent then became a post birth assessment. This resulted in GW, being placed with the parents without a comprehensive assessment of the risk, if any to the new born baby. While no evidence existed at the time of GW's birth for any kind of high level intervention, the birth and the positive reaction of the parents to it appears to have led SW2, TM1 and health care professionals away from the objectives of the core assessment and the formal process of assessing risk in the situation. Therefore while the Child in Need Plan status of the case was probably appropriate before GW suffered the bruising' it was probably not afterward.

11.86 Relatively simple considerations concerning the age of the parents and their vulnerability seem to have been insufficiently recognised in respect of planning for GW's safeguarding. This is particularly the case in respect of GW2's disability issues. The effects of both the ADHD and Tourettes difficulties he suffered from do not appear to have been sufficiently considered. RMN1 failed to link the lapses in GW2 taking his medication with

the anger management issues he then experienced and the implications of the stress caused by him becoming a new parent and the possible implications of angry outbursts to a new born child. SW2 does not appear to have considered that these disabilities may have been a factor in safeguarding. The lack of information exchange between these two professionals was important. However, if there had been contact between the two it is by no means certain that either would have alerted the other to the possible implications of the disability issues. In the view of the author this issue is of significance as it limited the opportunity to plan for all scenarios. It raises questions about the awareness of adult focussed professionals being insufficiently aware of safeguarding children issues and children's services professionals being insufficiently aware of adult mental health and disability issues on the safeguarding of children. These issues potentially have implications for inter agency child protection training.

11.87 The Children's Services IMR details the view of SW2 and TM1 that a high degree of support was presented to the family. The support offered was significantly increased following the discovery of the bruise on GW's cheek

11.88 Risk management within child safeguarding is not an 'exact science' as noted in earlier in this review with reference to the work of Munro (2011). However, the identification and recognition of risk to a child through high quality assessment is a key facet. This has been discussed earlier. Once identified, the assessed risk can often be planned for and mitigated through interventions requiring parents to engage in, for example, parenting classes or anger management programmes. Feedback obtained from those interventions can provide evidence on which to more effectively plan for a child.

11.89 Closer scrutiny of the support provided in this case appears to show significantly increased levels of monitoring (essentially check visits) of a situation that SW2 and TM1 were becoming increasingly concerned about. The overview author would characterise this situation as 'high support, low challenge' where the challenge to the parent's ability to keep the child safe was too low. For example arrangements had been put in place for GW1 and GW to attend the local family centre but these arrangements became delayed and never came to fruition.

11.90 The development of the Child in Need Plan for GW has been difficult to follow and was interrupted when the meeting on 13 November 2012 had to be cancelled because of the discovery of the bruise on GW's face. The author has had difficulty in understanding exactly what the Child in Need Plan consisted of, and what were the roles and responsibilities of the various professionals were within it.

11.91 The Children's Services IMR highlights that the family support worker involved with the family was very experienced. However it is difficult to pinpoint what role this worker was fulfilling other than providing general advice and support on issues such as housing appeals. This worker was not present at the meeting where the plan was approved. It is difficult to gain an insight into exactly what the concerns about GW were at this time, who they were

communicated to, and what were the expectations on GW1 and GW2 to ameliorate the concerns and what were the likely implications for GW if they did not comply.

11.92 The overall safeguarding situation, including progress against the Child in Need Plan could have been discussed at a child protection conference immediately post the incident of bruising to GW's cheek. Discussing children at child protection conferences or placing them on child protection plans does not in itself keep children safe. However, discussion at conference in this case would have given the opportunity for an exploration of what measures were required to satisfy those working with GW and the family that the risk factors were able to be mitigated. The opportunity for multi-agency discussion would also have ameliorated some of the information sharing blockages already discussed in this review. The conference would have presented an opportunity for issues of vulnerability brought about by the couple's precarious housing situation to be factored into the safeguarding equation. This was particularly important as at this time GW1 was experiencing depression because of the families housing difficulties. The matter was not referred for conference and so this opportunity was lost.

11.93 The Children's Services IMR author notes that if an initial child protection conference been called it could not reasonably have been held prior to GW's death. However, while this may be true, no plans were in place to hold a child protection conference which is the issue. In hindsight it is the view of the SCR Panel that an initial child protection conference should have been called in those circumstances, even though that action may not have changed the outcome of this particular case.

Management systems

11.94 Child safeguarding, in line with government guidance (*Working Together 2010*) is led by the local authority children's services with important contributions from other agencies. Those leading on this case from children's services; TM1, TM2 and SW2 were all experienced professionals with the necessary skills to work with children and families and manage the case.

11.95 None of the IMRs which contributed to this review cited excessive workload or lack of capacity as a specific issue in this case.

11.96 Worcestershire Local Safeguarding Board has comprehensive child protection procedures published and in place which are applicable to all of the agencies involved with GW and GW's family in this case. The procedures are shared with other LSCBs which form part of the West Mercia Consortium and have been available for Ofsted to inspect as part of their ongoing national inspection programme of safeguarding arrangements.

11.97 The Worcestershire procedures are available to all of the staff concerned with safeguarding children on the internet and have been viewed by the overview author as part of the preparation of this Serious Case Review Overview Report.

11.98 The IMRs detail that appropriate safeguarding supervision policy arrangements are in place within all of the agencies involved in this SCR.

11.99 The difficulties regarding the production and maintenance of case chronologies were described to earlier in this review. The problem of producing such chronologies from an electronic system, in the author's experience, is not peculiar to the agencies involved in this review. The software packages available to produce chronologies, particularly in children's services have a tendency to pick up often insignificant events producing lengthy documents which can be difficult to read. This potentially detracts from the essential purpose of a case chronology which is to provide a rapid and accurate précis of activity on a case file allowing workers to quickly identify key events and see trends and patterns within a holistic framework.

11.100 In the authors view, the access to such chronologies is an essential aide to safeguarding the absence of which mitigates against clear planning. The production of chronologies was felt so important by Lord Laming that he made the keeping of them a recommendation in his inquiry into the death of Victoria Climbie (recommendation 58). The implementation of that and other recommendations was later audited as part of a national safeguarding inspection. The LSCB will want to consider this issue in relation to the findings of this SCR.

11.101 In the authors recent experience difficulties in producing and maintaining a simple up to date chronology of key events in a case is a recurring theme. As detailed above, this may be a 'systems' issue rather than an issue of professional practice and may be of interest to the newly formed national panel concerned with serious case reviews.

11.102 The difficulties regarding information from paper case files being accessible or 'flagged' on the electronic system and its effects in this case is dealt with at 11.6 -11.8 above.

11.103 The migration of information from paper to electronic systems reflects a significant challenge. However, ensuring that relevant historical information is not only available but also accessible to those who could reasonably be expected to need it must be a guiding principle. In the case under review, it was only the personal prior knowledge of TM1 that facilitated SW2 being aware of some significant background history on GW2 and his family. The situation is potentially unsafe and leaves professionals, organisations and most importantly children vulnerable.

11.104 As noted above all of the agencies contributing to this serious case review confirmed that appropriate management oversight and professional supervision arrangements were in place in the organisations.

11.105 It has been difficult for the author to judge the effectiveness of some of those arrangements as some IMRs are insufficiently explicit on the point. The health overview report gives a useful amount of detail in respect of health

professionals.

General Practitioners

"*There is no evidence within the reviewed IMRs that GPs had any discussions with wider multi-agency teams, sought advice from the Safeguarding Lead or that safeguarding supervision was sought."*

Community Midwives

"The community midwife did not recognise the impact of potential risk factors such as unplanned pregnancy, teenage parenthood, compounded by poor quality living environment and therefore did not refer to the specialist midwife or other professionals that could have provided support to the parents."

Consultant Paediatrician

"CP2 should have involved the Named or Designated Doctor for Safeguarding and/or more senior consultant colleagues following his examination of GW after discovery of the bruise/ mark on her cheek. CP2 as the health specialist should have made his concerns for the child explicit. Safeguarding supervision had not been routinely offered to consultant paediatricians at the time of the review but the Acute Trust plan to initiate this as part of the recommendations from the SCR."

11.106 The SCR Panel was struck by the picture of isolated 'silo' working that these comments portray. As was discussed earlier in this review the key to safe safeguarding practice is for those involved to share information and allow their practice to be constructively challenged. Klein (2000) cited by Munro (2011) reflects the ways in which 'experts' learn is by a process of

- Engaging in deliberate practice, setting specific goals and evaluation criteria
- Compiling extensive experience banks
- Obtaining feedback that is accurate, diagnostic and reasonably timely and
- Enriching their experience by reviewing prior experiences to derive new insights and lessons from mistakes

11.107 The SCR Panel found evidence that a number of practitioners across the agencies involved in this case worked too much in isolation with too little communication between them and with insufficient challenge to their professional practice. There was evidence that systems of supervision are in place, however, the provision of consistent professional challenge to practice within those systems was believed by the panel to be less certain.

11.108 In the authors view these processes should form the basis of robust safeguarding supervision. This review has highlighted that aspects of supervision were lacking, in particular in respect of those requiring supervision (or in other words 'consultation') asking for it and when it was requested, gaining challenging and accurate feedback from it.

11.109 As previously stated in this review there was a consistent and high degree of supervision provided by TM1 to SW2 and there is evidence that this was, on occasion effective. However, on balance it is the view of the author that overall TM1 provided an insufficient overview and challenge to SW2 of the family situation at all times in the case particularly at the stage of core assessment completion.

12 Conclusion

12.1 This review has examined a complex mixture of elements, which when taken together, give a detailed picture on the safeguarding of GW. The information presented in the IMRs and the Health Overview Report, and discussions in the panel has assisted the SCR Panel to form the view that those involved with GW and family acted in good faith and with what they believed at the time to be in GW's best interests.

12.2 This in no way discounts the fact that this case provides a significant opportunity to learn from the events which took place. This learning is widely applicable across all of the agencies which form the LSCB.

12.3 A combination of gaps in communication, information systems limitations, insufficiently robust assessments, the application of the rule of optimism, and insufficiently robust professional supervision are all active elements in this case. Some of these aspects, in particular difficulties with inter and intra-agency communication, have been highlighted in a previous serious case review (AW) in this LSCB area which was completed in March 2012. The SCR Panel were particularly concerned to discover that serious inter and intra agency communications difficulties, demonstrated in this serious case review remained unresolved given the recommendations made in the serious case which was completed over twelve months ago. The SCR Panel is of the view that the remedial action planned following that review has not, as yet, ameliorated the identified difficulties. The author of this SCR has therefore addressed this issue as a recommendation from this serious case review.

12.4 While reflecting on the issues described in paragraph 12.3 the author has considered the issue of whether GW's death was preventable. The responsibility to determine this rests with the Child Death Overview Panel (CDOP) under the guidance contained *in Chapter 7 (Working Together 2010).* However, judgments are made by CDOP which are informed by the Serious Case Review at the conclusion of the SCR process.

12.5 When considering whether a death was preventable guidance on this issue in Working Together (2010) refers to *"modifiable factors, ...for example in the family and environment, parenting capacity or service provision, and*

(requires) *consider what action could be taken locally and what action could be taken at a regional or national level."*

12.6 It is the view of the author that following the unexplained bruise to GW's cheek on 13 November 2012 it was predictable that some form of significant harm was likely to come to GW while living with GW1 and GW2. The author believes that the social worker in the case, SW2, also feared this to be the case which can be deduced from SW2's contemporaneous case recordings "*GW seen alive and well"* made by the social worker following the event. At that moment in time it is the view of the author that events could have been modified through a more comprehensive medical examination of GW including a full skeletal survey, and other checks which were not undertaken.

12.7 The examinations and checks may not have been conclusive, a point the SCR Panel accepts. However, if these checks had been undertaken and the results available to the professionals involved in safeguarding GW, a more comprehensive assessment of the risks to the child could have been undertaken.

12.8 The contention that the calling of a child protection conference following the event of bruising would not have prevented the death due to the timescales for holding a conference is a correct assertion. However, a conference was never planned and from the perspective of facilitating future learning, this review has concluded that a conference should have been planned in this case.

12.9 When all of the elements discussed in this review are taken together, gaps in communication, information systems limitations, insufficiently robust assessments and insufficiently robust professional supervision over time, they set up a situation where GW was insufficiently safeguarded. All of these factors were interacting together against a backdrop of the family being in temporary and unsuitable accommodation, necessitating the family often moving location. This led to increased stress in the family and difficulties for professionals tracking the family's progress. It is worthy of consideration if any of these factors were modifiable using the definition from Working Together (2010). In addressing this issue the author believes it useful to ask the question 'what if?' What if the core risk assessment been better informed by information on GW2's propensity to take his medication variably resulting in angry outbursts? What if the stress of the housing issues had been recognized and factored into a more risk focused core assessment? Following GW's facial bruise what if the physical examinations had been more comprehensive? All of these factors were, in the words of the guidance, "modifiable". Bearing these factors in mind the author and the SCR panel can only conclude that, on balance, GW could have been better safeguarded.

13 Lessons Learned

13.1 There are a number of key lessons to learn from this serious case review:

1) The awareness of and access to historical case information when completing assessments in children's services is essential to forming an accurate view of a case and to provide a basis on which to plan.

2) The formulation and maintenance of a simple chronology of case events that is readily accessible on the electronic case file is an essential aide to safeguarding children

3) Assessments led by children's services are best completed in close collaboration with other colleagues involved in the case, in particular key health care professionals. This may require reflection by social workers and their supervisors in order to ascertain exactly who is involved in a case and should include the consideration of adult services and mental health professionals.

4) Professional supervision for all those involved in child safeguarding work is essential. The supervision policies of organisations need to reflect the requirement for supervisors to rigorously challenge case involvement on a regular basis, and provide oversight and professional challenge of key processes such as professional assessments.

5) Inter and Intra agency communication is the bedrock on which systems to safeguard children are built. Those involved in child safeguarding should be actively asking themselves questions about what information they know, what information they need to know, who might have relevant information and why, who else needs to know what they know and what the missing links in the information chain might be.

6) Social Workers leading the process of safeguarding need to feel confident to challenge health care professionals who carry out specialist examinations or assessments. There is a need to ensure that they are satisfied that all information that can be obtained from such assessments or examinations has been obtained and need to feel confident to escalate their concerns to managers or senior clinicians.

7) Colleagues in housing services, while not in the core business of safeguarding children have a crucial role to play in providing information to the safeguarding process and potentially assisting with aiding the stability of vulnerable families. It is essential that housing staff are invited to, and supported to attend relevant meetings concerning safeguarding children.

8) The child protection conference system needs to strike the balance between discussing cases which clearly fall within its purview and those

which are more marginal and perhaps would benefit from discussions in other forums. The criteria for the calling of a child protection conference needs to not only reflect this balance but should not discourage those who may feel a conference is required.

14 Recommendations

14.1 The overview author would endorse and support all of the recommendations made in the IMRs and health overview report and these are listed below.

The overview author would add to these the following three recommendations.

1) Action should be taken by Children's Services to ensure that simple chronologies of involvement are present on electronic files in line with Recommendation 58 (Victoria Climbie Inquiry, 2003)

2) A review of paper based files in Children's Services should be undertaken to ensure that appropriate references are made on the electronic information system as to their existence and their access arrangements.

3) The Worcestershire Local Safeguarding Children's Service should review the progress of inter and intra agency communication recommendations from the AW serious case in order to be satisfied that appropriate action has or is being taken to implement the recommendation.

14.2 Recommendations from the Individual Management Reviews:

Children's Services

- There were no specific recommendations made by Children's Services. The senior management of Children's Services believe that the learning from this case closely reflected the learning from two earlier, but comparatively recent SCR's; BW and CW published in July 2011 and FW published in January 2013. In this report reference is also made to the similarities with the SCR on AW published March 2012. The author of this report and chair of the panel acknowledge the fact that there are no new lessons, but more evidence of the difficulty in embedding the necessary changes in the organization.

  Children's Services have made available an existing Action Plan in which they set out the changes they are committed to implementing which seeks to address the ubiquitous problems of assessment quality, supervision and inter-agency communication.

  As a plan of work this is acceptable, the refinement that needs to be added is the monitoring function and reporting of progress to the WSCB; as an independent body they have a role in holding all agencies to account.

West Mercia Police

- West Mercia Police to reinforce the importance of the correct and timely recording of intelligence to its staff.

Redditch Borough Council Housing

- Referring agencies should be asked to provide clear details about the support needs of households before the home start service makes appointments with customers (to avoid confusion about the need for cancellations)

Suggested Recommendations for other agencies made by RBCH

- The process of inviting relevant organizations to attend Child in Need review meetings should be reviewed (as in this case no invitation was received by the housing department leading to confusion over the status of the homelessness application amongst professionals from other organizations).

Worcestershire Acute Hospital Trust (WAHT)

- In all cases where physical abuse is suspected in a child less than 12 months of age, a clear view of the fundi must be obtained and a skeletal survey and CT head scan undertaken prior to discharge.

- When consultants have any difficulty deciding when physical abuse should be suspected they should discuss the case with the named or designated doctor or a senior consultant colleague.

- All child protection medical reports should be reviewed independently by a consultant colleague, preferably the named doctor for safeguarding children, before final submission to social services.

- All consultant paediatricians should have obtained at least level 3 safeguarding children training and must be able to demonstrate that their training is up to date.

- A model of safeguarding supervision and mentorship should be introduced within the Trust, for all consultant paediatricians, particularly those who are recently and newly appointed.

- In order to obtain a better assessment of the social circumstances of young/ vulnerable parents to be and their immediate family members, the antenatal and postnatal social assessment tool needs to be made more robust.

- A more in-depth assessment and recording of fathers health needs and social history, needs to be recorded early on during the pregnancy, and reviewed prior to the birth of the baby, particularly where the parents are young /vulnerable.

- Explore the possibility of introducing an electronic flagging system for the duration of maternity care of young/vulnerable pregnant women, using the Oasis data base within the trust.

- Immediately following the birth of a baby where there is known to be ongoing social worker/children's services involvement, a safeguarding divider is placed into the notes of the baby along with a summary of concern.

- To develop a social assessment tool relating to parents and their immediate family members for use by SCBU/Neonatal Intensive Care Unit and Neonatal outreach team.

- The 'parent/social' text box available on the Badger System discharge letter used by SCBU and Neonatal Intensive Care Unit needs to be completed for every baby, so that the current social circumstances/safeguarding issues for the baby are shared with other professionals involved with the family.

- The Countywide System to be used for notifying the health visitor of a woman's pregnancy, and receiving any feedback from the health visitor requires standardization, clarification and dissemination amongst health professionals.

- To clarify the countywide process of how midwives document and store information that cannot be recorded in the patient held green notes.

- To continue to monitor that all staff are accessing the relevant level of safeguarding children training.

Worcestershire Health and Care Trust (WHCT)

- Communication between the Midwifery Service in the Acute Trust and the health visiting service is improved in order to allow for robust assessment of families by health visiting services in the ante natal period.

- Trust Services working with children should clearly record in their assessments, that they have asked parents about other services they are engaged with and even evidence direct questioning of this.

- Trust Services working with adults should clearly record in their assessments, that they have asked parents about services that their

children are engaged with and even evidence direct questioning of this. The health visiting service should explore ways of recording third party information related to parental issues that relate to their own experiences of parenting in a way that is safe and does not breach information governance and confidentiality where this hasn't been readily disclosed by the parents. This is particularly the case where there is already children's social care involvement as there are identified needs.

Suggested Recommendations for other agencies made by Worcestershire Health and Care Trust

- All agencies working with children should clearly record in their assessments that they have asked parents about other services they are engaged with and evidence direct questioning of this.

- Children's Services staff working with families where there is an unborn or new born must ensure that the health visiting service is notified and becomes engaged with any assessment and child in need/ child protection processes.

NHS England (Arden Area Team)

- Policies and procedures should reflect LSCB safeguarding policies and procedures and should be followed at all times to ensure children and young people are safe and kept free from harm.

- GP Practice staff to undertake safeguarding training to include findings from serious case reviews and 'Think Family' agenda.

- GP Practices to ensure they have a robust system to promote and maintain communication links and information sharing between health & social care professionals and GPs.

- To ensure children and young people are safeguarded, it is essential that GPs make comprehensive and accurate records in a timely manner. In line with safeguarding policies and procedures GPs and Practice staff should log alerts on computer system to highlight concerns regarding individuals and families.

- GPs need to understand, that where there are safeguarding concerns, there is a requirement to share information with relevant agencies. Working together (2013) highlights the need for early sharing of information so that prompt intervention can help keep children safe and prevent harm. Additionally, information sharing is a statutory requirement for purpose of Serious Case Reviews/ Safeguarding Reviews.

- GP Practices should ensure regular supervision sessions with colleagues to promote reflective practice and discussion about

concerns.

Interagency

- Health Visitors and GPs need to ensure and maintain a robust system/means of communication regarding child safeguarding concerns especially when they are not based in the same building.

- Review the 'local NHS' process/ arrangement regarding transfer of GP records between GP Practices a)to prevent delay in access to patient GP records and b) to improve communication and information sharing between GP Practices by removing 'concealment' of previous GP Practice.

West Midlands Ambulance Service Foundation Trust (WMASFT)

- There are no recommendations for WMASFT.

14.3 The Health Overview Author makes the following recommendations:

- A review of the processes for identifying risk factors for teenage parents needs to be undertaken so that early referral to appropriate specialist services can be made. This recommendation should be incorporated into a 'pregnancy care pathway for teenage parents' developed and adopted by GPs, WHCT and WAHT. Professionals need to recognise and have a multi-agency service approach to try and engage with young parents who may be a 'child in need' themselves.

- NHS England Arden Area Team to develop an improved system of information sharing between GP practices when patients transfer to a different practice, where there are safeguarding or other concerns as happens with other professionals within Primary Care.

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Addendum to the Independent Overview Report of the Serious Case Review Concerning the Death of Child GW

Completed 3 March 2015

1 Introduction

1.1 The WSCB requested that an addendum report be completed in relation to this matter. The report will provide details on the outcome of the criminal investigation and information from the family engagement in the review.

1.2 The independent chair of the WSCB Quality Assurance sub-group has completed this addendum on behalf of the Board.

1.3 As well as providing information to the Board as an update, the author has advised the Board on the subject of publication of this report. The conclusion of this consultation is that the report should be published in full.

2 Criminal investigation

2.1 In June 2014 GW2 pleaded guilty to manslaughter and was sentenced to 9 years in custody.

2.2 GW1 was found not guilty of cruelty, however there was a hung jury for 'causing or allowing the death' of GW. She was retried for this offense and was found guilty. She received a suspended sentence of 9 months suspended for 12 months, and a 12 month supervision order in December 2014.

2.2 The trials were reported in the local and national media.

3 Family engagement

3.1 The WSCB were keen to engage with both Mother and Father in order to enhance learning. Meetings were undertaken with both GW1 and GW2 in February 2015.

3.2 The siblings of GW1 are now in the care of the Local Authority, and visits were undertaken with three of the older children. This was to establish if there was any additional learning to be gained from them, to provide them with information on the SCR, and to assess the impact on those children of the publication of the full report.

3.3 GW's Mother, GW1 is living in the community and has a Probation Officer she sees regularly since her conviction in December 2014. The author of this addendum report met with her to discuss the SCR, its publication, and to establish if any additional learning could be ascertained regarding the involvement with partner agencies of the WSCB during the period of the scope of the SCR, 1 October 2011 and 12 December 2012.

3.4 GW1 understood the need for an SCR and wanted to contribute. She stated that she felt there were lessons to be learned by the professionals involved.

3.5 The first issue she raised was that the majority of the work undertaken pre and post GWs birth was with her, and that GW2 was not consulted or involved to any extent. As he was also living with the baby she felt this was an oversight and the author agrees. Ages of Concern[2] summarises what has been identified in many serious case reviews in regards to this issue: 'Previous Ofsted reports have highlighted the lack of attention to the role of fathers or male members of the family. With cases concerning babies this message is a recurrent theme. Again and again, the reviews found that fathers had been marginalised, describing them as ignored, 'invisible' to practitioners or 'the ghost in the equation'. Because generally the mother is the parent who is seen much more frequently by practitioners, the reviews concluded that too often there had been insufficient focus on the father of the baby, the father's own needs and his role in the family.' This appears to have been the case here.

3.6 A further issue identified by GW1 was that she was in a violent relationship with GW2, who was physically abusive, emotionally abusive, and controlling. She did not feel safe enough to be able to admit this to practitioners. She was asked on occasion if there was any violence, but she always said no. This was because GW2 was always around at the time of the interview, and because she felt trapped with nowhere to go if she had to leave with the baby. The only support was from GW2's family. GW1 also stated that at the time she did not have any expectation of a non-abusive relationship, as she had grown up in a home where her Mother had a number of abusive partners.

3.7 GW1 was aware that GW was on a child in need plan, but interpreted this as having professionals to support with getting secure and appropriate housing. With hindsight she thinks that both she and GW2 should have had an in-depth parenting assessment to ensure they could safely parent their child, due to their age, their own family experiences and the concerns known about GW2's behaviour. She acknowledged however that even she did not believe that GW2 had the potential to kill their child until he admitted manslaughter.

3.4 GW's Father, GW2, is in prison. The author of this addendum report met with him to ensure he was aware of the SCR, the plan for publications and to hear his views on the involvement of agencies during the period in question.

3.5 GW2 accepted that he had issues with anger control and that he had no idea how to care for a small child. He also spoke of the stress of living in temporary accommodation, with various family members and in a damp flat. He also spoke about his frustration at being unemployed and having to survive on benefits. He stated that they had to spend £50 a week to run a dehumidifier.

3.6 GW2 spoke of domestic abuse in his relationship with GW1 and recognises he was not a good partner. GW2 continues to receive support for his ADHD while in custody and is being assessed for on-going mental health concerns. When asked about his sporadic use of his medication after the birth of GW,

[2] OFSTED: "Ages of Concern: Learning Lessons from Serious Case Reviews" October 2011

GW2 stated he wanted to stop using the medication to fulfil his wish of joining the army.

3.7 GW2 stated that his need for anger control sessions was the main missed opportunity prior to the death of his daughter. He recognised that he did not have the opportunity to build any relationship with any of the professionals involved in his daughter's case, and that he did not feel able to ask for help. He stated that he needed support, but no one asked him what would help.

3.6 The eldest of the siblings of Mother are settled in foster care. They had little contact with GW and her parents after her birth. They were able to share information, as they did in the criminal investigation, of GW2s poor anger control and the couple's isolation from the wider maternal family.

3.7 The children were not able to contribute to the learning of this review due to limited contact with their sister and her family. They all stated that they were glad that there was a review being undertaken into their niece's death.

3.8 The family's views on publication have been shared with the WSCB.

4 Learning

4.1 The additional learning that has been gained from the family engagement is as follows:

- Professionals who suspect domestic abuse in a relationship should always ensure that they ask the potential victim about this in an interview where the alleged perpetrator is not aware of either the question or the answer.

- Any assessment and plan for support should equally consider both the mother and the father/male partner.

5 Conclusion and recommendations

5.1 The WSCB can be satisfied that the relevant family members have been consulted. They have given their views and shared their experiences of the professional involvement in their child's life. Additional learning has been gained from this engagement as stated at 4 above.

5.2 There are no new recommendations for the WSCB in light of the family engagement in this serious case review. However the additonal learning should be shared in any briefings and training that the WSCB provide.