Local Safeguarding Children Board

Serious Case Review
Sofia

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1 Introduction

1.1 Why this case was chosen to be reviewed

The Tri-Borough Safeguarding Children Board[1] determined to conduct a Serious Case Review (SCR) because the circumstances of this case met the following criteria:

(a) abuse or neglect of a child is known or suspected; and
(b) (i) the child has died

(Working Together to Safeguard Children, 2013:68*)*

1.2 Summary of case

1.2.1 This case concerns the services provided to Sofia[2], a young child whose mother was a European National and suffering from breast cancer, as well as being homeless and living a transient lifestyle. It is thought that the mother had lived in Britain for approximately six years prior to 2012. During that time she was in a relationship and lived in a flat that was paid for by her partner. There is no record that the mother worked during this period and she did not claim benefits. The mother was not married to this partner who was thought to be in a financially secure position. The partner was not the father of Sofia and the relationship ended soon after the mother became aware she was pregnant. Following the mother's relationship ending with this partner, she had to leave the flat, and it appears that from this point forth she had no permanent address. Little is known about Sofia's father apart from that he is Asian and came to Britain on a student visa which expired in mid-2012.

1.2.2 The cause of Sofia's death has been determined as asphyxiation (the child aspirated food and choked). The preliminary autopsy findings suggested that she was significantly underweight and that prior to her death had experienced a number of historic injuries that did not appear to have been medically treated. At the time of her death Sofia was living with her mother and father in privately rented accommodation which was unsuitable for a child. They seemed to have no toys or baby equipment for her and she had not been seen by any professional for over nine months. It is noteworthy that during the period reviewed by this SCR, no professional knowingly had contact with Sofia's father, who was described by the mother as living abroad. It has become clear during the review process that the father was staying in Britain illegally and it is likely that the mother was deliberately concealing his whereabouts from professionals.

1.2.3 During the early part of Sofia's life she was seen by medical staff (including midwives, GP and health visitors) as well as being supported by social workers, housing professionals and the police. There was involvement during the review period by professionals from seven local authority areas: City of Westminster, Camden, Haringey, Hillingdon, Ealing, Luton and the London Borough of Hammersmith and Fulham. During this time concerns were raised about the mother's accommodation and financial difficulties but no professional deemed Sofia to be at continuing risk of significant harm and no evidence of physical injury or neglect was confirmed. When Sofia was three months old her mother moved without notice and Sofia was not seen again by any professional until her death.

[1] London Borough of Hammersmith and Fulham, Royal Borough of Kensington and Chelsea, City of Westminster

[2] Sofia is not the real name of the child who died but is a pseudonym given for the report to ensure that appropriate anonymity is

[2] Sofia is not the real name of the child who died but is a pseudonym given for the report to ensure that appropriate anonymity is maintained for the wider family members

1.2.4 At the time of writing this report there are ongoing police investigations and both parents have been interviewed by the police and are on bail. It is likely that they will be charged separately and at present it is probable that the charges will be neglect.

1.3 Family composition

Professional contact with the family was limited to Sofia and her mother as her father was reported to be in India. It is probable that he was in fact living in London throughout the review period and may have been seen at a distance in the hospital immediately prior to Sofia's birth, when he was described by the mother as a friend. There was telephone contact with the maternal grandmother who lived in Europe. There was no contact with paternal grandparents who are reported to live in Asia and nothing is known about the wider family. Sofia's mother had a previous relationship for six years prior to January 2012.

Family member	**Age at October 2013**
Mother	34 years old
Father	26 or 29 years old
Sofia	1 year old
Maternal grandmother	Not known
Mother's previous partner	52 years

1.4 Timeframe

The review period is from January 2012, when professionals first became aware that the mother was pregnant, until October 2013, when the mother contacted emergency services and Sofia was found to be in a very poor condition and soon after died.

1.5 Organisational learning and improvement

Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including serious case reviews states that:

'Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.' (*Working Together* 2013:65) and

'Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.' (*Working Together* 2013:66)

Triborough Safeguarding Children Board (LSCB) identified that the SCR of this case held the potential to shed light on particular areas of practice including addressing the following questions:

- What does this case tell us about support that is available for mothers and potential mothers who are not going to get assistance from the state as they have no leave to remain?
- What does this case tell us about how the system monitors and works with babies whose parents have not been given leave to remain?

- What does this case tell us about how agencies work together when working with a mobile family who do not wish to cooperate, and have no leave to remain?
- What does this case tell us about how well professionals are able to track transient families when they move within London?
- What does this case tell us about how well professionals are able to track transient families out of the London area (and back in again) – how well do organisations outside London know and understand how organisations in London work to track families?
- What does this case tell us about the effect on families of making emergency housing placements at some distance outside the authority area?
- What does this case tell us about how we work with people whose first language is not English?

2. Methodology

2.1 Statutory guidance requires SCRs to be conducted in such in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings. (2013: 67)

It is also required that the following principles should be applied by LSCBs and their partner organisations to all reviews:

- there should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process (2013: 66-67)

In order to comply with these requirements the Tri-Borough LSCB has used the SCIE Learning Together systems model (Fish, Munro & Bairstow 20010). Detail of what this has entailed is contained in the Appendix 1 of this report.

2.2 Reviewing expertise and independence

The SCR has been led by two people independent of the case under review and of the organisations whose actions are being reviewed. Fiona Johnson and Sally Trench are both accredited to carry out SCIE reviews, and have extensive experience in writing SCRs/IMRs under the previous 'Chapter 8' framework. Neither has any previous involvement with this case, or any current relationship with the local authorities or partner agencies[3] involved in this case.

The lead reviewers have received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

2.3 Acronyms used and terminology explained

Statutory guidance requires that SCR reports be written in plain English and in a way that can be easily understood by professionals and the public alike (2013: 70) Writing for multiple audiences is always challenging. Throughout the report footnotes are provided

[3] Sally Trench is the independent Chair of one of the Tri-borough Adoption & Fostering Panels but has no direct involvement in managing staff or services through this role

to explain relevant aspects of professional practice. In the Appendix 2 we provide a section on terminology which aims to support readers who are not familiar with the processes and language of the safeguarding and child protection work. Tri -Borough LSCB and SCIE are both keen to improve the accessibility of SCR reports and welcome feedback and suggestions for how this might be improved.

2.4 Methodological comment and limitations

2.4.1 This was a very complex serious case review as it involved five Local Safeguarding Children Boards, five different children's social care departments, one adult social care department, three GP practices and three health visiting services as well as a hospital and the police. A multi-agency, cross-area Serious Case Review Panel, that was independently chaired, was established to oversee the review process. The aim of this group was to ensure that all agencies were fully involved in the process and that any difficulties could be resolved speedily.

2.4.2 Participation of professionals

The lead reviewers and the review team have been impressed throughout by the professionalism, knowledge and experience that the case group (the professionals involved with the family, from all agencies) have contributed to the review; and their capacity to reflect on their own work so openly and thoughtfully in the review process. Several case group members have remarked that it has been a positive experience to contribute to learning from the tragedy. All this has given the review team a deeper and richer understanding of what happened with this family and within the safeguarding network and why, and has allowed us to capture the learning that is presented in this report.

Police involvement in the review process was severely limited by the resourcing difficulties currently experienced within the Metropolitan Specialist Crime Review Group. This meant that the police representative on the review team was only able to attend two out of eleven meetings.

Luton Borough Council, supported by the LSCB, was not able to commit staff to participate in the full schedule of review meetings which they thought would have entailed their staff attending 11 days of meetings. This was not considered proportionate to the level of involvement Luton had in the case and the likely learning for the LSCB. Agreement was reached at an early stage about how Luton would participate and Luton cooperated fully with this. The lead reviewers went to Luton to meet with the relevant front-line staff and these staff provided useful information about their limited involvement with the family. Luton was also represented at all SCR Panel meetings.

It may have helped some of the review team's understanding of Luton's involvement if staff had been invited to attend one of the multi-agency case group meetings. The review team regretted that this option was not considered or suggested to Luton.

2.4.3 Perspectives of the parents

As the parents were both the subject of a criminal investigation throughout the review it was not possible to involve them in the review process. This was a severe limitation on the review as they were the only people who could inform the review team about what happened to Sofia between January 2013 and her death in October 2013. It also meant that it was not possible to know the reasons for their avoidance of professional contact after December 2012. It is assumed that this was because of concerns about the father's immigration status but without talking to the parents it is not possible to know whether there were other factors. Similarly we were not able to fully understand why the mother did not wish to return to Europe where she would have been able to access better financial support.

2.5 Structure of the report

Section 1 of the report provides background information and Section 2 describes the methodology used to undertake the review. Section 3 is an overview of 'what' happened in this case and 'why' - providing an appraisal of professional practice and including the review team's judgements about the timeliness and effectiveness of interventions. This leads on to Section 4 which is a presentation of the eight priority findings about what needs to happen in the multi-agency safeguarding system to reduce the risks of recurrence. Each finding concludes with some key questions for LSCB member agencies. It is the responsibility of the LSCB to decide how best to respond to the findings, with the aim or reducing the recurrence of poor practice. The questions are intended to support their considerations. Appendix 1 provides more detail about the methodology used in the review, Appendix 2 is a glossary of terms and abbreviations used in the report and Appendix 3 is a bibliography.

3. Professional practice appraisal

3.1 This section provides an overview of 'what' happened in this case and 'why'. The purpose of this section is to provide an appraisal of the practice that is specific to the case and it therefore includes the review team's judgements about the timeliness and effectiveness of practice including where practice was below expected standards. Such judgments are made in the light of what was known and was knowable at that point in time. For some aspects of the case the explanation for 'why' will be further examined in the findings in section 4 and a cross reference will be provided.

3.2 Despite the fact that contact was eventually lost with Sofia and her mother, overall the review team were impressed by the tenacity with which many frontline professionals worked to keep in contact with the mother regardless of her apparent unwillingness to trust them and her deliberate evasion of contact. The midwives who supported the mother during her pregnancy and birth particularly are to be commended for their repeated referrals to Westminster CSC and their commitment to supporting the mother once Sofia was born including ensuring that she was given all possible advice about her options for treating her breast cancer both prior to and after the birth. Further positive practice was that all professionals had considered the mother's language needs and she was offered interpreters, including telephone interpreting, throughout the review period. All professionals, however, were clear that the mother read and spoke good English.

3.3 Sofia's mother discovered that she was pregnant in January 2012 when she had a routine pregnancy test prior to receiving treatment for her breast cancer. During the mother's pregnancy she was seen regularly by midwives who identified early that she needed additional support because of her housing problems and breast cancer. In April 2012 she was referred by midwifery to Westminster Children's Social Care (CSC) for an assessment. This first referral was not progressed because her problems were primarily deemed to be related to accommodation and so she was referred to the Westminster Housing Options Service. Usual practice is to delay conducting a pre-birth assessment until the pregnancy has been shown to be viable and the review team felt that this practice was understandable given that the pregnancy was at an early stage.

3.4 The mother was seen by Westminster Housing officers on three occasions during her pregnancy and they consistently and correctly assessed her as not meeting the criteria for re-housing as a homeless person because she was an EU national who was neither working, nor part of a household where someone was working, nor a self-funded student. The mother was provided with appropriate advice about finding accommodation in the private sector and was given details of voluntary sector organisations which could provide support, including day and family centres. A significant challenge for all members of the review team was in understanding the housing and benefit legislation that was applicable to the mother's situation. This was complicated by a number of professionals wrongly using terms such as 'not eligible for public funds' and reflected the complexity of current legislation which is not well understood by workers in all agencies, and contributes to potentially ill-informed responses. The impact of this is examined in **Finding 1**. The review team were aware of the pressures upon the very busy Assessment Service in Westminster CSC, and staff reported how difficult it could be to refuse funding for accommodation to ineligible homeless people.

3.5 Two further referrals were made by midwifery staff to Westminster CSC, one in August 2012 that reported that the mother was now 'street homeless' and continued to be vulnerable because she was over seven months pregnant and had breast cancer. At this point Westminster CSC decided that as the child was unborn, and there were no

additional indicators of abuse, responsibility for providing assistance lay with Westminster Adult Services. This decision was not in accordance with expected practice given the late stage of the pregnancy and the need to plan for the unborn baby. At a minimum there should have been an assessment of need conducted jointly by Adults and Children's Services. The review team identified that the custom and practice, at this time, was that Westminster CSC would not undertake an assessment of a homeless pregnant women prior to the birth of the child unless known indicators of abuse (such as domestic abuse, substance misuse and mental ill-health) were present; this is explored further in **Finding 2**. This practice may reflect the very high level of housing-related demand from foreign nationals with limited incomes in Westminster. At this point the mother had also accessed legal advice, via the Bayswater Family Centre[4], and lawyers contacted Westminster Council, on the mother's behalf, asking for an assessment and accommodation. In response to this letter, attempts were made by Westminster Adult Services to provide bed and breakfast accommodation but there were delays in finding a placement and the mother made her own arrangements. Apart from one night in hostel accommodation no accommodation was provided to Mother during the pregnancy. Scrutiny of housing records for the review period showed that no rough sleeping agency had contact with the mother when she was said to be 'street homeless'.

3.6 The mother was not allocated a social worker to undertake an assessment of need until after the birth of her child. Because of this Sofia and her mother remained in hospital for nine days whilst arrangements were made to provide them with temporary accommodation. While it was very positive that the hospital did not force the mother to leave when she had no accommodation it was clearly not in Sofia's interests for her to remain in hospital because of a lack of planning for her future. There was significant delay in Westminster CSC undertaking an assessment (which should have started before the child's birth) because of the previous decision that responsibility for undertaking an assessment lay with ASC until after the birth of the baby. After the baby was born there were also delays due to difficulties in finding accommodation for Sofia and her mother and also because the allocated worker was off work due to sickness.

3.7 After Sofia was born a social worker from Westminster CSC arranged for her and the mother to be housed on a temporary basis in bed and breakfast accommodation in Haringey. There was delay in finding this accommodation which meant that it was not possible to arrange a discharge planning meeting involving the local community health staff. At the point of discharge the midwives provided the mother with clothes for Sofia and the social worker provided baby milk. However there was no crib and Sofia had to co-sleep with her mother. She was visited speedily by a midwife and health visitor working in Haringey. All professionals worked proactively together to support the mother and provided her with baby equipment, including a 'moses' basket and bedding. There was evidence of good inter-agency working to support the family at this point. The social worker started an assessment and made contact with the relevant embassy and maternal grandmother in Europe in order to see whether there were impediments to the mother returning there with Sofia. A human rights assessment was undertaken on the mother to determine whether it was safe for her to return to her country of origin. This determined that it was appropriate for her to return to Europe and the mother was advised that she could be given financial assistance to do this. Professional advice was given to the mother that return to Europe was the best option for her and was the best means to resolve her housing and income issues. The mother indicated however that she did not wish to do so and the social worker had some sympathy with that position as the maternal grandmother had not presented as a positive support. The exploration of

[4] Bayswater Families Centre offers support to: Vulnerable families in Westminster who are homeless, in temporary accommodation or threatened with homelessness. Families who have experienced domestic abuse. Families needing parenting skills or support with finding work.

the mother moving back to Europe was appropriate – this was a clear option for helping the mother, given that she would be eligible for benefits in her native country. The social worker however also needed to consider the needs of the child. If the mother continued to refuse to return to Europe there was another potential option which was the use of section 17 funds[5] to provide medium-term support for the mother until she was able to work. This alternative was not explored at this point and it was probably too early in the assessment for it to be fully considered. It was apparent however to the review team that there was little awareness of this option amongst staff. It is likely that this would not have been a route that would have been favoured by managers, given the high level of expenditure involved. The issue of what options are available to staff working with families from abroad with benefit issues is explored further in **Finding 1.**

3.8 Sofia and her mother remained in bed and breakfast accommodation in Haringey (placed by Westminster) for nine days and then left without notice and without advising professionals of their move or providing a forwarding address. The social worker and health visitor made (unsuccessful) attempts to trace the mother and contacted Hillingdon CSC as she was reported to have requested a taxi to take her to Hayes. The mother was not reported as a missing person and, as professionals did not have child protection concerns, a missing child alert was not raised with regard to Sofia. This was considered a legitimate decision by the review team and case group as these alerts are usually limited to missing children where there are active child protection concerns.

3.9 In fact the mother and Sofia had moved to Ealing where immediately the mother registered herself and Sofia with a GP. Although the GP did record the fact of Sofia's registration, the GP did not inform the allocated health visitor or the health visiting team of the family's registration. There appeared to be no consistent approach to assuring that families registering at the GP Practice, with children under five years, were reported in a timely way to health visiting services. The GP was unaware that there was an electronic system for informing health visitors about new arrivals and placed the information in a message book which was not accessed for over a month. This resulted in a delay in allocating a health visitor and contact being made with the family. The mother did not take Sofia for her six to eight-week developmental assessment and Sofia was not seen until five weeks later when she was taken by her mother to a drop-in health visitor clinic. The issue of communication and liaison between health visitors and GPs is considered further in **Finding 3**.

3.10 The health visitor at the clinic was concerned that the mother appeared to have no regular income and was saying that she spent all her money on rent, eating at a local temple. When the health visitor examined Sofia she observed that Sofia's weight gain was poor. She therefore suggested to the mother that the child's weight should be regularly monitored and when the mother refused to co-operate, the health visitor made a referral to Ealing CSC. This was considered by the review team to be a positive response by the health visitor.

3.11 Ealing CSC responded to the health visitor referral immediately and attempted a home visit involving the police to support them in accessing the house where the child was said to be staying. On gaining access to the premises the social workers found that the family were not living at the address that had been given to the GP and health visitor and despite telephone contact with the mother were not successful in seeing the child. As a result they started a section 47 inquiry[6], following a telephone strategy discussion

[5] Section 17 of the Children Act 1989 (S.17) gives local authorities the power to provide accommodation and financial support to families with 'children in need

[6] s.47 enquiry refers to section 47 of the Children Act 1989 which gives local authorities the duty to 'make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote

with the police that agreed a single-agency investigation by Ealing CSC[7]. The main concerns considered at the strategy meeting were the child's failure to gain sufficient weight and the mother's unwillingness to co-operate with regular oversight of Sofia by the health visitor. Although the health visitor had made the referral, and had the most contact with the mother, the practice of using a telephone strategy discussion, between CSC and Police, meant that she was not involved in this process. The review team felt that this contributed to an over-emphasis on concerns about weight gain, and a lack of consideration of the health visitor's other concerns. The absence of health input to strategy discussions is examined further in **Finding 4**.

3.12 As Sofia's whereabouts were unknown, and there were concerns about her well-being, a national missing child alert was also issued by the local authority and the social worker reported her missing to the police, which was good practice. After four days, the mother made contact with the police and the mother and Sofia were seen at the police station by social workers. Ealing CSC then arranged for the family to be temporarily housed in bed and breakfast while an assessment was completed. The mother was provided with financial support and was bought bottles and formula as it appeared that she did not have any baby equipment. Ealing CSC also arranged for Sofia to be seen by a paediatrician because of the concerns about her weight gain. The mother failed to co-operate with the medical assessment, was unwilling to answer the doctor's questions and refused to undress her daughter. At this stage the social worker discussed with the police the possibility of placing the child in foster care using police protection powers.[8] This did not happen because the mother agreed to Sofia being medically examined by a paediatrician. The paediatric assessment did not identify any worries about Sofia who was described in the report as 'a healthy happy child with an acceptable weight gain and no medical concerns'. The outcome of the medical examination was a reduction in child protection concerns about Sofia within the multi-agency group. The review team's opinion was that this was not justified given that the other factors of concern had not been addressed. The review team was concerned about professionals' understanding of neglect and the degree to which there was undue focus on physical manifestations such as weight gain and less notice taken of more complex issues such as life-style and willingness to accept professional advice. This is examined in **Finding 5**. It was notable that, at this time, no professionals considered the mother's destitution and transient lifestyle to constitute a 'safeguarding' issue – despite the clear risk that Sofia's health and wellbeing could be endangered by the mother's material poverty. It appeared that professionals judged 'safeguarding concerns' according to their understanding of the mother's intention, rather than from the perspective of the child's experience. This is explored further in **Finding 6**

3.13 At this point the social worker in Ealing had started, but not completed, a child and family assessment of the family's needs[9]. Although the social worker considered that the child protection investigation was completed, she had not fully assessed whether the family would be best supported in the longer term via a child protection plan or as a 'child in need'. As the assessment had not been finished there had not been any management decision about the recommended outcomes from the assessment. The manager had been involved in supervising day to day decisions but had not reviewed

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the child's welfare' when they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm (Working Together 2013)

[7] A strategy discussion or meeting is convened when there is reasonable cause to suspect a child has suffered or is at risk of suffering significant harm. The purpose if for agencies to share information and decide whether to initiate or continue enquiries under s.47 of the Children Act 1989, and to plan any such enquiries (Working Together 2013)

[8] Under section 46 of the Children Act 1989, where a police officer has reasonable cause to believe that a child could otherwise be likely to suffer significant harm, the officer may: remove the child to suitable accommodation (Working Together 2013)

[9] 'An in-depth assessment which addresses the central or most important aspects of the needs of a child and the capacity of his or her parents or caregivers to respond appropriately to these needs within the wider family and community context'. (Framework for the Assessment of Children in Need and their Families DH 2000)

with the worker the best way to safeguard Sofia in the future. There was a delay in completing the assessment and there was also no inter-agency strategy discussion (either meeting or by phone) to agree further action following the ending of the child protection investigation. Best practice would be to hold an inter-agency strategy discussion at the end of the investigation which could consider options for the longer term planning for the family. The delay in completing the assessment was in part, because the social worker was on leave for a week. Another pressure identified within the team was how to respond to a major increase in numbers of referrals, without any extra resources. This had been reported to senior managers and action was taken soon afterwards to resolve the situation but at the time all staff were working under significant and growing pressures.

3.14 In the event the mother and Sofia remained in bed and breakfast for three weeks paid for by CSC and then left abruptly, apparently to move to an address (this time, given by the mother) in Luton. When the mother moved the Ealing social workers contacted the Luton Duty Social Work team on Christmas Eve and asked them to visit. There is significant confusion about the status of this referral to Luton. The form that was used to pass on the information was entitled 'child in need, including child in need of protection'. The Ealing social worker considered that the immediate child protection concerns had been resolved but that she was still assessing their longer term needs. She was also clear that Sofia needed ongoing support and that if the mother had not left Ealing the recommendation would have been for longer term work with a social worker. The social worker was less confident about the nature of that support and considered that it might have been as a 'child in need' but might also have been as a child subject to a child protection plan depending on the outcome of the assessment. This meant that status of the referral to Luton was not clear. The request was treated as a welfare visit to establish the whereabouts and wellbeing of the child. This was because there was no explicit request in the papers sent from Ealing to follow this up as a child protection concern and it appeared from the papers that the child protection issues had been resolved by the positive medical examination that had taken place in Ealing. The task was therefore to locate the child and determine whether further assessment was required. The report that was passed by Ealing to Luton was detailed and did fully record the child protection investigation and the concerns about Sofia that had been identified. These concerns were confirmed by the Luton Team Manager who indicated that at the time he was surprised that the referral had not been made with a child protection status. Case transfer is a time when there is a need for clarity about the status of intervention that is required. Given that the assessment in Ealing was not complete and had not been written up it would have been better if the referral had been made indicating that Sofia was the subject of an incomplete child protection assessment. This is explored further in **Finding 7**.

3.15 Over the Christmas period attempts were made by Luton social workers to contact the mother and visits were made to the address that she had given, but these were unsuccessful. In early January 2013 there was telephone contact between the Luton duty social worker and the Ealing referring social worker which agreed that further efforts would be made in Luton to contact the family. Soon after this conversation the Ealing social worker closed the case without writing up the assessment or checking that Luton had made contact with the family. Despite significant efforts the Luton social worker was not able to find Mother and after three weeks, and discussion with the manager, it was concluded that it was possible that the family had not moved to Luton. The Luton social worker then wrote to Ealing CSC advising them that they had not been able to see Sofia. Following this the case was closed to Luton CSC. The review team considered that the absence of direct communication between the practitioners in Ealing and Luton at this stage was not the best practice. Neither Luton CSC nor Ealing CSC knew whether Sofia had been found at the point that they respectively closed the case. The mother's earlier

behaviour had shown that she was not prioritising Sofia's needs and neither service should have closed the case until they knew that the child's whereabouts had been confirmed.

3.16 After the move from Ealing Sofia remained registered with the same GP in Ealing. The health visitor was aware that the family was reported to have moved to Luton but did not make contact with health visitors in Luton or transfer Sofia's health visiting records. The expected practice would be that the Ealing health visitor would make contact with the Luton Health visitor and arrange a transfer of records. The review team were concerned that as Sofia had previously been assessed as needing additional health visiting service (enhanced) there should have been greater effort placed on contacting the Luton health visitors.

3.17 In February 2013 the Ealing GP's, Practice Manager telephoned the mother about Sofia's immunisations and was told that Sofia was in Europe with her grandmother. The review team have not been able to find any evidence that Sofia ever left the UK. In April 2013 the Ealing health visitor noticed that the mother's address had changed on the NHS spine[10] and that she had given an address in Westminster[11]. She then made a verbal referral to Westminster health visitors. In May 2013 the Westminster health visitor tried to contact the mother by phone on two occasions but when there was no response sent an SMS message asking her to contact the health visiting team to arrange a home visit. The mother did not respond and there was no further action taken by the health visitor who did not comply with local procedures regarding accessing families who are avoiding contact.[12]It is noteworthy that the health visitor did not attempt to visit the address as this would have identified that it was in fact a day centre for homeless people and not a 'proper' home address for the mother. In June 2013 the health visiting records were transferred from Ealing to Westminster but there was no direct contact between the health visitors. The records were not accessed by the Westminster health visitors who therefore did not know about the past history. This practice was not in accord with health visitor guidance. The issue of transfer arrangements for mobile families is discussed further in **Finding 8.**

3.18 It is not known where Sofia and her mother were living between December 2012 and October 2013. There is no evidence that during this time Sofia was seen by any professional and her personal child health record, known as the 'red book', which was taken by the police in the criminal investigation, has no evidence of any further contact with a health professional. An issue of significant concern for the review team was that there was no evidence that Sofia was seen by a health visitor during the last nine months of her life. This was despite previous concerns about her weight gain which meant she was assessed as needing an 'enhanced' health visitor input which should have required her to be visited more frequently.

3.19 Sofia's mother contacted the ambulance service during the night in October 2013 reporting her daughter's medical crisis. She appeared to be unable to give the address where she was living and was barely comprehensible to the ambulance control desk staff which led to delays in the ambulance dispatch to her address in Hammersmith. Initially it was thought that these communication difficulties were caused by the mother being unable to speak English, but the review has established that she spoke fluent English. It appears more likely therefore that the communication difficulties were due to the mother's state of mind, and potentially a lack of knowledge of details such as the address. The ambulance arrived at 04.36am, when Sofia was found lying on the floor

[10] The NHS Spine includes The Personal Demographics Service (PDS) which is the central and single source for patient demographic information, such as NHS number, name, address and date of birth.
[11] This address was identified by the review team to be a day centre for the homeless
[12] CLCH (2013) Safeguarding and Young People Procedure. CLCH

limp, unconscious and unresponsive, cyanosed; vomit was cleared from her airway and cardiopulmonary resuscitation was commenced. Sofia was taken to hospital arriving at 04.40 and CPR was continued by hospital staff but her condition did not improve. Sofia was pronounced dead at 05.21.

4 The findings

4.1 Introduction

Statutory guidance requires that serious case review reports provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence. Section 3 provides the analysis of what happened and why, whilst section 4 provides the findings about what needs to happen in the multi-agency safeguarding systems to reduce the risks of recurrence. The SCIE Learning Together systems approach uses the learning from an individual case to provide a 'window on the system' into how well the local multi-agency safeguarding systems are operating.

4.2 What light has this case review shed on the reliability of our systems to keep children safe?

4.2.1 This case review has highlighted the difficulties for professionals working with families who are avoidant and resist supportive interventions. With hindsight it is probable that the mother was fearful of agency involvement because her boyfriend was staying in the community illegally and therefore she was never honest with any professional which made it almost impossible for any assessment to be effective. There are aspects of this case that were unique and unlikely to be replicated, in particular the mother's significant health problems. It was clear, however, that the complexities of working with transient families who live in significant poverty because they are unable to access benefits could be generalised, This is also a growing problem in London with increasing house costs, changes to benefits and a population that is becoming increasingly mobile.

4.2.2 In order to help with identification and prioritisation, the systems model that SCIE has developed includes 6 broad categories of these underlying patterns. The ordering of these in any analysis is not set in stone and will shift according to which is felt to be most fundamental for systemic change:-

- Innate human biases (cognitive and emotional)
- Family-professional interaction
- Responses to incidents
- Longer term work
- Tools
- Management systems

There is, of course, overlap between categories. The precise nature of each Finding, expressed in its headline, forms a sub-category within each pattern.

4.2.3 The task in developing each finding is to present a clear example of how the issue manifests itself in the case, and then to:

- identify in what way it is an underlying issue – not a quirk of the particular individuals involved this time and in the particular constellation of the case;
- highlight any information gleaned about how general a problem this is perceived to be locally, or data about its prevalence more widely;
- be clear about why it matters; and
- state how the issue is usefully framed for the LSCB to consider relative to their aims and responsibilities, the risk and reliability of multi-agency systems.

4.3 Summary of findings

4.3.1 This section contains eight priority findings that have emerged from the serious case review. The findings explain why professional practice was not more effective in protecting Sofia. It does this by considering patterns that are supportive of good quality work and patterns that introduce or increase risk to the reliability with which we can expect professionals to achieve good quality work.

4.3.2 Each finding also lays out the evidence identified by the review team that indicates that these are not one-off issues. Evidence is provided to show how each finding is indicative of potential risks to other children and families in future cases, because they undermine the reliability with which professionals can do their jobs. Findings for which there is only initial or emerging evidence of prevalence outside this case have been presented as questions.

4.3.3 The review team have prioritised eight findings for the LSCB to consider and they are listed below: -

	Finding	**Category**
1	There is a pattern, particularly across London, whereby the complex nature of housing and benefits legislation (as it applies to foreign nationals) means that professionals are ill-equipped to explore all options open to families.	Communication and collaboration in longer term work.
2	Is there a pattern in Westminster Children's Social Care whereby high demand is managed by setting a threshold for accessing services, such that homeless pregnant women are not assessed where housing is deemed to be their primary problem, potentially placing their unborn children at risk?	Human–management system operation
3	Because there is no single system for passing information between GPs and health visitors, in a formalised and standardised way, reliable oversight of babies' health is undermined.	Communication and collaboration in longer-term work
4	There is a pattern in London whereby strategy discussions have become 'diluted' to a brief telephone communication between Police and Children's Social Care, resulting in other agencies not being included in strategy discussions, even when they have the greatest knowledge of the family.	Communication & collaboration in responses to incidents
5	There is a pattern of professionals over-focussing on physical manifestations of neglect such as weight loss and failing to identify more complex less visible, indicators.	Communication and collaboration in long term working.
6	A tendency to assess risk from the parent's perspective, and not to focus on the child's experience, means that destitution, and resulting transience, are not seen as potential child protection issues.	Communication and collaboration in long term working.
7	Being unable to complete an assessment because a family is 'avoidant' at point of transfer may lead to children inappropriately being described as 'in need' rather than 'in need of protection'.	Communication and collaboration in long term working
8	Is there a pattern in London that insufficiently robust handover arrangements in Health Visiting can mean that when avoidant families with vulnerable children move, they may become 'lost to the system' and therefore at risk of possible harm?	Communication & collaboration in response to incidents

4.4 Findings in detail

4.4.1 Finding 1

There is a pattern, particularly across London, whereby the complex nature of housing and benefits legislation (as it applies to foreign nationals) means that professionals are ill-equipped to explore all options open to families.
(Communication and collaboration in longer term work).
All professionals working with vulnerable families must work within the relevant legislative frameworks, particularly in determining to what services and benefits individuals are entitled. For cases such as this, involving individuals from outside the UK, these frameworks can be extremely complex. This case has suggested that there is inconsistent understanding of these frameworks by professionals which undermines their confidence in exploring all options.

4.4.2 How did the issue feature in this particular case?

Prior to January 2011 the mother had lived in Britain for six years supported financially by her partner and not working. Her accommodation and financial problems began when she became homeless and was unable to work because she was pregnant (with a different partner) and had breast cancer. Throughout the review period the mother was directed to specialist advice and was given correct advice about the benefits to which she was entitled, and a lawyer also lobbied Westminster Council on her behalf.

The mother was ineligible for publically funded housing or maintenance because she had not previously worked in the UK. The mother was eligible for assistance in her home country in Europe but did not wish to return there. The only assistance she was eligible for in the UK was via the National Assistance Act 1948 which required that she was destitute and had no resources to support herself; or under section 17 of the Children Act 1989, which gives local authorities the power to provide accommodation and financial support to families with 'children in need', if they have no recourse to public funds. Both these forms of assistance are intended to be short term and to support individuals in emergencies. They are also funded from very limited budgets which are subject to close scrutiny by the local authority in question.

All professionals involved with Sofia and her mother were clear that she was not entitled to claim most state benefits or housing from the council. When asked in what context the mother could have claimed most professionals were less clear and did not understand that if the mother had been available for work then she might have been able to claim some benefits. On a number of occasions the review team was erroneously told by front line professionals that the mother had 'no recourse to public funds' or was not entitled to claim any state benefits because she was not a British citizen.

Most professionals reported to the review team that they understood that in the long term the mother's choices were limited to 'returning to Europe' or her child becoming 'looked after'[13] by CSC. As the mother was consistent in saying that she would not return to Europe, frontline professionals were presented with a dilemma as they did not know what alternatives were available to her. This lack of clarity meant that they did not have the confidence to challenge managers who were advising the mother to return to Europe as they were concerned to avoid a significant pressure on limited budgets.

[13] Under section 20 of the act local authorities must provide accommodation for any child in need who has no-one with parental responsibility to care for them. This may also be extended to children that have a parent available if it is deemed that by staying with them it would put the child at risk.

In fact, there was a third legally possible option. This was to support the mother in the medium-term, using Section 17 funding, until she was able to work, at which point she could have claimed both housing benefit and working tax credit and child tax credit. It is probable that she would have required assistance with a 'rent deposit' to access privately rented accommodation (as most privately rented flats require a significant lump sum as a deposit) but managers in both Ealing CSC and Luton CSC did identify this as a possible way forward. It was clear to the review team that this was not understood by all front line professionals and that because it was a very expensive option would be used very rarely and was not encouraged by managers.

4.4.3 How do we know it is an underlying issue and not something unique to this case?

Many people who come to the UK cannot get public funds. 'Public funds' means most welfare benefits and local authority housing but does not include NHS treatment or attending a state school. However foreign nationals from within the European Economic Area (EEA) are treated differently as they have the right not to be treated worse than a British citizen. In practice an EEA jobseeker who has never worked in the UK is not able to claim benefits such as Income Support, income-based Jobseeker's allowance, Child Benefit, Housing Benefit or Council Tax Reduction. An EEA worker who has been employed in the UK before becoming unemployed may be able to claim benefits whilst looking for new work. This varies dependent on which EEA country the foreign national is from and how long they have worked in the UK. When an individual becomes destitute (that is, has no money or resources and is homeless) they may be entitled to support from Adult Services under the National Assistance Act 1948 and if a person with children is destitute then Children Social Care may assist under Section17 of the 1989 Children Act. Neither of these legal frameworks was intended to provide long-term support and the 1948 National Assistance Act was brought in to replace the Poor Law and was intended as a short term safety net to cover those members of the population who had not paid National Insurance contributions.

The rules about EEA nationals claiming benefits are described as being very complicated by experienced agencies such as the Citizens Advice Bureau. All of the professionals involved in this case (including specialist agencies such as Housing) reported that the regulations are very complex and that it is almost impossible for the lay person to be clear about what support could be provided. Discussions with the review team and case group showed that almost universally professionals lacked confidence in their understanding of benefit legislation and that this influenced their planning and work with families. Interestingly feedback from the case group identified that in Haringey and Ealing there are specialist teams who work with people in the mother's circumstances and it was suggested that professionals in these teams are able to become more experienced and knowledgeable about benefit entitlement.

4.4.4 How common and widespread is the pattern?

It is difficult to obtain accurate data about the numbers of families who are affected by these issues. Most records are of people claiming benefits, not of those who are unable to claim because they are not deemed to be entitled to benefits. According to Department of Work and Pensions estimates, of the 1.44m people claiming job seekers allowance in 2011, 8.5% of these were non-UK nationals, of which fewer than 38,000 claimants were from EU countries (approximately 2.6%). And the claimant rate for EU nationals of working age is around 3%, compared to about 4.5% for the native population.[14] However, a report by Michael O'Connor, a former policy official at HMRC,

[14] 'Nationality at point of National Insurance number registration of DWP benefit claimants': Department of Work and Pensions January 2012

suggests that migrants are more likely to be claiming working tax credit than the rest of the population. The data shows that 14.6 per cent — or one in seven people — claiming working tax credit is a non-UK national. It also disclosed that one in six people — or 17.6 per cent — of those claiming both working tax credit and child tax credit is a non-UK national.[15] Anecdotal evidence from case group members was that within Westminster there are high numbers of families who are foreign nationals and unable to support themselves and who are not able to access benefits. They commented that although the mother's particular circumstances were extreme (pregnant and with breast cancer) there were significant numbers of families with similar benefit problems.

4.4.5 What are the implications for the reliability of the multi-agency child protection system?

As a foreign national unable to support herself and without access to benefits the mother became both homeless and destitute placing her child in significant poverty and at risk because of her destitution. Ascertaining the services and benefits to which non-UK nationals are entitled is a complex area; at present, inconsistencies in understanding of this legislation can mean that:

a) in the short term, families may not receive all the support to which they are entitled;
b) longer term planning for families may be based on false assumptions about what they will, or will not, be entitled to.

This can in turn mean that support and planning for families is limited, leaving children at greater risk. Staff therefore require support to better understand this legislation, either directly or by making greater use of specialist services, such as the Bayswater Family Centre involved in this case. It is important to note that, even with consistently accurate interpretation of housing and benefits legislation, some non-UK families, living in the UK without the means to support themselves, will be left in an extremely vulnerable financial position which could potentially place any children at risk. However, this is an issue for national, rather than local, policy-making.

Finding 1: There is a pattern, particularly across London, whereby the complex nature of housing and benefits legislation (as it applies to foreign nationals) means that professionals are ill-equipped to explore all options open to families.

The complexities of the inter-linking systems of housing law, benefits law, and immigration are not well understood by workers in all agencies, and this contributes to potentially ill-informed responses to cases like this one potentially placing children within such households at risk.

Considerations for the Board and partner agencies

- Is this a known problem to the Board?
- How can the Board ensure that professionals understand the legislation and its implications?
- Are there ways in which other bodies such as specialist agencies and the voluntary sector can be enabled to assist core child care professionals with this work?
- What is the best use of budgets to support children whose parents are not able to access benefits?
- Does the Board think that they have sufficient input at board level from housing professionals about these issues?
- Should the Board be encouraging the government to clarify the legislation?
- Has the Board discussed the implication of poverty and destitution for the safety and wellbeing of children?

[15] Fiscal effects of migration to the UK: Working Tax Credit claimant numbers Michael O' Connor September 2013

4.5.1 Finding 2

Is there a pattern in Westminster Children's Social Care whereby high demand is managed by setting a threshold for accessing services, such that homeless pregnant women are not assessed where housing is deemed to be their primary problem, potentially placing their unborn children at risk?

(Human–management system operation)

Nationally, Children's Social Care teams are receiving a high, and increasing, number of referrals, and all CSC teams must operate thresholds in order to prioritise families most in need of a social care response. This case has suggested that, in City of Westminster, there has in the past been a practice norm in which cases are not assessed pre-birth by CSC if the primary problem is deemed to be housing, and no additional risk factors are thought to be present. This can mean, as in this case, that non-housing related risks in these families are not picked up, leaving children vulnerable. This finding poses the question of whether this practice norm is still operating, and the potential impact of this on the reliability of the child protection system.

4.5.2 How did the issue feature in this particular case?

During the mother's pregnancy she was referred to Westminster CSC on three occasions for an assessment because she had no permanent accommodation, was pregnant and had breast cancer. At this time the custom and practice within the Westminster CSC assessment team was that pregnant women, where the primary issues were accommodation, would not be assessed unless there were additional child protection concerns, most commonly falling into the areas of substance misuse, mental health problems or domestic violence. Instead such women were referred to the Westminster Housing Options Service who would undertake a housing assessment, and, if they were ineligible for rehousing, would give advice about accessing accommodation via the private sector.

The first time the mother was referred to Westminster CSC she was three months pregnant and said she was staying temporarily with friends in Ealing. She was referred to Westminster Housing Options Service. The second referral reported that the mother was 'street homeless'. By this time the mother had accessed a solicitor, through the legal advice provided by a specialist service within a family centre, and she presented a letter formally requesting an assessment and support. As a result, although there was no assessment by CSC, they did refer her to Adult Services for assistance under the National Assistance Act 1948. They did not consider supporting her via section 17 of Children Act 1989 as they decided, erroneously, that this support was not available until after the birth of the baby. Funding via section 17 required an assessment of need to be completed which Westminster CSC would only undertake pre-birth if there were safeguarding concerns - usually substance misuse, mental health or domestic violence. Homelessness was not considered a safeguarding matter, so an assessment under the Children Act 1989 was not considered to be needed. Eventually, after the baby was born, an assessment under the Children Act 1989 was undertaken and the mother and Sofia were placed in bed and breakfast funded via the Section 17 budget.

4.5.3 How do we know it is an underlying issue and not something unique to this case?

The review team was informed by professionals from Westminster CSC, and by referring agencies, that it was common practice not to assess families where the primary problem is deemed to be housing. In the case group front line professionals suggested that they were unhappy about this approach and the reason that families were sometimes passed to ASC for an assessment was because they felt that this ensured that an assessment was completed even if it did not include a judgement about parenting. The review team was told that a particularly robust approach was taken by managers at that time. However, during the review, other senior managers endorsed

this way of managing difficult levels of demand including the significant housing-related demand in Westminster. This was confirmed by the referring agencies. Representatives from the two hospital teams represented in the case group (UCH and St. Mary's) said that, where there are no parental factors of drug misuse, DV or mental ill health, it is uncommon for the referral of a homeless pregnant woman to be accepted because of homelessness alone.

4.5.4 How common and widespread is the pattern?

Pregnant women or mothers, present with housing needs including claims of homelessness in high numbers; the demand can rise to 15 cases in a week, many of whom, like Mother in this case, are not entitled to local authority housing. Westminster shares these dilemmas with many other London boroughs and areas outside London, where there are high levels of transient, homeless families, some of whom also have problems with their immigration status. Many of these families either have No Recourse to Public Funds (NFPF) or cannot claim income benefits for other reasons. The complexities of their circumstances and of the legal frameworks are likely to pose a challenge to housing, health and social care workers across the country. Responding to all these cases therefore represents a significant resource pressure on the service.

However there are differences in the way that CSC teams respond. For example, in this case, the review team were told by managers in Ealing and Luton that they would assess women in mother's situation, as they would view the unborn child as a potential 'child in need'. Some of these authorities have specialist teams for families where the primary issues are housing related and this may mean they are able to screen those where there is a need for a 'child in need' assessment.

4.5.5 What are the implications for the reliability of the multi-agency child protection system?

The most significant risk is that during pregnancy and afterwards, if homeless mothers are turned away without an assessment, then the health and wellbeing of babies will not be known about and there will be no planning to ensure their needs are met.

Finding 2: Is there a pattern in Westminster Children's Social Care whereby high demand is managed by setting a threshold for accessing services, such that homeless pregnant women are not assessed where housing is deemed to be their primary problem, thus potentially placing their unborn children at risk?

Many, especially urban, local authority CSC departments can find it difficult to manage the numbers of families experiencing some form of homelessness and inadequate income. One way of managing these cases is to regard the families' difficulties as distinct from other types of concerns, which pose more obvious risks to small children (e.g., DV or parental mental ill health), and to exclude these cases from assessment. However, this means that the needs of these children are not properly considered, and a 'blanket' response of not assessing their needs could leave some of them at risk of 'significant harm'.

Considerations for the Board and partner agencies

- Is this a known problem to the Board?
- How does the Board view risks to babies and children who are homeless and without a 'subsistence' level of income?
- What is known about consistency across the Tri-borough CSC 'front doors' in this area of work?
- Is there evidence from CSC in other local authorities, about how to manage high demand from families in these circumstances?

4.6.1 Finding 3

Because there is no single system for passing information between GPs and health visitors in a formalised and standardised way, reliable oversight of babies' health is undermined. (Communication and collaboration in longer-term work)

Timely communication between GPs and health visitors is vital to ensure the safety of babies. The GP is the principal point of contact for primary health information for families, and the health visitor is the key professional having regular contact with families soon after birth. Effective information sharing between these two professionals is therefore vital for safeguarding children. This is particularly true where families move frequently meaning that there needs to be speedy and efficient transfer of information between agencies. This case has suggested that current information sharing arrangements vary across Boroughs and practices, with some not fit for purpose.

4.6.2 How did the issue feature in this particular case?

During the review period, Sofia and her mother moved across a number of local authorities, with different GPs and health visiting services. There were some examples in which communication between GP and health visitors was ineffective, leading to delays in contact with the child.

For example, when the mother moved to Ealing she immediately registered with a GP and also registered Sofia. At this point the GP should have advised the health visiting service that a very young baby had moved into the area so that contact could be made. The GP was unaware that there was an electronic system for informing health visitors about new registrations and instead placed the information in a message book which was not accessed for over a month. In the event, Sofia was not seen by a health visitor until five weeks after she had registered with the GP and this contact was only because the mother brought her to a walk-in health clinic in Southall.

4.6.3 How do we know it is an underlying issue and not something unique to this case?

The review team and case group all agreed that it was not uncommon for there to be delays in information being passed between GPs and health visitors. It was also reported that there are a number of different systems for recording and sharing information including paper records and electronic systems and that this probably increases the confusion. Currently the expectation is that across London GP practice data systems should report child health data regularly to the Child Health Information System (CHIS). The CHIS system provides a link from the registration of a child with the GP, prompting screening, immunisation and vaccination appointments to be sent. A link is also prompted to the health visiting service, indicating that development assessments should be arranged

NHS England has also recently written to Chairs of LSCBs alerting them to an audit that is currently being undertaken across England to assess the completeness of data transfer between Child Health Information System (CHIS) and GP systems. This is as a result of an incident where an accidental child death highlighted that the child and family were not known to the health visiting service. Subsequent investigations confirmed that there was a system communication issue between the GP surgery clinical data system and the Child Health Information System (CHIS).

In the last five years, as a result of the restructuring and re-commissioning of health services, links between health visitors and GPs have become more tenuous. All GP practices in London have allocated health visitors and there is an expectation that there should be regular meetings between the GPs and the health visitors; however there is variable practice with regards to frequency and attendance. In this case, Ealing

Community Services had in place a plan for improving communication between general practice and community nursing teams which required that practices should be offered a meeting with the link health visitor at least monthly. It was reported that no meetings were held between the Health Visitor team aligned to the GP in 2012 and only one meeting occurred in 2013. These meetings take place at the discretion of individual GP practices.

4.6.4 How common and widespread is the pattern?

The changes in the commissioning and organisation of health visiting and GP services happened across London and reflected changes that were implemented nationally. The effects on communication systems between GPs and health visitors are varied and the review team was told of practices where regular meetings have been set up to facilitate information–sharing and where electronic processes for data transfer have been implemented. It is thought that in practice there is a wide variation and lack of consistency with regard to communication processes.

4.6.5 What are the implications for the reliability of the multi-agency child protection system?

Speedy communication between professionals is crucial to maintain an effective and reliable child protection system. It is particularly important with regard to health visitors being informed about families moving into the area, as small babies are particularly vulnerable and early contact is essential to ensure their safety.

Finding 3: Because there is no single system for passing information between GPs and health visitors in a formalised and standardised way, reliable oversight of babies' health is undermined. (Communication and collaboration in longer-term work)

The current communication systems between GPs and health visitors are not working effectively in many areas which means that key facts are not exchanged as rapidly as they should be. In particular the wide range of different mechanisms for passing data, including the use of message books that are reviewed infrequently, means that there can be delays in information sharing.

Considerations for the Board and partner agencies

- What does the Board know about the impact on children of poor communications between GPs and health visitors?
- What action can be taken locally to improve communications between GPs and health visitors?
- As this is likely to be a London-wide problem is it something that should be raised with the London Safeguarding Children Board?
- Is there any action that could/should be taken nationally with regard to this issue?

4.7.1 Finding 4

There is a pattern in London whereby strategy discussions have become 'diluted' to a brief telephone communication between Police and Children's Social Care, resulting in other agencies not being included in strategy discussions, even when they have the greatest knowledge of the family.
(Communication & collaboration in responses to incidents)

Working Together 2013 states that the local authority Children's Social Care Services should convene a strategy discussion to determine the child's welfare and plan rapid future action whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm. This might take the form of a multi-agency meeting or a telephone call. *Working Together* 2013 recommends that a local authority social worker and their manager, health professionals and a police representative should, as a minimum, be involved in the strategy discussion. This case has suggested that the tendency to use brief, telephone strategy discussions is precluding involvement of all relevant professionals, as recommended in the guidance.

4.7.2 How did the issue feature in this particular case?

When Ealing CSC were unable to visit Sofia and her mother because they were not living at the address that had been given to the GP and health visitor, they initiated a section 47 investigation and had a telephone strategy discussion with the police. No other agency was involved in the strategy discussion although other agencies were consulted as part of the assessment. The outcome of the discussion was that the main concerns identified were the child's failure to gain sufficient weight and Mother's unwillingness to co-operate with regular oversight of Sofia by the health visitor. After the paediatric medical identified that the child's weight gain was within a normal range, there was no consideration given to calling a further follow-on strategy discussion meeting.

The initial referral to Ealing CSC came from the health visitor who had three main concerns: the child's failure to gain weight, Mother's unwillingness to co-operate with professionals and her accommodation and financial problems. Without the health visitor attending to clearly state what her concerns were, and the fact that all three were, in her view, of equal importance, the strategy discussion focussed on the first issue giving greater prominence to weight gain than homelessness. The prioritisation of concerns regarding weight had the knock-on effect that, after the paediatric medical identified that the child's weight gain was within a normal range, there was no consideration given to calling a further follow-on strategy discussion meeting. If there had been a review strategy discussion meeting to consider the outcome of the initial investigations it is possible that the wider issues of Mother's transient life-style and financial difficulties and their impact on Sofia would have been discussed further.

4.7.3 How do we know it is an underlying issue and not something unique to this case?

The case group members from health agencies gave examples of not having been involved in strategy discussions and confirmed that telephone strategy discussions were often used meaning that only police and CSC were involved. CSC case group members reported consulting with health colleagues by phone but admitted that these conversations were not recorded as part of the strategy discussion. Health case group members also suggested that when they provide CSC with information they are not told whether this is part of a strategy discussion. It was believed that a lack of multi-agency involvement could be due to the need for prompt investigative responses leading to the use of telephone strategy discussions. However it was also felt that a lack of resources within the police meant that attendance at strategy discussion meetings was unusual unless there was a clear criminal investigation. It was reported that the use of telephone

strategy discussions to meet minimum requirements of joint investigation had become the norm resulting in other agencies being precluded from the discussions.

4.7.4 How common and widespread is the pattern?

Both the review team and case group reported that it was the practice in London for most strategy discussions to be by telephone and to involve, primarily, Police and Children's Social Care. This was explained as being to ensure timely discussions in response to concerns and because of staffing pressures.

The review team also reported that local file audits have shown an improving picture of health involvement in strategy discussions where a meeting was organised, but acknowledged that this was not the case where there was a telephone conversation between police and CSC. In Westminster CSC, efforts are being made to follow up telephone strategy discussions between police and CSC with telephone contact with health professionals and have now made amendments to their recording process and ICS system to make it mandatory to record health's contribution to strategy discussions. Health professionals however reported at the case group that they are not aware that they are being asked to contribute to a strategy discussion and considered these approaches to be requests for information rather than involvement in planning investigations.

4.7.5 What are the implications for the reliability of the multi-agency child protection system?

The lack of involvement of agencies other than police or CSC in strategy discussions and in assessments may lead to a gap in understanding of what is known about the needs of a particular child. This is particularly problematic with very young children where often the only agencies to have had significant contact will have been Health. To be effective such information sharing has to be a two-way process so that all professionals fully understand each other's concerns.

Research has shown that effective communication requires an openness to detail, a willingness to engage with referrers and an avoidance of hasty categorisation. The facts are rarely out there simply to be passed on; rather, a case formulation emerges through discussion and interaction.[16] The strategy discussion meeting is a key opportunity for joint working enabling better planning of the investigation and subsequent work with families. However, brief and/or telephone-based strategy discussions may not provide the best environment to effective information processing and decision-making.

[16] Ten pitfalls and how to avoid them What research tells us Dr Karen Broadhurst, Professor Sue White, Dr Sheila Fish, Professor Eileen Munro, Kay Fletcher and Helen Lincoln September 2010 www.nspcc.org.uk/inform

Finding 4: There is a pattern in London whereby strategy discussions have become 'diluted' to a brief telephone communication between Police and Children's Social Care, resulting in other agencies not being included in strategy discussions, even when they have the greatest knowledge of the family?

This review identified a pattern of the use of telephone strategy discussions between CSC and police which leads to an absence of multi-agency involvement in investigation and assessment. It raised the question whether the right balance had been achieved focusing on timely investigations and assessments with ensuring the right professionals are contributing effectively to improve the outcomes for children.

Considerations for the Board and partner agencies

- Since the revisions made in *Working Together* (2013), can the Board be assured that there is an appropriate balance between the focus on timeliness of investigations and assessments with ensuring involvement and engagement with other agencies?
- Are there technological mechanisms that can facilitate greater involvement of agencies in telephone strategy discussions separate from face to face meetings?
- How can the Board be assured that other agency information is given the same status as that from police and social care?
- In the context of constant change how can strategy discussions be more effective at ensuring there is evaluation of risk in the discussion of the issues with all relevant agencies?

4.8.1 Finding 5

There is a pattern of professionals over-focussing on physical manifestations of neglect such as weight loss and failing to identify more complex less visible, indicators.

(Communication and collaboration in long term working.)

Neglect is a multi-faceted issue, which can include dimensions such as emotional, supervisory and medical neglect, as well as neglect of physical care (Horwath, 2007)[17]. In order to understand whether neglect is occurring, therefore, a range of factors must be considered including emotional and developmental needs as well as the immediate need for an adequate diet, warmth and shelter. This case has suggested an over-focus on physical manifestations of neglect such as a child's failure to gain weight and inadequate consideration of the impact on the child of destitution and a transient life style combined with a lack of co-operation with professionals.

4.8.2 How did the issue feature in this particular case?

When Ealing CSC undertook the section 47 child protection enquiries, a number of concerns relevant to neglect were raised, including the health visitor's judgement that Sofia's weight gain was insufficient. In the context of the mother's accommodation and financial difficulties, this raised worries about whether the child was being fed adequately. Whilst this was clearly an important issue, there were also other potential indicators of neglect. At this stage the mother had left accommodation provided by Westminster CSC without notice, making herself and Sofia homeless. She had presented in Ealing without fixed accommodation or income and did not have the baby equipment and clothes that had been given to her when in Westminster. The mother had failed to co-operate with the health visitor when concerns were expressed over Sofia's rate of weight gain and had initially been unwilling to allow her to be examined by the paediatrician.

Despite the multiple indicators of neglect, it was apparent that once the paediatric medical was completed and the doctor had indicated that the weight gain was within acceptable limits, professionals' anxiety about whether Sofia was being neglected reduced. This was particularly evident in the social worker's actions after the medical when, despite previously having considered the possibility of the child being accommodated, no action was taken to initiate a child protection conference and the core assessment was not completed.

4.8.3 How do we know it is an underlying issue and not something unique to this case?

Neglect is notoriously difficult to define as there are no clear, cross-cultural standards for desirable or minimally adequate child-rearing practices. While neglect generally refers to the absence of parental care and the chronic failure to meet children's basic needs, defining those needs is not straightforward. *Working Together* 2013 defines neglect as: 'the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.' It includes in the description 'a parent or carer failing to provide adequate food, clothing and shelter' and a failure to 'ensure access to appropriate medical care or treatment'.[18]

An aspect that was repeatedly discussed within the review team was whether the mother's transient life-style and inability to provide adequately for her child constituted

[17] Horwath, J (2007) Child Neglect: Identification and Assessment, Basingstoke, Hampshire: Palgrave Macmillan

[18] *Working Together* 2013, DfE

neglect. It was apparent from conversations with a range of front-line professionals that for most of them this was not deemed neglectful parenting because it was viewed as being beyond her individual control. Research into neglect could support this approach with the emphasis being placed on the responsibility for the act of omission and the intention behind it. Some researchers argue for the importance of distinguishing deliberate harm, which is defined as abuse, from instances of harm that occur as a result of carer ignorance or competing carer priorities, which they define as neglect. Others consider carer or parental acts to be neglectful irrespective of the reason why they occurred and warn against a pre-occupation with determining carer intention as it may over-shadow concern about the impact on the child and also hinder working with parents. [19]

What was apparent to the review team was that when there appeared to be a physical effect on the child of her mother's choices (i.e. a failure to gain weight) action was immediately taken by both the health visitor and the social worker. This was discussed with case group members who confirmed that in the absence of clear detriment to the child as a result of her mother's actions it was hard to clearly identify that her behaviour was neglectful, and that this led to a focus on physical manifestations such as failure to gain weight. Discussions within the review team confirmed that this was likely to be repeated in other circumstances, and that it was in part why the medical assessment of a child was deemed to be such an important facet of the child protection investigation, as it provided the opportunity for concrete evidence. Research has also shown that the cases that are most likely to catch the attention of the frontline practitioner are those that present the clearest evidence of harm. Research on biases in human reasoning finds that recall is stronger for very vivid or emotive material, such as visible injuries to children [or significant weight loss]. Clearly, it is important to give priority to serious injuries [or significant weight loss]; however, the practitioner must remain sensitive to less obvious signs and symptoms of harm, or the risk of such harm, to children and young people.[20]

4.8.4 How common and widespread is the pattern?

Neglect is the most common reason for someone to contact the NSPCC (NSPCC, 2012). Neglect has been described as the "most serious type of child maltreatment and the least understood" (Dubowitz, 1999 p.67). It is the most common reason for a child having a child protection plan in the UK. In the year ending 31 March 2011(or 31 July 2011 in Scotland), 44 per cent of child protection registrations in the UK related to children considered to be at risk of neglect. [21] Within the Tri-Borough local authorities, 60 (that is 65%) of children with child protection plans in RBKC have child protection plans because of neglect; 45 (25%) of children with child protection plans in LBHF have child protection plans because of neglect; and 26 (26%) of children with child protection plans in WCC have child protection plans because of neglect. In Ealing there are 117 (41%) of children with child protection plans because of neglect.

National research has also highlighted the difficulties professionals face in ascertaining whether certain behaviours constitute neglect (Gardner, 2008[22]; Rees et al. 2011[23]). It is noteworthy that although neglect is a factor in determining many children to be either 'vulnerable' or 'in need' there is currently limited data collection about this matter.

[19] Neglect: research evidence to inform practice Dr Patricia Moran, Action for Children Consultancy Services
[20] Ten pitfalls and how to avoid them What research tells us Dr Karen Broadhurst, Professor Sue White, Dr Sheila Fish, Professor Eileen Munro, Kay Fletcher and Helen Lincoln September 2010 www.nspcc.org.uk/inform
[21] Neglect NSPCC research briefing August 2012
[22] Gardner, R. (2008) Developing an effective response to neglect and emotional harm to children. London: NSPCC
[23] Rees, G. et al. (2011) *Adolescent neglect: research, policy and practice.* London: Jessica Kingsley

4.8.5 What are the implications for the reliability of the multi-agency child protection system?

For children to be effectively protected professionals need to be confident in their understanding of all aspects of neglectful parenting. Over-emphasis on one aspect of neglect will result in a failure to identify children at risk and could result in other risk factors not being fully understood.

Finding 5: There is a pattern of professionals over-focussing on physical manifestations of neglect such as weight loss and failing to identify more complex less visible, indicators.

This review has identified that professionals working with children who may be neglected focus on physical tangible evidence of neglect such as a failure to gain weight rather than examining other aspects such as choices about life style or willingness to take their child to medical appointments. This potentially places some children at risk if all aspects of neglectful parenting are not fully explored.

Considerations for the Board and partner agencies

- What does the Board know about multi-agency consideration of neglect factors and how professionals work together with neglectful families?
- Is the Board confident that all professionals operate to the same standards when considering neglect?
- How can the Board develop a multi-agency strategy to address neglect?
- What are the barriers to and what will promote a mult-agency approach to neglect?

4.9.1 Finding 6

A tendency to assess risk from the parent's perspective, and not to focus on the child's experience, means that destitution, and resulting transience, are not seen as potential child protection issues.

(Communication and collaboration in long term working.)

Working Together 2013 emphasises the importance of child-centred safeguarding systems, and the risks posed to practice when professionals lose sight of the needs and views of children, or place the interests of adults ahead of the needs of the children.[24] This case highlighted a tendency to assess the seriousness of the situation in terms of the intentions and motivations of the parent, rather than the impact on the child. This had the consequence that a transient lifestyle and near-destitution were not considered to be safeguarding issues.

4.9.2 How did the issue feature in this particular case?

Throughout the review period, Sofia's mother was essentially destitute, with insufficient funds to provide for basic physical needs. During her pregnancy she was homeless, and thought to be getting food from local Hindu temples. After Sofia was born, her mother had no material means of support and was homeless. She was breastfeeding but, due to her cancer, needed to supplement her breast milk with formula, which she had no means to purchase. Professionals recognised these difficulties and acted quickly to provide material support, such as clothing, equipment and food. However professional activity during the case, and reports during this review, showed that the needs resulting from the mother's destitution were not regarded as child protection or safeguarding matters. The impact of her destitution on the child did not prompt concern, or any discussion, about the potential consequences of homelessness and destitution for a foetus, a baby, or a small child in her first year of life – despite the fact that it was not known how the child would be properly fed and kept physically safe and well.

Professionals were asked specifically about this during the review, and their replies suggested that they saw the mother's deep desire to have the child, and her caring and attentive behaviour towards the baby after birth, as protective and sufficient to keep the baby safe and well. In other words, it seemed that practitioners based their judgement of 'safeguarding' from the perspective of the parent. Because practitioners felt that the mother's inability to care for her child was unintentional, and based on her material poverty, this did not constitute a safeguarding concern. This led to a view that the mother was doing her best in the face of adversity and should be supported and encouraged, not penalised.

4.9.3 How do we know it is an underlying issue and not something unique to this case?

Discussions with the Review Team and Case Group identified that Mother's situation did lead to professionals over-empathising with her resulting in a lack of focus on the risk to Sofia's health safety and well-being, particularly as there was no obvious evidence of physical harm to the child. Case group members confirmed that this was not unique to this case and clearly stated that destitution and homelessness are not seen as child protection issues unless combined with other factors such as substance misuse or domestic violence. Services for pregnant women and mothers of small children adopt a clear hierarchy regarding concerns about risks. Where there are parental features of mental ill health, drug/alcohol abuse, or domestic violence, the foetus or small child will be regarded as potentially at risk, and an assessment will be carried out. Where none of these features is present, it is suggested, there is less concern about homelessness or

[24] Working Together 2013 p9

no income, particularly if this poverty is seen as being outside of the control of the parents.

This is confirmed by research into neglect which has identified that definitions of neglect vary in relation to the emphasis placed on responsibility for the act of omission and the intention behind it. Some researchers consider it necessary to distinguish 'deliberate harm, which they define as abuse, from instances of harm that occurs as a result of carer ignorance or competing carer priorities, which they define as neglect (Golden et al, 2003).' An alternative view suggests that parents and carers can be neglectful irrespective of the reasons for its occurrence (Dubowitz et al, 2005) and 'warn against a pre-occupation with determining carer intention as it may over-shadow concern about the impact on the child and also hinder working with parents'.[25]

4.9.4 How common and widespread is the pattern?

This finding links to Finding 1, where it has been asserted that there are destitute parents and children who present to housing and CSC services in such numbers that they cannot be properly assessed for their broader needs/risks. It follows that the consequences of destitution for children are frequently not seen as presenting serious risk to their safety and wellbeing. However, it is not known to the review team how widespread this pattern is in other local authority areas around the country.

4.9.5 What are the implications for the reliability of the multi-agency child protection system?

A safe multi-agency child protection system is one where professionals are able to assess and evaluate risk from the perspective of the child and are not unduly influenced by sympathy for adults' experiences. The focus of professional intervention needs to be on the child's experience regardless of the causal factors.

Finding 6: A tendency to assess risk from the parent's perspective, and not to focus on the child's experience, means that destitution, and resulting transience, are not seen as potential child protection issues.

This review has shown that professionals may fail to acknowledge the impact of poverty and homelessness on children because they judge risk from the perspective of the intention and motivations of the parent, rather than the experience of the child. This means that apparently unintentional destitution is not considered a safeguarding issue and children may continue to be exposed to the risks this engenders.

Considerations for the Board and partner agencies

- What does the Board know about what enables professionals to be able to assess risk from the point of view of the child?
- How can the Board ensure that multi-agency risk assessment of destitution and transience is sufficiently robust?

[25] Neglect: research evidence to inform practice Dr Patricia Moran, Action for Children Consultancy Services

4.10.1 Finding 7

Being unable to complete an assessment because a family is 'avoidant' at point of transfer may lead to children inappropriately being described as 'in need' rather than 'in need of protection'. (Communication and collaboration in long term working). This case has highlighted the challenges associated with working with mobile families who move abruptly. This mobility presents agencies with difficulties in transfer of information and can lead to delay in services being provided. When families move, there are different responsibilities for social workers depending on whether the legal framework for their involvement was because of child protection concerns or as a 'child in need', a distinction that is based on the level of assessed risk. This case has suggested that, whereas handover arrangements are very clear for children in need of protection, they are less clear for 'children in need'. Whilst these cases are not at the highest levels of risk, they may still include significant concerns, such that a lack of handover between local authorities presents a risk to the children involved**.**

4.10.2 How did the issue feature in this particular case?

Despite there being three separate episodes of social work involvement with this family (Westminster CSC, Ealing CSC and Luton CSC) there was never a completed assessment because the mother always moved prior to it being finished. This was particularly relevant when the family were living in Ealing, where a child protection investigation was undertaken. This concluded that that there was no immediate risk of significant harm but there was a need for further assessment to judge whether the child's needs warranted formal intervention via a child protection plan, or could be better supported by voluntary support as a 'child in need'.

Such decisions are complex and require the completion of an assessment involving both the collection of information but also the analysis of that information to evaluate possible and probable risks of different interventions. When the mother and Sofia left Ealing that evaluation was incomplete but the social worker involved had to make a decision about how to frame the referral to Luton CSC. In the event the social worker made the referral indicating that the support to the family should be on a voluntary basis.

It cannot be known whether that decision would have been different if the assessment had been completed but the social worker and her manager did indicate in conversations that with hindsight they thought it probable that a child protection plan would have been considered. It is also definite that if the family had not moved there would have been an opportunity for the worker to have reviewed the assessment in supervision with a manager.

It was relevant that the request by Ealing CSC for an assessment was not made within the context of formal child protection processes. If Sofia had been the subject of a child protection plan then Ealing CSC would not have closed the case until Luton CSC had seen the child and accepted full case responsibility via a face-to-face meeting with professionals. Similarly if there had been an ongoing child protection investigation, neither local authority would have closed the case until the child had been seen by a social worker.

4.10.3 How do we know it is an underlying issue and not something unique to this case?

There are no prescribed systems for case transfer across local authority boundaries for 'children in need' but there is an expectation that professionals will share information about possible needs and risks for families. There are no specified arrangements about professional responsibilities in connection with making contact with the family and

seeing the child. Once the information has been passed on there is no obligation on either local authority to keep the case open.

In contrast, when a child who is the subject of a child protection plan moves, the local authority with key worker responsibility maintains the duty to visit the family until case responsibility has transferred following a face to face meeting between key agencies working with the family. Where a family that is the subject of an incomplete section 47 child protection assessment moves there is an expectation that case responsibility remains with both local areas until contact has been made with the family and the child has been seen and the risks assessed.

Research suggests that assessment can be rather too focused on the content of the referral – the immediate issue – while failing to consider a case history. Incidents need to be considered in context; concerns need to be connected in order to build up a fuller picture of a child's life. It is absolutely vital that a careful sifting of case history be integral to assessment and that time must be made available for this essential analysis. The problems of making decisions on the basis of incomplete information are well documented. Harm to children, not readily manifest when presented alongside requests for housing assistance, etc., is easily missed where assessment is essentially rushed and incomplete. A review of serious cases of child abuse by Dale et al (2002) found that premature categorisation and misdiagnosis significantly contributed to failures on the part of agencies.[26]

When workers are not able to fully complete assessment work it is probable they will fail to identify sufficiently less apparent risk factors and it is in this context that their judgement is more likely to identify the child as being 'in need' rather than in 'need of protection'. It is possible that they may also fail to identify strengths and therefore be over-protective but at a time of reduced resources and increased rationing of services this is less likely.

4.10.4 How common and widespread is the pattern?

In this case the reason for the assessment being incomplete was the mother's decision to move prior to the work being completed and the levels of mobility of families within London are discussed in more detail under finding 8. It is probable that in this case the mother was deliberately avoiding professionals through her moves and this is a well-documented feature in serious case reviews. Marion Brandon reported in 2008 'A recurring theme was the difficulty faced by professionals working with families who moved frequently and the potential for agencies to 'lose track' of children in these highly mobile families.'[27] She repeated the same finding in 2009 saying that 'mobility and lack of parental co-operation are common factors and need to be recognised as a risk factor that should heighten concern rather than simply being a reason why children don't receive a service… More effort is needed precisely because the family is mobile'.[28]

4.10.5 What are the implications for the reliability of the multi-agency child protection system?

Good assessment work is fundamental for a safe multi-agency child protection system. If professionals do not have sufficient time to consider all aspects of risk and to fully

[26] Ten pitfalls and how to avoid them What research tells us Dr Karen Broadhurst, Professor Sue White, Dr Sheila Fish, Professor Eileen Munro, Kay Fletcher and Helen Lincoln September 2010 www.nspcc.org.uk/inform

[27] Marion Brandon et al Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005p 92

[28] Marion Brandon et al Understanding Serious Case Reviews and their Impact A Biennial Analysis of Serious case Reviews 2005-2007 p 73

evaluate families with the benefit of reflective supervision then assessments will be partial potentially placing some children at risk.

Finding 7: Being unable to complete an assessment because a family is 'avoidant' at the point of transfer may lead to children inappropriately being described as 'in need' rather than 'in need of protection'.

Current case transfer arrangements for vulnerable children do not guarantee that contact will be maintained with the family potentially leading to those children's needs being overlooked. This means that mobile families are able to avoid contact with professionals and the systems do not enable sufficient focus on the needs of vulnerable children. Arrangements for case transfer need to be developed that respect the privacy of families whilst enabling professionals to maintain contact with vulnerable children.

Considerations for the Board and partner agencies

- How does the Board know if assessments are complete at the point of transfer?
- How can professionals be enabled to ensure that their assessment work adequately considers both risks and protective factors at the point of transfer?
- If it is not possible to complete an assessment because the family has moved should the default position be to consider the child to be 'in need of protection' until the assessment is completed?
- How can the Board be sure that professionals are able to access robust and reflective supervision in a timely manner?
- Has the 'Haringey judgement' made a difference to social work practice at the front line?

4.11.1 **Finding 8**

Is there a pattern in London that insufficiently robust handover arrangements in Health Visiting can mean that when avoidant families with vulnerable children move, they may become 'lost to the system' and therefore at risk of possible harm? (Communication & collaboration in response to incidents)

This case has highlighted the challenges for health visitors associated with working with avoidant mobile families who move abruptly. This mobility presents health visitors with particular difficulties in transfer of information and can lead to delay in services being provided.

4.11.2 How did the issue feature in this particular case?

When Sofia and her mother moved from Haringey to Ealing the health visitor lost contact with them, and health visitor involvement was only resumed because the mother took Sofia to a drop-in clinic. When the health visitor saw Sofia in Ealing she was assessed as requiring an enhanced health visiting service because of concerns about her low weight gain and her mother's limited engagement with professionals. When the Ealing health visitor became aware that the mother was moving to Luton there was no contact with the Luton health visiting service and the mother was advised to make contact with the health visitor in that area when she arrived.

Some months later the Ealing health visitor noted that the mother's address had changed to Westminster so contacted the Westminster health visiting service and made a verbal referral. There was no formal handover and the risks that had previously been identified (which had resulted in Sofia being deemed a child who required an enhanced service) were not shared with the Westminster health visiting staff. The Westminster health visitor was unable to make contact with the mother and sent her a message asking her to make an appointment. There was no attempt made to escalate the matter further.

4.11.3 How do we know it is an underlying issue and not something unique to this case?

For health visiting, there are no national formal arrangements for handing over cases across geographical boundaries, even when children require an enhanced health visiting service. There are national standards that require that a health visitor should make contact with a family within seven working days of the notification of the child moving into the area. This standard was not reached on a number of occasions within this case history. Within the case group it was acknowledged by health visitors that it is a challenge to maintain contact with mobile families who move frequently. Caseloads for health visitors mean that only the most vulnerable children receiving the most enhanced service (such as children who are the subject of child protection plans) will be monitored intensively. For most children there is a dependence on parents accessing support for their children voluntarily. This system becomes vulnerable when a family is avoidant, particularly if they are also mobile.

4.11.4 How common and widespread is the pattern?

Research has shown that Londoners in general move more than non-Londoners and that there are "likely to be some parts of any borough where there is rapid mobility".[29] Another study has shown that new migrants move more than established households. There has been a substantial increase in international migration to London within the

[29] Scanlon, K., Travers, A., and Whitehead C., (December 2010) Population churn and its impact on socio-economic convergence in the five London 2012 host boroughs Department for Communities and Local Government, London

past decade. There is now a net increase in the overseas-born population of about 100,000 per year. However, the turnover of people moving in and out of the city (excluding within London moves) is – officially – approaching 250,000 per annum. Unofficial (and uncounted) mobility will almost certainly add to this number. London has some boroughs where population mobility is greater than 35% per annum, and where the private rented sector is the largest tenure.[30]

Changes in Housing legislation and housing benefit arrangements are also likely to increase population mobility within London, as central London accommodation becomes less accessible to families dependent on state benefits. The review team were aware of increasing pressure on accommodation leading to families becoming more mobile, with families requiring temporary accommodation often being placed some distance away from the borough with responsibility for re-housing.

4.11.5 What are the implications for the reliability of the multi-agency child protection system?

Effective transfer arrangements for health visitors are required to avoid losing sight of vulnerable children when families move across local authority boundaries. Without these systems it is possible that some children will drop below the radar and could be vulnerable to abuse. This case has shown that, at present, arrangements for transfer of vulnerable children are not robust which places some children at risk.

Finding 8: Is there a pattern in London that insufficiently robust handover arrangements in Health Visiting can mean that when avoidant families with vulnerable children move, they may become 'lost to the system' and therefore at risk of possible harm?
Current case transfer arrangements for health visiting do not guarantee that contact will be maintained with the family potentially leading to those children's needs being overlooked. This means that mobile families, who wish to remain 'out of sight', are able to avoid contact with health visitors and the systems do not enable sufficient focus on the needs of vulnerable children. **Considerations for the Board and partner agencies** • Does the Board consider that the current health procedures provide sufficient structure for transfer arrangements within and outside of London? • Do the current arrangements for contact with children receiving an enhanced health visiting service ensure that vulnerable children are always seen including when they move across geographical boundaries? • Is there sufficient known about mobile families and how can the Board find out more?

[30] Population Mobility and Service Provision A report for London Councils Tony Travers, Rebecca Tunstall and Christine Whitehead with Segolene Pruvot LSE London

5 Conclusion

5.1 This was a case review resulting from the death of a young child and criminal proceedings are ongoing. A significant feature of the review was her mother's transient life style and her resistance to working co-operatively with agencies. There was no professional contact with Sofia for the majority of her life and it is not known what happened to her during that time.

5.2 This review has identified a number of factors which affected the work of the professional safeguarding children network with Sofia. It has analysed the judgments and actions of those involved in the case, and the reasons for these. It has also explored what this case has told us about weaknesses and vulnerabilities in the multi-agency child protection system.

5.3 A key part of this story remains unknown. As it has not been possible to involve the parents in the review because of the ongoing criminal process their perspective is missing. Without their insights and information it is not possible to have a full picture of their experience of the professional interaction. It is not known yet whether the parents will be willing to contribute to the review in some way after the criminal trial has concluded.

5.4 In a 'systems' case review, the individual case acts as a window on the local systems, so that broader learning can emerge. Through this case, eight priority findings have been identified, relating to:

- The complex nature of housing and benefits legislation as it applies to foreign nationals;
- Thresholds in Westminster Children's Social care for assessing homeless pregnant women;
- Weaknesses in the communication systems between GPs and health visitors;
- The nature of strategy discussions and whether all agencies are fully involved;
- A pattern of professionals over-focusing on physical manifestations of neglect and failing to identify other aspects;
- A tendency to assess risk from the parent's perspective;
- The risks associated with transfer arrangements where there are incomplete assessments;
- Insufficiently robust handover arrangements in Health Visiting.

Appendix 1 – Methodology

1. This SCR has used the SCIE Learning Together model for case reviews. This is a 'systems' approach which provides a theory and method for understanding why good and poor practice occur, in order to identify effective supports and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high risk areas of work, such as aviation, it was taken up in Health agencies, and from 2006, was developed for use in case reviews of multi-agency safeguarding and CP work (Munro, 2005; Fish et al, 2009). National guidance in the 2013 revision of *Working Together to Safeguard Children* (2013) now requires all SCRs to adopt a systems methodology.

2 The model is distinctive in its approach to understanding professional practice in context; it does this by identifying the factors in the system that influence the nature and quality of work with families. Solutions then focus on redesigning the system to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.

3 Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit.

4 The basic principles – the 'methodological heart' – of the Learning Together model are described in summary form below:

a. **Avoid hindsight bias** – understand what it was like for workers and managers who were working with the family at the time (the 'view from the tunnel'). What was influencing and guiding their work?
b. **Provide adequate explanations** – appraise and explain decisions, actions, in-actions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it
c. **Move from individual instance to the general significance** – provide a 'window on the system' that illuminates what bolsters and what hinders the reliability of the multi-agency CP system.
d. **Produce findings and questions for the Board to consider**. Pre-set recommendations may be suitable for problems for which the solutions are known, but are less helpful for puzzles that present more difficult conundrums.
e. **Analytical rigour**: use of qualitative research techniques to underpin rigour and reliability.

5 Typology of underlying patterns

5.1 To identify the findings, the Review Team has used the SCIE typology of underlying patterns of interaction in the way that local child protection systems are functioning. Do they support good quality work or make it less likely that individual professionals and their agencies can work together effectively?

They are presented in six broad categories of underlying issues:

1. Multi-agency working in response to incidents and crises
2. Multi-agency working in longer term work
3. Human reasoning: cognitive and emotional biases
4. Family – Professional interaction
5. Tools

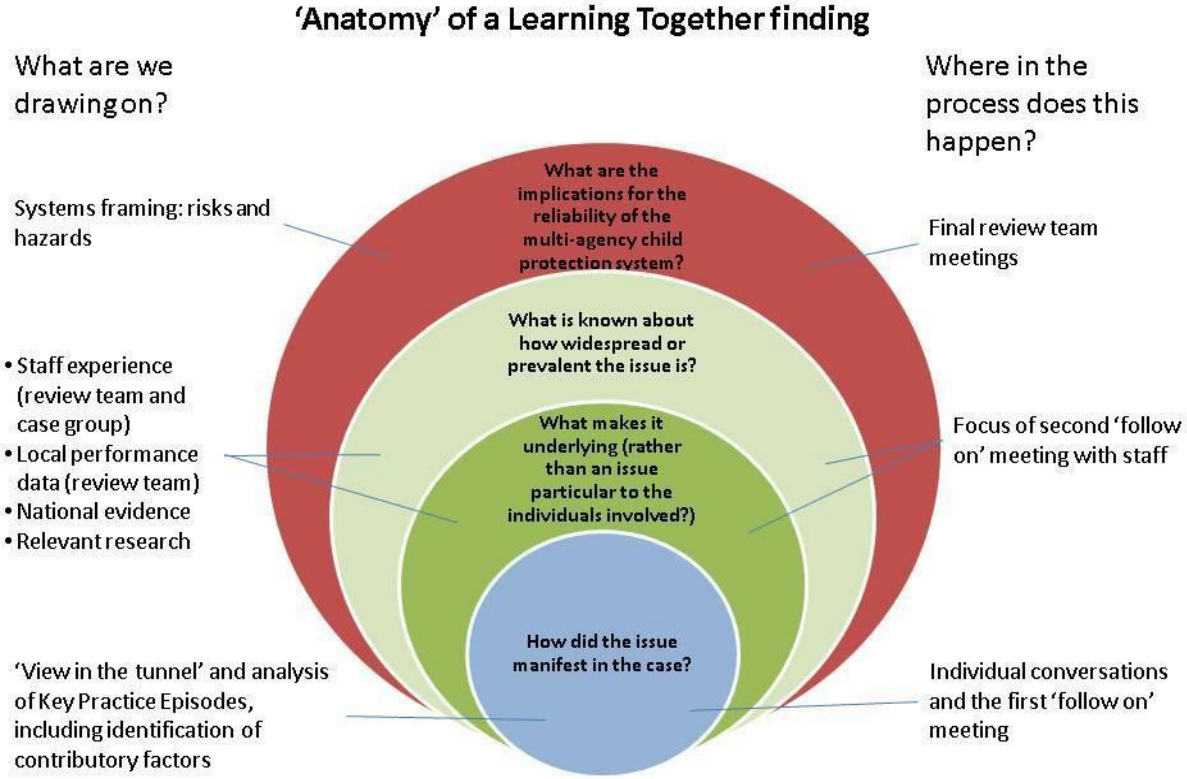
6. Management systems

Each finding is listed under the appropriate category, although some could potentially fit under more than one category.

6 Anatomy of a finding

For each finding, the report is structured to present a clear account of: -

- How the issue manifests itself in the particular case
- In what way it is an underlying issue – not a quirk of the particular individuals involved this time and in the particular constellation of the case?
- What information is there about how widespread a problem this is perceived to be locally, or data about its prevalence nationally?
- How the issue is usefully framed for the LSCB to consider relative to their aims and responsibilities, the risk and reliability of multi-agency systems. This is illustrated in the Anatomy of a Learning Together Finding (below).



7

7 Review Team and Case Group

7.1 Review Team

The Review Team comprises senior managers from the agencies involved in the case, who have had no direct part in the conduct of the case. Led by two independent Lead Reviewers, they act as a panel working together throughout the review, gathering and analysing data, and reaching conclusions about general patterns and findings. They are also a source

of data about the services they represent: their strategic policies, procedures, standards, and the organisational context relating to particular issues or circumstances such as resource constraints and changes in structure. The Review Team members also have responsibility for supporting and enabling members of their agency to take part in the case review.

Review Team Members
Fiona Johnson, SCIE independent Lead Reviewer
Sally Trench, SCIE independent Lead Reviewer
Supporting People and Homelessness Strategy Manager
Head of Safeguarding CLCH
Head of Quality Assurance and Safeguarding Ealing Children's Services
Tri Borough Head of Safeguarding
Specialist Crime Review Group SC&O 21(2)
Designated Nurse(UCLH)
Designated Nurse Safeguarding Children (Hammersmith & Fulham/Hounslow/Kensington and Chelsea /Westminster)
Triborough LSCB Board Manager

7.2 Case Group

The Case Group are the professionals who were directly involved with the family. The Learning Together model offers a high level of inclusion and collaboration with these workers/managers, who are asked to describe their 'view from the tunnel' – about their work with the family at the time and what was affecting this.

In this case review, the Review Team carried out individual conversations with 25 case group professionals, and up to 30 professionals were invited to attend the case group meetings which discussed the practice in this case and agreed the findings.

7.3 Structure of the review process

A Learning Together case review reflects the fact that this is an iterative process of information-gathering, analysis, checking and re-checking, to ensure that the accumulating evidence and interpretation of data are correct and reasonable.

The Review Team form the 'engine' of the process, working in collaboration with case group members who are involved singly in conversations, and then in multi-agency 'Follow-on' meetings.

The sequence of events in this review is shown below: -

Date	**Event**
	Scoping meeting between Lead Reviewers, LSCB Chair and Manager
3.02.14	Introductory meeting for the Review Team

7.02.14	Introductory meeting for the Case Group – to explain the Learning Together model/method, and the case review process which they will be part of.
11, 12, 17 and 19.02.14	Four days' conversations with members of the Case Group (individual sessions of about 1.5 hours with each member of the Case Group; normally conducted by two members of the Review Team)
27.02.14	First Review Team analysis meeting
04.03.14	Second Review Team analysis meeting (2)
12.03.14	First Follow-on meeting (Review Team and Case Group) In this meeting, the group works together on • identifying Key Practice Episodes (KPEs) in the case which affected how the case was handled and/or the outcome of the case • appraising the practice in these KPEs • considering what was affecting the work/workers at the time (the 'view from the tunnel')
20.03.14	Third Review Team analysis meeting
24.03.14	Lead Reviewers' updating presentation to SCR Panel
08.05.14	Fourth Review Team analysis meeting
16.05.14	Second Follow-on meeting (Review Team and Case Group) At this meeting, the group are provided with a draft report which sets out the emerging underlying patterns and findings, and are asked to consider whether these are **specific to this individual case** or **pertain more widely and form a pattern**.
19.05.14	Lead Reviewers' updating presentation to SCR Panel
19.06.14	Fifth Review Team meeting – to consider the draft final report
23.06.14	SCR Sub-Group meeting – to consider the draft final report
15.06.14	LSCB meeting – to consider the draft final report
TBC	Final report, fit for publication, to be submitted to Department for Education (DfE)

7.4 Scope and terms of reference

Taking a systems approach encourages reviewers to begin with an open enquiry rather than a pre-determined set of questions from terms of reference, such as in a traditional SCR. This enables the data to lead to the key issues to be explored.

7.5 Sources of data

Data from practitioners

- Conversations, as described above, with members of the Case Group; these were recorded and discussed by the whole Review Team.
- Two Follow-on meetings in which members of the Case Group responded to the analysis of the case and gave feedback about accuracy and fair representation of

their views. In relation to the emerging findings, the Case Group were asked to comment on whether these were underlying and widespread/prevalent. In other words, could we draw conclusions about whether, and in what way, this case provides a 'window on the system'?

- Members of the Case Group have also helpfully responded to follow-up queries and requests from the Lead Reviewers and the Review Team for clarification or further information, where this has been needed.

7.6 Key Practice Episodes and Contributory Factors

The data from the conversations with the Case Group translates into their 'view from the tunnel' and thence into a selection of Key Practice Episodes (KPEs) which enable us as reviewers to capture the optimum learning from the case. These KPEs are significant points or periods in relation to how the case was handled or how it developed. Case Group members are also an invaluable source of information about the why questions – an exploration of the Contributory Factors which were affecting their practice and decisions at the time.

7.7 Participation

The Lead Reviewers and the Review Team are grateful for the willingness of the professionals to reflect on their own work, and to engage so openly and thoughtfully in this SCR. The tragic circumstances of the child's death have meant that the process has been a very painful one for most if not all members of the Case Group. Nonetheless, they have participated very responsively in individual conversations, which have recalled their role in the child's story, and in group discussions which have at times been very difficult and challenging. Several have remarked that it has been a positive experience to contribute to learning from the tragedy. All this has given the Review Team a deeper and richer understanding of what happened with this family and within the safeguarding network, and has allowed us to capture the learning which is presented in this report.

7.8 Data from documentation

The Lead Reviewers and members of the Review Team reviewed the following documentation:

- The records of the agencies in the case, which were then translated into an integrated chronology
- Referral and information records (CSC)
- CP Medical report (December 2012)
- Record of Strategy Discussions December 2012
- Detailed records of Mothers antenatal care

7.9 Data from family, friends and community

As in traditional SCRs, the Learning Together model aims to include the views and perspectives of family members as a valuable element in understanding the case and the work of agencies.

In this review, the status of the parents as possible perpetrators in criminal proceedings has ruled out the offer of conversations with them at this time. It is hoped that at a future point, it will be possible to engage both parents in a dialogue about their experience of working with agencies.

Appendix 2 GLOSSARY OF TERMS AND ABBREVIATIONS

CID	Criminal Investigation Department
CPT	Child Protection Team (Police)
CSC	Children's Social Care
Core assessment	'An in-depth assessment which addresses the central or most important aspects of the needs of a child and the capacity of his or her parents or caregivers to respond appropriately to these needs within the wider family and community context'. (Framework for the Assessment of Children in Need and their Families DH 2000
ICPC	Initial Child Protection Conference
LSCB	Local Safeguarding Children Board
s.47 enquiry / Section 47 enquiry /child protection enquiry	s.47 enquiry refers to section 47 of the Children Act 1989 which gives local authorities the duty to 'make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare' when they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm
SCR	Serious case review
Single Assessment	Single Assessment process is the assessment process used in children's social care which replaced initial and core assessments
Strategy meeting / discussion	A strategy discussion is held when there is reasonable cause to suspect that a child has suffered or is likely to suffer significant harm. This may be following a referral and initial assessment or at any time during an assessment where a child is receiving support services if concerns about significant harm to the child emerge. The purpose of the strategy discussion is to enable the Children's Services' department, Police and other relevant agencies (e.g. health services, schools) to share information, make decisions about initiating or continuing enquiries under s. 47 of the Children Act 1989, what inquiries will be made and by whom, whether there is a need for action to immediately safeguard the child, and what information about the strategy discussion will be provided to the family. Decisions will be made regarding the provision of any medical treatment, how to handle inquiries in the light of any criminal investigation and whether other children affected are in need or at risk.
TM	Team manager

Appendix 3 Bibliography

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