CHILD G

SERIOUS CASE REVIEW

Independent Lead Reviewers:

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1.1 The Circumstances that led to Undertaking this Review

1.1.1 In the early summer of 2014 Child G, who was aged less than one year old, died whilst in the care of his mother's new partner. Post Mortem examinations were unable to find the cause of death but identified seven fractures which predated Child G's death.

1.1.2 The Hertfordshire Safeguarding Children Board's Serious Case Review (SCR) Sub Group recommended to the Chair of the Safeguarding Children Board that the case had met the criteria for a Serious Case Review as identified in Working Together to Safeguard Children 2013[1], in that there was information that:

(a) abuse or neglect of a child is known or suspected; and

(b) (i) the child has died.

The Chair of the Board accepted the recommendation and commissioned the Review.

1.1.3. A Police investigation was still in progress at the time of writing. Both Child G's mother and her partner were arrested placed on bail. The mother has been charged with neglect and her partner with neglect and failure to secure Child G in a car seat on the night of his death.

1.1.4. Child G's three siblings were taken into police protection and are currently the subject of an Interim Care Order pending the outcome of proceedings in the Family Court.

1.2 Family Composition

1.2.1 The family members relevant to this review will be referred to as follows:

Family member	**Anonymisation**	**Age at Summer 2014 (Date of Child G's death)**
SUBJECT	**Child G**	**Under one year**
Mother of Child G	Mother	
Father of Child G	Father	
Mother's partner at time of Child G's death	Mother's partner	
Subject's sibling	Sibling G1	Under 6 years
Subject's sibling	Sibling G2	Aged 4 years
Subject's sibling	Sibling G3	Aged 2 years
Child G's maternal	Maternal	

[1] Working Together: HM Govt 2013

grandmother	grandmother	
Child G's maternal great grandmother	Maternal great grandmother	

1.3 Brief Summary of the Case

1.3.1. Child G lived with his[2] mother and three older siblings, Sibling G1, G2 and G3. The mother had recently formed a relationship with a new partner who was living with the family. At the time of Child G's death he had been in the care of mother's partner. Mother's partner's account of what happened is as follows. He had taken Child G out in his van and had been driving him around for about two hours. Child G was lying on the front bench seat of the van; he was not strapped into a car seat. Child G's head had been covered with a blanket, to stop the glare from the streetlights. It was later established that mother's partner was out collecting scrap metal but also visiting a drug supplier during the evening. A blood sample taken from the mother's partner on the 1st June 2014 detected a high level of amphetamines 'that could have been lethal to some people'. Whilst mother's partner was driving back to the family home he said he noticed that Child G had stopped breathing; he commenced Cardio Pulmonary Resuscitation.

1.3.2. An ambulance was called from the family home and Child G was transported to hospital where he was later pronounced dead. The ambulance crew informed the police. A post mortem identified possible old fractures to the both wrists, both ankles and the left knee area which may have occurred at different times, but all within a period of 25 -50 days (13th April-8th May 2014) before his subsequent death. There was no underlying cause or illness to render Child G susceptible to fractures. Expert opinion is that the fractures would cause immediate and severe pain, the pain would be worse on handling and dressing Child G. The parents/carers of Child G did not seek any medical attention in respect of these injuries.

2. Methodology

2.1. This is included in Appendix 2.

[2] To protect children's anonymity all the children are referred to using the male pronoun.

3. How Professionals Understood the Case at the Time

3.1. The following section is a summary reconstructing how professionals understood the children's experience and their situation at the time.

3.2. The father and mother of Child G and his three siblings had been in a relationship for five years. They met when they were both teenagers; the relationship between the two was punctuated by violence and temporary separations. The family had been in receipt of a number of services from different agencies, including Health Visiting, General Practice, Children's Social Care and Primary and Nursery school provision. The relationship ended four months prior to Child G's death in February 2014 when mother asked father to leave the family home following another allegation of domestic abuse. It is thought that shortly after this, mother's partner moved into the family home.

3.3. The mother of Child G is from a Gypsy, Roma and Traveller heritage, it is unclear how father defines himself. Mother's partner is from a Gypsy, Roma and Traveller heritage. For the purpose of this review the families will be identified as Travellers because this is how they defined themselves.

3.4. In the middle of January 2013, mother attended E&NH Hospital; she was 16 weeks pregnant; she requested a home birth. The details of the father were not recorded but mother stated that he was supportive. Mother kept her antenatal appointments.

3.5. Father had been subject to a two-year supervision order from July 2011 for a serious assault on his brother; he co-operated with the Probation Service and despite the nature of his offence was found by that service to be open and compliant. Father reported that he had stopped using drugs and alcohol. The father did not live with the children's mother, but spent time with them and sometimes brought the children to his supervision appointments. The Probation Officer considered that the children seemed happy to be with their father, but also described them as 'grubby - rather than dirty'. The Probation Officer considered making a referral to CSC but decided against it, as she perceived that the risks to the children had not changed. (A referral had been made by Probation to Children's Social Care (CSC) during the pre-assessment report in February 2012; CSC took no further action).

3.6. In early January 2013, mother's partner (at this time he was not a member of the family household) was sentenced to a 12 month Community Order with a Supervision Order, for a breach of Non-Molesatation Order with a previous partner and a requirement to participate in the Integrated

Domestic Abuse Programme (IDAP)[3]. The Probation Service made a Safeguarding referral to Children Social Care (CSC) with regards to mother's partner's children from a previous relationship. Mother's partner failed to attend any further appointments with his Probation Officer and stated in clear terms that his lifestyle as a Traveller was not compatible with supervision and he would get any help he needed from friends and family within his community. Due to his lack of engagement he was returned to court for breach of his Order in February and March, when he was fined and the Order continued. Following continued failure to comply he was returned to court for a further breach and received a 12 week custodial sentence. He was released from prison in the middle of December 2013; because the sentence was for less than 12 months there was no supervision on licence at the time of his release and there was no further involvement with the Probation Service.

3.7. Child G was born in July 2013 at the home of his maternal great grandmother. In early September of 2013 his mother requested that the Health Visitor visit them at home as she was finding it difficult to get to the child health clinic with the four children. Child G was observed being prop fed[4] by his mother, who was advised about the risk of choking, MG said 'she has fed all her children in this way' and did not accept the HV's advice. Child G's weight was on the 75th centile[5]. The family were assessed by the Health Visitor and allocated to the core service[6].

3.8. In early January 2014, mother attended a meeting at the school to discuss G1's poor attendance (65.2%). Mother told the school that G1 was being bullied, that he did not like school and told lies and that she was worried about what he said at school.

3.9. Early in February 2014, a referral was made to CSC by someone close to the family. The referrer told the Social Worker that mother had 'dumped' two of her four children with the father, who was on probation for assault, and who had no money or food. The referrer thought that the children were being neglected and 'being passed from one person to the next'. The Social Worker made contact with father and confirmed that he was at the family home with G1 and G3, but that mother had G2 and Child G with her and her partner who was a drug user and had just come out of prison. The Social Worker asked for confirmation that there was food and heat at the house and that he was coping with the children. Father wanted mother and the other children to come home. Father was advised an assessment might be necessary because of the number of concerns.

3.10. Four days later the case was allocated by the Team Leader to a Social Worker and Student Social Worker. The Team Leader directed the Social Worker and Student Social Worker to:

[3] This is a group work programme that is run over 27 weeks for men who have abused their wives, partners or ex-partners.
[4] The bottle is wedged by a pillow or blanket into the mouth of the baby, which increases the risk of choking.
[5] Centile chart World Health Organisation growth charts
[6] Universal or core service whereby families are offered developmental assessments and encouraged to access child health clinics for advice and support.

- see the children and their bedrooms to assess how father was coping
- establish whether he has parental responsibility.
- find out what level of contact father had with the children before this incident
- find out what the plan was if mother returned; whether there were support needs or safeguarding concerns.

The focus at this time was on father; the initial concern was about his history of violence and the possible risk that he posed in caring for his children. The following day father informed the Social Worker that he was now only looking after G1 and was staying at maternal grandmother's house.

3.11. Twelve days after the initial referral the allocated Social Worker and Student Social Worker visited father and G1 at maternal grandmother's house. Child G, G2 and G3 were with their mother at the family home. The Social Worker realised that all four children needed to be assessed. Maternal grandmother was described as intimidating. The Social Worker and Student then visited mother who appeared nervous and said her mother had been taking her benefits away from her. Mother said that her mother (maternal grandmother) was siding with the father, as she didn't like mother's partner The name and date of birth of mother's partner were recorded. Mother had asked father to leave the family home after another alleged domestic abuse incident. Consent was given by mother and father for a Section17[7] assessment to be undertaken, including the school, Children's Centre, Health Visitor and GP.

3.12. The Section 17(Child and Family) assessment identified that mother did not have a close attachment with G1 and was willing to allow G1 to live with his father despite his lack of stable accommodation. The Student Social Worker identified that mother was an isolated young mum who said she had 'no life, no friends' and thought people looked down on her as she was from a Traveller background. G1 was seen at school by the Social Worker and Student Social Worker, and said that he loved his Mum and Dad but did not like his mother's partner because 'he is horrible and doesn't buy me presents'. The next day G1 was upset at school, because he was worried that his father would be beaten up, by someone who appears to be mother's partner.

3.13. The Child and Family Assessment[8] also identified: outstanding immunisations for all the children, poor home environment, the family sleeping in one room. Despite this, the conclusion was that mother had shown some strengths and was able to protect her children; the case was

[7] A Child In Need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a satisfactory level of health or development. Social Workers carry out an assessment under Section 17 of the Act.
[8] Child &Family Assessment Working Together (2013)

recorded as Child In Need (CIN). Mother's partner was not included within the assessment.

3.14. The school had also raised three records[9] of concern between the end of January and the middle of March (2014): G2's very poor attendance at nursery; supervision of the other three children when mother dropped G1 at school and G1 watching a horror movie The Student Social Worker visited the family at home, but there was no improvement in the living conditions and all four children, who were now back with their mother, were in 'grubby clothes'.

3.15. The day before the Child In Need (CIN) meeting the Social Worker discussed the case in supervision. She was concerned about neglect; the poor home conditions and mum's lack of motivation to make the necessary changes. She thought that the case was 'borderline' and might reach the threshold for Child Protection, but it was ultimately concluded it should be assessed as CIN[10].

3.16. The CIN meeting was held at the school and was attended by the Social Worker and Student Social Worker, the Health Visitor, Attendance Improvement Officer and a Teacher and Children Centre Worker. Mother and maternal grandmother were present. The purpose of the meeting was to assess whether the family could be supported under Children in Need, or if it needed to progress to an Initial Case Conference to prevent the children suffering from risks of significant harm. Mother had refused consent to share the Child and Family Assessment with the other professionals. The meeting was described as being very difficult, with maternal grandmother shouting and swearing, and saying: 'we are Travellers, we don't need to go to school, the only person who can liaise with us is the Travelling Link Worker.' (Access to Education Manager). Some of the professionals reported being frightened by maternal grandmother. The recommendation was for a Child In Need Plan to be delivered in conjunction with Thriving Families.[11] The plan focused on the need to improve mother's relationships with all the agencies working with the family, to improve attendance at school and nursery for G1 and G2, and to improve the home conditions and the Health Visitor to monitor the children's' development.

3.17. On 7th April 2014 the Police received an anonymous phone call reporting the sound of a child screaming at the family home. The attending police officer saw Child G who was dressed in a nappy and made thorough enquiries with the family who said that Child G was crying due to constipation. The Police Officer checked the parents on the Police National Computer, it was noted that the mother's partner had an Harassment Order against him, but that it wasn't against mother.

3.18. The Health Visitor made a home visit on the 16th April. Child G was seen sitting on mother's partner's knee dressed in a nappy and was eating an

[9] Record of concern identified by the school and sent to CSC.
[10] Children in need of support rather than protection
[11] Hertfordshire's Thriving Families is an early intervention programme, which incorporates the government's Troubled Families initiative.

iced bun. The Health Visitor advised mother that this was not appropriate food for him but she just laughed.

3.19. On the 9th May the Access to Education Manager visited the family home as agreed at the CIN meeting. She had worked with the extended family and supported them to access education. The manager was unaware that the family had an allocated Social Worker. Mother reported that Child G was in the van parked on the driveway; he was in the care of mother's partner's teenage son from a previous relationship.

3.20. Mother attended the second CIN meeting in the middle of May on her own, she had requested that her own mother was not invited. The decision was that the case would be referred to Thriving Families (TF) after the next meeting. The view was that TF could offer more intensive practical support to the family.

3.21. The Student Social Worker made her last visit to the family on the 21st May. She observed a man working on a van parked on the drive and was told by the mother that he was her partner, but that he didn't live in the house; he helped her with the children in the mornings as he worked nights. This was contrary to the information that mother shared during the assessment. The Student Social Worker saw Child G who she described 'as a lovely boy who responded well to his mother but looked grubby'. G2 was described as 'skinny' and G3 'needed his nappy changed' and 'was grubby'.

3.22. The Health Visitor made a home visit on the 27th May 2014 to undertake Child G's developmental check. She found it difficult to gain access to the home but persisted as she could hear children crying and noted that they were poorly supervised. She saw the children and described Child G as overweight; he was not yet crawling or pulling to stand[12]. The health visitor felt that the delay with his gross motor development was due to his size and limited opportunity to explore his environment; he was either being held or strapped into his buggy. G1 returned to the house with maternal great grandmother who said that she could not cope with G1 who was picking on the other children'.

3.23. In the early hours of the 27th May, a Police Patrol searched a parked van with two males, one of whom was mother's partner. One of the Police Officers noticed a baby, sitting in a car seat at the back of the van, he was awake and did not appear distressed but there was a strong smell of cigarettes and the car was full of smoke. Mother's partner said that Child G had trouble sleeping so he would take him out for a drive to settle him. He was unable to give Child G's date of birth but the Police Officers were aware that he was living with the mother and were satisfied with his explanation. The Police Officer completed an internal Common Assessment

[12] Normal milestones for development are that a baby sits unsupported by 7-8 months and pulls to stand from 10 months old.

Form (CAF)[13] on his return to the police station because he was worried about the baby being in such a smoke filled van.

3.24. In early June 2014 Child G was taken to hospital by ambulance after becoming unresponsive whilst being driven around during the night by his mother's partner and subsequently died.

4. Appraisal of Practice and Analysis

4.1. I**ntroduction**

This section of the Review assesses the quality of multi-agency practice at those key points which were considered to provide the most significant learning. In doing so, it takes into account both the contemporary required standards and also the information that was known, or could have been known at the time of the events. Where there is information about why practice may not have met required standards these are explained. By understanding **why** things happened in the way that they did, rather than simply **what** happened, the Review is seeking to achieve a greater depth of learning about safeguarding systems within Hertfordshire and beyond this individual case. Where learning in relation to individual agencies' practice has been identified within the agency learning summaries it is not repeated here. The recommendations for individual agencies, which were produced at the outset of this Review, are included in Appendix 4.

4.1.1. The cause of Child G's death remains unexplained. The post mortem identified that Child G had seven healing fractures to both wrists, both ankles and his left knee. Expert opinion is that the injuries occurred probably 25 – 50 days before his death and possibly at different times. Each of these fractures was as a result of significant forces applied to the bone, typically from a blow, impact, or bending or snapping action. Child G would have been in considerable pain at the time of the injuries and for a few days after when being handled and his discomfort and distress would have been apparent to his main carers. Neither his mother nor her partner sought medical attention for Child G. The injuries only came to light after his death.

4.1.2. The injuries were inflicted during the period 13 April 2014 – 8 May 2014, which was a period when there were four visits by professionals to the family home. Child G was seen on three of these visits, twice by the Health Visitor and once by the Student Social Worker. There were no concerns about any possible injuries reported following these visits. When the Access to Education Manager visited on the 9 May, Child G was reported to be asleep in the van being supervised by mother's partner's son. The reason for this home visit was to discuss school attendance for G1 and it was in this context that the Manager accepted the explanation given by mother that Child G was asleep in the van parked on the drive way.

[13] Police officers complete the form on the intranet and send to a central point that makes decision about further action.

4.1.3. This Review has given careful consideration as to whether any of the professionals concerned could reasonably have been expected to identify that Child G had been injured. For the professionals to have identified the injuries they would have had to see Child G within a few days of the injuries taking place, when his distress would have been visible, or to have physically handled Child G. At the first visit made by the Health Visitor on 16 April she observed Child G sitting on mother's partner's knee wearing a nappy and feeding himself. Her next visit was at the end of May when the fractures would most probably have been healed. The Student Social Worker visited on 21 May and observed mother changing Child G's nappy and dressing him. Child G was described as happy and contented and responding to his mother's voice. Child G did not show signs of distress and the professionals had no reason to physically handle him. The injuries only came to light following Child G's death. It is now believed that they were inflicted at around this time. Given the nature of the professional contacts it would not have been possible to identify them during his life.

4.1.4. Child G and his siblings had been identified as Children In Need. The initial concern following the referral to CSC was focused on whether there were any safeguarding issues for G1 and G3 when their mother left them in the care of their father. When G1 and G3 were returned to mother the focus of the intervention for the family moved to a supportive one. The Child and Family Assessment failed to explore the significance of mother's new partner who was living in the family home. CSC was aware that mother's family were unsupportive of the new relationship and were aware that it had created tension within the extended family. Background checks on mother's new partner were not undertaken and therefore CSC did not make the connections with mother's partner's previous relationships, including a history of violent behaviour against women, and that his children were also known to CSC.

4.1.5. Although there was evidence for some concern about how Child G and his siblings were cared for, the Review Team were clear that there was no specific evidence that they would experience serious physical harm. In these circumstances, neither Child G's death nor his injuries could reasonably have been predicted. In the absence of clear evidence that there was a risk of serious physical harm, professionals, and in particular Children's Social Care would have had no justification in taking preventative action such as removing Child G from his mother's care. However, there was evidence to suggest that all of the children may have been at risk of long-term neglect, which could have led to a different course of action in the longer term.

4.2. **The reluctance to name neglect by professionals involved with the family.**

'*Neglect can be difficult to define because most definitions are based on personal perceptions of neglect. These include what constitutes 'good*

enough' care and what a child's needs are. Lack of clarity around this has had serious implications for professionals in making clear and consistent decisions about children at risk of neglect' (NSPCC.2012).

4.2.1. Before the period covered by this SCR an outline chronology of professionals' involvement with the family featured several reported incidents of domestic abuse, children dressed inappropriately for the time of year and or weather conditions, failure to complete the immunisation programme for each child and general lack of stimulation within the family home. Good practice would be that given these concerns and the age of the parents when G1 was born for agencies to have intervened early, this did not happen.

4.2.2. The Health Visitor had worked with the family for over four years. The Health Visitor was used to the fact that mother disregarded advice given by her, particularly around nutrition, diet and socialisation. The Health Visitor recorded these observations and facts yet did not recognise the possible cumulative significance of these events and the impact it might have on the overall development of the children. Mother could become aggressive and hostile at times, mostly when she was being challenged about aspects of her care: and there was a level of known violence and intimidating behaviour within the extended family.

4.2.3. The family had been assessed for the core health visiting service which meant that the onus was placed on the family to access the service. Appointments for developmental assessments and immunisations would be sent. Following the CIN plan the visits by the Health Visitor although regular, occurring once a month, were unfocused with no clear outcome recorded or goals set for each child. It appeared that the Health Visitor became 'desensitised' to the situation and had become used to the family and home conditions and accepted them as the normal. The Health Visitor was the key professional that had known the family the longest and was in a unique position to gather evidence of signs of neglect including unmet emotional needs of the children, poor diet, home environment and lack of supervision. The Health Visitor was also aware of the violence within the home between the parents and that G1 and G3 were aggressive to one another and using inappropriate language for their age. It was therefore surprising that despite having undertaken the Graded Care Profile (GCP) training, at no time did she consider using the GCP tool[14] to assist her in understanding what the issues were for each of the children.

4.2.4. The home conditions were frequently commented on by professionals as being poor. Professionals became focused on clearing up the house and offering practical support to the mother rather than improving her parenting skills and outcomes for the children. The children were described as 'grubby' by more than one professional, which seemed to indicate that this was not ideal, but acceptable and therefore did not trigger further action.

4.2.5. Staff at school had raised a cause for concern report about several aspects of the children's care. It is clear that the professionals that worked with the

[14] Graded Care Profile is an assessment tool used to assist in the identification of neglect

family wanted to improve G1's attendance at school and this was reflected in the CIN plan. However, the level of attendance at school was not identified explicitly as being neglectful.

4.2.6. The Social Worker identified during supervision that she was concerned about neglect, (this was the only professional that actually used the word neglect) the poor home conditions and that the mother appeared to lack the motivation to make the necessary changes, and failed to act on professional advice. However, there appeared to be a lack of professional follow through of these concerns. The next day at the CIN initial meeting the plan instead focused on practical help to sort the home conditions. There appeared to have been little if any analysis done on what the impact of living in these circumstances was for the children on a daily basis, or that mother had failed to meet her children's basic needs; 'the persistent failure to meet children's basic physical and/or psychological needs and which is likely to result in the serious impairment of the child's health or development'.[15] This may also have been influenced by the family ethnicity and how professionals responded; this will be covered under the section on the **Significance of ethnicity and culture.**

4.2.7. It is well known that neglectful parenting is almost inevitably a sign of complex and longstanding problems such as mental-ill health, domestic violence, a poor physical environment or entrenched behaviour by a parent or parents. The children's needs should always be assessed and addressed fully, including the family history and context. It is apparent that the CIN plan became focused on sorting out the immediate practical issues of the physical environment; such as clearing up the house and garden and ensuring that G1 attended school; these interventions were easy to measure and made professionals feel that they were effecting change and that the case was moving forward. The plan was about support for the mother, rather than assessment and response to risks and there is little evidence of what consideration was given to the safety and well-being of the children. Research suggests that professionals can find it difficult to say to a parent that their children are neglected because this implies that the parents are to blame and given the difficulties of working with this family, this may have been a feature here.

4.2.8. The question is what allows professionals to fail to name neglect? The Health Visitor was the only professional involved with the family over a significant period of time. The Social Worker did identify that she thought that the children were neglected but didn't follow this through and became focused on the practical solutions for the family. The practitioners who contributed directly to this Review were asked directly why the Graded Care Profile was not used for this family, the response was that it would take too long to complete. Training for the Graded Care Profile (GCP) has been implemented by Hertfordshire Safeguarding Children Board (HSCB) since April 2014 and has trained a total of 114 staff; prior to this individual agencies were responsible for training their own staff in the tool. What is apparent is that the GCP was not at the forefront of practitioners' minds in

[15] Working Together 2013

working with this family and did not appear to be part of any routine consideration. The current Board strategy (advocated by CSC) is that the Graded Care Profile is a tool that can be used by professionals should they wish to use it or think it appropriate to use.

Ofsted commented that *'those local authorities providing the strongest evidence of the most comprehensive action to tackle neglect were more likely to have a neglect strategy and / or systematic improvement programme across policy and practice, involving the development of specific approaches to neglect'*[16]

Neglect is a complex safeguarding issue that requires a complex response. Being able to respond effectively to cases of neglect is particularly important given the numbers of children who are the subject of a child protection plan under the category of neglect. In February 2015, over 600 children in Hertfordshire were subject to a child protection plan under the category of neglect. The number of children on CP Plans outweighs the number of GCP's by a factor of 10. If the GCP was being used successfully to identify neglect and offer help, it could be expected that this would be reflected in the numbers of children subject to CP Plan for neglect. **Recommendation1**

The Board needs to challenge agencies to demonstrate that they are working in line with its strategic approach to neglect.

4.3. The importance of robust assessments and identification of risk.

4.3.1. A good assessment including family history and identification of risk factors is fundamental in ensuring that a strong and appropriate plan for the level of intervention is put in place. In this case the assessment made by the professionals was too superficial and focused very much on the 'here and now'. The assessments did not adequately take into account the family history and dynamics, including the 'break-up' of the relationship between mother and father, and as a consequence the loss of contact father had with his children. There was no assessment of mother's new partner even though it was known that her own family was unhappy about the new relationship and there would have been information available both within CSC's own records and other agencies, such as the Probation Service about risks such as violence and drug use. There was a lack of critical review about whether interventions previously tried with the family were effective. This may have led to the wrong thresholds being applied.

4.3.2. The Health Visitor assessed the family as meeting the core service despite the fact that the HV identified that mother had experienced domestic abuse and had a history of non-engagement, failure to keep scheduled appointments for the children's immunisations, social isolation and lack of stimulation for the children. It is difficult to understand the rationale behind this decision, even acknowledging the benefit of hindsight. Although the Health Visitor visited monthly when the children became CIN, the visits remained unfocused and there was no clear plan of expected outcomes

[16] In the child's time: professional response to neglect Ofsted.

for each child. The Health Visitor should have been more evidently concerned about a number of aspects of the children's care and development, including Child G's gross motor development delay.

4.3.3. Following the referral to CSC in February 2014 the initial focus was on the two children, G1 and G3 who were residing in the care of their father who had a known history of violence. The Team Leader gave appropriate direction to the Social Worker and Student Social Worker on the areas to be included in the assessment. After the visit to father, it became evident to the Social Worker that all four children needed to be included in the assessment. This was an opportunity to move to a holistic assessment and move away from a focused narrow view.

4.3.4. The Child and Family Assessment(C&FA) was completed and despite the long list of concerns including the fractured relationship that mother had with her own mother, the ages and therefore vulnerability of the children, the poor home conditions and the possible risk of abuse from father, the analysis was fairly positive and concluded that mother had shown strengths and the ability to protect her children. Despite mother's stated willingness to co-operate with the agencies, the evident lack of engagement and hostility to such is evident at the CIN meeting on the 2 April 2014 but went unchallenged. There was no re-assessment of mother's ability to prioritise or meet the needs of her children following this incident.

4.3.5. The omission of including Mother's new partner in the assessment is of significant concern and falls below good practice standards. The Team Manager said that the normal practice would be to check all adults that were living in the house. Background checks were not completed on mother's partner; he was described as supportive towards mother, helping her in the morning with the children. There was conflicting information about whether mother's partner was actually residing in the family home permanently. Agencies were aware that mother's family did not approve of her new relationship. Despite this no enquiry was raised on mother's partner. No assessment of mother's ability to protect her children within this new relationship was undertaken and as a result no risks considered.

4.3.6. Neither was there much consideration given to father, initially the concern was for G1 and G3 as they were in the care of their father. In fact attendance at school for G1 improved whilst he was living with his father. When G1 returned to live with his mother, there was no exploration with mother about the relationship that she had with G1, given that she had been willing to allow G1 to live with his father and had expressed that she didn't have a strong bond with G1. Following the return of G1 to the family home, he had no further contact with his father. Good practice would have been to discuss this situation with mother, father and G1. This did not happen. There was no further contact with father from the professionals involved with his family; neither did he see his children (apart from a period of about 5-7 hours on the 17th April when Child G was taken to hospital and the three other children were left in his care). What is apparent is that there was an absence of focus on both of the men within the children's

lives, an issue which has been a feature of previous reviews within Hertfordshire.

4.3.7. Risk should be assessed from the perspective of the children and should not be unduly influenced by sympathy for the adults' experience. There is a danger that when professionals from the key agencies fail to identify the risks or understand the significance of them, children are left living in risky situations. Potential and actual risks to the children were not clearly defined or included in the CIN plan. Research evidence from SCRs (Brandon et al[17]) suggests that history is an important part of assessing current and future parenting capacity, and should be considered as a potential risk factor. It is apparent that 'the past is the best predictor of the future'. Reder et al[18] have written about a cognitive error, which results in disregarding new evidence that might challenge the current direction or concept of the case (e.g. family support as opposed to child protection). Within this family history should have suggested a risk of continuing poor care and neglect of the children's needs across a variety of their developmental needs. A safe child protection system needs to deal proficiently with risk and probability and the impact; it is not enough to respond reactively after an incident of harm has been caused to a child

4.3.8. The assessment of this case was that the multi-agency intervention, i.e. Child in Need procedures was not underpinned by an adequate, robust assessment of the full family circumstances and all the needs of and risks to the children. These procedures are intended to be built on good quality assessments, by developing a plan of action, which is owned by the multi-agency group and reviewed regularly to see what progress is being made to promote children and young people's outcomes. Without an adequate assessment, the decision to manage the family within Child in Need was flawed, and in practice appeared to encourage a focus on supporting the mother rather than identifying or managing possible risks to the children. The review is not challenging the decision to manage the family within Child in Need but is highlighting the need to constantly review and assess the progress being made against the CIN plan and take the appropriate action where there is no change or lack of engagement. Both the practitioners and members of the Review Team considered that this case was not untypical of practice and that staff across the agencies felt that increasing numbers of children in circumstances such as these were being managed under Child in Need.

4.3.9 CIN and CP numbers within Hertfordshire have been unstable for some time and at times CP numbers have been considerably higher than statistically comparable authorities. The reasons for fluctuations in these numbers are not always easy to identify. There has been a concern within Hertfordshire to reduce them and this is an ongoing feature of management planning. What is very apparent from the experience of Child G is that if in the future Hertfordshire's ambition is to meet the needs of more children as CIN then there must be a very robust CIN assessment process. This also requires a recognition by professionals of the need to

[17] Brandon et al: 2008
[18] Reder et al 1993

escalate or reconsider the level of intervention when the CIN process is not working in neglect cases. This is what should have happened quickly in this case when there was no improvement at home and the CIN meeting failed to meet its objectives.

4.3.10. What is therefore very significant learning from the experience of Child G is the crucial importance of the assessment process in order to ensure that the intervention is appropriate to the needs and risks facing children. **Recommendation 2**

The Board needs to be assured that appropriate and proportionate assessments are undertaken to ensure that those families and children managed under Children in Need are the correct ones and are properly reviewed.

4.4. Management oversight and supervision.

4.4.1. It is well documented that in working with families to safeguard children, the sense that professionals make of information they receive will inevitably be vulnerable to common errors of human reasoning (Munro, 1999). As Munro (2008) notes:

'*Psychological research has shown that people are very bad at policing their own biases. Social workers need regular critical supervision to ensure that their biases are not distorting their assessments*.'

4.4.2. The Health Visitor did not identify this as a case that she wanted to take to safeguarding supervision during the timeframe of this Review. There is a potential risk to the rigour and strength of supervision if the cases under consideration are only those with very evident high risk factors such as previous physical abuse, excluding those with longer term but repeated concerns, such as those associated with neglect. This is particularly a risk for services such as health visiting where supervision prioritises cases known to be high risk, but is equally applicable across services. During discussion with the practitioners in this case there was some acceptance that possibly because of the family culture and ethnicity a different threshold of parenting was accepted. Supervision can become even more important when a family has been known to agencies for "years" to provide a critical and challenging view that allows the facts to be viewed from a different perspective. It also allows professionals to be able to communicate and express their anxieties about the work that they are undertaking with the family, and identify gaps and risks in the multi-agency system.

4.4.3. From January 2014 the health visiting teams moved to a corporate caseload. The Information System that Health Visitors use also changed in February 2014 which now allows managers and the Safeguarding Team to have an overview of families with identified concerns, including CIN and children in receipt of a child protection plan. The supervision policy within

HCT has been recently updated to ensure that cases such as this one are brought to supervision.

4.4.4. The Social Worker received supervision on this case the day before the initial CIN meeting. It is interesting to note that she thought that the children were neglected, and that mother lacked the motivation to change. Although it had been assessed as a CIN case she was of the view that it might reach the thresholds for child protection. The meeting took place the following day and there is no evidence in the minutes of the meeting that the concerns raised in the supervision arena were explored. The CIN meeting had been difficult and professionals had found the experience challenging and intimidating. It is difficult to understand why those present at the meeting failed to feed this back to their respective line managers or reflect on the behaviour and attitude of maternal grandmother in particular and what the consequences of this display were in relation to the CIN Plan.

4.4.5. Supervision varies across agencies. Within CSC there is an expectation that Social Workers receive monthly supervision on all their caseload and if that isn't possible the manager will help identify those cases that need to be discussed. Only two supervision sessions were recorded in the time frame (rather than four). There was also evidence of a possible over reliance on using email to share information in managing this case. The reasons cited for using e-mail by the professionals working with the family included unavailability or difficulty in accessing staff at the time of the visit, lack of time, and by sending the information electronically it provided an audit trail. The danger of this is that the focus is on evidencing actions taken, rather than good professional information sharing and that the opportunity to discuss the case and challenge one another face to face is lost and the importance of new information may not be picked up.

4.4.6. The Social Work Team leader gave very clear direction to the Social Worker and Student Social Worker about what needed to be included in the assessment. It is evident from the conversation with the team leader that this wasn't one of the significant cases that they were dealing with and that once the perceived risk of two of the children being in the care of father was removed with them returning to mother the urgency of obtaining information and background checks diminished.

4.4.7. We know that practitioners across agencies are working with a high number of families with concerns that may not immediately stand out as meeting the thresholds for intervention but nevertheless continue to cause concern. It might be argued that it is these very cases that the practitioners should be bringing to supervision on a regular basis. However, the focus for many agencies when identifying cases for safeguarding supervision is often those cases, which are already within Child Protection procedures. There is little evidence to suggest that individual agency managers were aware of the changing circumstances of the family. Further work needs to be done on reviewing the types of cases that are discussed in supervision; to ensure the correct cases are taken to supervision and that there is a clear plan to support the professional in working with families and children. Such a review should focus on those cases that may not immediately

present as a high risk, but may need attention for example due to being on the edge of thresholds for long periods, or to help workers identify where they are becoming 'stuck' with a particular family. **Recommendation 3.**

The Board needs to be assured by partner agencies that high quality supervision plays an integral role to improve assessments and practice in order to further safeguard children.

4.5. To what extent did the culture and ethnicity becomes the defining influence in shaping the agencies' response to the family situation?

4.5.1. It was identified at the outset of this Review that there was potential learning about the way in which agencies worked with families from the Traveller community. Information provided to the review has frequently highlighted that this was a Traveller family and that some professionals felt that they could be difficult to work with. Hertfordshire has one of the largest Gypsy and Traveller populations in England accommodated on 41 sites. A significant number of Travellers have also been provided with permanent housing locally. Mother and her extended family were all housed locally. Research suggests that when the decision to leave the Traveller sites is made, families can be exposed to more direct and immediate forms of public hostility focused on their ethnicity or lifestyle. This is coupled with the fact that they may be forced to move further away from their wider communities, culture and support systems and can lead to a cycle of disadvantage, oppression and marginalisation.[19] Mother expressed feelings of isolation, being bullied at school and 'being looked down on' because she was a Traveller. Staff need to be equipped to understand and support those who identify with a Traveller heritage but now live in fixed accommodation.

4.5.2. Mother appeared to have different relationships with the different professionals involved in her care and this appeared to be shaped by the role they had within the family. The Midwives were universally accepted by mother and maternal great grandmother, and were made to feel welcome at the home of maternal great grandmother during the birth of Child G. The Health Visitor was accepted (she was allowed into the home) but advice that was given was often ignored or disregarded. Both the Social Worker and Student Social Worker had been refused access to the family home on different occasions and had experienced verbal aggression. Mother's interactions with GPs were mostly around care for an acute condition for either her or the children, which were appropriate. Mother attended E&NH Hospital on at least three occasions when she went against medical advice and took her own discharge, twice towards the end of her pregnancy and then following an operation. Mother also walked out of the Emergency Department with Child G because she didn't like the advice that she had been given by the Consultant. There was a general acceptance that this was her pattern of behaviour and there was little

[19] Lau and Ridge, 2011

evidence found that the reasons behind mother taking this action were fully explored with her, or whether any consideration was given that if this was how mother looked after herself; how does she care for her four children?

4.5.3. There appeared to be limited insight from professionals within the acute hospital about what the needs of children living in this community might be. Good practice would be that staff across the Trust, in this case, the Emergency Department would complete an Information Sharing Form that is sent to the liaison Health Visitor, who would then communicate directly with community staff. This did not happen on this occasion; the Hospital Trust has acknowledged that this was an omission. Child G, G1 and Mother were seen in the Children's Emergency Department, the Day Assessment Unit and the Adult Emergency Department. All are located in different areas within the Trust and with different members of staff. Currently there is no facility for incidences such as 'discharge against medical advice' to be shared within the Trust and as a consequence the incidences were viewed in isolation. In the community a record system is used whereby community staff can view information and alerts. Both the Review Team and Independent Reviewers were also concerned that there was no evidence shared with us that staff in the hospital, but in particular the Emergency Department, had considered whether there were other children within the family and who was caring for them. Further work has been undertaken by the hospital trust for all staff to 'Think Family' and is reflected in Appendix 4.

4.5.4. During conversations and meetings with the frontline staff the issue about applying different thresholds to families from a Traveller background was raised. A significant number of professionals involved with this family felt that although the same threshold should apply, in practice they are different, and they have become over familiar with seeing certain practices and accepting them as normal. Examples were given that small children were under stimulated and parented in a neglectful way whilst older children were allowed to play in a destructive way without challenge. Professionals seemed reluctant to challenge, often because if they did they feared it would be met with aggression and hostility (some of the professionals were scared when working with this family) and might jeopardise their ongoing relationship with the family and possibly with the wider Traveller community.

4.5.5. The behaviour of mother and maternal grandmother at the CIN meeting in early April was aggressive and challenging. Maternal grandmother made it very clear that because they were Travellers they didn't need to send their children to school and it was up to the parents as to whether they wanted their children immunised. Mother refused to allow the Children & Family Assessment to be shared with the other professionals at the meeting and continued to be uncooperative. There appeared to be lack of consideration or reluctance by the professionals to stop the meeting and reschedule, possibly as a consequence, the plan was task centred rather than focused on meeting the needs of the children to support them in achieving their

maximum potential. It is clear that the meeting achieved the minimum acceptable level of intervention, one of support and practical assistance, rather than developing a plan that was child focused and addressed the disparity of mother's behaviour towards the agencies working with the family and whether she had the ability and motivation to make the required changes. Given the powerful description of the meeting, it is the Review's conclusion that this was significantly, although quite possibly unconsciously, influenced by the family's behaviour.

4.5.6. Professionals were unaware of the Access to Education Team (AET) for Travellers and Refugees and the specialist knowledge and experience that the team has. It became apparent during the review that staff within the team had acclimatised themselves, or believed that they were uniquely placed to help Travellers without going through the legitimate safeguarding channels. As a consequence there continues to be a risk of the Access to Education service not referring concerns.

4.5.7. Over the course of the SCR there has been much discussion about how professionals found it difficult to challenge and work with Travellers. This was because some professionals felt scared and intimidated, whilst other professionals did not fully understand the culture of the Traveller community or had preconceptions, which they did not question. The knowledge of the professionals about the culture and values of the Traveller community appeared to be at a superficial level and was interspersed with 'stereotypical' views of how Travellers behaved.

4.5.8 We know that there are a number of significant attitudes and values that are widely shared within Traveller communities, although it is absolutely crucial that each family's individual values and traditions need to be explored and understood (see Bristol City Council, Myth busting booklet on Gypsies and Travellers) Commonly family and particularly children are extremely important to Travellers and a source of great pride and aspiration for their children. The extended family tends to support and look after one another. Travellers have an oral culture passing their traditions from one generation to the next. Men and women generally still follow the more traditional gender roles, men provide for the family and women look after the children and the house/trailer. Travellers live by their set of values and behaviour codes; they have strict rules on cleanliness, modesty and faithfulness. The special hygiene rules (including using different washing up bowls and anything such as a bag that has been on the floor will never be put on the table)[20] are in some ways stricter than those of the wider community but are not well understood outside the Traveller community. Had more of the professionals working with the family known, for example, about the importance of cleanliness, more time might have been spent understanding what the implications might be within this family of such rules not being observed.

[20] Good practice guide Working with housed Gypsies and Travellers,2008

4.5.9 If the professionals did challenge behaviour and parenting practice some were anxious that they would be seen as discriminatory towards Travellers. It is therefore crucial that staff need to be able to engage with the wider Traveller community, be curious about that communities typical norms and value and feel confident about being able to challenge behaviour and child rearing practice when it does not conform to the expected standards within the wider community

4.5.8. Although this review was on a family with a Traveller heritage which provided a particular focus on how agencies work with the Traveller communities, the issues and lessons learnt have wider implications for the agencies in Hertfordshire as more families from different ethnic groups move into the area. Agencies must ensure that the workforce is equipped to work with all families, to develop greater understanding of different cultures and beliefs and how to engage constructively with different communities in order to deliver a safe but sensitive service, respecting cultural differences but ensuring that the same standards and thresholds are applied. **Recommendation 4**

Partner agencies need to assure the Board that they are equipping their workforce to deliver safe and effective services for children within its traveller communities and to use this learning to further enhance services to other minority communities within Hertfordshire.

4.6. Concluding comments from the review.

At the time the Review was commissioned the following two issues were identified as of particular interest:

- What do the findings in relation to the care provided to Child G tell the HSCB and member agencies about the strengths and vulnerabilities to safeguard and promote the wellbeing of children?
- What steps should the HSCB or member agencies consider taking in order to improve services for vulnerable children?

These two overarching questions have formed the basis for this analysis and the following recommendations.

5. Recommendations.

This section brings together the recommendations arising out of the learning from Child G's experience, which the Review Team concluded provided insights into safeguarding practice more widely and therefore will require further consideration and prioritisation by the Board.

5.1. The Board needs to challenge agencies to demonstrate that they are working in line with its strategic approach to neglect.

5.2. The Board needs to be assured that appropriate and proportionate assessments are undertaken to ensure that those families and children managed under Children in Need are the correct ones and are properly reviewed.

5.3. The Board needs to be assured by partner agencies that high quality supervision plays an integral role to improve assessments and practice in order to further safeguard children.

5.4. Partner agencies need to assure the Board that they are equipping their workforce to deliver safe and effective services for children within its traveller communities and to use this learning to further enhance services to other minority communities within Hertfordshire.

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Appendix 1: **ACRONYMS AND TERMINOLOGY**

AET	Access to Education for Refugees and Travellers.
CAF	Common Assessment Framework.
CG	Case Group
CIN	Child in Need.
CPP	Child Protection Plan
CSC	Children Social Care.
C&F	Child and Family Assessment.
DA	Domestic Abuse.
E& NH	East & North Hertfordshire NHS Hospital Trust.
E&NH CCG	East &North Hertfordshire Clinical Commissioning Group.
GP	General Practitioner / Family Doctor.
GCP	Graded Care Profile.
HCT	Hertfordshire Community NHS Trust.
HSCB	Hertfordshire Safeguarding Children Board.
HV	Health Visitor
IDAP	Integrated Domestic Abuse Programme.
IVT	Intravenous Therapy.
PO	Probation Officer.
RT	Review Team.
SCR	Serious Case Review.
SW	Social Worker.
St SW	Student Social Worker.
TF	Thriving Families.

Appendix 2: **METHODOLOGY**

2.1.1. Statutory guidance within Working Together requires Local Safeguarding Children Boards to have in place a framework for learning and improvement, which includes the completion of Serious Case Reviews. The guidance establishes the purpose as follows:

> *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)*

2.1.2. The statutory guidance requires reviews to consider: "*what happened in a case, and why, and what action will be taken*". In particular, case reviews should be conducted 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.*

2.1.3. In order to meet these requirements the model adopted in undertaking this review uses a 'systems approach', which draws significantly on the work undertaken by Professor Munro[21] and SCIE [Social Care Institute for Excellence]. A 'systems approach' to learning recognises the limitations inherent in simply identifying what may have gone wrong and who might be 'to blame'. Instead it is designed to identify which factors in the wider work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely. The purpose therefore is to move beyond the individual case to a greater understanding of safeguarding practice more widely.

2.1.4. The process was led by two Independent Reviewers working with a Review team and included:

- Consideration of chronologies and learning summaries produced by 10 key agencies.
- 4 meetings of the Review team.

21Social Care Institute for Excellence (Fish et al,2008)

- 1 meeting with the 'Case Group' – key practitioners involved in the case.

- Conversations with 11 key practitioners.

2.1.5. Two Independent Lead Reviewers, Ann Duncan and Sian Griffiths were commissioned to lead the review. Ann Duncan, an independent consultant who has experience in undertaking Serious Case Reviews, authored the Review. Sian Griffiths is an independent consultant who has significant experience in undertaking Serious Case Reviews. Both the Lead Reviewers were independent of the case and of all the agencies involved.

2.1.6. The Review Team was comprised of the Independent Lead Reviewers, and the following senior managers/senior professional leads who were independent of the case:

Job Title / Role	Organisation
Child Protection & Statutory Review Service Manager	HCC
Named Nurse for Safeguarding	HCT
Lead Adviser, Health &Wellbeing	HCC
DCI	Hertfordshire Constabulary
Senior Manager	National Probation Service
Head of Early Help & Thriving Families	HCC
Interim Named Nurse for Safeguarding	E&NH Hospital Trust
Named GP for Safeguarding	E&NH CCG
Acting Business Manager	HSCB

2.1.7. The Case Group consisted of key front line practitioners and first line managers who had worked with the family in various capacities. Individual conversations took place with 11 of these practitioners in order to obtain a detailed picture of what happened in this case, with a particular focus on establishing what the practitioners knew at the time the events unfolded in order to avoid the bias of hindsight. The members of the Case Group attended a Learning event at which the emerging analysis was discussed with the Review team.

2.1.8. As well as the individual agency chronologies and agency reflection and learning summaries, the Review Team requested and had access to a range of other documentation, including Pathology reports and the minutes of the initial CIN meeting, Child and Family Assessment and supervision records.

2.1.1. The **timeframe** under consideration for this Review was:

1st January 2013 – 2nd June 2014

The period under review covers the pregnancy and birth of Child G, the breakup of the relationship between MG and FG and the referral to Children's Social Care. We have also included information about MP in the year before the relationship between MG and MP started as it provided a useful background and context. The review finishes at the time of Child G's death.

2.1.10. In order to minimise the risk of pre-judging any learning, the Review did not set out specific terms of reference. However the Review took into account two questions posed when the review was commissioned, which are as follows:

- What do the findings in relation to the care provided for Child G tell the HSCB and member agencies about the strengths and vulnerabilities of wider arrangements to safeguard and promote the wellbeing of children?

- What steps should the HSCB or member agencies consider taking in order to improve services for vulnerable children?

2.1.11. **Family involvement.** The involvement of key family members in a Review can provide particularly helpful insights into the experience of receiving or seeking services. Letters were sent to five family members: MG, FG, MGM, MGGM and MP, informing them about the process and inviting them to contribute. However, due to the ongoing criminal investigation we have been advised by the police not to meet with the family. Further consideration will be given to meet with family members at the conclusion of the criminal proceedings.

Appendix 3: **KEY DATES TABLE**

03/01/13	MP sentenced to 12 month Community Order with a Supervision Order and a requirement to participate in the Integrated Domestic Abuse Programme (IDAP)
17/01/13	MG, late booking at 15 weeks +5 days and requests a home birth.
15/02/13	MP breaches order.
06/03/13	MP guilty of breach of Community Order, fined.
10/07/13	G born at MGGM house.
04/09/13	Health Visitor (HV) makes home following request from MG.
11/09/13	MP returned to court for further breach of the Community Order. Community Order revoked and MP re-sentenced to 2 year Community Order plus supervision requirements and unpaid work. There is no IDAP requirement with new order.
28/10/13	Child G is seen in emergency department with nappy rash, MG left as did not like the advice that was given.
20/11/13	MP receives three-month custodial sentence No supervision on licence after this as sentence less than one year, Case terminated by Probation Service.
26/11/13	MG has operation, takes own discharge.
13/12/13	MP released from prison.
06/02/14	Referral made to Children Social Care (CSC) that raises concerns about the children.
08/02/14	General Practitioner receives police notification of Domestic Abuse (DA). MG told FG to leave the family home.
10/02/14	Directions given by Team Leader to allocated Social Worker (SW) and Student Social Worker. (St.SW)
25/02/14	Home visit by CSC to inform MG re the findings of Section 17 enquiry MG agrees to work with HV.
25/02/14	SW and St SW meet with G1 at school. G1 stated he did not like MP, was happy with his Dad and MGGM but not with his Mum, MP or MGM. G1 said his Mum was happy with MP but not with his Dad.
26/02/14	G1 upset at school, worried about his Dad being at home as he was going to be beaten up by someone called (name of MP) School inform CSC.
10/03/14	Child & Family Assessment completed.
21/03/14	Home visit by HV, MP present. Child G eight month check undertaken, Child G is not sitting un-supported.
01/04/14	Case work supervision, SW states home conditions poor- MG described as lacking the motivation to make changes and that whilst case originally assessed as Child In Need (CIN) SW

	considers could be CP. CIN meeting to take place on the 02/04/14 at the school.
02/04/14	CIN meeting held at the school. MG and MGM present. MGM noted to be forceful and shouting and swearing at times.
07/04/14	Police called by neighbour after reports of child screaming and visited home. No evidence for concern.
16/04/14	SW makes a phone call to MG to arrange a home visit, access denied. HV visits and observes Child G sitting on MP's knee.
17/04/14	MG advised by Paediatrician that G1 needed to be admitted into hospital for Intravenous (IV) antibiotics, MG refuses and takes G1 home. MG attends with G1 daily at the day centre for 4 days of IV therapy.
09/05/14	Access to Education Manager visits family at home to discuss school attendance. Child G reported to be asleep in the van parked in the driveway. MP's teenage son from a previous relationship reported to be supervising him.
13/05/14	CIN meeting held at Children's Centre, MGM not invited at the request of MG. Plan to step down at the next meeting and refer to Thriving Families. Next CIN meeting 20/06/14.
14/05/14	MP stopped by police at 05.05 hours. MP verbally aggressive towards officers.
21/05/14	SW visits the family home; Child G and G3 described as grubby and require a nappy change.
27/05/14	HV visits to undertake developmental assessment on Child G. Identified that Child G is delayed in his gross motor development. Home conditions poor.
29/05/14	MP stopped by the police at 04.40 hours. Another male in the car as well as Child G in a car seat.
June 2014	MP takes Child G out in the van he is not in a car seat. On the journey back home, MP noticed that Child G wasn't breathing, MP started CPR. Ambulance called to home address, the ambulance crew informed the police. Child G taken by ambulance to hospital and was pronounced dead in the early hours of the following day.

Appendix 4: **ACTIONS ALREADY TAKEN BY INDIVIDUAL AGENCIES**

The following actions were identified by individual agencies at the outset of this Review based on their initial analysis of the practice:

General Practice.

The way to respond to and deal with failure to have your children vaccinated for reasons other than conscientious objection needs to be discussed and agreed.

Hertfordshire Community NHS Trust.

1. Concerns for children must not be considered in isolation, previous care/ family history should be considered.

2. The risk of domestic abuse must be fully assessed. Failure to engage in assessment may leave children at risk of harm and may lead to a child protection referral. Details of father's and partners must be recorded on appropriate health records.

3. Accurate record keeping needed to assist in the assessment of risk.

4. Increasing the recognition of vulnerability and risks to children.

East & North Hertfordshire NHS Trust.

1. Communication and liaison both inside and outside of the organisation is essential where there may be small concerns as this can inform a bigger picture but this can only be achieved and is dependent on the capacity or understanding of the health professional involved in the case at that particular time. There were missed opportunities for information sharing and although East & North Herts Trust have limited viewing access to SystmOne for the child health module it is possible that greater functionality would have assisted in this area.

2. It is likely that not enough indicators identifying the family as vulnerable were recognised at individual health contacts, however staff need to be aware that the small concerns help inform a bigger picture and could identify a referral opportunity.

3. Since the appointment of the Named Midwife in January 2014 the HSCB Pre-Birth Protocol has been rolled out. This document has been disseminated to all community midwives, managers and team leaders. It is available on the Trust Intranet and is referred to in supervision and during training.

4. Safeguarding children supervision has been introduced on an individual or group basis to staff who carry a children's caseload or who have regular contact with children. The supervisee is expected to take responsibility for their supervision by bringing cases for discussion where there are concerns. This includes where there are CP plans, concerns regarding parental behaviour e.g. DV or drug and alcohol use. The impact on parenting is discussed and plans made during the episode of care being delivered. The supervision is offered on a four monthly basis and contract agreed outlining expectations.

Hertfordshire County Council Children's Services

1. Lack of robust challenging of family members, even when drift or lack of change evident.
2. Focus on supporting mother rather than the safety and well-being of the children.
3. Lack of identification and assessment of risk factors. Poor assessment of risk. Risk factors evident but not explored nor resolved nor assessed, particularly in relation to mother's new partner
4. No risk assessment of mother as a consequence of her relationship with her new partner and her lifestyle and choices.
5. SSW working with what appears to be minimal support and/or direction by supporting SW.
6. Lack of evident supervision of SSW and possibly the SW.
7. Concern re management oversight and understanding of concerns.
8. Management of CIN by Children's Services.
9. The effectiveness of multi agency working on this matter must be an issue for consideration.

Hertfordshire Police Constabulary

In relation to the stop check and submission of intelligence there may be an issue regarding professional judgement and safeguarding awareness.

National Probation Service

1. **Routine contact** with both CSF and the Police Domestic Abuse Unit would have enabled the Offender Manager to feel more confident that the positive things being shared were backed up by a lack of call outs/social work intervention. Again this would have added weight to providing a more investigative approach to support or challenge the perception created of a settled relationship and household (which may have been true at this time of course).

2. The issue of **Home visits** is one which would benefit from further consideration by the NPS in terms of its current policy; I am satisfied that there were no specific incidents of concern which may have led to the Offender Manager missing an opportunity to conduct a home visit but

wonder in general terms, when there is a young family with very young children and some issues of concern with regards to their support network, that there should be an expectation that a home visit is made to see the family interact in their environment. This will have resourcing issues and thus would suggest that this is an issue for review and consideration by the NPS at this time.

Access to Education Team for Refugees and Travellers

1. Look to ways of improving information sharing across agencies and improve joint working practices
2. Early alerts from other agencies should be routine.
3. Good practice models of partnership work with social workers in certain districts to be shared with teams in other districts.