CHILD D

A SERIOUS CASE REVIEW

OVERVIEW REPORT

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1. INTRODUCTION

1.1. Between 25 November 2013 and 18 August 2014 Sutton Local Safeguarding Children Board (LSCB) conducted a Serious Case Review (SCR) in respect of the death of Child D. The case met the legal requirement to undertake a SCR (Reg. 5 of the LSCB Regulations 2006) i.e. where a child has died and abuse or neglect is known or suspected.

The Review was conducted under the statutory guidance of 'Working Together to Safeguard Children 2013'[1], applying the principles of learning and improvement from that guidance. The report was reviewed following the publication of 'Working Together 2015'[2] to consider revised SCR guidance to prepare for the publication of the overview report. 'Working Together' states:

"SCRs and other 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 organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at that 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."

1.2. The Terms of Reference do not refer to a specific methodology, but the LSCB, through the SCR Panel, wanted the SCR to take a broad view of systemic issues that had a bearing on the case, as well as practice issues. It confirmed that the involvement of family members and of professionals was an important part of the Overview Review process.

1.3. A Serious Case Review Panel was established, chaired by the then Independent Chair of Sutton's Local Safeguarding Children Board (LSCB), Kevin Crompton. All relevant agencies involved with Child D and the family were invited to be part of the Panel and Individual Management Reviews (IMRs); background reports were requested from 20 agencies.

1.4. The Judiciary declined to undertake an IMR with the office of the President of the Family Division writing on 27 March 2014 that "For constitutional reasons it would not

[1] HM Government (2013) Working together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children, London: The Stationery Office.
[2] HM Government (2015) Working together to safeguard children: statutory guide to interagency working to safeguard and promote the welfare of children, London: The Stationery Office.

be appropriate for the judiciary to produce an Individual Management Review." Copies of the relevant Judgements in the case were provided.

The Independent Social Work Agency, 'Services for Children' (S4C), was unable to produce an IMR as there was no independent person in their organisation who had not been involved in work on the case; but they provided a background report detailing their work and made all their reports available to the Overview author.

1.5. Agencies were asked to produce their IMRs by 14 March 2014 and extensions were granted to 30 April 2014. There was significant delay to 06 June 2014 in receiving S4C's report and to 30 June 2014 in the production of the IMR by the Police due to a lack of capacity in the Metropolitan Police Service to undertake this work. A Health Overview Report was also produced to summarise the involvement of all the health organisations involved with the family. The SCR Panel met on 7 occasions; the membership of the panel is contained in Appendix C; and the Overview Report was accepted by the Sutton LSCB on 10 September 2014.

1.6. Altogether 19 IMRs and the background report were submitted to the SCR Panel. Most responded well to the Terms of Reference in respect of the areas in which the agency had a direct contribution to make, giving chronological accounts, reviewing practice and undertaking an analysis of events. The Health Overview report was thorough in quality assuring the reports of health organisations, being explicit where there were shortcomings and commenting on the effectiveness of each IMR. Only one IMR was inadequate, that of the Chelsea and Westminster Hospital NHS Foundation Trust, which was written in two separate parts and had significant errors, including wrong names and dates of birth of family members.

1.7. Several IMRs went to great lengths to cover the complexity of the case, probing what actually happened and drafting clear recommendations. Those which are particularly thorough in their analysis and gave good consideration to the learning from this Review include Legal Services, London Probation Trust, Epsom and St. Helier University Hospitals NHS Trust, Sutton and Merton Community Services, General Practice and Cafcass.

1.8. Marion Davis was commissioned to write this Overview Report. She is a qualified social worker and senior children's social care professional with over 30 years experience. She is independent of all the organisations involved in this Review and had no previous knowledge of the family. A full biography is provided in Appendix A.

1.9. The full Terms of Reference for this SCR were agreed at the SCR Panel on 16 January 2014 and are reproduced in Appendix B. The SCR covered the period from 01 January 2000 up until the death of Child D on 28 October 2013. In addition to a list of standard questions to address, IMR authors were asked to consider 6 specific

questions of particular pertinence to this case. These are contained within the Terms of Reference.

1.10. The family of Child D was informed of and involved in the review as appropriate.

1.11. The Independent Reviewer and the Sutton LSCB would like to offer their condolences to the grandparents, who contributed to this review, on the sad death of Child D. It is important to acknowledge the work of all the professionals and support staff who have enabled this report to be produced and the contribution of individuals, organisations and the family to the content of this complex review.

2. SUMMARY

2.1. Critical Incident leading to the SCR

Child D was aged 6 years and 10 months and living with the mother (who will be referred to as Ms M), father (who will be referred to as Mr F) and younger sibling (who will be referred to as Child S) at the time of death. On the day of the incident, an ambulance was called to the family home where Child D was found to be non-responsive and to have a head injury. CPR was administered, the child was taken to Hospital 1 and shortly afterwards was declared dead. Post-mortem results show that Child D died of a head injury. An inquest was opened and adjourned.

A criminal investigation was initiated, with Mr F being charged in March 2014 with the murder of Child D and Ms M with intending to pervert the course of justice. Both parents have been charged with child cruelty.

2.2. Family Tree

[REDACTED]

2.3. Narrative of Events

The history and multiple nature of agencies' involvement with the family is a long and complex one. Given that a fully integrated chronology has been compiled and that there is a significant amount of detail in the IMR / background reports, it is not proposed to reproduce the full history of Child D's life and that of the child's family here. This narrative is intended to provide some contextual information and a description of key events.

2.3.1. Prior to Child D's birth and parental backgrounds.

Ms M, mother of Child D, had a difficult relationship with her parents, particularly her father. She was married in 2000, but was divorced by the time she met Mr F in 2006. There were no children of this marriage.

She is recorded as having a history of depression. She has held various jobs, most recently working as a full-time graphic designer.

In respect of Mr F's health, records describe a pattern of frequent injuries related to alcohol, assaults and fights as well as a history of depression. Police and Probation records show a long history of offending, including a 3 year 11 month prison sentence for armed robbery with violence and witness intimidation, charges of ABH and an assault on a pregnant ex-girlfriend. Many other alleged incidents did not proceed to court as witnesses / alleged victims would not pursue a case against Mr F. He frequently breached community orders and failed to co-operate with Probation staff. He reported a history of being sexually abused as a child by a relative, had a history of self-harm and was referred for psychotherapeutic help. Mr F appears not to have held employment for many years.

The relationship between Ms M and Mr F appears to have been casual in that they did not live together and were separated by the time of Child D's birth. Ms M was supported by her mother at the birth (which was a ventouse[3] delivery) but agreed that Mr F should be enabled to play a role in Child D's life from the very early stages if he wished.

2.3.2. Early months

At 5 weeks old, Child D was staying overnight with the father and suffered burns to both index fingers and forehead, said to be caused by rolling into a radiator. Ms M took Child D to the GP the next day but there was no referral to Children's Services and no follow up.

One week later, on 15 February 2007, when Child D was again staying with the father, Child D was taken to Epsom and St Helier Hospital after he noticed the baby "suddenly soft and limp". This was a life-threatening event and during scans and investigations Child D was found to have sub-dural haematomas[4], retinal haemorrhages and suffered seizures. The child was also discovered to have an unusual combination of a laryngeal cleft and a cyst at the back of the tongue. Children's Services were contacted as the injuries were believed to be non-accidental; discussions with the Police took place and a child protection investigation was initiated. The medical information from several scans (in more than one hospital) was complex but at a Strategy Meeting on 27 February 2007 it was concluded that the injuries were not accidental. A Child Protection Conference was held on 08 March 2007 which placed Child D on the Child Protection Register in the category of physical abuse. Child D

[3] A ventouse is a vacuum device used to assist the delivery of a baby (an alternative to a forceps delivery)

[4] A subdural haematoma is a collection of blood on the brain and is usually the result of a serious head injury. National Library of Medicine. July 2012.

was made subject of an Interim Care Order on 09 March 2007 and was discharged from hospital into a foster care placement on 16 March 2007.

Ms M and Mr F did not accept the medical opinion regarding the cause of Child D's injuries and there were doubts as to whether the grandparents (Mr GF and Mrs GM) were able to contemplate that these were caused by the father. An adoption plan was considered for Child D, but subsequently Mr GF and Mrs GM were joined to the court proceedings and assessed as potential carers for Child D. This plan was supported by the Child's Guardian (CG1), and Child D moved to the home of Mr GF and Mrs GM on 24 July 2007. They subsequently applied for a Special Guardianship Order.

Ms M and Mr F were enabled to have contact with Child D, separately, as they stated they were not in a relationship, but these visits were frequently cancelled by the parents (CG1 noted that by March 2008, Ms M had missed 13 contact visits with Child D) and were often a source of tensions between family members.

2.3.3. 2008/9 First set of Court Proceedings

- January 2008. Within the Care Proceedings a finding of fact hearing determined that Child D's injuries were caused by Mr F and that Ms M had failed to protect Child D.
- February 2008. A Consultant Forensic Psychiatrist was commissioned by the Court to undertake a risk assessment on both parents.
- In March 2008 the Psychiatrist's reports on each parent were presented to the court, having had access to a wide range of background material. In respect of Mr F his family, employment and criminal history are covered. It notes there are significant discrepancies in his and the Police accounts of the seriousness of the assault on his former girlfriend and there were discrepancies in his account given to the Judge regarding Child D's injuries. He also denied he had been abused as a child. He admitted to having a temper. There was no evidence of any symptoms of mental disorder. The conclusion (bearing in mind the timing of this assessment being after Judge 01's finding of fact against him, but before his criminal conviction for injuring Child D) was that *"the potential risk to a child in his unsupervised care would have to be said to be high"*. This was further judged to be compounded by his level of denial. In respect of Ms M the report again details her family, employment and relationship history. It notes that no symptoms of mental disorder or clinical depression were found and also records that Ms M had no intention of resuming a relationship with Mr F. The report concludes *"If any evidence of a closer relationship did emerge at any stage, given the level of risk posed by* [Mr F], *I would have very significant concerns about* [Child D].
- April 2008. Judge 01 ruled Ms M out as a suitable long term carer for Child D.
- August 2008. Special Guardianship Order awarded to Mr GF and Mrs GM.
- March 2009. Mr F was found guilty of GBH in respect of Child D's injuries and was sentenced to 18 months in prison.

During this period Child D made good progress with the grandparents, including being supported through regular medical appointments. Parents often missed contact sessions with Child D, with Ms M having no contact between May and December 2009.

2.3.4. 2009 – 2012: Events that changed the plan

Mr F was released from prison on 30 June 2009 on bail pending an appeal against his conviction for GBH in respect of Child D's injuries.

Child S, full sibling to Child D, was born in Worthing (although it took some time to establish that Mr F was the father). Ms M had concealed the pregnancy and birth from agencies in Sutton and from her family, and Child S's existence was only discovered when Ms M was arrested on 07 February 2010 for shoplifting and had a young baby with her. At this point Ms M tried to evade Children's Services by claiming to have moved to Liverpool. On 21 March 2010 Ms M and Child S were located by the Police in Sussex; there were concerns about Child S e.g. being found in filthy clothes, which suggested neglect and the child was removed into Police Protection. Child S was placed in foster care and Care Proceedings were commenced.

On 17 June 2010 the Court of Appeal quashed Mr F's conviction for GBH on the basis of new expert medical evidence which raised areas of doubt.

During 2010/2011 both Ms M and Mr F were convicted of criminal offences, had numerous health problems (including Ms M having 16 hospital admissions in 8 months) and a poor record of contact visits. During January 2012 Child S had a period of serious illness but still Ms M declined to visit.

In May 2011 Ms M was successful in her application to re-open the Finding of Fact in respect of Child D's 2007 injuries. Full hearing scheduled for one year hence.

08 May 2012 – 05 July 2012 High Court Hearing which concluded in the overturning of the previous Finding of Fact. This meant that the parents were found not to be culpable of involvement in Child D's injuries and had suffered a miscarriage of justice. Judge 02's judgement was based on extensive and complex medical evidence by expert witnesses.

After the conclusion of the Court Hearing the children were not subject to any orders, and Children's Services did not have a formal role with the family as the court had found that the threshold criteria were not met.

The Local Authority was required by the court to send a letter to all agencies who had worked with the family to inform them of Mr F's quashed conviction and exoneration and directing that this letter should be prominently referenced in their files. It included the statement *"*[The Judge] *concluded that not only was she satisfied that* [Mr F] *had never caused harm to his child, in fact there was an innocent explanation for his child's suspected injuries."*

During the above hearing the Judge appointed an Independent Social Work Agency, Services 4 Children (S4C), as she believed that work between the parents and the Local

Authority would be “doomed to failure”. S4C was appointed to carry out an assessment of Ms M and Mr F with a view to the rehabilitation of Child S to Ms M (potentially with support from Mr F).

S4C is a small Independent Social Work Agency with just two social workers who, since their establishment in 2008, have carried out over 30 cases for courts and local authorities in respect of a range of issues, many of which feature in this case.

The Letter of Instruction issued to S4C covered such matters as the timescale for reunification, contact between Child S and Child D and other family members and “*the various help, support and services that the mother, alternatively the mother and the father, will need to realise the reunification of* [Child S] *to her/their care.”* At this point the parents stated that they had no plans to co-habit. In the course of a subsequent hearing in September 2012 the remit of the assessment was broadened to include Child D moving to the parents’ care and the Court approved a new plan of work to form the basis of a second Letter of Instruction to be issued to S4C.

The draft court order records that “the maternal grandparents agree in principle to [Child D] returning to the parents’ care.”

After brief introductory visits and with significant supportive input from the foster carer, Child S was placed with Ms M and Mr F on 08 October 2012. According to S4C Ms M and Mr F responded well to caring for Child S. Their background report states *“In the first phase observations were made that indicated Mr F and Ms M had sufficient parenting skills to take on the care of* [Child S]. *The observations of contact were that Mr F and Ms M sufficiently understood the needs of* [Child S].” They note that in the lead up to Child S being placed, Mr F took the primary role in introductions as Ms M was on a training course, did not free herself from work commitments as planned and was evasive when challenged about this (She was encouraged to specify dates she would not work in order to prioritise the children’s moves but did not, in the event, do so). Nor was their accommodation ready in the necessary timescales and Mr F and Ms M had not managed important practicalities such as the switching on of utilities and the arrival and assembly of a bed.

The September 2012 court report of S4C stated *“*[Child D’s] *position is yet to be fully ascertained”* and no direct work had started with the child, but there was mention that a move to live with the parents and sibling could take some time. S4C became involved in mediation work between the parents, grandparents and extended family and were concerned about the potentially harmful effect on Child D of extended introductions in a climate of tension. Originally S4C had no predetermined plan or instruction to place Child D with the parents. They acknowledged the importance of the bond with the grandparents who had cared for Child D for more than five years, and hoped that it would be possible for the parents and grandparents to cooperate in an extended family arrangement whereby Child D would have the benefit of long term stability and might move between carers easily when Child D wished as the child got older. They had not appreciated the depth of the rifts and hostility between Mr GF (and Mrs GM) and Ms M (and Mr F) that they believed made it

impossible to realise such an arrangement. Despite a range of sessions of mediation which aimed to bring family members together around Child D's wellbeing, some of which brought positive steps forward, they eventually had to conclude that this was unlikely to be achieved. S4C's September 2012 report says Mr F stated that he might have to "fight" for Child D through a residence order application. He behaved forcefully at times including "bouts of extreme shouting" which S4C worked hard to try to ameliorate, and there are accounts of similarly intransigent views from Mr GF. By the time they submitted their report to the court on 13 September 2012 S4C concluded that an amicable transition was unlikely, and *"Therefore the possibility of someone having to grieve the loss of* [Child D] *is real."*

Despite saying at this stage that they reserved a view about who this 'someone' would be, the plan soon shaped up to entail a placement of Child D with the parents and her sibling. An extract from the draft order of the court proceedings between 25 and 28 September 2012 states *"There shall be a continuation of the assessment of Services for Children in respect of* [Child D]*, to encompass when and how [Child D] shall be returned to the care of the* parents".

Direct work with Child D continued as did work on the fractured family relationships but S4C determined that the effect of the ongoing tensions on Child D was detrimental and led them to condense the introductions from a previously mooted period of a year, down to the end of 2012 and then an even shorter timescale. The reunification programme was accelerated and the move was scheduled for 09 November 2012.

It had been planned that during the first weekend in November that Child D would spend extensive time with the parents including an overnight stay. This did not happen as the parents had moved to their new house but were without power, they made themselves unavailable for any contact and S4C were unable to talk to either of them.

At this stage the parents expressed their lack of readiness for Child D's move. S4C's November report says *"The cancellation of* [Child D's] *contact on the weekend of 4 November was not prioritising* [Child D] *and the child's feelings. However the overwhelming stress of the situation meant that for a brief period* [Child D] *got lost in it all."* During the last few days prior to moving to the parents' home, concern was expressed by a number of agencies, including Child D's school and a paediatrician who had seen the child that week, about the speed at which the move was happening and Child D's lack of preparedness for it. It was suggested that Child D's Guardian, CG2, might meet with the child, but due to sickness she was unable to do so. The move went ahead on 09 November 2012.

2.3.5. 2012 – 2013 - Period from children's return to parents to death of Child D

In October 2012 Child S's early weeks in the parents' care seem to have been uneventful and S4C were positively surprised by the few adjustments and difficulties Mr F and Ms M had experienced and particularly impressed by the way a previously very poor sleeping pattern had settled.

However, in November 2012, only 4 days after Child D was placed, both Ms M and Mr F telephoned S4C to express concern about Child D's behaviour. They alleged the grandparents had not brought Child D up properly. The report of the conversations suggested Child D was upset, thought that going home would happen, was constantly lying, told tales on Child S, was fussy about eating and responded with a "no" to everything. Mr F is reported as describing Child D as "*an odd child".* There appears to be a marked difference in the parents' descriptions of their children's personalities with Child D presenting them with more challenges.

On 04 December 2012 Ms M presented at St. Helier Hospital with the two children who were hungry and were fed by a nurse. After being told that Children's Services were to be informed, Ms M left the hospital in the early hours of the morning, taking the children to Mr F. Ms M was later admitted to the hospital and found to be pregnant but wished to conceal the pregnancy from her family and partner.

On 5 January 2013 Ms M was pregnant and admitted to Chelsea and Westminster Hospital for gynaecological investigations. Child S was admitted on social grounds, Ms M saying there was no-one to look after the child, having given false details, and failed to mention the existence of Child D. A few days later, once correct data was ascertained, Children's Services were contacted and it was suggested by hospital staff that Ms M was exhibiting bruising (this was not substantiated and later withdrawn). In the course of trying to locate Child D on 08 January 2013 it was established that Child D was not in school and a home visit only elicited an angry response from Mr F refusing to deal with Children's Services. S4C were asked to try to make contact with the parents and the Police to do a home visit which they did but found no one at home. S4C made contact with both Mr F and Ms M by phone and also spoke to Child D – it was established that Ms M had collected Child D from Mr F and was staying in a hotel overnight with the children before going to stay with a friend in Portsmouth for a break. S4C were told that the relationship was in difficulties and the couple had separated. Ms M then failed to attend her appointment with S4C on Friday 11 January 2013. Discussion between the Police and Children's Services resulted in an agreement to convene a Strategy meeting if the children had not returned by Monday. This was not necessary as contact was made and no child protection investigation was required.

During early 2013 Ms M had various hospital contacts, the family's tenancy went into rent arrears, Child S's attendance at nursery was very poor, Child D's school attendance declined and there were missed medical appointments (both of which had been close to 100% whilst in the care of the grandparents). Children's Services held a professionals' meeting on 28 January 2013 which resulted in an offer of multi-agency support to the parents, but there were deemed insufficient grounds to justify a statutory intervention. No response was received from the family to this offer and professionals believed that the parents would not voluntarily engage with any agency at this stage (with the exception of S4C). S4C describe the events of January 2013 when the parents separated as having threatened the whole arrangement, but believed that the parents had learned from it. They did however have concerns at Ms M's "evasive flight strategy" and the impact it could have on the children, especially if Mr F was not present in the household. Ms M was urged to

take up the offer of counselling. Child D's education and low attendance is commented on but it was believed that the parents were addressing this.

Ms M was again admitted to Chelsea and Westminster Hospital on 27 March 2013 with bleeding attributed to a termination of pregnancy. She gave false information, including denying that she had children or that she had previously been in that hospital. However, several days later staff recognised her and contacted Children's Services out of hours emergency duty team and the Police. At the request of the hospital the Police made two or three home visits on 31 March 2013, initially finding no-one at home but returned and found Mr F and the children there. The Police reported that the children were "safe and well" and there were no concerns.

A Senior Practitioner in Sutton's Children's Social Care was asked to consider whether an assessment or intervention should be undertaken. After reviewing the records, liaison with S4C and with senior managers it was concluded that there was no evidence to justify a formal investigation. Subsequently a nurse telephoned the Multi Agency Safeguarding Hub (MASH) on 04 April 2013 to report that Ms M was being discharged and there was a suspicion that she had been raped. No supporting evidence was brought forward and there was confusion as to the origin of this information. Without something more concrete to go on and nothing to suggest that Mr F was the alleged perpetrator it was considered there was still insufficient evidence to instigate any safeguarding procedures in respect of the children.

S4C concluded their work with the family in March 2013 and submitted a report to Children's Services dated 12 April 2013. The report is generally very positive regarding the development of the relationship between Child D and Child S. It also describes how the parents had made shifts in their outlook and S4C observed not only their appropriate attention to the children's everyday needs but also an enjoyment of their parenting and shared activities with the children and a setting of boundaries where needed.

On their final contact with the family S4C say they *"were able to see* [Child D and Child S] *and their parents in a relaxed state" "smiling and happy"* which *"was in the opinion of S4C attributable to the care being offered to them at that time".*

Parents continued to be resistant and hostile to any Children's Services involvement and Mr F submitted complaints. The final contact between Children's Services and the parents was in May 2013 when the MASH received a copy of a letter from the Consultant Ophthalmologist to the parents regarding Child D having missed appointments. The Social Worker in the MASH sent a standard letter to the parents offering help and stating that no action would be taken at this time. This resulted in a very aggressive telephone call from Mr F followed by a formal complaint from his lawyer.

Mr GF and Mrs GM maintained contact with Child D and Child S but many contacts were cancelled by the parents.

In June 2013 Child D was seen by the GP with facial bruising and grazing; an accidental explanation by Child D, in the presence of the father, was accepted and no further action was taken. At around the same time at a contact session the grandparents thought that Child D had facial bruising and scratches but this was concealed by face paint and they were not allowed to speak with the children alone.

During this period Ms M was suffering from depression and receiving medication and Mr F was not complying with requirements from the Probation Service and was made subject of a suspended sentence.

Most professional contacts with Child D and the family during the last months of the child's life were with universal services – mainly the school, but also with the school nurse and the health visitor and with housing (in connection with the continuing rent arrears on the family home).

Child D died on 28 October 2013 at Hospital 1.

At the time of Child D's death, Child S was present at the hospital and well cared for by staff, but there was no medical examination. Ms M subsequently declined permission, an Emergency Protection Order (EPO) was obtained, Child S was placed in foster care and when examined the following day bruising to the back was recorded.

On 11 March 2014 Mr F was charged with the murder of Child D and also faces a charge of child cruelty. He was remanded in custody.

On 22 April 2014 Ms M was charged with intending to pervert the course of justice and also faces a charge of child cruelty. She was remanded on bail.

Child S continues to be placed in foster care.

3. ANALYSIS: General Questions

IMR authors were asked to address a set of standard questions (see Terms of Reference in Appendix B).

Not all 13 questions were relevant for all agencies and responses are detailed in the IMRs and will not be repeated in full in this Overview Report. Key points of what worked well or at least satisfactorily include:

- In the majority of the numerous professional contacts with Child D and the family over the period covered by this Review, practitioners acted with sensitivity to the children's needs and in accordance with agency policies and procedures in respect of safeguarding.
- Senior Managers were appropriately involved in most instances and there is evidence that many examples of assessment and decision making were conducted in an informed and professional way.

- Resource issues and organisational difficulties do not appear to have played a major role in service delivery to this family. The L.B of Sutton Children's Services was subject to a Notice of Improvement between September 2012 and March 2014 which inevitably caused some turbulence in the organisation, but at practitioner level this does not appear to have had a significant impact on this case for those working at the front line.
- Whilst there were a high number of social workers involved in this case over six and a half years, many of these held specialist roles (e.g. permanency, multi agency safeguarding hub and looked after children) and there were no gaps when the case was unallocated.
- Whilst multi-agency practice was not always as good as it should have been, the deficits were not of a nature to expose a child to risk.
- IMR authors have appropriately highlighted where better compliance with guidance and further embedding of good practice are required.
- There are references to a number of instances where professionals in various agencies appropriately consulted line managers and safeguarding specialists and received appropriate advice, supervision and support in dealing with concerns, dilemmas and complex issues.
- Examples of good and effective practice are recorded in respect of a number of professionals in several agencies and it is clear that many individuals made strenuous efforts to act in Child D's interests in the face of extreme resistance and hostility from the parents.

Key messages of professional concerns include:

- The Health Overview author questions whether the incident when Child D, aged five weeks, sustained burns to the forehead and index fingers, allegedly by rolling on to a radiator, should have been referred to Children's Services as this was an incident involving injuries to a non-mobile baby. The Legal IMR makes reference to issues of capacity within the team at the time and questions whether not appointing a Queen's Council (QC), as other parties did, may have had a detrimental bearing on the case. It concludes that there was no evidence to support that the case was handled anything but appropriately, but queries whether the status of the advocate might have resulted in them being regarded as less influential in the court arena.
- The delay of a year in listing the re-hearing of the Fact Finding in the High Court was not helpful.
- The only other organisational factor of note is the absence on sick leave of the second Children's Guardian (CG2) during the key period July- December 2012. Whilst she was away from work for planned surgery, her work was not reallocated or covered by her manager, and although she attempted to undertake elements of the role whilst on sick leave, her engagement and contact with Child D was not at the level needed, nor at the level she would have wished to provide at the crucial point when Child D was returning to the parents. The Cafcass IMR author comments on this shortfall and that the supervision of a case of this complexity was not sufficient.

- Although several key professionals engaged in purposeful direct work with Child D, there is a general absence of focus on Child D and Child S as individuals and their wishes, feelings and characters do not feature strongly in material I have read. Much more narrative and professional attention is paid to the parents' behaviour and the impact of this will be referred to later.
- Some practice issues have been raised in respect of information sharing and recording and, amongst others, the Health Overview report clearly documents instances where procedures were not followed. These predominantly, but not entirely, relate to events in 2007 and multi-agency policy and practice is reported to have improved in the intervening years.
- Analysis of reports suggest that across and within agencies there were elements of silo-working and some opportunities for triangulation of information and good handover were not pursued.

4. ANALYSIS: Specialist Questions.

4.1. Child D's father's conviction for shaking the child as a baby was overturned by the courts and Child D, along with Child S, returned to live with their parents. An Independent Social Work Agency was appointed to work with the family. Did these decisions have an impact on the way the agencies worked further with the family?

The overturning of Mr F's conviction for GBH in respect of Child D's injuries as a young baby and the letter that was directed by the Court in September 2012 to be sent to all relevant agencies outlining the parents' exoneration, undoubtedly had a very significant bearing on this case. It meant that the parents could no longer be regarded as having harmed or failed to protect Child D and that any future concerns could not take these past events, that had been previously considered as a serious non-accidental injury, into account.

There was an expectation that support and help would be offered to the family to enable the return of the children to their parents to be successful, but acceptance or not of any support was left to the parents to decide. Without the previous conviction on the record, the threshold for statutory intervention was deemed not to have been met and therefore the Court made no orders in respect of the children and discharged those that were prevailing at the time. Staff from various agencies have expressed surprise, and in some cases incredulity, that the children were placed with their parents without, for example, a supervision order or child protection plan and felt this removed a *"protective framework"* to work within. This was, however, the logical conclusion of the quashing of the conviction and the re-hearing of the Finding of Fact. Some agencies, less used to dealing in the court arena, found this extremely hard to comprehend. Furthermore, any future intervention with the family that was not agreed by the parents would need to meet the "significant harm" threshold anew. As the L.B of Sutton Children's Social Care IMR says *"this made anything short of Section 47 [child protection] impossible".*

The impact of the court case gave a strongly empowering message to the parents and an equally disempowering message to professionals. Many IMR authors refer to professionals feeling *"powerless" or "paralysed".* The appointment of an Independent Social Work Agency to work with the family seems to have compounded this feeling as many agencies were generally unfamiliar with such an organisation and it effectively distanced the Local Authority social workers, with whom partners were used to working with, from the case.

As the Health Overview report says: *"Health professionals perceived that they were disempowered as part of this arrangement, they were unclear of their remit and what plan of care was in place for the children; in the main they felt or were excluded from any decision making and partnership with the ISW Agency".*

One of the hospital IMRs states *"it is the opinion of Consultant Paediatrician 3 that* this *decision had a huge impact on the way agencies worked together with the family and a new independent social worker had been allocated to the family. CP 3 was not contacted by the independent social worker as part of any monitoring or assessment undertaken".*

The Health Overview Report summarises the position as follows *"However the absence of a child protection plan or a court order, and the presence of an Independent Social Work Agency, should not have deflected health professionals from their core work to safeguard and promote the welfare of children. In this case it did not, but this set of circumstances appears to have been more challenging than the experiences of working with a local CSC [Children's Social Care]".*

The Local Authority ceased to be a party to the family court proceedings on 28 September 2012, when the remaining issues were dealt with in private law proceedings, through to the final review hearing on 11 December 2012. During this period there was a lack of clarity on the part of several agencies regarding the role of the Local Authority vis-a-vis the role of S4C. According to the Children's Social Care IMR a social work team manager "n*oted her concerns that Services for Children had not kept Children's Services updated with their preparations for Child D to return to live with the parents. She was also concerned that they had not completed mediation work between the parents and the maternal grandparents".* Similarly, S4C allege that they did not receive good communication from Children's Services. School and health professionals were confused and it was difficult for agencies to operate in a co-ordinated way.

Two agencies dealing with Mr F, Probation and the Mental Health Trust, report that if Mr F's conviction for GBH had not been overturned, their subsequent handling of his involvement with them would have been different in view of the risk he would have been considered to pose.

4.2. Were there occasions where child protection processes should have been followed but were not as a consequence of the legal judgement?

The view from the IMRs seems to be that despite the lack of statutory orders and the unfamiliarity of working with an Independent Social Work Agency, agencies still did follow standard procedures when concerns arose.

For example, Consultants still pursued matters when parents failed to attend or to take up Child D's appointments. The most testing time to consider whether child protection concerns were followed up was in January 2013 when Ms M was admitted to Chelsea and Westminster Hospital with Child S, giving false information with no mention of Child D, whose whereabouts were unknown for a short period of time. Initially there were claims that Ms M had severe bruising (which was later not confirmed) and the hospital social worker referred concerns to Children's Services. Contact was made with the school and a home visit was made to the family home where Mr F was very angry and was only prepared to speak to the social worker from S4C. The link was made to S4C who made contact by telephone with Mr F and Ms M (although she then failed to keep her appointment with them). The Police were also involved in making a visit to the home and discussed the situation with social workers, concluding that a strategy meeting would be held if Child D hadn't been spoken to after the weekend. Legal advice was also sought regarding whether any escalation of matters was appropriate. Essentially, there was good liaison and follow up by all relevant agencies to conclude this incident.

Likewise when Ms M was admitted to the hospital in March 2013, again giving false information, there was liaison and follow up between Children's Services, the Police, and the hospital due to a verbally reported suspicion by a nurse that Ms M may have been raped. Without any evidence being produced that rape had taken place (let alone that Mr F was involved) the social worker, in appropriate consultation with line managers, after much reflection, concluded, correctly, that there were no grounds for formal intervention.

One incident that I and the Health Overview author have concerns about is on 25 June 2013 when Child D was taken to the GP by Mr F with quite severe bruising and grazes to the face. Questions were asked of Child D in the presence of the father, and the explanation seemed plausible, but the GP did not fully examine the child or refer to Children's Services, which the Health Overview author believes did not meet expected safeguarding procedures.

4.3. There were a number of contacts between agencies regarding Child D and Child S after they returned to live with their parents in October and November 2012. Were these contacts handled and responded to in an appropriate and timely way?

As referred to in the previous section, some key contacts in respect of child protection concerns were responded to well. Most agencies completing IMRs had little contact after the children went to live with their parents.

There is a strong view from some health professionals that they were excluded by the Independent Social Work Agency in that when S4C was the lead agency they did not consult professionals, who in some cases had known Child D for years, or inform them of what was happening.

There are suggestions that failure to pick up the fact that Child D was not being brought to medical appointments (e.g. for eye checks) was not followed up swiftly enough by the GP and that Child D should have been seen prior to issuing a sick note relating to the low level of school attendance.

The Health Overview Report concludes that *"communication during this period was at best challenging and at worst absent".*

4.4. Was information received by different agencies following Child D's return home considered collectively and triangulated? Could this have made a difference?

Some agencies were unaware that Child D had gone to live with Ms M and Mr F, some were unclear of the dates of the children's return home, and several conveyed that they believed that the two children had returned on the same date, rather than Child S on 08 October 2012 and Child D on 09 November 2012. Consultant Paediatrician 3 is of the opinion *"that an opportunity should have been available to consider information shared collectively; it may have made a difference to Child D's welfare."*

Most organisations assumed the Local Authority would share the relevant information, but given they did not have parental responsibility or any other locus in the case after the end of the September 2012, it could be argued that it was the responsibility of the parents themselves (who had parental responsibility by this stage), or the Independent Social Work Agency, to inform the relevant organisations of the moves of the children.

Neither S4C nor the parents did this and on reflection it would probably have been helpful for there to have been a forum for multi-agency discussion about the changed circumstances for the children and the roles of the professionals. To the surprise of some professionals, once the children were living with their parents and certainly during the last few months of Child D's life, the main agencies in touch with the family were universal services, predominantly Child D's school.

Two examples of attempts to co-ordinate support to the family during this period are of note.

Firstly a "professionals meeting" was convened on 28 January 2013 to respond to concerns from Child D's school. It was attended by Children's Services staff, S4C and the school, but not health professionals, and a letter was sent offering a range of supports to Mr F and Ms M. These included: a nursery place for Child S, individual or couple counselling and support from the School Nurse and Health Visitor. There is no record of any response from the parents.

In April 2013, and for the rest of the term, Child D's school continued to have concerns about the low level of attendance and tried to follow this up through discussion with the parents and by organising a Common Assessment Framework (CAF) meeting. The response from the parents to these offers of support included aggression, evasion, and the cancelling of meetings (even when arranged at their convenience) which continued up to the time of Child D's death.

4.5. Would any other advice, information, support or intervention have prevented the child's death?

IMR authors and the individuals they and I interviewed have pondered this question long and hard. Most concluded that once the Court conclusion was reached and an Independent Social Work Agency was undertaking work to the exclusion of Children's Services, there was little that could be done to prevent Child D's death.

Professionals who had read the Judgement (from the High Court hearing ending July 2012) concluded that it handed all the power to the parents and did not leave *"even one per cent chance that it might be different".* Given the known pattern of the parents' behaviour – lies, aggression, threats, missed appointments, "disguised compliance" and resistance, one IMR author commented that "*The decision made that allowed the parents to dictate who they will and will not work with is extremely concerning practice that had a monumental impact for Child D and all professionals involved and should be reviewed with courage and conviction to shape future decision making ".*

On a specific level, Legal Services considered whether the decision not to appoint a QC to represent the Local Authority's case had a bearing on the outcome, but concluded there was nothing that would suggest that the Senior Counsel was *"anything but effective"* or that there was anything lacking in the way the case of the Local Authority was presented in Court.

The Metropolitan Police Service IMR stated that there did not appear to be anything likely to have made a difference, and the Children's Services IMR author concluded it was difficult to think of an acceptable intervention that would have been protective.

4.6. The Finding of Facts against the parents following the hearing in January 2008 before Judge 01, were set aside by Judge 02 in the High Court on 06 July 2012 following a re-hearing. Were judicial decisions following all court hearings reasonable?

The re-hearing of the fact finding took place between 08 May 2012 and 05 July 2012, the majority of the time being taken up with evidence from some 14 medical experts with specialties ranging from neurosurgery to ophthalmology and radiology. Other consultants who knew Child D were on standby to give evidence but were not called. The evidence was complex as was the detail of Child D's pre-disposing factors of a ventouse delivery, cleft abnormalities and a laryngeal cyst, but was quite a different set of expert presentations from that given to the court in the previous findings of fact before Judge 01 in 2008. Furthermore, it is suggested that, whilst uncertainties remain, there had been significant advance in medical research and knowledge between the 2008 and 2012 judgements. What was not at issue was the chronic haemorrhaging in Child D's brain with inter-cranial bleeds and re-bleeds of different ages, retinal haemorrhages and seizures. Various causations were considered including an airway obstruction giving rise to an increase in venous pressure and shaking or impact. The scans could not definitively show whether the trauma was accidental or non-accidental.

The Judge weighed the evidence, some of which was new, alongside Mr F's account and concluded that on the balance of probabilities, the medical evidence did not support a finding that Mr F had intentionally shaken Child D. She stated she accepted Mr F's account and confirmed that she believed there was an innocent explanation.

In respect of the radiator burns Child D suffered to the index fingers and forehead when the child was five weeks old and non-mobile, Judge 02 accepted Mr F's account, describing his actions as those of an inexperienced parent and due to carelessness rather than recklessness and says "*I make no finding of culpability of the father in respect of the burns".*

The Legal IMR author says *"Based on all the expert evidence before the Judge this* [the conclusion that the injury was not a non-accidental one] *was not an unreasonable decision".* I agree with this conclusion. The Local Authority sought counsel's advice on whether the judgement might be appealable and whilst it was considered to be "thin on analysis" there were not sufficient grounds for an appeal.

Having made this judgement on the medical experts' evidence, the Judge considered other evidence, documenting matters such as the parents' histories of offending, the concealment, both of Child S's existence and of the DNA evidence confirming Mr F's paternity, missed contacts, alleged domestic violence and the lies and evasion in dealing with authorities. She concluded that the Local Authority's case did not prove the threshold criteria in the proceedings. However she then went further than making a non-finding against Mr F and exonerated the parents of all wrongdoing stated that they had suffered a miscarriage of justice and should be completely exonerated. She also required the Local Authority to send a letter, to be displayed in files of all relevant agencies that had dealings with Child D, to ensure that the past conviction and fact finding was not to be taken into consideration in future dealings with the family.

The way in which the approved judgement of the hearing reads is interesting. The Judge accepts that the parents have no trust in the Local Authority and that any *"assessment or work to be done would be doomed to failure if it were to be managed by the Local Authority"* and agrees the recommendation by the Guardian that S4C be appointed. There is no record that the Judge considered another Local Authority Children's Services be approached to carry out the assessment.

A Letter of Instruction, previously referred to, was agreed by all parties, and described the work S4C was to carry out.

S4C did not have a comprehensive picture of the complicated background to this case and were told, when they enquired about other information, that the detail contained in the July 2012 Judgement should be sufficient. It might be suggested that they should have requested more information about the parents' criminal, health and social backgrounds, but on the other hand they could not have been specific as they did not know what they did not know.

In addition to the clauses of the Letter of Instruction it was also recommended that there be some form of assessment of Ms M's emotional state by a psychologist or psychiatrist, but this never happened as Ms M appears not to have agreed to it.

In her conclusions the Judge works through the parents' shortcomings and in many instances frames them in the context of being victims of a wrongful conviction and the difficulties they have suffered as a result, and seems ready to accept their explanations for their unhelpful behaviour. She states *"I was impressed by the father"* and refers to the parents "*opening up"* and states that once free from the *"shadow of blame" "They are going to change".*

The IMR author for Children's Social Care makes a strong statement in response to this question.

"Judge 02 having decided that the medical evidence in respect of the injury to Child D did not hold, then chose to ignore all the other evidence". "She chose to dismiss the evidence of the parents' hostile and non-cooperative behaviours and appeared to conclude that it was to be expected given that Children's Services had removed their children".

In the absence of an IMR or other report from the Court it is difficult to conclude just what weight was given to the non-medical evidence and it is not clear that the Judge would have necessarily been aware of the full scale of such factors as:

- Parents' criminal behaviour: Firstly, Mr F's 18 convictions including several between 2010 and 2012 and several which are offences against the person and 1 warning. Secondly, Ms M's shop lifting incident in 2010 which led to the discovery of Child S and her 2011 conviction for benefit fraud.
- Long term mental health problems: Records refer to Mr F's long term involvement with psychiatric services, including a history of self-harm and depression (including medication until he ceased this in August 2013), and to Ms M's history of depression. Both have a history of failing to attend appointments for counselling and therapeutic help.
- Both parents' numerous hospital attendances: For injuries and illnesses, which for Ms M include lacerations to legs, arms and head, bruising (including serious facial bruising), falling down stairs (twice), gynaecological problems, at least 2 terminations, over-use of opiate medication for pain, potential fabricated illness.
- The number of missed contacts with professionals: Particularly by Ms M, giving reasons such as work commitments, illness and holidays, and that after missing a significant number of contacts, Ms M and Mr F continued to demand an increased level of contact with Child D.
- The scale of lies and deception: Including the concealment of Child S's birth and paternity, including during the first court hearing, giving false names, addresses, GP details and refusing to give agencies details of their whereabouts, giving untrue locations or making themselves unavailable on telephone numbers given and at times to suit them.

- The frequent use of complaints: Or the threat of complaining against professionals, (including Ms M making 8 visits to the Patient Advice and Liaison Service at one hospital alone) and threats of legal action.

What is not prominently considered is what the impact of the above behaviours, which were entrenched over a number of years, might be on the children and whether the parents had the capacity to put the children's needs and interests above their own.

The Health Overview Report includes a comprehensive "Lessons Learnt" section which covers mental health, alcohol and domestic violence issues and the factors that fit within the experience of working with uncooperative families. It concludes, however, that at the time the bigger picture was not aggregated.

Moving on from the Judgement made in July 2012 there was then a further hearing from 25 to 28 September 2012. As per the Letter of Instruction, S4C submitted an interim report on 17 August 2012 and another on 13 September 2012. The latter report details the work undertaken by the two S4C social workers with the parents, grandparents and the two children; it does not appear that information was sought from the many organisations, who had years of knowledge and experience of the family. One paediatrician took the initiative to contact S4C to express her concerns about Child D's move and shared the information that the child had ongoing health needs that required monitoring. This was new information to S4C but the paediatrician did not feel listened to and no other health professionals were contacted.

In addressing the issues of Child S's return to the mother/parents, the help and services proposed to support this, and the contact with Child D, S4C's report stated that direct work with the parents and grandparents was yet to be completed and concluded there was still some way to go in determining Child D's future.

S4C stated that resolving issues between the grandparents and parents were unlikely to be resolved without the assistance of family therapy and *"Repairing such damaged relationships via long term family therapy is unlikely to be achievable in a reasonable timescale for* [Child D]". Even accepting that it was unlikely to be *"an amicable transition",* S4C were giving active consideration to Child D moving from the grandparents' care to being placed with the parents.

In September 2012 lawyers for Mr GF and Mrs GM informed the Local Authority that they were prepared to consider returning Child D to the parents if it were in the child's interest. At the hearing on 28 September 2012 the grandparents' representative informed the court and parties that this was the case.

The Judge agreed to the implementation of the plan put forward by S4C, including stating in the judgement *"There shall be a continuation of the assessment by Services for Children ....to encompass when and how* [Child D] *shall be returned to the care of the mother".*

Whilst accepting that the introductions of Child S to the parents were going well, with the positive support of the foster carer, it is perhaps surprising that the judgement talks, not

about “if” [Child D] returns to the mother / parents but “when and how”. The parents’ original application only requested that Child S was moved to their care and for there to be increased contact with Child D so this was a significant shift. Given that these parents had only cared for their children separately, for a few weeks / months respectively, it might have been expected that there would be a more comprehensive parenting assessment and a detailed analysis of Child D’s attachment to the grandparents who had cared for the child continuously for over 5 years of the child’s life. S4C acknowledge that Mrs GM had been Child D’s primary attachment figure and health professionals and the school expressed unanimously positive views about the grandparents devotion and their commitment to Child D’s development and progress whilst in the extended family’s care, including keeping the many medical appointments, enabling excellent school attendance and promoting social activities with children of the child’s own age. The longer term emotional impact of Child D’s moving away from this stable and supportive environment is not comprehensively considered.

During Child D’s introductions to the parents there was a stage in early November 2012 when both Child D and the parents were said not to be prepared for the move, it is surprising that there was not a pause for reflection. Arguably in any introductory programme (e.g. to adopters, birth parents or kinship carers) there might have to be a slowing of the pace in order to be sure that everyone is comfortable and committed to the placement and there can be an exploration of what might be learned from the hiatus. S4C, however, took the view that the tensions between the parents and grandparents and the uncertainty were becoming intolerable for Child D and that delay would be harmful to the child. Even without using the benefit of hindsight this decision has to have some question marks attached to it.

At the hearing at the end of the September 2012 the Local Authority ceased to be a party to the proceedings as only private law matters remained to be concluded. The final hearing was held on 11 December 2012 when in respect of Child D a Residence Order was made to the parents (with contact to the grandparents) and the Special Guardianship Order to Mr GF and Mrs GM was revoked.

It is perhaps surprising that the Local Authority did not convene a de-brief meeting (after the July or September hearings) to discuss the outcome of and learning from the case. It is believed that there was a meeting within the Local Authority Legal team but no record of it has been located. A wider meeting might have led to a multi-agency plan of how to work with the family, to share information and concerns across partners and to give consideration as to how to maximise the protection of the children in the future.

4.7. To what extent was domestic violence an issue in this case and were agency responses appropriate?

There are many references in professionals’ dealings with Mr F and Ms M that express concerns about domestic violence being an issue between them, but much less conclusive information.

What we do know is that Mr F was convicted of a serious assault on a pregnant ex-girlfriend and received a prison sentence. He was also involved in a number of other incidents brought to the attention of the police as either the instigator or victim of assaults. The Police IMR states "[Mr F] *was a violent man who clearly saw the solution to difficulty in his life in confrontation and the use of violence".* In 2008 when the Police witnessed Mr F verbally abusing Ms M, they had to formally warn him before he desisted and left the scene. We also know that Ms M reported having experienced domestic violence in her first marriage.

Various hospitals treated Ms M for injuries and the incidence of these seems exceptionally high:

i) Epsom and St Helier Hospital – several occasions during 2009-2012 but no evidence of domestic violence enquiries being initiated.

ii) Kings College Hospital – 3 admissions in 2010/2011, one recorded as a suspected broken nose following an assault (which Ms M said she reported to the police but this has not been verified), one for alcohol-related dizziness and the other for a fall down stairs. Again there is no record of her having been questioned about domestic violence.

iii) Guys and St. Thomas' Hospital – there was a direct recognition of the possibility that Ms M had experienced domestic violence and she was showing signs of being reluctant to return home. Even after staff had witnessed Mr F being aggressive to her on the ward where she was an in-patient and staff had a direct conversation with her, she denied any concerns at home. Staff appropriately involved the Mozaic Team (hospital based advocacy for victims of domestic violence) but no disclosure was forthcoming.

iv) Chelsea and Westminster Hospital – January 2013. Ms M was admitted (with Child S, claiming there was no-one to look after the child, and she was pregnant). When the hospital contacted Children's Services it was initially stated that there were concerns about Ms M having bruising, but this was later withdrawn as unable to be substantiated.

v) Chelsea and Westminster Hospital – March/April 2013. Ms M was admitted with "post abortion bleeding"; she was asked about sexual assault and after being initially reluctant to discuss the topic, denied it. In a telephone conversation with Children's Services a few days later a member of hospital staff expressed concern that Ms M had been raped, but the veracity of this allegation was doubtful and it was not possible to proceed to investigation.

vi) There were also many presentations to GPs for injuries and depression, but no domestic violence enquiries are noted.

It is recorded that Ms M had at least two terminations, possibly more, between 2010 - 2013 and suffered complications of pregnancy and other gynaecological concerns. She was also adamant that she did not want Mr F or her family to know that she was pregnant. These

behaviours may be indicative of domestic violence as it is well researched that domestic violence can increase in pregnancy.[5]

No-one at the time had an overview of the very high number of hospital attendances by Ms M for injuries, and there may be others of which we are unaware. Those known included lacerations to the legs, arms, head, bruising to the back and face, suspected broken nose, broken ankle etc. A range of explanations was given, two being assaults by unknown assailants, and Botox injections were said to be the cause of bruising close to her eyes. This was one of a number of explanations for events that were accepted by the Judge.

Several IMRs have made recommendations about policy and practice in respect of domestic violence, including the adoption of routine enquiry to promote disclosure, including in universal services. However most IMR authors believe that even if this approach had been used at the time, it would not have produced any different responses from Ms M or Mr F.

Whilst there is therefore no conclusive evidence of domestic violence found to be a feature in this case, the combined information raises concerns that it may have occurred and at the very least is highly suggestive of unhealthy power and control issues in the relationship with the potential for aggression and violence. S4C comment in their reports on Mr F's tendency to interact in a verbally aggressive manner, including a pattern of sustained shouting or bursts of temper, without any reference to how this might have been considered to have an adverse impact on the children.

No agency reflects on the potential impact of the repeated parental injuries (several reported to be linked to alcohol and assaults) on the parenting of the children and the possibility of them suffering neglect as a consequence.

4.8. To what extent did the manner of the parents' interaction with agencies impact on this case? Are there learning points to be taken from this?

As previously documented, Mr F had a long history of responding to people in a confrontational and aggressive manner, which extends to a history of violence to prison staff. There are numerous incidents reported in the IMRs such as this one from Probation describing Mr F as *"uncooperative during this order and ..... he has been aggressive on at least three occasions with three different members of staff.* [Mr F] *has stated clearly that he will not talk about his private life as we are not trained psychologists. He has been a difficult man who manipulated and directed the supervision sessions".* Throughout his years of involvement with Probation, he was breached on many occasions for non-compliance with court orders and returned to court, faced with alternative disposals but rarely maintained any commitment to measures such as "Thinking Skills" or "Anger Management" that might have helped him.

[5] 1. Women's Aid report 2010.

2. British Journal of Obstetrics and Gynaecology 2004, Lorraine Bacchus, Gill Mezey, Susan Bewley and Alison Haworth. " Prevalence of domestic violence when midwives routinely enquire in pregnancy

These characteristics of non-cooperation, manipulation and attempting to control others run through the descriptions of many agencies. A number of hospital staff felt threatened and unsafe, one to the extent of needing to be escorted to her car through fear of meeting Mr F. Ms M and Mr F, sometimes together and sometimes separately, would be verbally aggressive to professionals, refusing to cooperate and threatening them with complaints, legal action, referral to their professional body and exposure in the media if their demands were not met.

Several social workers experienced this behaviour, for example when a worker in the MASH sent a standard letter to Ms M and Mr F regarding Child D's ophthalmology appointments being missed and offering help. The response was a very aggressive phone call from Mr F, followed up by an e-mail from his solicitor to Sutton Legal Services demanding an apology.

Interestingly it is noted in the Legal IMR that Mr F's legal team could also be very demanding and their e-mails and phone calls were perceived by the Local Authority lawyers as bullying and harassing in nature. Witnesses in court have also reported on the adverse tone of questioning and were left feeling dealt with in an unprofessional manner.

Ms M and Mr F were difficult to manage as patients of the NHS, submitting multiple complaints to PALS (including 8 times by Ms M in the course of one hospital admission when she did not like being challenged about her demands for opiates and her wish not to be discharged), telling lies and giving false information. There were many more examples of avoidant behaviour - not attending appointments or answering phone calls (even when the times had been arranged at their convenience) and constant changing GP surgeries and hospitals. Despite the detail in a high number of IMRs it is still very likely that it has not been possible to collate the complete picture of agencies these parents were in touch with, so it was no wonder that professionals on the front line struggled at the time to piece the jigsaw together.

On some occasions the parents used "disguised compliance", appearing, for example, to welcome offers of help and support from the Health Visitor who made a home visit after the children had returned home, but they then never took it up.

On other occasions such as dealing with their rent arrears and the concerns that Child D's school had regarding the level of attendance, Mr F and Ms M would do just enough to keep professionals from escalating concerns to a higher level.

However, more often the parents' modus operandi was openly resistant and non-compliant and they achieved some success in keeping agencies at bay. A notable example is the concealment of Child S's existence, which but for Ms M's criminal activity in being arrested for shoplifting, might have succeeded for much longer, and on another occasion Ms M was successful in taking legal steps to prevent the Local Authority having access to her medical information – hence some of the information in this report is likely not to have been known to the Court.

S4C express an interesting view of Ms M and Mr F's interaction with agencies. S4C were aware from their early work with this case that the two different behaviour styles of the parents kept agencies away. They characterise these styles as "evasion" and "aggression" respectively. The parents refused to work with the Local Authority Children's Services saying they were fearful and mistrustful of them. S4C were able to work with the parents, even though, at times, they also experienced a level of evasion and a presentation from Mr F which is described as aggressive. They describe him as getting very angry and remaining so for 10 – 15 minutes before it abated, but at other times he conducted himself with *"charm and directness".* They continue *"The parents' interaction with agencies kept them away and there was little that could be done about this whilst their duties were of a non Child Protection nature". "The interaction of S4C was being sanctioned and backed up by the court who had exonerated the parents*. *Therefore there was less resistance to this from the parents*".

Many professionals have struggled to understand the continued level of hostility demonstrated by Mr F and Ms M after the children moved to live with them and they seemed to have had all their wishes and demands met. As the Children's Social Care IMR remarks the parents were *"if anything less cooperative and more hostile ".* It may only be speculated whether this behaviour was a smokescreen to distract attention from what was really happening in the household. There remain unanswered questions about what was actually happening when the parents kept Child D off school and cancelled contacts with the grandparents.

After the judgement exonerating Mr F and Ms M there was a great deal of interest in this case, not just from local media, but also national newspapers and journals, and the parents appeared on breakfast TV and used the services of the publicist Max Clifford. At the time of writing, professional studio photographs of the family and details of the case could still be found through the internet and social media channels.

Local Safeguarding Children Boards have procedures and training that provide information and guidance regarding work with families who are reluctant, resistant or hostile because of the well documented risks such parents can pose to children, and Sutton LSCB has run training on these themes.

Good practice would suggest that where parents are considered to be threatening or hostile, any presumption that they are different with their children should be rigorously tested. As the Health Overview states, *"Reports did not consider what it would be like for a child living in a highly volatile environment where tempers and behaviour was unpredictable."*

In this case there is plenty of evidence that there were professionals who remained alert to the concerns for Child D and Child S, and who continued to liaise with partners to share information.

The professionals meeting held on 28 January 2013 is one such example where Children's Services, S4C and the school came together (although it is not clear why the Health Visitor who had been in close contact with the school was not included). At its conclusion a letter

was sent to the parents offering an appropriate range of supports, but again there is no record of help being taken up.

A few weeks after this, on 07 March 2013, S4C ceased their involvement and although agencies, particularly Children's Services, responded appropriately to new information, it was never of a scale to trigger a statutory intervention. It is observed that new incidents were dealt with individually and sequentially rather than being aggregated into a picture of wider concern. This left only universal services in contact with Child D, mainly the school. Apart from Child D's poor attendance from the time of beginning a second primary school in January 2013 until the death, there were few problems identified; the school worked hard to maintain a relationship with the parents and to pay close attention to Child D's progress. By all accounts Child D presented at school as a happy child, including in the company of the parents. The school had tried to organise a CAF in April 2013 as a means of addressing the low attendance and thought they had secured the involvement of the parents, but Ms M cancelled at the last moment, asking for the reasons for the meeting to be put in writing to show her solicitor. After further prevarication and unauthorised absence in the autumn term, a meeting date had been reset for November 2013.

Given the habitual response from these parents it is important to ask whether their behaviour made the children less visible and their needs less central. One can try to imagine how two young children might have experienced life in a household where parents were behaving in this manner, spending so much of their time and energy avoiding engagement with people who could have been sources of support. It would appear that their exoneration of causing harm to Child D and their high profile in the media as victims of a miscarriage of justice did little to bring about the change that the Judge had predicted.

5. INVOLVEMENT OF FAMILY MEMBERS

5.1. Letters were sent to Mr F, Ms M, Mr GF and Mrs GM informing them of the decision to undertake a SCR. Because of the parallel criminal investigation, the parents were not invited to take part in this review. Mr GF and Mrs GM were invited to become involved, which they accepted and the Overview Author and a representative of the Local Authority met with them at their home on two occasions during the completion of the report. They were joined by Mrs GM's sister (Mrs GA) and their support worker from the voluntary organisation, Victim Support.

5.2. Given that the grandparents had cared for Child D for over five years they were able to describe Child D vividly and showed us many photographs of their grandchildren and told us about Child D's life with them. They described the child as a happy and outgoing child and they made sure that progress was maximised by prioritising attendance at all medical appointments, ensuring health issues were monitored (e.g. Child D's sight and developmental progress checks to assess whether an overdose of radiation the child had received from a hospital scanner as a baby was causing any difficulties.) They spoke proudly of Child D's progress at school and both they

and Child D seem to have built good relationships with staff and other children. Mr GF and Mrs GM spoke positively of the help they had received from a number of professionals and had felt secure that Child D would remain with them for the rest of her childhood.

Mr GF and Mrs GM's negative views about Mr F and Ms M were strongly expressed (never referring to them by their names) and if anything their opinions about Ms M were even more vehement than about Mr F. They did acknowledge that the relationship with their daughter had been very difficult for many years.

5.3. Understandably the grandparents were in a state of grieving the loss of a much loved grandchild and were experiencing sadness combined with anger as they grappled with questions about how the death could have happened. They said it had felt like bereavement when Child D left them to go to live with the parents and the death was a double loss. They described their motivation for getting involved in the SCR as achieving *"Justice for* [Child D]*"* and made it clear that they hold a range of parties, including the Judge and lawyers, responsible for the death as they *"did not heed the warnings".*

Mr GF and Mrs GM had spent their life savings (£80k) on legal representation at the High Court hearing and Mr GF told us how, when invited to make a statement near the end of the case, he had spoken to the court in the strongest of terms about the risks to Child D returning to Ms M and Mr F, warning the court *"that they may have blood on their hands".*

5.4. The period leading up to Child D's return to the parents was a very difficult one for Mr GF and Mrs GM and they did not find the relationship with S4C easy. They stated that Child D was often unhappy to meet with the social workers, hiding behind curtains when they were expected and talking about not wanting to leave. Most of all they were disappointed that in their view the S4C social workers were unable to see the dangers that the parents posed to Child D.

Mr GF and Mrs GM talked about the planned introductions to the parents not working with no overnight stays taking place and the timescale being rushed. They were positive about Child D's developing relationship with Child S but did not believe that their grandchild wanted to leave them and told us that Child D had asked if it was possible to see the Judge. Mr GF and Mrs GM felt that S4C dismissed these concerns and relayed that the S4C social workers had told them not to discuss the move with Child D, whereas they wanted to prepare Child D properly. They even believe that with the latter stage of introductions being compressed, that on the day Child D moved, the child thought it was only for a sleepover.

5.5. Mr GF and Mrs GM conveyed their worries to the head teacher at Child D's school, who in turn discussed the grandparents' concerns with S4C on their behalf.

Alongside the concerns expressed by the school regarding Child D's feelings about the move and the proposed handover at the school, the grandparents were surprised that there was no clarity about matters such as the details of Child D's routine, the readiness of the bedroom and favourite belongings to be taken to the new home.

A number of the contentions made by the grandparents are contradicted by S4C who were involved in the detailed management of Child D's move. However Mr GF and Mrs GM tried hard to participate in discussions and meetings about tensions and difficult relationships in their family in order to help Child D's transition. Two days before the move Mr GF and Mrs GM took Child D for a routine monitoring appointment with the Consultant Paediatrician and told her about the move (she had not been informed from any other source). She was gravely concerned not only at the planned move but also that Child D seemed to be behaving out of character- wasn't smiling or wanting to draw pictures- and so she contacted S4C to make her views known. The grandparents also commented that at a similar time Child D's ophthalmologist had commented that Child D's sight was "down" and that the child seemed unhappy".

However despite these various expressed concerns the move went ahead on 09 November 2012 with the grandparents taking Child D to school as usual, saying goodbye to their grandchild there and Mr F and Ms M collecting Child D from school in the afternoon. Both the school and S4C have commended the grandparents for the exemplary way in which they handled this event.

5.6. After the move it was planned by S4C that there would be no face to face contact for four weeks to enable Child D to settle with the parents. Mr GF and Mrs GM kept a written log of their contacts with Child D between the return and the death and it reads as a catalogue of promised contacts followed by cancellations by the parents, with approximately fifty percent of arranged calls or visits being achieved. They did not see Child D at Christmas nor on the child's sixth birthday. They also established that Child D was not being taken to medical appointments and noticed that her squint had worsened and there were concerns about the child not wearing glasses regularly. Their perception is that Child D had lost weight and looked less well.

During 2013 a number of joint family outings took place and on two of them Child D was wearing face paint and Mr GF and Mrs GM thought they could detect signs of bruising and scratches but were prevented from speaking to Child D on their own. Their last contact with their grandchild took place on the day before Child D died and they describe Child D as *"unkempt, bedraggled and discolouration showing on face ...."*. This was during half term so Child D was not in school.

When asked why they did not raise any concerns about their observations, either directly with the parents or to professionals, Mr GF and Mrs GM responded saying that they were afraid to say anything as they believed they would lose all contact with their grandchildren.

6. INVOLVEMENT OF PROFESSIONALS

6.1. It is good practice for an Overview Report to have input from professionals who have been involved in the case so as to test out material gathered in the course of the review and probe areas where there may be a lack of clarity or a divergence of opinion and the need to explore why certain things happened.

6.2. I was able to interview (in person or on the telephone) fourteen professionals from 7 different agencies and wish to thank them for their time and reflective thoughts on the work with this family, the services provided to them and the developing themes from this review.

6.3. This was clearly an overwhelming case for many individuals and the impact of Child D's death has been significant, with a number of people giving long and careful thought as to whether, and how, the outcome might have been different.

6.4. The views of these individuals included perceptions about how frustrating, and on occasions frightening the parents could be to work with, how difficult the process of the High Court case was to deal with and the constraints that its outcome placed on working with concerns about the risks posed to Child D in living with the parents.

6.5. I have striven to accurately represent the views of these professionals in the body of the report.

7. FINDINGS

7.1. This SCR is different from many in that neither the IMRs nor the Overview Report have found a catalogue of practice issues to address. This is not to suggest that everything was perfect or that there is no room for safeguarding practice to improve across the agencies involved.

7.1.1. Indeed it is important to highlight the instances where practice was less than satisfactory:

- GPs not making a referral to Children's Services about injuries that might have been suggestive of child protection concerns a) in February 2007 when Child D, aged five weeks, had radiator burns to fingers and forehead and b) in June 2013 when Child D had bruises and grazes.
- Lack of communication and triangulation across agencies and some non-adherence to child protection procedures (these are detailed in the IMRs and occurred mainly, but not solely, in 2007).
- The work of the Guardian (CG2) not being covered by Children and Family Court Advisory Support Service (CAFCASS) when she was off sick between July and December 2012. Although she tried to carry out her duties at times during this

period, this was not a satisfactory arrangement for a professional whose role is crucial in representing the children's interests.

- Child S not being examined when Child D was admitted to hospital and died of suspected non-accidental injuries.
- S4C conducting their work without the benefit of full background information and there being a lack of clarity about the respective roles of the Independent Social Work Agency and the LA Children's Services.
- The absence of a debrief or multi-agency planning meeting after the conclusion of the High Court case.

7.1.2. These examples are highlighted for agencies to reflect on and take action as appropriate, but do not, when taken individually or in sum, suggest that had they not been present, that the outcome for Child D would necessarily have been different.

7.1.3. Indeed agencies were asked, in Specific Question 4.5, whether any other actions or interventions could have prevented Child D's death and all have found it difficult to cite actions that they believe would have made a difference.

7.2. The unanimous view of the various report authors and staff interviewed is that the outcome of this case hinged on the Judgement from the High Court in July 2012. Professionals and family members alike believe that this was the crux of the matter.

7.3. After careful consideration I believe that Judge 02's finding of fact (or non-finding), based on the balance of probabilities, was not unreasonable. It was almost entirely based on the experts' medical evidence which was weighed at length and in great detail, and some believe that the other information about the parents' suitability to care for their children was not so thoroughly considered or else that the parents' explanations were too readily accepted.

7.3.1. However the Judge articulated that she wished to go further than the fact finding and her direction of a letter regarding Mr F's exoneration goes much further in stating that he *"had never caused harm to his child, in fact there was an innocent explanation for his child's suspected injuries".*

7.3.2. According to many professionals it was this statement that left them feeling "*powerless to act"* despite their remaining sense of unease about the safety of Child D returning to the parents.

7.3.3. The Probation IMR is one that expresses this well. *"The over-riding issue in this case is the acquittal for GBH against Child D. It confirmed Mr F as a satisfactory parent. It rationalised his failure to comply ...and served to place the subject of child welfare "off limits" to those supervising Mr F".* It also refers to *"his intention to make professionals "pay" for the trauma they had caused him".*

7.3.4. Once it was deemed that the Local Authority had failed to prove the threshold of significant harm (actual or likely) in respect of Child S, no orders could be made to govern the future work with the family. This meant that, despite their best efforts and use of their professional judgement, when agencies were unable to find sufficient evidence to undertake a statutory intervention, there was little they could do in the face of parental opposition to voluntary engagement.

7.3.5. In another recently published SCR[6] (the only one I have found with similar characteristics, where a finding of fact asserted a parent's "innocence" of causing an injury and the child was subsequently killed by the same parent), there is a reflection that the court outcome undermined professional judgement. Whilst in both cases this does not appear to have prevented professionals from exercising "respectful uncertainty" in their approach with parents, they felt as though there was nowhere to go with their concerns.

7.3.6. The Derby SCR went so far as to suggest that a "Lesson Learnt" should be *"Professionals should treat court decisions for what they are; a legal finding not a manifestation of truth".*

7.4. Another crucial factor was the appointment of an independent social work agency to undertake the work in place of the Local Authority's Children's Services (because it was believed the parents' mistrust of the Local Authority would make working together untenable). This disconcerted professionals, to a greater degree than expected, perhaps because agencies did not know the individuals in S4C, had no previous experience of an independent social work agency and, more importantly, had not seen any plan that they were working to, let alone any indication of whether and how they would be involved. Some, for example the Health Visitor, had expected to be contacted and several health professionals were surprised that S4C did not seek their views or direct engagement.

7.4.1. It is evident that both Children's Services and S4C expected more communication from the other and this lack of a defined working relationship led to confusion such as who was responsible for informing other agencies about the plan of work, the progress towards it, the dates when the children would return home, and the outcomes of legal processes such as the revocation of the SGO.

7.4.2. S4C was seen as working to the Court's agenda, which is accurate in the sense that they were commissioned by the Court and were asked, via a Letter of Instruction (agreed by all parties), to carry out specific tasks such as determining the speed of Child S's return to the parents and the package of help, support and services to be offered to the parents in order to enable this to be successful. When the new element

[6] Derby Safeguarding Children Board. Serious Case Review in respect of DD12 (18.02.14)

of returning Child D to the parents was introduced into the case, events moved at a faster pace with S4C communicating to parties in late October that a move was planned for November in order to resolve the uncertainty. They outlined their plan of visits for six weeks after the move and a one-off session with a psychotherapist but there was not a plan comprising a package of long-term support or oversight of any kind as Mr F and Ms M did not believe this was necessary. S4C have said that with hindsight they would have formalised this further.

7.4.3. Whilst the Court provided the framework, particularly determining in late September 2012 that Child D as well as Child S should move to their parents, S4C are clear that if they had had any concerns about either child's wellbeing or best interests that they had avenues to raise this and would have done so. They do, however, acknowledge that more joined up working might have made for greater clarity in their work.

7.4.4. The task of an author of an Overview Report is not just to describe what happened in this case, but also to reflect on **why** it happened and I shall try to address the key findings from the Review in this way.

a) Why does it appear that no-one had the "big picture" overview of what was happening in this case?

Reasons may be:

- the number of agencies involved (including outside of the Borough and the wider London area)
- after the outcome of the court hearing in July 2012, the judgement was interpreted as sending out a signal for agencies to "back off"
- the deliberate actions by the parents to ensure that the pieces of the jigsaw were not put together (by giving false details, the concealment of Child S, use of multiple hospitals and GPs etc.)

b) Why were the children less of a focus ("less visible") than they might have been?

Reasons may be:

- the parents' behaviour was so demanding to deal with, leading in some instances to "anxiety" and "paralysis"
- there was no tangible evidence of abuse or risk to the children; the prospect of emotional abuse or neglect being harder to assess, especially when workers had no ability to demand access to the children
- links are not evidenced to messages from research regarding the impact on children of parents who exhibit resistant and confrontational behaviour

c) Why were multi-agency professionals not more confident in pursuing concerns after the children went home?

Reasons may be:

- there was "nowhere to go" (no legal framework to intervene) without the parents' agreement
- there was no unequivocal evidence of abuse or neglect to the children arising from the parents' behaviour and the concerns that are documented about Child D's low level of school attendance and missed medical appointments did not warrant a statutory intervention. The evidence from both S4C and the school that the children were happy and doing well, including positive interactions with their parents
- fear of threats and complaints from parents. One professional who offered support to the parents said *"the parents told me if I persisted, I was setting myself up for big trouble".* It is important to observe that despite such threats professionals were not deterred from continuing to try to protect the children

d) Why was the Judge so ready to accept the parents' explanations, and to believe, once exonerated, that they would change?

- it is difficult to respond to this question in the absence of any analysis that would have come to the SCR if there had been involvement from the Judiciary or Courts' Service via an IMR or attendance at the SCR Panel

e) Why was no multi-agency meeting held either in July or September 2012 after the conclusion of the Court Case? This could have helped in understanding and communicating the legal ramifications of the judgement and the implications for practice.

Reasons may be:

- shock? One professional described this event as "*losing the unloseable case"* and others disagreed with the outcome and may have maintained the narrative that Mr F was responsible for the injuries to Child D and the Judge had "*got it wrong"*
- there was no set framework for such a meeting (in the same way that exists for example for Strategy Meetings or Child Protection Conferences)
- Children's Social Care felt they had been excluded from or marginalised in managing the case and that it was for S4C to take the lead role

7.4.5. To conclude, the High Court judgement had a profound impact on this case in the messages it gave both to the family and to professionals. It is not possible to assess the extent to which individual professionals did or did not feel disempowered, and many continued to work determinedly with the family. However it certainly appears to have made securing the parents' cooperation even more difficult, and there were

serious consequences from the Judgement (or at least from its interpretation), even if they were unintended.

8. LEARNING POINTS

8.1. Even where a series of individual contacts or interventions with a family pay due regard to safeguarding issues and are delivered to a good, or at least satisfactory, standard, children may not always be protected. There needs to be greater attention paid to the bigger picture and a wider lens used to see who else may be able to supply information or expertise in complex cases. A summary of the learning points in this section can be found in Appendix D.

8.2. The focus on the child's needs and experiences must never be lost, however demanding or distracting parents may be. The child's voice needs direct consideration when assessing his or her journey through receiving help and services (Munro[7]). There was little evidence in this Review of truly child-focused work that heard what the child said and paid heed to the theoretical frameworks that should underpin practice. In this case, issues around the importance of attachment (particularly of Child D to the grandparents) should have been of higher profile, with greater consideration given to Child D's long term wellbeing and likely emotional response to moving quickly from the security of five years in the grandparents' care to parents and a sibling that the child did not know very well.

8.3. There are learning points about working with an independent social work agency, both in terms of how that experience should have been more co-ordinated in this case. Whilst S4C was the lead agency, they did not consult professionals who in some cases had known Child D for years, or inform them of what was happening.

8.3.1. Given that various independent professionals are more often being commissioned to work in child care cases, and the government's recent consultation paper on the potential outsourcing to private and voluntary sector organisations of children's services, including child protection elements, this is an issue that LSCBs and their constituent partner agencies need to think about. Issues about quality assurance of practice, accountability and how independent social work agencies are selected need to be considered, alongside how the agency works in a multi-agency context.

8.3.2. In this case it is clear that the Court commissioned S4C (on the recommendation of the Guardian and her legal representative) with an initial agreed Letter of Instruction. By the time the second hearing had concluded at the end of September 2012, the Local Authority ceased to be a party and there is some ambiguity about who agreed

[7] Professor Eileen Munro, The Munro Review of Child Protection: *A child-centred system* (2011), DfE

the second Letter of Instruction, commissioned the work and to whom S4C reported. S4C believes that after November 2012 the Local Authority was the "sole commissioner" of their work; although the Local Authority was paying their costs, they query the "sole commissioner" status. What is evident is that reporting arrangements should have been clearer.

8.3.3. It would appear that S4C's role changed from initially one of assessment (firstly in respect of Child S's return to the mother/parents, the contact with Child D and support to the family, and secondly an assessment of how Child D should move to the parents care) to a role much more akin to case-holding social work. This latter phase covered the direct work with Child D, the management of the move and the majority of the monitoring of the family between the time the children were placed and S4C's withdrawal from the case in March 2013. This shift in role from assessment to social work service provision was not well understood by various parties in the case.

8.3.4. Both S4C and Children's Services believe their dialogue should have been more regular so as to remain up to date on events in a planned way, rather than responding to individual events (although it does appear that communication and cooperation at these times was reasonably effective.)

8.4. In respect of the contribution of an independent social work agency to a SCR, this case has exposed a gap. It has been usual for a SCR to request IMRs from all agencies involved in a case, with the expectation that an independent IMR author will be appointed, who has knowledge of the relevant profession/organisation but no connection with the family or line management of the case. Whilst W*orking Together* 2013 gives LSCBs more flexibility and discretion over the style and methodology underpinning a SCR, many are still finding the compilation of comprehensive IMRs a useful way to proceed. In the case of a small independent social work agency such as S4C, there may be no-one independent of the case in the organisation who can undertake this task. Even if the agency was to pay another professional to complete the report, there may be questions about their independence. S4C corresponded with BASW and the chair of the SCR Panel about the difficulty of producing an IMR and eventually the two social workers who comprise S4C produced a background report which contained some analysis of their role and responded to some of the questions posed in the Terms of Reference. I am unaware whether this is an issue that has cropped up in other SCRs but it might be helpful for consideration on a national level, especially as independent contractors within children's services are likely to continue to be part of the landscape.

8.5. Too often in the work in this case (and arguably in the SCR itself) there was a loss of focus on Child D, with the child's vulnerabilities, needs, wishes and feelings appearing to be overtaken by a concentration on the behaviour, demands and challenges of the adults. There was no reference to the adverse impact on the children of living with a

parent who interacted in a verbally aggressive manner, including a pattern of sustained shouting or bursts of temper.

9. RECOMMENDATIONS

9.1. A number of IMRs have produced relevant and thoughtful recommendations, though not all have chosen to do so, and these are produced in Appendix E.

As Overview Report writer I have made an additional five recommendations below.

Sutton LSCB considered and endorsed these recommendations on 10 September 2014 and confirmed that they cover the important issues arising from the review and that they are able to be implemented. The LSCB will ensure that the learning from this review is disseminated in a timely way, informs training and practice and ultimately contributes to improved outcomes for children.

9.2. OVERVIEW REPORT RECOMMENDATIONS

9.2.1. All agencies should reinforce the importance, throughout their work, of focusing on the needs of the child at the centre of a case and good practice in the direct recording of the child's voice should be adopted.

9.2.2. When working with parents who are resistant and hostile, professionals should not be deflected or distracted by parental behaviour and should focus on assessing the potential risk posed to children in these families by emotional abuse or neglect. The adequacy of multi-agency training in this topic should be assessed.

9.2.3. When outcomes from court cases occur which are not expected by key agencies, and may have the potential to raise concerns for children, the Local Authority should convene a multi-agency meeting to share information arising from the unexpected outcome. This should provide clarity about future actions, roles and responsibilities of various organisations and establish communication channels that can respond to any escalation of concern.

9.2.4. Given that working with independent social work agencies and other independent professionals is likely to continue to be a feature of children's services work, there is a need for clarity regarding respective roles and responsibilities and accountability so that it is clear who is doing what in a multi-agency context. The Local Authority should take the lead in defining how commissioning, contracts and communications will be managed.

9.2.5. The position of the Courts, specifically the Judiciary, in respect of SCRs should be clarified. In this case the request for an IMR was declined; no other form of report,

other than a copy of the Judgement, was provided and there was no representation from the Courts Service (HMCTS) on the SCR Panel. Given the significance of Court judgements in this case, this lack of engagement raises questions that require serious consideration at a national level. The findings of this SCR should be brought to the attention of the President of the Family Division and the Family Justice Council. They should be asked to respond and to clarify the responsibility of the courts to LSCBs in respect of Serious Case Reviews.

10. CONCLUSIONS

10.1. All SCRs are unique, but this was an exceptionally unusual case and an overwhelming one for many involved. The factors that cause it to be so include:

- The number of agencies involved (and hence the volume of IMRs and number of professionals in contact with family members over the period concerned)
- The extreme level of avoidance, deception and resistance from the parents, who were often evasive, contradictory and aggressive and who regularly resorted to complaints and threats. This pattern of behaviours was sustained even after the parents' exoneration and the children were returned to live with them
- The use of an independent social work agency in the assessment and the management of the reunification of the children to their parents, and the exclusion of the Local Authority Children's Services from this role
- Despite a significant range of concerns and worrying incidents (albeit below the threshold for statutory intervention) being documented by agencies before and after Child D went to live with the parents, the effect of the court judgement and exoneration, combined with the parents refusal of any voluntary engagement with support services, meant that no intervention that might have made a difference was possible
- The Judge in the High Court case pronounced with perhaps undue certainty that the parents' previous patterns of behaviour would change. She said *"Now they have been unburdened from the shadow of findings against them" "They are going to change".* Sadly this did not turn out to be the case.

11. APPENDICES

Appendix A - Biographies

Christine Davies, CBE was appointed the Independent Chair of the LSCB in Sutton in April 2014. Christine had previously worked with Children's Social Care Services as the Chair of the Improvement Board, and is now steering and strengthening the effectiveness of Sutton's multi-agency safeguarding partnership.

Christine has extensive experience in Education and Children's services leadership and delivery and is a current Trustee of the Early Intervention Foundation (EIF) and a member of the Youth Justice Board for England and Wales. She has created, developed and delivered national organisations and local services, securing a national reputation for excellence and performance. Christine has worked with every Local Authority in England and many in Wales, over 80,000 schools, Health Services, Police Authorities, Children's Charities and the voluntary sector. She has advised the UK Government for over 14 years, covering education; safeguarding and child protection; child poverty; early years; special educational needs; early intervention and youth offending.

Christine Davis, CBE, Independent Local Safeguarding Children Board Chair, which is a statutory function under *Working Together* Guidance (2013, 2015)

Kevin Crompton had a successful 30 year career in the public sector including posts as Chief Executive in Haringey (3/10 -9/12) and Luton (11/05-02/10). In 2012, Kevin set up Kevin Crompton Solutions LTD to offer leadership and management services. He was the independent Chair of Local Safeguarding Children Boards in Sutton, Merton and Northamptonshire until he took up the post of Director of Children's and Adults' Services for Bedford Borough Council in spring 2014.

Independent Local Safeguarding Children Board Chair until March 2014 and SCR Panel Chair until June 2014

Marion Davis, CBE is a qualified and registered Social Worker with over 30 years experience in children's social care. She held a range of practitioner and management appointments before serving as Director of Children's Services in Warwickshire from 2005 - 2011. She was President of the Association of Directors of Children's Services for 2010/11. Since taking early retirement she has worked as an independent children's services consultant, including having been an independent chair of an LSCB and acted as an adviser to the House of Commons Education Select Committee. She was awarded the CBE for services to children and young people in the 2012 New Years Honours.

Marion Davis has declared her independence from the London Borough of Sutton and confirmed that she had no previous knowledge of this case prior to being commissioned by Sutton LSCB to become the Child D Independent SCR overview author.

Independent SCR Overview Author

Appendix B - Terms of Reference Serious Case Review (SCR)

CHILD D

Agreed following the third meeting of Serious Case Review Panel 16th January 2014

Introduction

Child D died of a head injury in 2013 following an incident at the child's home. The child's father was arrested and a criminal investigation is ongoing. Child D was known to a range of agencies since shortly after the birth and had previously been a Looked After Child. The history of agency involvement, both local and national, is long and complex. There is the potential for national media focus on the case as the family and their situation had been reported on in 2012 when Child D returned to the parents' care. Ofsted have been advised that we anticipate that the review may take longer than the standard six months.

1. Purpose of the SCR

In line with the government's guidance in *Working Together to Safeguard Children* 2013, the SCR will aim:

- To establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
- To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
- To improve inter-agency working and better safeguard and promote the welfare of children.

2. Scope of the Serious Case Review:

The Serious Case Review will look in depth at all agency activity and involvement from 1st January 2000 until 28th October 2013.

Attention should be paid to times of transition between agencies and within agencies.

3. Chronology and Individual Management Review (IMR)

Each agency will complete an Individual Management Review which will follow the guidance below. Prior to that each agency must produce a chronology of all activity from 1st January 2000 until 28th October 2013. A common template will be provided by SLSCB and will need to be used by all agencies.

4. Analysis:

Each IMR author to address the following *Working Together* Standard Questions:

- Were practitioners aware of and sensitive to the needs of the children in their

work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?

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

- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?

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

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

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

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

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

- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations?

- Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

- Was there sufficient management accountability for decision making?

5. Specific Questions to consider in this case

I.
   a. Child D's father's conviction for shaking the child as a baby was overturned by the courts and Child D, along with Child S, returned to live with their parents. An independent social work agency was appointed to work with the family. Did these decisions have an impact on the way agencies worked further with the family, and
   b. Were there occasions where child protection processes should have been followed but were not as a consequence of the legal judgements?

II. There were a number of contacts between agencies regarding Child D and Child S after they returned to live with their parents in October and November 2012. Were these contacts handled and responded to in an appropriate and timely way?

III.
   a. Was information received by different agencies following Child D's return home considered collectively and triangulated? Could this have made a difference?
   b. Would any other advice, information, support or intervention have prevented the child's death?

IV. The finding of facts against the parents following the hearing in January 2008 before Judge 01, were set aside by Judge 02 in the High Court on 6th July 2012 following a re-hearing. Were judicial decisions following all court hearings reasonable?

V. To what extent was domestic violence an issue in this case and were agency responses appropriate?

VI. To what extent did the manner of the parent's interaction with agencies impact on this case? Are there learning points to be taken from this?

6. Organisations to be involved in this SCR

IMRs or background reports will be requested from the following agencies in relation to their involvement with the family / household members (see 10):

Cafcass
Chelsea and Westminster NHS Trust
Epsom and St. Helier University Hospitals NHS Trust
Farnborough hospital, Kent
General Practitioner
Housing Needs and Homelessness Prevention
Judiciary
London Ambulance Service
London Borough of Sutton Children and Young People Learning Directorate
London Borough of Sutton Education Service
London Probation Trust
Metropolitan Police Service
Other Health Trusts as identified
Services for Children (S4C)
South London Legal Partnership
South West London and St George's Mental Health NHS Trust
St. George's Hospital
Sutton and Merton Community Services Royal Marsden NHS Foundation Trust
Sutton Clinical Commissioning Group
Sutton Housing Partnership
The Evelina Hospital
West Sussex Hospital

7. Involvement of the family

Members of the family will be contacted where possible and informed of the nature and purpose of the Serious Case Review by the LSCB Business Manager and the Independent Chair of the Serious Case Review.

Family members will subsequently be invited to participate in the review process by the overview author.

8. Legal Advice.

The panel will be supported as necessary by a legal advisor from the Local Authority team who was not involved in this case as required.

9. Timescale

The Serious Case Review, having commenced on 25th November 2013 will be concluded by 22nd April 2014 and submitted as a final report before 14th May 2014

To ensure this timescale is met the following dates have been agreed for IMR authors:

- Agency chronology to be provided to the LSCB Business Manager: 24/01/2014
- Draft IMRs to be provided to the LSCB Business Manager: 28/02/2014
- Final IMRs to have been approved within agency and submitted to the LSCB Business Manager: 31/03/2014
- Health Overview to be completed by 31/03/2014
- Draft overview report submission date: 14/04/2014
- Final overview report: 25/04/14

10. Family members

Each agency to compile a chronology and management review of their involvement with family members **The records to be accessed by each IMR author are those of Child D, Child S, Mr F, Ms M**

Appendix C - Child D SCR Panel

Independent Chair, LSCB and SCR Panel Chair

Independent Overview Report Writer

Cafcass:

Service Manager, National Improvement Service
Children and Family Court Advisory Support Service

Health:

Clinical Children's Services Director, Sutton and Merton Community Services Royal Marsden NHS Foundation Trust

Designated Nurse Safeguarding Children - Sutton CCG

Designated Doctor - Sutton CCG

Named Nurse for Safeguarding Children, St George's Hospital

Named Nurse, Safeguarding Children Epsom and St Helier NHS Trust

Head of Paediatric & Neonatal Nursing Epsom and St Helier University NHS Trust

Associate Medical Director, NHS England

Sutton Council:

LSCB Business Manager

Head of Quality Assurance

Practice Lead & Team Manager, Social Care and Education (Legal Services)

Executive Head of Safeguarding

Strategic Director

Police:

DI - Metropolitan Police Service

DI - Specialist Crime and Operations

Education:

Head, Primary School 1

Education, Safeguarding and Well-being Lead

Probation:

Assistant Chief Probation Officer

Other:

Social Care IMR writer

Specialist Crime Review Group (IMR author)

Health Overview Report writer

Appendix D - Summary of Learning Points

Item	Learning points	Ref.[8]
1.	There needs to be greater attention paid to the bigger picture and a wider lens used to see who else may be able to supply information or expertise in complex cases.	8.1
2.	The focus on the child's needs and experiences must never be lost, however demanding or distracting parents may be.	8.2
3.	The child's voice needs direct consideration when assessing his or her journey through receiving help and services (Munro).	8.2
4.	There was little evidence of truly child-focused work that heard what the child said and paid heed to the theoretical frameworks that should underpin practice.	8.2
5.	The importance of attachment of Child D to the grandparents should have been of higher profile.	8.2
6.	The work with the independent social work agency could have been more co-ordinated	8.3
7.	Consideration needs to be given to how independent social work agencies can contribute to a SCR	8.3
8.	There are issues about quality assurance of practice, accountability and how independent social work agencies are selected and commissioned, alongside how the agency works in a multi-agency context	8.3
9.	There are unanswered queries about 'sole commissioner status', and ambiguity about to whom S4C reported. What is evident is that the reporting arrangements should have been clearer.	8.3
10.	The shift in the independent social work agency's role from assessment to social work service provision was not well understood by various parties in the case.	8.3
11.	The dialogue between S4C and Children's Services should have been more regular to remain up to date on events in a planned way, rather than responding to individual events	8.3
12.	In the case of a small independent social work agency, there are learning points regarding how independent social work agencies in general can contribute to a SCR. There may be no-one independent of the case in the organisation who can undertake this task.	8.4
13.	There was a loss of focus on Child D, with the child's vulnerabilities, needs, wishes and feelings appearing to be overtaken by a concentration on the behaviour, demands and challenges of the adults.	8.5
14.	There are important lessons to be learnt about working with resistant and hostile parents and not losing sight of how the child experiences these behaviours.	8.5

[8] Section in chapter 'Learning Points'

Appendix E - Summary of IMR recommendations

The IMR recommendations are the responsibility of each agency to implement, and the oversight and scrutiny of a detailed action plan is the responsibility of the Case Review Group.

INDEPENDENT MANAGEMENT REVIEW (IMR) RECOMMENDATIONS	
Item	**Recommendations**
1.	**Cafcass**
1.1	The Children's Guardian to seek supervision on complex cases.
1.2.	Liaison to take place with the IRO whilst children are accommodated.
1.3.	Comprehensive information about relevant aspects of parents' past histories being established.
1.4.	Consideration of the risks to the child's safety and welfare where the parents do not co-operate with the Local Authority.
2.	**EDUCATION**
2.1	All schools maintain the levels of Safeguarding/CP training for their staff and the specific training for Designated Persons.
2.2	Record keeping content should be adjusted so that all information is passed from one school to another, including where there is engagement of an independent social worker supporting a family.
2.3	Information sharing protocol and expectations should be drafted as a model for all schools to use and share with independent social work providers in future. These should include the process by which schools will make complaints about independent social workers and how to escalation concerns to the local statutory services.
3.	**HEALTH**
3.1	**Health Overview Sutton CCG**
3.1.1	Agencies involved in this review should be reminded of the theoretical frameworks to inform professional practice and these re-launched through a variety of mechanisms including: • Safeguarding training • Safeguarding supervision processes • Reflective practice opportunities • Feedback from learning reviews, including this Serious Case Review Audit processes
3.1.2	Sutton CCG require each agency within their health economy to increase staff competency relating to the co-existence of domestic abuse, mental ill health and substance misuse, and to provide evidence of compliance on a quarterly basis via safeguarding metrics.
3.1.3	Sutton CCG Board must understand and be assured that appropriate governance arrangements are in place to code safeguarding issues in GP Independent Services.
3.1.4	Sutton CCG Board requires each agency within their health economy to provide evidence of direct discussions with children and young people during healthcare contacts.
3.2	**Epsom and St. Helier University Hospitals NHS Trust**
3.2.1	Develop a Trust Domestic Violence and Abuse Policy in accordance with NICE guidance published in February 2014
3.2.2	Develop a rolling programme of Domestic Violence and Abuse training.
3.2.3	Continue dip sample audit of ED and maternity records so that staff respond appropriately when coming into contact with people who experience domestic violence and abuse.

3.3	**St. George's Healthcare NHS Trust**
3.3.1	The introduction of ward risk assessment tool
3.3.2	The involvement of the named doctor in complex cases.
3.3.3	Learning from this IMR is summarised and widely shared throughout the paediatric workforce, in particular the emergency department consultants, consultant paediatricians and their teams.
3.4	**Chelsea and Westminster Hospital NHS Foundation Trust**
3.4.1	Develop a rolling programme of Domestic Abuse awareness training
3.4.2	Develop training for leads (Domestic Abuse leads) to be support in wards and departments in leading Domestic Abuse advice
3.4.3	Define organisational response and responsibilities for supporting people at risk of domestic abuse
3.4.4	Appoint a Hospital based Independent Domestic Abuse advocate with administrative support to co-ordinate training and engagement
3.4.5	Enhance documentation of disclosures of Domestic Abuse and how information can be shared with appropriate agencies
3.4.6	To enable staff to be aware of the services and resources available to support a person's disclosure of domestic abuse and their onward access to advocacy services (see IDVA) action above. For staff to be competent to conduct the Co-ordinated Action Against Domestic Abuse (CAADA) – DASH Risk Assessment Tool. Clarify referral process to MARAC.
3.4.7	Review escalation procedure in Child and Young People's Safeguarding Policy
3.4.8	Adult DNA (Do Not Attend) follow up procedure to be put in place.
3.5	**GP Services: Sutton and Merton**
3.5.1	GPs should attain Level 3 training in Safeguarding of Children and needs to be a priority.
3.5.2	All practices should give priority to the summarisation of the medical records of children newly registered with the practice
3.5.3	Priority should be given to recruit a Named GP for Safeguarding Children in Sutton.
3.6	**South West London and St. George's Mental Health Trust**
3.6.1	All current and historical safeguarding or welfare concerns should be included in referrals to Improving Access to Psychological Therapies (IAPT) services.
3.6.2	Historical or overturned safeguarding concerns should be reviewed and confirmed with the referrer.
3.7	**Sutton and Merton Community Services (hosted by Royal Marsden NHS Foundation Trust)**
3.7.1	Review of the role of the link health visitor with allocated GP practice
3.7.2	SMCS safeguarding team to monitor the quality of record keeping and information sharing when conducting safeguarding supervision with practitioners, raising competency issues early with the support of the Universal service managers
3.7.3	Transfer of records and information from the health visiting service to the school nurse service needs to be revisited and strengthened.
3.7.4	'Silo' working is evident throughout the SMCS IMR and needs to be addressed.
3.7.5	Routine enquiry to be introduced within SMCS to improve the communication and outcomes of clients experiencing domestic abuse.
3.8	**Western Sussex Hospitals NHS Trust**
3.8.1	Refer all women who book late in pregnancy to Children's Social Care and inform relevant agencies as outlined in the Trust safeguarding policy.
3.8.1	The Maternity Division is to implement guidelines to follow if antenatal appointments are missed.

4.	**LEGAL**
4.1	Issues of competency within a team need to be dealt with effectively and quickly before they start having an impact on team morale and upon clients' confidence within the legal team.
4.2	When considering choice of counsel in complex proceedings, there should also be consideration of influence in the court arena, perception of the Local Authority, status of other representatives and past experience of working closely with lawyers within the team as well as cost considerations.
4.3	When allocating a complex and lengthy matter to a locum in the team, consideration should be given to extending their notice period to ensure there is time for an effective hand over.
4.4	Ensuring the management of the child care legal team is undertaken by an experienced child care lawyer with sufficient experienced lawyers to deal with complex cases at a senior level.
4.5	To have in place a strategy to deal with difficult and aggressive telephone and email correspondence to lawyers within the team to ensure that the team feel supported whilst they work.
5.	**POLICE**
5.1	The manager of the Sexual Offences, Exploitation and Child Abuse command Croydon & Sutton Child Abuse Investigation Team ensure that a record is created of the Initial and Review conference process that took place in respect of Child D.
6.	**PROBATION**
6.1	There need to be clear probation policies on (i) the retention of records of supervision where individuals are acquitted after statutory contact has begun and (ii) on the way probation staff use this material to inform later periods of statutory contact.
6.2	The need to respond to information received, even where it is obviously incorrect, so that there is a clear audit trail on record.
7.	**SOCIAL CARE**
7.1	Children's Services should formally meet with their legal teams after care proceedings particularly where they have been unsuccessful in achieving the desired outcome to debrief and ensure lessons are learned and entrenched in future practice.
7.2	Where care proceedings have been unsuccessful, Children's Services should meet with partner agencies to consider learning points and to consider how they can best safeguard the child(ren) in the future.
7.3	In complex cases, strategy meetings should take precedent over strategy discussions, whereby all agencies involved in the case are invited to take part in the discussion, share information and chronologies, to enable more robust decision making to take place

Appendix F LSCB ACTION PLAN – CHILD D

RECOMMENDATION	RATIONALE	ACTION	LEAD	BY WHEN	INTENDED IMPACT
1. All agencies should reinforce the importance, throughout their work, of focusing on the needs of the child at the centre of a case, and good practice in the direct recording of the child's voice in case recording should be adopted.	The Munro review of Child Protection emphasises the importance of providing a continuum of support from early help to specialist services; and front-line practitioners not losing sight of the welfare and protection needs of the child.	1.1 To seek assurance that each agency within the partnership has robust practice guidance that sets out clearly the expectations for practice to be child centred with standards for recording in place.	Chair of LSCB Policy and Practice sub-group.	June 2015	Where gaps are identified in policy and practice appropriate challenge will be presented to the agency for action to improve practice.
		1.2 To undertake a thematic audit of safeguarding partnership working for children under the age of 5 years old.	Chair of LSCB Quality & Assurance subgroup	Sept 2015	Evidence about the effectiveness of child centred work and case recording to provide assurance to the LSCB about effective child-centred practice.

RECOMMENDATION	RATIONALE	ACTION	LEAD	BY WHEN	INTENDED IMPACT
		1.3 Each agency identifies improvement targets for their service, as required, based on thematic case audit findings. This work is co-ordinated within the QA subgroup.	Chair of LSCB Quality & Assurance subgroup	Sept 2015	Case files capture clear evidence of direct engagement with children that outlines their needs, wishes and feelings.
		1.4 To review the LSCB training offer to incorporate effective observation and inter-action with children, including GP bespoke training.	Chair of LSCB Learning & Development sub-group.	Sept 2015	Evidence of impact of training on practice is evaluated and is judged effective.
2. When working with parents who are resistant and hostile, professionals should not be deflected or distracted by parental behaviour and should focus on assessing the potential risk posed to children in these families to emotional abuse or neglect. The adequacy of multi-agency training in this topic should be assessed.	It is well established that the complexities of the adults' problems can undermine children's welfare and protection needs. Practitioners are all too often able to describe parental behaviours and circumstances that pose challenges to their practice.	2.1To review the current LSCB training offer to incorporate effective approaches to working with highly resistant and hostile families targeted at professionals and managers.	Chair of LSCB Learning & Development sub-group.	May 2015	Training evaluation evidences increased confidence in staff, and improved skills to effectively identify, assess and engage hostile and challenging adults.

RECOMMENDATION	RATIONALE	ACTION	LEAD	BY WHEN	INTENDED IMPACT
	SCR findings identify the need to identify and effectively engage hostile and resistant parents.	2.2 To raise awareness about risk indicators from national SCR findings into parental behaviour that pose risks to babies and young children.	Chair of LSCB Learning & Development sub-group.	June 2015	Professionals within the Sutton LSCB partnership are able to identify and work effectively with highly resistant and hostile families with appropriate support.
3. When outcomes from Court cases occur which are not expected by key agencies, and may have the potential to raise concerns for children, the Local Authority should convene a multi-agency meeting to share information arising from the unexpected outcome. This should provide clarity about future actions, roles and responsibilities of various organisations and establish communication channels that can respond to any escalation of concern.	There is new learning from this case about independent social workers and specific issues that arise in multi-agency working within a local context that is not familiar to external organisations.	3.1 To ensure risk assessments inform decisions to convene multi-agency meetings following the outcome of court cases. This applies when there is dissent on the part of the Local Authority.	Head of Quality Assurance, People's Services Sutton Council	July 2015	Where risk is still identified, following the outcome of legal proceedings, the risk is assessed and escalated appropriately.

RECOMMENDATION	RATIONALE	ACTION	LEAD	BY WHEN	INTENDED IMPACT
		3.2 To issue practice directive that emphasises this requirement within children's social care.	Head of Quality Assurance, People's Services Sutton Council	May 2015	There are clear lines of accountability for initiating multi-agency case management meetings, and providing feedback to LSCB partners.
4. Given that working with independent social work agencies and other independent professionals is likely to continue to be a feature of children's services work, there is a need for clarity regarding respective roles and responsibilities and accountability so that it is clear who is doing what in a multi-agency context. The Local Authority should take the lead in defining how commissioning, contracts and communications will be managed.	There is new learning arising from this serious case review in respect of commissioning processes to clarify roles and responsibilities within the LSCB partnership.	4.1 To review the commissioning arrangements of expert assessments of independent providers to ensure contractual arrangements are robust, and linked to the service specification.	Executive Head of Safeguarding, People's Services Sutton Council	May 2015	Evidence to provide assurance to the LSCB about effective commissioning processes for expert assessment and other external social work services.
		4.2 To provide assurance to the LSCB that robust and safe service specification is in place for commissioned expert assessment	Head of Quality Assurance, People's Services Sutton Council	May 2015	

RECOMMENDATION	RATIONALE	ACTION	LEAD	BY WHEN	INTENDED IMPACT
		and/or other external social work services.			
5. The position of the Courts, and specifically the Judiciary in respect of SCRs should be clarified. In this case the request for an IMR was declined; no other form of report, other than a copy of the Judgement, was provided and there was no representation from the Courts Service (HMCTS) on the SCR Panel. Given the significance of Court judgements in this case, this lack of engagement raises questions that require serious consideration at a national level. The findings of this SCR should be brought to the attention of the President of the Family Division and the Family Justice Council. They should be asked to respond and to clarify the responsibility of the courts to LSCBs in respect of Serious Case Reviews.	Although there is learning from a previous SCR into the failure of the Crown Prosecution Service to contribute information to the SCR (Nottingham 2014), there is no collective evidence bank of the impact of decisions within the judiciary system on LSCB child protection systems.	5.1 To share the findings of this SCR with the President of the Family Division and the Family Justice Council.	Independent LSCB Chair	Within 1 month of publication of the overview report	Sutton LSCB and other LSCBs in England are clear about the expectations of statutory organisations to contribute to SCRs and IMRs.

RECOMMENDATION	RATIONALE	ACTION	LEAD	BY WHEN	INTENDED IMPACT
		5.2 To ask the President of the Family Division and the Family Justice Council to respond to, and clarify the responsibility of the Courts to Sutton LSCB in respect of the Serious Case Review.		As above	
		5.3 To share the response with the London Safeguarding Board for consideration of national policy making.		As above	

This action plan is reviewed quarterly by the relevant LSCB subgroups, alongside individual agencies' IMR action plans. The progress of implementing the recommendations is reported to the Chair's Group, which reports to the Independent LSCB Chair.