STRICTLY CONFIDENTIAL

REPORT OF THE SERIOUS CASE REVIEW REGARDING FAMILY 'S'

Author: Fiona Johnson

CONTENTS

1 INTRODUCTION

1.1 Background to the serious case review and summary of the case

1.1.1 This serious case review concerns two children aged 7 years, and 22 months who experienced significant neglect, because of parental substance misuse and alleged domestic abuse. The children were living with their parents in a privately rented flat and the home conditions were so poor that when professionals gained access to the accommodation it was deemed unfit for human habitation. Additionally, the older child was found to have a significant disability which had not been addressed and therefore means there will be a need for lifelong medical treatment.

1.1.2 The situation of the children was only identified when neighbours in the flat below reported seepage of an offensive liquid through the ceiling and the landlady visited and was so concerned at the conditions in the house that she contacted children's social care (CSC) leading to an immediate joint response by social workers and the police. The parents were immediately interviewed by the police under caution and the children were placed with their grandparents.

1.1.3 The case was referred to the LSCB by Health agencies for consideration of a possible serious case review because 'abuse or neglect was known or suspected' and 'a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child' (HM Government, 2015 p73). The Case Review Committee considered the matter on 18th January 2016 and recommended to the Chair of the Local Safeguarding Children Board that a serious case review should be commissioned. The Chair, Reg Hooke confirmed this decision on 25th January 2016.

1.2 The Terms of Reference

The specific terms of reference are attached as appendix 1 but all agencies were asked to complete Individual Management Reviews (IMRs) reporting on their involvement with the family and analysing how well that input addressed the needs of the children and safeguarded their well-being. The time frame of the review was from January 2008 (soon before the birth of the older child) until 17th November 2015 when the home conditions were discovered.

1.3 Review process

1.3.1 The review was conducted in accordance with Working Together 2015 guidance that:

- recognises the complex circumstances in which professionals work together to safeguard children;

- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings'. (HM Government, 2015 p74)

Further detail about the methodology used for the review is included in Appendix one.

1.3.2 The overview report was completed based on information provided in the IMRs. The overview author was also provided with executive summaries from previous serious case reviews held in East Sussex that were considered to be relevant. The overview author was also given access to some relevant CSC assessment reports. The author also saw education records from the school attended by the older child.

1.3.3 Frontline practitioners were also involved in a workshop at which the Lead reviewer reported on initial findings from the review. There were productive discussions between members of the review team and practitioners about whether the issues identified in the review were usual practice and how they could be best addressed.

1.3.4 The Panel considered at all stages how early learning could be shared with relevant agencies and staff. The recommendations and action plans will be shared with staff and implemented immediately where possible.

1.4 Parallel processes

1.4.1 At the time of the review there was consideration of prosecution of the parents for neglect. The police first submitted to the Crime Prosecution Service (CPS) for charging advice in February 2016 and their recommendation was that it was not in the public interest to prosecute the parents. The police appealed against this decision and eventually in June 2017 the CPS recommended that the parents were cautioned for child cruelty contrary to section 1 of the Children and Young Persons Act 1933. This had happened with both parents by July 2017.

1.5 Family input to the review

As the parents were potentially facing criminal charges at the start of the review, the review team felt it to be inappropriate to involve them at that stage. Once the criminal process was ended attempts were made to contact both parents.

Unfortunately, father's current whereabouts are unknown, so this was not possible. Contact was made with mother and she indicated that she wished to contribute to the review and two appointments were made to meet with her. The first meeting she cancelled and when it was re-arranged she was not there when the Lead Reviewer visited. It was therefore agreed with the LSCB that no further contact would be made by the Lead Reviewer.

1.6 Methodological comment and limitations

1.6.1 The main source of information for the review was IMRs produced by agencies involved with the family. These reports were sound however it was felt that the review process would be enhanced by the Lead Reviewer meeting directly with frontline health and school staff who had been involved with the family. These interviews were conducted by the Lead Reviewer supported by a member of the review team. These interviews provided significant additional information to the review; mainly regarding understanding the 'whys' associated with professionals' actions.

1.6.2 Unfortunately, as most of the IMR authors had also interviewed frontline staff this meant that some people were interviewed twice which they found stressful. The review team has noted this difficulty with the current SCR process and will in the future consider whether IMRs should be written based only on written records or whether staff should be warned that there might be further interviews.

2 SUMMARY OF FACTS

2.1 Family details – all names have been changed for reasons of confidentiality

	Age at the time of the report of the incident
Mother	42
Father	42
Child 1	8
Child 2	2
Maternal grandmother	65
Maternal grandfather	67

2.2 Timeline of key events

Earlier contextual information	
There is very little information from any agency about the parents prior to 2008 however Father was known to have been a looked after child in his teens and to have a longstanding history of substance misuse leading to a 12-month Community Order for a Public Order Offence. Mother had also been involved in substance misuse in her twenties including intra-venous (IV) heroin use leading to a successful methadone rehabilitation programme.	
Date	**Event**
April 2008	Mother booked in for antenatal care disclosed previous IV drug-use father present with mother.
October 2008	Probation referred couple to CSC because of expected baby when Father is subject of a community order and on a methadone programme.
October 2008	Social Work assessment visit – Mother assessed as very capable - outcome of assessment is to close the case.
October 2008	Child 1 born, parents living together.
November 2008 - January 2009	Mother did not attend six-week baby check but was eventually seen by GP and immunisations were provided – baby doing well.
February 2009	Baby seen by health visitor – large weight-gain no other issues.
July 2009 – September 2009	Mother moved to new private rented flat and is awarded housing benefit but does not cash cheques, so benefit is suspended. She responds by asking for the housing benefit to be paid direct to landlord. Payments of full housing benefit were made to landlord from 20.7.09 till 23.11.15.
February 2010	Health visiting records requested by Central Records – address of

	child 1 is unknown.
May 2010	Police record of complaint from Mother that Father is abusive at access visits and sometimes will not leave – parents have been separated for 8 months and father is reporting to the Substance Misuse worker that he is no fixed abode. Information shared with CSC who send a letter offering advice to the mother.
January 2011	Child 1 seen by out of hours GP - probably at maternal grandparent's home – no record of outcome.
January 2011	Both Mother and Child 1 were removed from GP lists as they were reported to be living out of the area.
June 2013	Mother attended walk-in clinic – is pregnant then registered with new GP but did not include Child 1 on registration with GP.
July 2013	Mother booked in for antenatal care again disclosed previous IV drug-use - father not present.
November 2013	Child 1 started school late – school staff thought the child has moved from London. Child 1 visited school with Mother prior to starting. Child 1's disability is noted but Mother said that the child was able to do everything and did not need any specific assistance. School did not notice Child 1 to have any difficulties and the child could access all parts of the curriculum without any assistance or special adjustments. The school perceived Child 1 to be a well presented, happy, confident, emotionally stable and high achieving child during the time at the school.
November 2013	Three days after Child 1 started school, the child felt unwell at lunchtime and talked through some circumstances of home life with a teaching assistant. This included Father no longer living with them, and needing to go to the Salvation Army, and friends of Father being drunk and displaying evidence of violence, including a black eye. Child 1 also volunteered information that they had left their home and had now returned to it.
December 2013	Mother seen in antenatal clinic where spontaneous bruising was noted. A blood test was performed, and the results indicated that she had a high platelet count. The midwife consulted with the obstetric consultant who reviewed the blood results and reported that Mother had "mild thrombocythaemia[1] since 2008 during her previous pregnancy".

[1] Essential thrombocytosis (ET; also, known as essential thrombocythemia, essential thrombocythaemia, primary thrombocytosis) is a rare chronic blood disorder characterised by the overproduction of platelets by megakaryocytes in the bone marrow. Beer, PA; Green, AR (2009). "Pathogenesis and management of essential

January 2014	Child 2 born – normal delivery no issues
January 2014	Midwives visited mother at maternal grandmothers' house – no home visit undertaken at family home.
January – February 2014	Health visitor attempted to see Child 2 at home – when this was unsuccessful she wrote to GP to inform him of no contact with Mother or child.
March 2014	GP saw Child 2 aged nine weeks – all normal
November 2014	Mother pregnant again
Feb 2015 – May 2015	Child 1's attendance at school was poor. Education Welfare Officer (EWO) became involved – five letters were sent to Mother with no response being received.
9 June 2015	Child 1 was noted to be out of school for a ten-day period and Mother did not respond to letter from EWO so EWO made a home visit but could not gain access.
12 June 2015	EWO made further home visit - no reply. Contacted CSC as child had not been seen for 19 days and was told to contact the police. Police located family at maternal grandparents' house. Both children were observed to be safe and well, Mother's explanation for Child 1's absence from school was that she and children had food poisoning and she had miscarried and so had gone to stay with maternal grandmother. Child 1 returned to school the next day.
23 June 2015	Meeting held with Mother to discuss attendance (agreed to review in three weeks) following this attendance at school by Child 1 improved significantly and remained good till November 2015.
17 November 2015	Tenants contacted landlady because of seepage through ceiling from property. Landlady contacted CSC – visit with police arranged and property was found to be unsuitable for human habitation.

2.3 Appraisal of Practice

2.3.1 A significant feature of this serious case review was the low level of contact that professionals had with the mother and the children. A detailed analysis of that contact is provided below which identifies those areas where practice could have been more robust alongside some explanation of the reasons for the less than optimum practice.

thrombocythemia" (PDF). Hematology / the Education Program of the American Society of Hematology. American Society of Hematology. Education Program: 621–8. doi:10.1182/asheducation-2009.1.621. PMID 20008247.

2.3.2 In contrast the father had regular and sustained contact with the substance misuse services which is described at the end of this section. The reasons for the separation of these reports is that most professionals had limited contact with Father and few knew that he was living in the family home. The exception to this was the school who had regular contact with the father at the school gate and this is analysed in the later sections.

Birth of Child 1 (April 2008 – February 2010)

2.3.3 Mother booked in for her pregnancy in April 2008 and reported that she had a history of intra-venous heroin use and that she was prescribed methadone and Subutex by a Specialist Substance Misuse Service in the past. This was also evident in the GP Referral for Maternity Care letter which stated that she had been "on hard drugs for 5 years until 3 years ago". Mother also reported that she had depression in the past and had made a suicide attempt previously. There was no indication in the notes that any multi-agency communication took place between the Specialist Substance Misuse Service, GP or maternity about these matters. It would be normal practice where a pregnant woman is known to have previously abused drugs or experienced mental health problems for an Additional Support Form (ASF) to be generated which would be then sent to the Deputy Named Midwife, GP and health Visitor. This did not happen in either pregnancy and none of the midwives involved can provide an explanation for this omission. **The practice concerning use of Additional Support Forms is considered further in the analysis section.**

2.3.4 Just before the birth of Child1 there was a referral made by Probation to Childrens Social Care raising concerns about Father's history, lifestyle and behaviours in the context of him becoming a father. These issues included him being subject to a 12-month Community Order for a Public Order Offence, an 8-year history of heroin use, though currently on a methadone programme, and concerns about his alcohol consumption. In response to the referral it was decided to complete an Initial Assessment, a proportionate response to the concerns.

2.3.5 The social worker undertook a prearranged visit to the parents at Mother's flat. The purpose of the visit was to assess and analyse the potential risks to the baby arising from substance/alcohol misuse. Both parents were seen, and the social worker discussed fully with them their drug-use. Father confirmed that he was on a methadone programme and Mother said she no longer used drugs. Mother reported that her family and friends offered a good support network but that she had no contact with Father's mother who she alleged used illicit drugs. Mother asserted that she would not tolerate drug or alcohol misuse around the baby; and

would end their relationship if Father relapsed. Preparations had been made for the baby's arrival and the social worker had checked with Mother that she had engaged with ante natal care. The flat was described as small and cramped but clean and tidy and the parents said they had contacted the Housing Department for housing support. The social work assessment was that Mother presented as clean and well presented in appearance; an 'articulate, sensible and independent woman who will be capable of making safe and appropriate decisions for herself and the baby'. Father conveyed complete acceptance of the 'terms' of their relationship and said that he was committed to making it work. The assessing social worker concluded that the concerns were not substantiated. Agreement for 'No Further Action' was given by the Practice Manager. Whilst possibly an optimistic assessment this was not an unreasonable response in the circumstances.

2.3.6 Mother had an uneventful pregnancy and gave birth by ventouse delivery. Father was present for labour and delivery. Mother and Child 1 were discharged home when the baby was two days old and both were seen three times by the community midwife at home. Mother was breastfeeding and there were no concerns reported. Mother had good continuity of care both antenatally and postnatally with her named midwife. Child 1 was deemed to be thriving, and was therefore transferred to health visiting, when ten days old.

2.3.7 The health visitor completed the 'New Birth Visit', within accepted timescales, at the home address. There was then a period of erratic engagement, with the mother failing to bring Child 1 to the child health clinic for a six-week check. The health visitor contacted the GP after two failed attendances, to find that the GP had completed a six-week check in December 2008, and that there were no concerns. The health visitor then asked the parents to bring Child 1 to clinic and both parents attended with the baby. The only issue of note was that the baby had a large weight gain, increasing the weight by three percentiles. There were no safeguarding concerns identified. Weaning was discussed, and it was agreed that attendance at clinic should be at the parent's discretion until the next mandated check was due at six months of age.

Change of address (February 2010 – June 2013)

2.3.8 The health visitor had no further contact with Child 1 and in February 2010 Child Health Records (CHR) requested the records be returned to the centre. It is not clear why the notes were requested. The health visitor reviewed the records and tried to contact the mother to ascertain further detail but received no reply. She

also contacted the GP and was told that Child 1 was last seen in surgery in April 2009 and that subsequent appointment letters had been returned marked ‘gone away’. The records were sent to CHR as requested.

2.3.9 In July 2009 Mother applied for housing benefit at the new address and for the first time reported the birth of Child 1; there was no mention of Father. In May 2010 Mother contacted the police and reported that Father was visiting her home to see his child but would become ‘verbally nasty’ to her when asked to leave. She said he was of ‘no fixed abode’ and would ask her to let him move back in. She said that Father drank and took methadone. She stated that there were no formal contact arrangements in place. The police advised Mother, over the phone, to get a custody order and arrange for the visits to be somewhere other than at home. Following this, Mother was seen at her parents’ address by a uniformed police officer and was advised to seek a formal custody order and to arrange Father’s visits away from her home. The information about the contact was passed by the police to children’s social care who sent Mother a letter of advice. The actions of both police and children’s social care in response to this incident seem appropriate and proportionate, however if the information had been passed to the health visitor the records would have been requested from CHR and further checks may have been completed.

2.3.10 In January 2011, a Duty GP was called out to an address in a neighbouring town to see Child 1, The record of the outcome of this visit is not available. Two days later a letter was sent to mother stating that as the Practice were aware she and her child were now living in another town, they were both being de-registered because they were now living outside the Practice area. It is not clear what address this letter was sent to as the GP’s paper records are lost. There is evidence that the practice had sent letters that were returned marked "gone away" to Mother’s old address however they did not have a record of her new address. **The question of when and how children should be removed from GP lists and whether any checks should be made is further considered in the analysis section.**

Child 1 starts school (November 2013)

2.3.11 Child 1 started school in November 2013, the child was a ‘late-starter’ and was five. The parents visited the school prior to the child starting and school staff were immediately aware of the disability. This was discussed verbally with Mother who said that it did not cause Child 1 any problems and that there was no need for any special responses or adjustments to be made. The school staff understood that the family had newly moved into the area from London and that this was why the child was starting school late. Three days after starting school

Child 1 told a teaching assistant (TA) that Father was no longer living with them, and needed to go to the Salvation Army, and that friends of Father had been drunk and that they had been violent talking about one of them having black eye. Child 1 also told the TA that they had left their home and had now returned to it. This information was recorded by the TA and passed to the designated teacher, which was good practice, however no further action was taken.

2.3.12 Child 1 settled into school well and was considered to be a well presented, happy, confident, emotionally stable and high achieving child. There was good contact with both parents who were seen to be supporting the child's attendance at school positively. With hindsight, this is particularly unusual as there is no evidence that Child 1 had attended any pre-school provision which could have placed the child at a disadvantage with other pupils. At this time, it was the school's policy to conduct a home visit to all reception pupils – but only to do this for 'late starters' if there were additional concerns. The class teacher and senior leader at the time did not consider the child to have any additional needs – and felt that the child's presentation outweighed any concerns raised by the disclosures made to the TA. Whilst understandable this decision was unfortunate as a home visit would have provided an opportunity for a professional to see the conditions in the family home.

2.3.13 A factor that may be relevant to this decision-making is that at the time of Child 1's entry to the school, the substantive head teacher was asked by the local authority to lead another school for five days per week, requiring temporary 'acting-up' leadership arrangements. This resulted in the class teacher being asked to 'act-up' to a leadership role and to be out of the classroom for two days per week. Whilst all staff and governors report that there was good consistency in the leadership of safeguarding achieved through the temporary arrangements, this may have impacted upon the capacity for safeguarding leadership.

2.3.14 It is usual practice when a child starts school, for all reception children to be offered a vision and hearing screen for which parents' consent is required, and parents are requested to complete a school health questionnaire which includes questions about immunisation status, bedwetting concerns, asthma, epilepsy and anaphylaxis. Dependant on the answers to these questions, parents may be sent information, signposted or contacted by a member of the school health team. This consent form and questionnaire was completed by Mother who agreed to Child 1 being screened however the child was not seen by the school nurse. This appears to be because the child was a late starter and the process for children starting late, to be seen by school nurses, was reliant on individual schools informing local teams of new arrivals. **The issue of whether arrangements for**

school nursing checks are sufficiently robust is considered further in the analysis section.

Birth of Child 2 (January 2014 – March 2014)

2.3.15 In June 2013 Mother attended a GP as a walk-in patient because she thought she might be pregnant. She was advised to register with the GP and did so but did not register Child 1. When Mother was seen for her 'New Patient Check' the GP identified that she had an older child not registered at the practice but did not take any action. The GP referral to Midwifery was also inadequate as it did not include any details of Mother's past substance misuse or her mental health difficulties. The Practice had significant difficulties in staffing in 2015 which meant that responsibility for all areas of clinical and administrative work requiring a lead, which were usually shared out between permanent GPs, had to be undertaken by one permanent GP, and this may have affected practice. The practice fully acknowledges these limitations and are working with the Named GP for child protection to resolve the issues. There is no evidence that this reflects normal practice across GPs.

2.3.16 Mother was late in booking in for ante-natal maternity care. She told midwives about her past mental health and substance misuse, however they did not complete an Additional Support Form (ASF) and could not provide an explanation for this omission. The pregnancy and birth were uneventful, and Child 2 and Mother were discharged from hospital within 48 hours and went to stay with maternal grandparents. They were seen by the community midwives on five occasions postnatally, with all contacts being either at the hospital or at the grandparents' home. There was no continuity of midwifery care either antenatally or postnatally during this pregnancy. Mother and Child 2 were discharged to health visiting care fifteen days after the birth, and Mother told the midwife she would be returning to her home later that week. The midwives therefore never saw the family home in which the child would be living. **The issue of home visits by midwives is further discussed in the analysis section.**

2.3.17 At this point the midwife passed responsibility for the care of Child 2 to health visiting. Normal practice would be for a health visitor to undertake a new birth visit where a Family Health Assessment and assessment of Child 2's health needs would be completed. The health visitor attempted to engage with the family and contacted Mother by telephone and letter and making three visits to the family home which were all unsuccessful. Mother only responded once to any contact when she asked for a visit on a Friday. Unfortunately, this could not be accommodated by the health visitor who was working part-time and there was no

other health visitor in the team who felt able to assist. After the third unsuccessful visit to Mother the health visitor wrote to the GP and advised him that she had not been able to see Child 2. The health visitor also discussed the issue with her line manager who advised her to 'keep in contact with the family and document everything'.

2.3.18 The health visitor had recently returned to practice following a ten–year period away from health visiting. She started work in October 2013 with a full caseload (despite working part-time), with no additional preceptorship or mentorship support, and at a time when there were significant staffing issues within the health visiting team. A further pressure for her, was a perception that it was inappropriate to make unplanned visits to families; this meant that any visit had to be preceded by a letter or telephone call. This view was widespread within the health visiting service at that time and may persist to this day.

2.3.19 Another relevant factor, at this time, was that the health visiting service was in the process of changing their records from paper records to a computer system, 'SystmOne'. The process for transfer of work over to the new computer was very disorganised. Health Visitors were expected to enter details of any families with whom they were actively working onto the new computer whilst administrators were transferring other records. Child 2's name was recorded on paper in the 'Birth Book', which records all new births for the team, however the Child 2's information did not get uploaded onto SystmOne online records when they came into use. Child 2 was not entered by the health visitor, probably because she had not contacted the family and did not consider that she was actively working with them. It was missed by later administrators uploading case details to SystmOne. The effect of this was that the electronic database system did not send out alerts or reminders to the health visitors that the family should be contacted for routine checks, thus there was no further opportunity for Child 2's needs to be assessed. **The impact of the culture, management and work pressures on the health visiting service at this time are discussed further in the analysis section.**

School attendance issues (November 2013 – July 2015)

2.3.20 From September 2014 Child 1's attendance at school deteriorated. Letters were sent to Mother in late November 2014 and then in February 2015 with no response. The parents were invited to a meeting with the Education Support, Behaviour & Attendance Service (ESBAS) in April 2015. The parents did not attend, and no reason was given, or sought by the school. Soon after this the school ceased working with ESBAS and commissioned a private Education Welfare Service – 'Team EWO'. 'Team EWO' then invited Mother to meetings in

May, she did not attend either of these meetings and gave no reason for her non-attendance. The Education Welfare Officer (EWO) then wrote to Mother arranging a home visit. When the EWO visited, she could not gain access to the house and so she contacted children's social care and reported concerns as the child had not been seen for nineteen days (half term included). The EWO was advised by the duty social worker to attempt a further visit and if that was unsuccessful to contact the police. The EWO visited again three days later and still could not gain access, so called the police and asked for a police welfare check. The police visited and also could not gain access and so left a letter asking Mother to contact them. Following the police visit, Mother contacted the police and explained that she was staying with her parents because she had been ill. The police then visited the grandparents' house and saw Mother and the children. Following the police visit Mother phoned the EWO, and Child 1 returned to school on the following Monday. After Child 1 returned to school, the EWO had two meetings with the parents to discuss attendance, and from that point forth the child's attendance at school was satisfactory.

2.3.21 Arrangements within the school for attendance management meant that classroom staff were not significantly involved and there seemed to be a lack of awareness that attendance issues could be linked with potential safeguarding concerns. The school were clear that they have strengthened the management of school attendance within the school but raised concerns about how the role of the local authority with regards to school attendance has changed and some lack of clarity about mutual responsibilities when safeguarding concerns are raised in the context of school attendance. **The issue of school attendance and how it relates to safeguarding are further discussed in the analysis section.**

Agency involvement with father (April 2008 – July 2015)

2.3.22 Father was well-known to the Substance Misuse Service and was receiving opiate substitution treatment in the form of prescribed methadone to support his physical dependence on heroin supported by psycho-social interventions to support him in his recovery. He had a longstanding addiction to heroin and was prescribed 60mg of methadone throughout his treatment which he picked up from the pharmacy three times a week. Father attended fortnightly one to one sessions with his key worker and collected his prescription at these sessions. As part of the treatment regime he attended medical reviews and provided regular drug tests, which showed no illicit drug use on top of his script. He did report having some issues around alcohol use, although he described his alcohol use as low, with no concerns.

2.3.23 Throughout his treatment Father reported to his substance misuse workers that he was single, that he had children with an ex-partner but that he was not living with them. He also reported having no fixed address and that he was 'sofa surfing'. During 'one to one' key-work sessions Father described having contact with his children at his ex-partner's parents' address and said that he was trying to rebuild his relationship with his ex-partner and children.

2.3.24 After the birth of Child 1, few professionals had direct contact with Father and Mother presented to most agencies as a single parent. The exception to this was the school who had regular contact with Father, as following the birth of Child 2 he regularly took Child 1 to and from school. The school staff described Father as very open and presentable, they were surprised to be told that he had long-term substance misuse issues and said that this was not apparent in his demeanour at any of his contacts with school staff.

3. ANALYSIS

Statutory guidance requires that serious case review reports provide a sound analysis of what happened in the case, why, and what needs to happen in order to reduce the risk of recurrence. The task for every review should be to answer the following question: -

What light has this case review shed on the reliability of our systems to keep children safe? The task in analysis is to consider all aspects of practice in the case and identify any problematic areas. To understand their relevance to the wider safeguarding system, it is important that the analysis is used to: -

- identify in what way it is an underlying issue – not a quirk of the particular individuals involved this time and in the particular context of this case;
- highlight any relevant information about how usual the problem is perceived to be locally, with any data about its wider prevalence;
- be clear about why it is important for the LSCB to consider the issues relative to their responsibilities, the risk and reliability of multi-agency systems.

The following section considers a number of areas where analysis of practice in this case identifies problems that are relevant to the wider safeguarding system in that the view of the review team in conjunction with frontline staff is that they are likely to be repeated as they are considered to be 'normal' practice.

3.1 General Practice

3.1.1 Child 1 was removed from the GP list because the Mother did not inform the practice of her change of address and did not respond to any of the letters sent

to her by the practice. Child 1 remained without a doctor for four years and was not seen by any health professional for that period. During that time, the child became increasingly affected by a congenital condition which was treatable if identified.

3.1.2 Although not mandatory, registration with a GP is universally available to all children and is an essential requirement to ensure effective delivery of health care and is also a means of monitoring and supporting vulnerable children. The NSPCC fact sheet '*Recognising signs of abuse at different stages of a child's development*' includes under general signs of neglect for children of all age groups: '*medical needs are not being met: not being registered with a GP*.'[2] Recent research regarding neglect compiled by Research in Practice in conjunction with the NSPCC and Action for Children defines medical neglect as including '*Where parents/carers minimise or deny a child's illness or health needs and/or they fail to seek appropriate medical attention*'[3] Clearly Child 1 experienced medical neglect, the issue of debate is how, and whether, the child's health needs could have been identified and treated sooner by professionals within the healthcare or safeguarding system.

3.1.3 One of the professionals able to identify and respond to the child's needs was the GP. The decision by the GP to remove the child from their list was reasonable given the assumption that the family had moved. The question this raises is whether the failure of the Mother to re-register the child with another GP should be considered as a safeguarding concern. Current systems for GP registration do not trigger any alert if a child is removed from one practice list and is not placed on another GP list and there are currently no mechanisms for knowing when this occurs. There is a central record of patients registered with GPs and when a patient is removed from a GP list the medical notes are returned to a central location from where they can be accessed when the patient registers on another GP list however there are no systems for checking when patients do not re-register.

3.1.4 NHS England has a statutory duty to maintain a comprehensive list of all NHS primary health service users and thus has responsibility for GP patient health records. Most GP health records are a combination of paper records and computer records, created or stored on the GP practice's computer system. NHS England provides a range of support services for primary care. These are

[2] Recognising the signs of abuse at different stages of a child's development | NSPCC 18/06/2014 11:51

[3] Appendix C Types of neglect and associated features **https://www.rip.org.uk/resources/publications/evidence-scopes/child-neglect-and-its-relationship-to-sexual-harm-and-abuse-responding-effectively-to-childrens-needs/**

known as Primary Care Support Services (PCS). PCS deliver predominantly back-office administrative and business support functions to GPs, Primary Care Support Services specifically to:

- Operate the database to record which patients are registered at each GP practice.
- Provide the logistical arrangements to move the paper medical records held by the GP when patients choose to move between GP practices.
- Store the paper patient medical record when a patient dies or chooses to no longer be registered with a GP.
- Provide access to the paper medical records it holds either under a Subject Access Request or Access to Health Records Request. [4]

Currently NHS England has contracted with Capita to provide PCS services for England. The contract with Capita started on 1 September 2015 and runs for seven years. The new service is known as 'Primary Care Support England' however NHS England retain accountability for how the service is delivered.

3.1.5 Discussion with practitioners indicated that, as there are a small number of families who move and do not inform their GP or register with a new GP, this is a situation that could recur. All present agreed that the failure to register a child with a GP was a risk indicator for neglect and it is included as such in current and past child protection procedures. There have other serious case reviews that have identified non-registration with a GP as a child protection concern. These include the Victoria Climbié report (2004), Sheffield Report (2005) and Danielle Reid (2006).

3.1.6 Possible solutions for addressing the problem that were discussed at the workshop included: -

- requiring NHS England to develop a system that raised alerts on any person under 18 years old who was not registered with a GP for a period of longer than three months;
- using the Children's Index locally to make an entry when a professional is aware that a child is not registered with a GP;
- Using the SCARF process[5] to pick up on this issue. There is a section for GP details on form – if this was blank the MASH[6] could pick this up and follow up.

[4] How NHS England is changing primary care support services - Overview for patients and the public **www.healthwatchbedfordborough.co.uk/.../how_nhs_england_is_changing_primary**

[5] SCARF is the electronic form used by the police to record and share information with other agencies about children and vulnerable adults.

3.2 Midwifery

3.2.1 At the booking appointment for both the pregnancies mother disclosed past intra-venous (IV) heroin use and a history of depression but midwives did not complete an Additional Support Form (ASF) and no contact was made with other agencies. The IMR provided by East Sussex Healthcare Trust (ESHT) indicated that 'usual' practice was for midwives to complete ASFs whenever a woman had additional needs however clearly the practice in this case was not in accord with that 'normal' practice. Problems with the use of the ASF has been identified in previous serious case reviews and a Domestic Homicide Review in East Sussex. Currently, there are audits of the use of the ASF, but these only review cases where the form has been completed, and do not include a review of files where no form was completed. The ASF is used whenever the woman has any additional need which might be for medical as well as social reasons. Findings from the audits would suggest that if anything the form was over-used which led to discussion amongst practitioners as to whether the form was mainly used by inexperienced professionals who were anxious to raise any concerns. Both the midwives who completed the booking process with Mother were very experienced.

3.2.2 There was also significant debate amongst frontline professionals about how to determine when historic substance misuse remained a current relevant social factor and what type and level of alcohol and drug-use should be included. There was consensus however that a history of intravenous heroin use should have triggered the use of the ASF. Another factor that could have been a possible influence on the booking midwives was Mother's presentation. The professionals who remembered their contact with her considered that she always appeared clean and well-dressed and seemed very capable. Most of the midwives had no memory of her and there was nothing recorded in her notes which suggested that her presentation raised any concern.

3.2.3 Professionals also thought that practice now would be different as the development of the MASH process meant that if Probation had referred this case to CSC there would have been an automatic consultation with midwifery and therefore greater scrutiny by midwives. Furthermore, there are regular liaison meetings between the Midwifery service and SWIFT and Adult Substance Misuse Service where pregnant women with a history of substance misuse are discussed, although this would only occur if the past substance misuse was identified as relevant. It was agreed however, that a random audit of all pregnancies (over a given period) to see when ASFs were completed would be

[6] MASH is Multi-Agency Safeguarding Hub which is the multi-disciplinary assessment team that responds to child protection concerns.

informative and might shed light on the reasons that the forms had not been completed in this case and whether this reflects general practice.

3.2.4 The second pregnancy and birth were uneventful, and Child 2 and Mother were discharged from hospital within 48 hours, and immediately went to stay with maternal grandparents. They were seen by the community midwives on five occasions postnatally, with all contacts being either at the hospital or at the grandparents' home. Mother and Child 2 were discharged to health visiting care fifteen days after the birth, and Mother told the midwife she would be returning to her home later that week. The midwives therefore never saw the family home in which the child would be living. This is usual practice as it is now commonplace for many postnatal contacts with midwifery to be at the hospital. While it is expected that at least one contact with the midwife would be in the community, there would not be an attempt to visit the usual home address if the mother is not staying there after the birth. This means that babies may be discharged home after birth with no professional oversight of home conditions which is a risk for children born to vulnerable mothers. The Review Team were concerned that this reflects a decrease in routine oversight of pregnant women and new-born babies which presents a challenge for agencies in identifying and safeguarding the most vulnerable children.

3.3 School Health Services

3.3.1 When Child 1 started school the child was not seen by the school nurse and therefore an opportunity for the congenital health problem to be identified was missed. This contact did not occur because the child was a 'late-starter' and there was no system in the school, or in fact across the county, to pass on the names of all 'late-starters' to the School Health Service. Since this review has started, new systems have been established across East Sussex whereby the central County School Admissions Service provides the School Health Service with updated school pupil lists every half-term. It should be noted however that the school nursing appointments require parental consent and if neither parents nor school report problems then it is unlikely that the school nurse will seek any further information. The school nursing appointment is not a medical assessment, it is a screening (vision and hearing) process that enables parents or school staff to raise concerns, which usually lead to sign-posting to other services, such as physio-therapy. The front-line professionals who discussed this considered that, as neither the school, nor the parents, nor Child 1 were raising concerns, it is possible that even if the child had been seen by the school nurse no further action would have been taken.

3.3.2 Another possible mechanism for Child 1 to have received assistance with her health needs would have been for the school to have initiated an individual health care plan. The Children and Families Act 2014 was passed in September 2014, and Section 100 designates specific responsibility to schools to ensure that pupils with medical needs can fully participate in all aspects of school life. The aim of the Act; 'is to ensure that all children with medical conditions, in terms of both physical and mental health, are properly supported in school so that they can play a full and active role in school life, remain healthy and achieve their academic potential.'[7] This is statutory guidance but parental involvement is voluntary and as school staff were clear that Child 1 had no difficulties accessing the school curriculum it is understandable that they did not consider an individual health care plan to be necessary. Given that the child's physical presentation made her condition apparent however, this case could have warranted the use of a health care plan to work with the parents and school nurse to plan for any current or future needs.

3.4 Health Visiting

Uploading records to SystmOne

3.4.1 When Child 2 was transferred from midwifery to health visiting the baby's details were recorded in paper records and the Birth Book but not uploaded onto SystmOne because of confusion about arrangements for inputting this data. This meant that no reminders were sent to health visitors for routine assessments of the child. There was significant discussion amongst the front-line professionals about this issue. When SystmOne was introduced and staff had to upload data themselves there were no additional resources provided and the training on how to do it was inadequate. Particularly, it was felt that a certain level of IT literacy amongst health visitors was assumed, and that in fact competency was very varied, with some staff experiencing problems and some continuing to struggle. There is further complexity as the processes for uploading data have been inconsistent and there are different ways of recording information which may affect its accessibility.

3.4.2 Frontline professionals were clear that inputting children onto the system is now routine however it was acknowledged there were children that could have missed being uploaded on to SystmOne at that time and therefore could continue to be outside of the reminder systems. The only mechanism for checking this, would be to manually review the Birth Book, and cross-reference with SystmOne which

[7] Supporting pupils at school with medical conditions Statutory guidance for governing bodies of maintained schools and proprietors of academies in England April 2014
https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3

would be very time-consuming. It is therefore unclear how many other children are in the same position as Child 2 and are not being offered routine checks by the health visiting service.

Workload pressures

3.4.3 When Child 2 was transferred from midwifery to health visiting there were significant numbers of vacancies in the health visiting service and caseloads were very high. The health visitor was very pressured as she was carrying a full-time caseload but working part-time. This was the reason she was unable to arrange a visit on a Friday and so was not able to see Child 2. The front-line professionals at the Learning Event identified that the team in which the health visitor was working did have capacity issues and that the team culture and working environment there made it unattractive to staff. The town centre has a more transient population, parking is difficult and there are greater numbers of families from ethnic minorities where English is not the first language. In the past staff, have been reluctant to move to work in the town centre which historically has had management issues. This has led to a lack of flexibility and co-operation between staff which was why Mother's request for a Friday visit could not be accommodated.

3.4.4 The extent to which the problems and pressures in this team continue is not clear. There are currently no capacity measures that enable workload across teams to be compared. Vacancies have persisted in this team and senior managers are currently reviewing data and workloads. There is some evidence of change and improvements have been noted however this is considered to be slow progress. Certainly, the individual health visitor who remains in this team when interviewed suggested that workload pressures continue.

Unplanned visits

3.4.5 When the health visitor was trying to visit to see Child 2 one factor that made it difficult to achieve the contact was a perception that there was a policy that health visitors should not make unplanned visits. Discussion with frontline staff confirmed that this had never been policy but that it was the management culture at the time. A senior manager with responsibility for health visiting (who did not have a health visiting or safeguarding background) felt strongly that it was disrespectful to visit without warning and advised all her staff that this was the practice she expected from them. Most professionals at the workshop did not think this perception continued however the health visitor when interviewed considered that the expectation for all visits to be planned and booked ahead remained.

3.4.6 This serious case review has identified some problems with the health visiting service. The issue of inputting to the computer data base clearly potentially affects all the service. It is less clear with the other two issues whether they are specific to that health visiting team or are applicable to general health visiting practice.

3.5 School Attendance

3.5.1 Child 1 had poor school attendance and the Education Welfare Officer (EWO) sent letters to the parents which they ignored. She attempted to visit the family home but could not gain access so contacted CSC who advised her to visit the house again and if access could not be achieved to ask the police for assistance in finding the child. School staff and the EWO when interviewed felt that systems and arrangements for managing safeguarding concerns associated with school non-attendance were not clear. In particular, there was confusion about whose responsibility it was for pursuing contact with children who had been absent from school for some time. The school were surprised that CSC did not take a more proactive role. On reflection, they accepted that managing pupil's attendance was a school responsibility in conjunction with the local authority however it was felt that changes in service provision had increased school responsibilities.

3.5.2 All children, regardless of their circumstances, are entitled to a full-time education which is suitable to their age, ability, aptitude and any special educational needs they may have. Section 436A of the Education Act 1996 requires the local authority to have arrangements in place that establish the identities of children in their area who are not registered pupils at a school and are not receiving suitable education otherwise than at a school. Schools' duties are to monitor pupils' attendance through their daily register and to inform the local authority of the details of pupils who are regularly absent from school or have missed 10 school days or more without permission. Schools should monitor attendance and address it when it is poor. It is also important that pupils' irregular attendance is referred to the authority. Schools also have safeguarding duties under section 175 of the Education Act 2002 in respect of their pupils, and as part of this should investigate any unexplained absences.[8]

3.5.3 Historically, the local authority employed education welfare officers whose responsibilities were to check on children with attendance problems and to facilitate their attendance at school. Over time with the transfer of budgets from the local authority to schools the responsibility for managing attendance has passed to the schools. The local authority still employs education welfare officers and the schools access them via the Education Support, Behaviour and

[8] 'Children missing education' Statutory guidance for local authorities January 2015
https://www.gov.uk/government/publications/children-missing-education

Attendance Service (ESBAS). At the workshop, it was reported that many schools do not directly employ an EWO but buy in a service from ESBAS. The resources they can access however are limited and may involve the EWO only looking at top 10 worst attendees. Child 1 was not the worst attendee in the school and it was thought that in another school the concerns raised by the EWO might not have been picked up as the child was not strictly missing as the mother had rung in and said that the child was sick.

3.5.4 Professionals at the workshop felt that mutual responsibilities regarding children absent from school were not clear. It is difficult to determine when low level attendance problems become a safeguarding issue. It was felt that this is hard to evidence and that expectations of schools are unclear. School staff said that they did not know if they were responsible for doing a home visit if children were absent for long periods and there was no response/contact from the family. They reported that this has been expected of them in several cases but that they were unclear if this was policy and questioned whether there was a protocol and if so how well known it was across schools.

3.5.5 School professionals felt that funding cuts had impacted on the response to attendance issues. They considered that the old model of an EWO allocated to each school no longer exists and that the establishment of the 'single point of advice' (SPOA) has introduced a more robust multi-agency approach to referrals, however school understanding of their responsibilities around attendance are not yet fully developed. In particular, school staff said that if the school knows that they are expected to visit/follow up during holidays and look to see if contact has been made with friends then the schools will build this into their resources. They felt, however, that there needs to be a clear protocol about what actions are expected prior to them referring to SPOA. Schools need a clear protocol written with all agencies, drawing on DfE guidance, regarding the approach to be taken when a child has a prolonged period of absence.

3.5.6 It was suggested that a positive way forward would be to develop a multi-agency working group to further explore the development of a set of protocols that could be applied in a range of circumstances.

3.6 Contact with Father

3.6.1 After the birth of Child 1 most agencies thought Mother was a single parent and little was known about Father's substance misuse. Father reported to substance misuse workers that he was single, that he had a child but that he was not living with the mother. Throughout his contact with Change, grow, live (CGL), Father worked positively with professionals, stated he was not using 'street-drugs' in addition to his prescription and tested negative, while generally seemed clean

and pleasant. He was always consistent with his explanation that he was only seeing the children at the grandparents' house which added to his credibility. CGL were unaware that he was collecting and delivering Child 1 to school and were also unaware of Mother's previous drug history.

3.6.2 Practitioners at the workshop reported that it was not unusual for service users attending CGL to be economical with truth. They would undertake home visits where it was known that there were children in the household however in this case Father told professionals that he was of 'no fixed abode'. CGL record details of partners and family members are also linked to the client on the CGL records meaning that information can be cross-referenced.

3.6.3 Other areas, for example Kent, are looking to introduce access to information systems that would for example, notify staff when a client takes an overdose and is attended by the ambulance. CGL have in fact, since signed an information sharing agreement with SECAmb and have secured access to their information data-base IBIS, but this is only just being introduced and wasn't in place at the time of the SCR. CGL also understand that they should be informed by GPs of any occasions when their patients are the subject of emergency calls.

3.6.4 This review has identified a pattern previously recorded in serious case reviews of agencies failing to take account of the role of male carers within the family process. 'There were instances of 'unknown' males in some households … [who are] invisible to practitioners working with the family or child.'[9] This reflects a wider issue about the lack of involvement by health and welfare professionals with men despite their significant involvement in children's lives. The need therefore is for all agencies to ensure that relevant information about men is collected during assessment processes and to ensure that their assessment processes are adapted accordingly.

[9] P52 Understanding Serious Case Reviews and their Impact: Brandon et al DCSF 2009

4 CONCLUSIONS

4.1 This Serious Case Review has presented a conundrum that it has not been possible to solve. The conditions in which the children were found to be living were truly awful and yet, even with hindsight, no professional could identify any evidence that would have suggested that their home was out of the ordinary. In part this is because the parents were very adept at preventing professionals visiting the family home however it is remarkable that Child 1, who was seen regularly at school, did not present more obviously as living in such a squalid environment.

4.2 The Review Team did investigate closely whether there were any indicators present that should have required a more proactive response by professionals however, despite some weaknesses in the safeguarding system being identified, there were no obvious interventions that would have highlighted these children's predicament.

4.3 As it has not been possible to interview either parent or the grandparents it is not clear when the home conditions deteriorated although they were not recent and may have been present prior to the birth of Child 2. It is also not clear why the adults allowed their physical environment to become so bad. It is known from information provided by professionals currently involved with Mother that she considers herself to be a victim of domestic abuse and it is probable that substance misuse by the parents is also relevant. These were not issues known to professionals prior to this review and there is little evidence of missed opportunities to discuss these concerns.

4.4 As with all reviews, the review has identified some areas where safeguarding arrangements could be improved. A significant feature was the absence of routine health contact with both children. Child 1 was not seen by any health professional for over four years despite having a significant congenital health problem that was treatable and Child 2 also had minimal contact with community health professionals. Some of the systemic problems identified have already been addressed (changes to notifications of late starters at school) however some are likely to remain without changes in practice. To that end the Review Team has included some recommendations for action to be taken, either to reassure that practice has changed, or to achieve changes in systems to enable children to be better protected in the future.

5 RECOMMENDATIONS

5.1 That East Sussex LSCB request that the CCG and NHS England consider the feasibility of developing systems for raising alerts on any person under 18 years old who is not registered with a GP for a period of longer than three months.

5.2 That East Sussex LSCB seeks assurance from East Sussex NHS Trust that the Midwifery Additional Support Form is fit for purpose and is being used consistently with women who meet the criteria for its use.

5.3 That East Sussex LSCB request East Sussex NHS Trust provide guidance to midwifery staff requiring that **all** women receive a post-natal visit at their **normal** address and that the Trust reports to the LSCB on compliance with this requirement.

5.4 That East Sussex LSCB request a report from the Local Authority, who have been providing the service since March 2016, regarding the capacity and workload pressures being experienced by the health visiting service. This report to address whether the practice of only visiting by prior appointment is universal or specific to that team.

5.5 That East Sussex LSCB request that the Local Authority review the impact of the past IT difficulties within the health visiting service and report any actions needed to resolve the safeguarding concerns.

5.6 That East Sussex LSCB request that the Local Authority establish a multi-agency working group to develop guidance regarding responsibilities for school attendance.

5.7 That East Sussex LSCB should continue to require that all agencies should satisfy the LSCB that their assessment processes enable the effective involvement of fathers, partners and other men within the household and where possible obtain independent verification of information rather than relying on self-report from service users.

Appendix 1 Recommendations from Individual Management Reviews

East Sussex Health Care Trust

Midwifery

1. An Additional Support Form (ASF) must be created for all women who have a past history of either substance misuse, domestic abuse or mental health issues.
2. There needs to be a system in place for community midwives to track whether women on their caseload have been asked the domestic abuse screening question.
3. Women with an ASF should be seen at least once in their home during their maternity care.
4. A system of tracking women's hand-held records needs to be developed to ensure that all notes are retrieved and filed.

East Sussex County Council

Health Visiting

1. That all Health Visitors should receive regular, documented clinical supervision.
2. That all Health Visitor cases where there has been no engagement with a family should be taken to safeguarding supervision and an outcome-focused action plan to encourage future engagement with Health Visiting (or an appropriate health agency) should be put into place.
3. That KCHFT School Health Teams should, (in conjunction with schools and ESHT child health records) review the process for determining pupils who require health assessments and produce a pathway for agencies to follow, thereby ensuring no child is missed.

Education

1. Review of record keeping approaches at an East Sussex school by the Standards and Learning Effectiveness Service (SLES) in order to ensure compliance with East Sussex LSCB and national guidance March 2016.
2. Record keeping training and development session for all staff at an East Sussex school to improve practice and ensure compliance with school and LSCB policy, as well as allowing DSL to review cases and quality assure recording and actions 09.05.16.
3. The health background and current involvement of health professionals should be evidenced and checked by school staff at the point of a child's entry to school, or upon the emergence of the issue – to be incorporated into DSL training in preparation for September 2016.

4. East Sussex DSL training needs to include substantial training sessions on using and understanding the continuum of need, and in particular, understanding early help. To be planned in new training designed for roll out from September 2016.

5. An East Sussex school to Introduce home visits for all pupils and develop a new proforma for completion by staff which include sections on health, parental responsibility, previous addresses and reasons for change of address/ move of schools etc, implemented from Easter 2016.

6. Poor attendance, including that for children in reception year, should be recognised by all agencies as a potential indicator of abuse. This needs to be a more significant section of the enhanced DSL training programme from September 2016.

7. East Sussex SLES to work with LA s and other organisations responsible for seconding headteachers to other roles, or expanding roles (e.g. through the creation of executive headships) should undertake a thorough review and risk assessment of safeguarding practice and leadership capacity for this in order to sustain and further develop standards of safeguarding whilst the interim arrangements are in place. SLES to action, in preparation for the new academic year.

8. Schools need to be more rigorous in requesting and accessing pre-school records for reception year pupils. The East Sussex transition guidance document should be updated by the SLES EY team to reflect this key message by September 2016.

9. East Sussex SLES to work with ESBAS to ensure that where ESBAS are invited to attend “informal” school-led attendance meetings, ESBAS maintain records of names of pupils and families, as well as required actions. To be adopted as procedures by September 2016

10. East Sussex SLES to ensure that East Sussex providers of educational welfare / attendance support for schools should liaise regarding school caseloads where there is a change of provider in order to ensure continuity. Schools should ensure that this occurs on change of provider and information with regard to this recommendation will be included in enhanced DSL training programme.

Primary Medical Care

1. Practice 2 to be supported by the Named GP to implement improved systems to enable effective child safeguarding.

CGL

1. The service will comprehensively review the treatment reviews for all clients who have contact with children and who are ‘stuck’ and / or ‘cruising’ in their

treatment. This will support early identification of possible risk to children. This will be completed by Team Leaders and supported by the Designated Safeguarding Lead and completed by end July 2016.

2. An assessment of the implementation of the Safeguarding Policy and procedures at the service to ensure that these are being followed by all staff and that any issues are being identified and acted upon.

3. CGL to launch the children and families page on the CRiiS case management system to help identify children's needs and support the early identification of risk to children. To be completed by end June 2016.

4. Training to be developed and delivered to the staff team to support their understanding of professional curiosity and disguised compliance and its importance in protecting our clients and their families. To be completed by end July 2016.

5. Review the management of clients living with or having contact with children so that they are reviewed in supervision and or clinical team meetings. This to be completed by the end of May 2016.

Appendix 2

1. Terms of Reference for the Individual Management Reviews

I. Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse, and about what to do if they had concerns about a child's welfare? Should the practitioners not have worked in this way, comment should be made about the reasons for this.

II. Did practitioners recognise any indicators of neglect in this case, and if so, were these appropriately documented and responded to.

III. When, and in what way, were the children's wishes and feelings ascertained and taken into account of when making decisions about the provision of children's services? Was this information recorded? If this work was not under-taken, the reason for this not taking place should be noted.

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

V. Did your agency consider that the threshold was reached for any relevant legal intervention at an earlier stage?

VI. What were the key relevant points/opportunities for assessment and decision making in this case in relation to the children and family? Do assessments and decisions appear to have been reached in an informed and professional way, and if this was not the case, what was preventing this?

VII. Were concerns about these children shared between the relevant agencies in a timely manner, with appropriate communication and analysis? Should communications be reviewed between agencies, in order to identify if there were issues of concern that were not shared?

VIII. Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments? If appropriate actions did not take place, what was obstructing this?

IX. 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?

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

XI. Were senior managers or other organisations and professionals involved at points in the case where they should have been? If this did not take place, what were the reasons for this?

XII. 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? If this was not the case, what was preventing this from happening?

XIII. 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?

XIV. Was there sufficient management accountability for decision making? If accountability was lacking, what would have assisted this in taking place.

2. Methodology for the Review

2.1 Individual agency reports were received from the following sources: -

- CRI – STAR Recovery Service now CGL
- ESCC, Children's Social Care
- ESCC, Education
- ESHT Acute and Maternity
- ESHT Community Health Visiting
- National Probation Service
- Primary Medical Care
- Sussex Police

2.2 Individual and group interviews were undertaken by the Lead reviewer and a member of the Review team with front line staff from the school and health visiting and midwifery services. Additionally, there was a practitioner event where the Lead reviewer shared with front line staff and representatives of relevant agencies the early findings to gain clarification and understanding or the services provided to the family.

2.3 The Lead Reviewer and author of the report was Fiona Johnson an independent social work consultant. Head of Children's Safeguards & Quality Assurance in East Sussex County Council between 2004 and 2010, Fiona qualified as a social worker in 1982 and has been a senior manager in children's social care since 1997 contributing to the development of strategy and operational services with a focus on safeguarding and child protection. Fiona is currently Chair of the East Sussex Child Death Overview Panel but is otherwise entirely independent of East Sussex LSCB and its partner agencies.

2.4 The Lead Reviewer worked with a review Team that was representative of the agencies involved with the family. The Review Team Membership was as follows: -

- Andrea Holtham, Sussex Cafcass (chair)

- Designated Doctor Safeguarding Children, East Sussex
- Designated Nurse Safeguarding Children, East Sussex
- Child Protection and Safeguarding manager, Special Investigation Branch, Sussex Police
- Head of Children's Safeguards & Quality Assurance, ESCC
- SLES Manager
- East Sussex LSCB Business Manager

Additionally, Fiona Johnson, the Independent Overview Writer attended review Panel Meetings.

Appendix 3

Glossary of terms

ASF	Additional Support Form
CAF	Common Assessment Framework
CAFCASS	The Children and Family Court Advisory and Support Services
CCG	Clinical Commissioning Group
CGL	Change, grow, live is a social care and health charity that works with individuals who want to change their lives for the better and achieve positive and life-affirming goals.
CME	Children Missing from Education
CSC	Children's Social Care
CHR	Child Health Records
ESCSC	East Sussex Children's Social Care
ESBAS	Education Support, Behaviour and Attendance Service
ESHT	East Sussex Healthcare NHS Trust
EWO	Education Welfare Officer
GP	General Practitioner
IMR	Individual Management Review
LSCB	Local Safeguarding Children Board
MASH	Multi-Agency Safeguarding Hub
NSPCC	National Society for the Prevention of Cruelty to Children
PCS	Primary care Support
SCARF	Single Combined Assessment of Risk
SCR	Serious Case Review
SLES	Standards and Learning Effectiveness Service
SPOA	Single Point of Access
SWIFT	Safeguarding with Intensive Family Treatment Service Family Substance Misuse Service
SUI	Serious Untoward Incident
SystmOne	Data base in use in the health visiting service
TA	Teaching Assistant
TAC	Team Around the Child
TAF	Team Around the Family