Independent Overview Report

Child J

Glenys Johnston OBE

Director

Octavia Associates Ltd

November 2014

TABLE OF CONTENTS

1. Introduction

Purpose

1.1. Working Together 2013 is clear that 'professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children' (Working Together, March 2013, Chapter 4 Para 1).

1.2. Serious Case Reviews 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 individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

2. About the Author

2.1. I, Glenys Johnston am the author of this Overview Report, I am an Independent Social Work Consultant with extensive experience in compiling Overview Reports for Serious Case Reviews and of chairing LSCBs; I have had no previous involvement in any aspect of the case.

3. Contextual Information

3.1. Peterborough has a child population in excess of 46,000. Within that cohort 38% are from minority ethnic groups compared to 24% nationally.

3.2. Approximately 1722 children are receiving services from Children's Social Care at any one time, of which approximately 374 will be children 'Looked After' by the local authority and 255 the subject of a child protection plan.

3.3. This case was allocated to suitably qualified and experienced Social Workers who were receiving oversight and direction from their line managers during the period covered by this review. Although facing considerable demands there are very few instances when a lack of resources affected practice.

3.4. The case of Child J was initially held by a Referral and Assessment Team in Children's Social Care who undertook the initial and core assessments and was then transferred to a Looked After Children Team for them to complete the Care Proceedings and secure permanence for him.

4. Terms of reference and Scope of the Serious Case Review

The circumstances that led to the review.

4.1. On 18th November 2013 significant injuries to Child J, a five month old baby and the subject of this review, were observed and, following examination, were diagnosed as incompatible with his Father's explanations, highly suspicious and suggestive of physical and sexual abuse; they were considered to be non-accidental.

4.2. Child J had been in the care of his 19 year old father for almost a month.

The scope of the Serious Case Review

4.3. The period covered for this Serious Case Review is from 12th February 2013, the date that Health advised the local authority that Mother was pregnant, until the 20th November 2013, when Child J was removed from his father.

4.4. Consideration of the key issues has been addressed in three periods:

- Pre birth
- From birth to placement with father
- During placement with father

Terms of reference

4.5. The review seeks to address the following issues:

A) 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?

Specifically:

- What was known about the adults and was there any evidence to suggest that they might pose a risk to the children?

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

Specifically:

- The quality of assessments and decision making and how that was recorded

- The quality and relevance of any service provided

C) Were there any issues, in communication, information sharing or service delivery? How was this information sharing balanced against consent and confidentiality issues?

D) Was there appropriate multi agency consideration of risk in this case?

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

F) Was the work in this case consistent with each organisation's and the LSCB's policy and procedures (Including bruising in pre mobile babies)?

G) Was there sufficient management accountability for decision making?

5. Methodology

5.1. This Overview Report focuses on Child J and his father, with more limited information in relation to his Mother, his half siblings and the extended family.

5.2. Although most of the information within the scope of this review pertains to the period agreed, significant events prior to the period have been included.

5.3. The review was commissioned by Peterborough Safeguarding Children Board (PSCB) on 7th March 2014 and notification was sent to the National Panel of Independent Experts and The Department for Education (DfE) as required.

5.4. Consideration of each agency's practice, their Individual Management Reviews and this Overview Report were considered by a Serious Case Review Panel, chaired by Jon Chapman who is an Independent Consultant with no previous involvement in the case; he chaired the Serious Case Review Panel which was made up of senior managers from each agency/department that had been involved in the case.

5.5. Each agency provided an Individual Management Review written by a manager who had not been involved in the case. Their reports were considered at the Panel meetings which were regularly held; during these the Panel explored and challenged the information provided by the Individual Management Reviews and identified key learning and themes.

5.6. The details of Panel members and Individual Management Review authors is contained below:

AGENCY	**SCR Panel Member** **Title**	**Individual Management Review Author** **Title**
CAFCASS	Issy Atkinson	Sonya Proctor-Shaw

	Service Manager	Improvement Manager, National Improvement Service
Cambridgeshire Constabulary	Gary Ridgway Head of Public Protection	Jim Bambridge Major Crime Review Officer, Bedfordshire, Cambridgeshire and Hertfordshire Major Crime Unit (BCHMCU)
Cambridgeshire and Peterborough Foundation Trust	Sharon Ward Named Nurse Safeguarding Children	Zoe Keast Specialist Nurse Safeguarding Children
Children's Social Care	Sharon Hawkins Interim Assistant Director Safeguarding Children and Communities	Phil Sawbridge Independent Author
General Practitioner	Emilia Wawrzkowicz Designated Doctor	Mansukhlal Shah Safeguarding Lead
Peterborough and Stamford Hospitals NHS Foundation Trust	Richard Brown Consultant Paediatrician	Sam Hunt Lead Nurse for Children and Neonates Named Nurse for Safeguarding Children

5.7. A meeting of the practitioners involved in the case was held on 20th August 2014 and their views have been included in this report, their honesty in reflecting what happened is commendable.

6. The Involvement of the Family

6.1. Family members were invited to contribute to the review. I have met the subject Child J, one of the foster carers and the paternal grandparents. The views and experiences of those I met have provided the review with their perspective of the services they received. They are included in this report and are appreciated.

6.2. Efforts were made for me to see Child J's Father, but he declined.

7. Genogram (Family Tree)

7.1. A genogram is a type of family tree which contains additional information about the family composition. It presents key information about the family in diagrammatic form and can include social data such as the births, deaths, age and gender of family members.

7.2. It is included at Appendix 1.

7.3. The family members are White British, their first language is English and there is no evidence that they practice a religion. Their difficulties are described in paragraphs 8.4 and 8.5.

8. Summary of facts and significant events prior to and during the period covered by the review

Background information

8.1. Child J's family were known to a number of universal and specialist services throughout their lives; this was not a family which was "below the radar of services".

8.2. Child J's Mother was also the mother of two other children, who are half-siblings of Child J. Both half-siblings are with foster parents and are below school age. Neither of the two siblings appear to have had had any contact with Child J's Father before, during or following his relationship with their Mother. They do now have contact with Child J through his foster carer's friendship with the foster carer of the siblings.

8.3. His Mother appears to have had a number of relationships with different men prior to her meeting the Father of Child J. The relationship between Mother and Father commenced when both were residents in the same supported hostel accommodation within Cambridgeshire.

8.4. Child J's Mother was known to have had a learning disability. She also had a significant hearing impairment. The family of his Mother had been known to professional health and welfare agencies since 2005, principally in respect of allegations of domestic violence between the mother and partner and welfare concerns for the younger sibling of Mother. At that time Mother was 15yrs old.

8.5. Child J's Father also had some special needs, he suffers from Attention Deficit Disorder (ADHD) and at times, from depression and suicidal thoughts. He has a speech impediment, which becomes more pronounced when he becomes anxious or agitated. He left his family home when he was 16 years old and had spent some time sleeping rough and in hostel accommodation in Lincolnshire before seeking similar hostel accommodation in nearby Cambridgeshire. He has a number of minor convictions, one criminal offence of burglary and three offences related to drunkenness and disorder. There are police reports of domestic abuse and information about his drug use. He has no previous convictions for offences of violence.

8.6. In December 2012, Child J's Mother reported that she was being harassed by her former partner, stating that he was persistently contacting her by telephone and text messaging. She also said that she was pregnant and expecting her child in May or June (2013). She was concerned for the welfare of the unborn child. Police Officers attended and made a full DASH referral (Domestic Abuse, Stalking and Honour-Based Violence) and issued a harassment notice, through the police force where the perpetrator lived. This incident was thoroughly assessed and dealt with by the attending and reporting officer. The victim was determined as being of a high risk and referrals were made to Independent Domestic Violence Advisors, Children's Social Care and Midwifery services.

8.7. In January 2013, an anonymous report was made that Child J's Father was at an address in the company of Mother and another named male and was 'drug dealing'. Mother was also reported as being pregnant by the source of the information. The Police attended the location and the attendance report indicates that *"2 negative drug searches"* were made.

8.8. In January 2013, Mother reported that she had been personally threatened with violence by Father. A second call stated that Mother had gone to hospital complaining of abdominal pains and she was pregnant. When the Police visited the following day, Mother denied making the call, indicating that it was a friend who had done so. Police Officers undertook a domestic abuse DASH review, this is a risk assessment tool used by the Police; it evaluated the risk to the victim as 'standard' and consequently no referrals to Children's Social Care or Health were made or required.

8.9. In February 2013 Children's Social Care received a Common Assessment Framework referral from the Advanced Midwifery Practitioner at the hospital because staff had become aware that Mother was 22 weeks pregnant with her third child and her two previous children had been adopted, due to concerns about her capacity to care for the children.

8.10. Following receipt of this information an initial assessment was completed by Children's Social Care and the recommendation was that an Initial Child Protection Conference should be held when Mother was 24 weeks pregnant

8.11. Between February 2013 and April 2013 a pre-birth core assessment was undertaken by Children's Social Care. It primarily focussed on Mother because when it began Child J's Father was a somewhat peripheral figure, who had not yet been proven to be the child's father due to mother having been involved in other relationships.

8.12. At the time that the core assessment concluded, the local authority held the following information about Father:

- He was sleeping rough.
- He had spoken to Mother and they were discussing getting back together.
- Mother had agreed Father could live with her once she obtained a new property.
- Father wanted to be part of the parenting assessment.
- Father had previous police involvement for drunk and disorderly offences. He suffered from depression but had stopped his medication as he felt he no longer required it.

- He had Post Traumatic Stress Disorder (PTSD), allegedly due to childhood physical abuse, perpetuated by his step-father.

8.13. The source of above information in relation to 'previous police involvement' is unclear; it is unlikely to have been obtained from Peterborough Police as they were not asked for information until July, after the core assessment had been completed. It is possible however, that this information was gathered from a neighbouring Police force where the offences occurred.

8.14. The outcome of the Core Assessment was a recommendation that a legal planning meeting should be held, as the risks were considered to be too high for the child to be cared for by his mother. At this time it was not clear who the father was due to mother having been involved in other relationships. The local authority's plan was for the baby to be removed at birth and an application made for an Interim Care Order in order for Peterborough City Council to share parental responsibility for the child.

8.15. In April 2013 the local authority received an email from Lincolnshire Police informing them of developments regarding historic allegations against Father, made by a 15 year old male with learning difficulties. The complainant had disclosed that Child J's Father had touched him inappropriately. He also reported that he had seen photographs of male genitalia on Child J's Father's 'phone. A child protection investigation was undertaken; Father was interviewed by the Police and denied the allegations. No further action was taken by the Police due to the young person's learning difficulties and being unable to fully disclose the details. Following the allegation the young person had received counselling during which he disclosed further details of the abuse i.e. that Child J's Father touched his penis through his clothing, the 'photos of the male genitalia were his and that Child J's Father had taken them. On another occasion the young person alleged that Child J's Father had hit him round the head. It was felt that the Police had insufficient evidence to proceed with a prosecution.

8.16. The allocated Social Worker discussed the allegations with Child J's Father in April 2013, he denied the allegations.

8.17. The Named Midwife for Safeguarding made contact with Children's Social Care in April 2013 to request an update on what would happen following the birth of Child J. She was advised that a legal planning meeting had been requested. The Named Midwife for Safeguarding requested a meeting to be arranged to formulate a hospital plan. This meeting took place on in May 2013 with Social Worker 1.

8.18. In May 2013, Children's Social Care contacted the Named Midwife for Safeguarding to request a new hospital plan for Mother and the baby when it was born. The plan included a request that the midwifery staff remove Child J from the care of his/her mother at night. The Named Midwife informed Children's Social Care that she could not accede to this request as Mother had parental responsibility and removing her baby would require her consent. An agreed hospital plan was distributed to cover what actions should be undertaken at the onset of labour. The hospital plan stated Child J must not be removed from the hospital, unless permission was given by Children's Social Care.

8.19. In May 2013 Social Worker 3 informed the Named Midwife for Safeguarding that the local authority would be issuing care proceedings and seeking an Interim Care Order following Child J's birth. Social Worker 3 advised that the Children's Social Care Referral and Assessment team would be in contact to arrange a discharge hospital plan.

8.20. In May 2013 information was shared by the hospital midwifery service with the community based health visitor. The information included the concerns about Mother and her previous history and stated the baby was due in June.

8.21. In May 2013 at 17.14 an email was received by the Named Midwife for Safeguarding from Social Worker 1 stating that Mother should not have the care of Child J after his birth, that an order should be sought to remove him immediately following the birth and that Mother or any other persons other than those designated by Children's Social Care should not have unsupervised contact. Social Worker 1 was contacted by the Named Midwife for Safeguarding and asked how Children's Social Care was going to achieve the removal at birth and how Children's Social Care would be providing the supervision. The same day, the Named Midwife for Safeguarding escalated her concerns to a Service Manager in Children's Social Care with regards to the discharge plan, as in the Hospitals view it was unachievable and the Maternity Service could not legally remove a new born baby from a mother without some form of court order. Following discussions, a temporary plan was put in place for the hospital in case Child J was born over the weekend and it was agreed that further discussion would take place on the following Monday when, following several discussions between Children's Social Care and the Named Midwife for Safeguarding and escalation by the latter to a Team Manager in Children's Social Care a final plan in respect of the supervision arrangements was put in place.

8.22. Child J was born in June 2013.

8.23. In June 2013 an Interim Care Order was granted by the court and a DNA test to ascertain Father's paternity and an Independent Social Work Assessment of Father as a full-time carer, were ordered by the court. Child J was discharged from the hospital and placed with foster carers the same day.

8.24. In June 2013 the Guardian filed a court report for the court Case Management Conference hearing in July 2013. Some sections of the report were not completed and no recommendations were made. The Guardian indicated (within the early permanence analysis section) that she was minded to support the reunification of Child J to Father if the DNA outcome confirmed he was Child J's biological father.

8.25. In July 2013 the Independent Social Work Assessment, ordered by the court was completed. Within the report concern was expressed about how Child J's Father would manage stress and, in the long term, whether he would revert to alcohol and drugs. There are several accounts from parents/workers that Father had been aggressive and abusive towards them and he had then minimised his behaviour however, despite these issues the author was of the opinion that Father had the potential to care for his son, depending on a further and positive assessment. The author recommended that if Father was confirmed as Child J's father then

either a community or residential based assessment should take place in order to keep Child J within his birth family. The author felt that because it would be difficult to assess and monitor the interactions between father and child, in a way that would ensure his safety, a residential assessment was preferable in the first instance.

8.26. A residential assessment did not take place as it was subsequently decided by the local authority that a Community Based Assessment would be more appropriate. Children's Social Care records indicate that the Guardian and Judge were content with the proposed assessment as it was felt that it would support the child's sense of stability and offer Father the opportunity to demonstrate the use his own support networks.

8.27. In order to carry out the Community Based Assessment a residential property was identified via an organisation called Key 2 Futures, a housing and support service for young people with complex and high support needs, and 1-2-1 Social Care, an organisation that incorporates within it a family assessment service, was commissioned to undertake the assessment.

8.28. The assessment took place by 1-2-1 Social Care between August 2013 and October 2013. Towards the end of the assessment Children's Social Care engaged the Direct Intervention Service to augment the work of 1-2-1 Social Care as the time Father spent with his son was being increased to all day; five days a week, in anticipation of a move to the full time care of his father two weeks' later.

8.29. The Community Based Assessment concluded *"Father was uncomforted as a child and was not helped to manage angry feelings and so he has no model for how difficult emotions can be contained and resolved. This leaves him and Child J very vulnerable at times of stress and may lead to sudden outbursts or intense blaming. The evidence of this assessment is that a full examination needs to be made of Father's ability to manage inter- personal stress, especially his ability to handle his own anger, before he has an opportunity to parent Child J in an unsupervised environment'.* This assessment, together with the previous Independent Social Work Report and observations of contact, led to the development of a plan for Child J's Father to be supported in taking on the full time care of his son.

8.30. Child J moved to live with his father under an Interim Care Order in October 2013.

- In October 2013 (a week after he began living with his father) a red mark was noticed on Child J's leg by a Direct Intervention Service worker. Father said he thought it was an insect bite. Although this looked to be a reasonable explanation and the mark was superficial, it was properly recorded and shared with the Social Worker. It is not known what action was subsequently taken.
- In October 2013 in a summary note from Key 2, scratches were noted on Child J's forehead and were recorded. Advice was given about cutting his nails. It is not known what action was subsequently taken.
- In November 2013 a Direct Intervention Service worker noticed a small brown bruise on Child J's left cheek. Father's explanation was that he had flung himself forward and hit Father's chin. The incident was recorded and backed up with a telephone call to the Social Worker. No medical examination took place.

- In November 2013 a particularly concerning event occurred, Child J was seen to have a bruise to his forehead and chin. Father's explanation was that Child J had fallen out of his swing chair. The Children's Social Care Team Manager was informed and passed the information on to the Social Worker. Concern had been previously expressed by staff about Child J moving about in the swing chair and the risk that it might topple over. No medical examination took place.
- 24 hours prior to the above incident, Father had rung to say that he had no food. When the Social Worker arrived Child J was seen in the bedroom which was said to be unusual and he was asleep.

8.31. In November 2013 a support worker saw a mark on Child J's forehead for which Father was unable to provide an explanation. The allocated Social Worker visited Father and Child J, saw the mark and advised that Child J should be seen by his General Practitioner (GP). Father took his son to the surgery and was initially seen by the Practice Nurse and then by the GP. The GP subsequently contacted the local authority and shared that there was evidence of bruising to Child J's head, buttocks, extensive bruising and a small tear in the genital area. These injuries led to Child J's removal from his father's care and his subsequent return to his original foster carers.

8.32. A full Care Order and a Placement Order have subsequently been made and the plan is for Child J to be adopted.

8.33. During 2014 Mother died unexpectedly.

8.34. Father was subsequently charged with neglect to which he admitted and for which he received a community sentence; he denied and was not charged with sexually abusing his son.

9. Analysis

9.1. This section considers the key questions agreed in the terms of reference and evaluates the quality of practice both, single and inter-agency during the following periods:

1. Pre-birth
2. Post birth until Child J was placed with Father
3. During the period Child J lived with his Father until the incident that led to his removal

Pre-birth

9.2. Before Child J was born, a number of professionals recognised that he and his mother were vulnerable, due to her learning disabilities, lifestyle and difficulties. Some professionals also knew that his mother had also had two previous children removed from her care and subsequently adopted.

9.3. Prior to his birth the Police were involved with Mother and Father on three occasions, the assessments and actions undertaken present a mixed picture of performance.

9.4. The incident in December 2012, when Mother reported to the Police that she was being harassed by her former partner and was pregnant, was thoroughly assessed and dealt with by

the attending and reporting police officer. The victim was identified as being of 'high' risk and referrals were made to Independent Domestic Violence Advisors, Children's Social Care, Under 5's and Midwifery services. The Individual Management Reviews by Children's Social Care and Health contain no reference to this referral of a vulnerable pregnant woman with whom they had had considerable contact, so what action was or was not taken as a result, is unknown.

9.5. In relation to the incident in January 2013, when an anonymous report was made to the Police that Father was with Mother and another named male and was 'drug dealing' and Mother was reported as being pregnant; there is no record of the searches made and the fact that Mother was pregnant could have triggered a referral for concern for the welfare of the unborn child to relevant agencies.

9.6. The Police DASH assessment of Mother as being of 'standard' risk following the incident in January 2013 was appropriate. Due to insufficient resources there was a delay of some 14 hours before Mother was actually seen by police officers at which point Mother denied that there had been any specific occurrence which left the Police with little opportunity to establish the facts. However, the earlier report in January, in respect of the drug dealing allegation and the fact that Mother was pregnant, was not known to them. Had this information been known, the risk would have been considered differently and referred to Children's Social Care as a 'medium' or potentially 'high risk'.

9.7. These occurrences potentially highlight gaps in practice where links to similar incidents, involving the same individuals and locations can be missed or overlooked by both the Police control room and the attending officers.

9.8. It is possible that the allegation against the father of Child J made by the young person with learning difficulties was a missed opportunity to provide specialist support to the 'victim' given the difficulties he experienced in providing information/evidence.

9.9. There were high quality assessments made within the maternity service during Mother's pregnancy. The Common Assessment Framework referral from the Advanced Midwifery Practitioner was comprehensive and appropriate. She had not only cared for Mother during her pregnancy with Child J but also with her previous pregnancy. Mother was therefore well known to her and also to the Named Midwife for Safeguarding who had also cared for her during her first pregnancy. Both practitioners liaised with all relevant members of Children's Social Care. Midwifery Services focussed their assessments and observations on Mother as they had not been made aware of any concerns about Father by Children's Social Care and during the pregnancy they were not aware he was to be involved in the future care of the baby.

9.10. Mother booked with maternity services during October 2012, the midwife, Advanced Midwifery Practitioner, completed her Common Assessment Framework referral in October 2012, when Mother was 22 weeks pregnant and submitted it at 24 weeks; this was not in line with the PSCB's multi-agency child protection procedures of August 2007 which had been

revised in March 2011. These gave no indication as to when referrals should be made but do stress the importance of not delaying. It appears that over time, partly due to changes in Children's Social Care front-line management and different interpretations of the procedures, maternity services had been told not to refer until 24 weeks of pregnancy. During the course of this Serious Case Review the procedures have been amended.

9.11. On receipt of the referral Children's Social Care did not follow the above procedures which require that:
"A multi-agency Strategy Meeting must be held where child protection concerns are identified. The discussion should be in the form of a meeting chaired by a Manager from Children's Social Care and include:

- *Community midwife or Maternity services representative*
- *Health visitor*
- *Social Worker*
- *Police*
- *Other professionals as appropriate for example obstetricians, mental health services, Probation"*

9.12. Instead of following the above procedures, an initial assessment, followed by a core assessment and, at 24 weeks, an Initial Child Protection Conference and the engagement of legal processes was recommended. This meant that the opportunity to meet face to face with professionals at an early stage was lost.

9.13. The Initial Child Protection Conference which was recommended by the Team Manager in Children's Social Care was also never convened and is a significant failure in this case because the plans for Child J were not based on a multi-agency risk based approach with shared decision making across agencies; instead a legal approach was taken that subsequently focussed on promoting and developing an attachment between Father and Child J, with a view to place Child J permanently with his father.

9.14. The Core Assessment was weak. It focussed on Mother, which was understandable at the beginning of the assessment as Child J's father's involvement was unclear however, at the end of the assessment and two days after it concluded, some significant information about Father was communicated to Children's Social Care in relation to his alleged sexual abuse of a young person. In addition, known information about Father's learning and mental health difficulties were not fully explored and remain uncertain to this day. Details of the circumstances surrounding previous removal of the children were considered however, the Children's Social Care Individual Management Review states there was good input from partner agencies into the Core Assessment, however partner agencies' Individual Management Reviews make no reference to their involvement, other than the Police who state that they were not asked for information.

9.15. The extent of the knowledge held by partner agencies should have informed the Core Assessment, and given the information received shortly after it concluded, about allegations of sexual abuse, it should have been updated.

9.16. Inter-agency practice in preparation for Child J's birth and immediately afterwards appears to have been unclear with inappropriate instructions being given to midwifery staff in relation to removing Child J at night and after his birth.

Summary

9.17. Prior to Child J's birth there were several opportunities for a thorough assessment including a risk assessment and clear decision making, information sharing and planned services as outlined above. There was some sound practice but several significant failures. Although Mother was identified as being pregnant and being vulnerable this could have been reported at an earlier stage by the Police. The hospital correctly identified Mother's vulnerability and appropriately referred this to Children's Social Care but did not follow inter-agency procedures and refer as soon as possible, instead they waited until Mother was 24 weeks pregnant, due to their experience of Children's Social Care managers telling them not to refer until this point.

9.18. There was a failure to convene a multi-agency child protection meeting (Initial Child Protection Conference) before Child J's birth to share information, identify risk and agree a multi-agency child protection plan. Instead, a legal route to protect Child J was embarked upon without the full knowledge of all known risk and without the engagement of partner agencies. When Father applied to have the care of Child J, the risks that were identified by Children's Social Care in relation to Father were not fully explored and at an early stage a positive view about him began to emerge.

9.19. The hospital midwifery service appropriately escalated their concerns about an undeliverable birth and neo natal discharge plan and this was resolved by senior managers within Children's Social Care, it indicates that social work practitioners were unclear about the authority of the hospital and issues of parental responsibility and consent. It is possible this lack of clarity and consistency was exacerbated by changes of Social Worker at this critical time.

9.20. Nevertheless, when Child J was born he was safe and well, hospital midwifery staff were clear what they needed to do should anyone try to remove him and appropriate legal processes to protect him and plan for his long-term care had begun.

Post birth until Child J was placed with Father

9.21. Child J was discharged from the hospital to foster carers when he was two days old. Children's Social Care was fortunate to be able to place him with the foster carers who had looked after his half-siblings, as they had a good relationship with Mother, who trusted them.

9.22. The period after Child J's birth, before he was finally placed in the full time care of his father in the October, included a considerable amount of work by Children's Social Care and other agencies as they sought to secure the care or shared care of Child J with Father, it being ruled out at an early stage that Mother could care for him. A number of processes took place, some in parallel some at different points:

- The court oversaw the plans and arrangements through their consideration of the application for a Care Order.
- As Child J was a 'looked after' child by virtue of the Interim Care Order Looked After Children review and planning arrangements were in place.
- An Independent Social Worker undertook an assessment of Father.
- An assessment of Father was undertaken to determine whether he had the capacity to instruct a solicitor.
- 1-2-1 Social Care undertook a community based assessment of Father.
- The health visitor was engaged in providing advice and monitoring Child J's physical and psychological development.
- A Family Group Conference was held in August 2013 to identify what help Father's family could provide

9.23. So what was Child J's experience of the first four months of his life? He received excellent care from his foster carers with whom he developed a good attachment. He began to develop a relationship with Father supported by the foster carers who were hugely supportive in facilitating contact with Father and with Mother although she rarely attended as she found it too stressful. He had a busy life being taken to Father on an increasingly frequent basis and gradually spending more time with him and he attended local sessions for babies at a children's centre.

9.24. He experienced reasonable care when with Father although there was a lack of consistency and routine. The foster carer I met said that Father always spoke gently and appropriately to Child J but he could be unreliable for example not buying baby equipment or clothes, despite promising he would do so. The foster carer provided made up bottles, nappies, clothing, toys and equipment for Father, despite his saying he already had these; it was evident he did not always have them. For example, all the nappies provided would be used and the bottles of milk would be drunk, though not always fully or on time. Sometimes Child J would be overdressed and extremely hot when he was brought back to the foster carers and his favourite comforting toys would not always be returned. The foster carer observed that Father spent a great deal of time out of the flat, travelling on a bus to see friends or relations. She is fairly confident that this included taking Child J to see his mother at the maternal grandmother's house, although Child J's grandparents do not share this view. It is unclear whether Children's Social Care were aware of this.

9.25. Observations of the number of professionals involved in overseeing, supporting and monitoring Father's care of Child J were largely positive, however there were occasional comments that Father resented being told what to do.

9.26. In July 2013, patrolling police community support officers came across Mother and Father arguing in the street. Officers found Father had been drinking and was aggressive. Mother explained to officers that she wanted Father to leave her flat. Father agreed to leave, although the indications are that Mother had already 'kicked him out' of the flat and that they had, until this point, been co-habiting. Officers completed a DASH referral, grading the report as 'medium' and referred the matter to the Multi-Agency Referral Unit, now called the Multi Agency Safeguarding Hub for partnership/agency consideration. Father left for a friend's address in the area and advised officers that he would seek alternative accommodation

through a housing association. The DASH form indicated that Mother had stated that this had been *"the worst incident"* in a series of domestic disputes, although there was no further detail given. There was no suggestion of actual violence or of assault by either party. This referral was shared with Independent Domestic Violence Advisors, Children's Social Care and Under 5's although the Multi-Agency Referral Unit record indicates that this was not actually shared with those agencies until August, which is some four weeks after the report was made, which is not appropriate.

9.27. The court processes were well managed with no undue drift or delay. The Guardian and the Social Worker communicated well and shared their developing assessment and plans; they do not appear to have held different views.

9.28. A Family Group Conference was well attended by a number of Father's relations. They offered a range of support including weekly visits, unlimited telephone contact, occasional respite care and short term emergency care, if Father was incapacitated, or a crisis occurred. I have no information as to how the agreed plan was monitored or delivered and how it contributed to the plan to place Child J with Father. However, the plan made at the Conference was not monitored by Children's Social Care as there are no arrangements in place to ensure this happens.

9.29. There are some areas of concern in relation to a full assessment of risk. The Independent Social Work Assessment ordered by the court is reported in the Children's Social Care Individual Management Review to be detailed and highlights that Father was suffering from PTSD, ADHD and depression however; there is no evidence that the Social Worker sought any additional information from health services to further explore this area and identify potential risks and the impact of these difficulties.

9.30. There is also evidence that despite not having a full understanding of risk or a multi-agency child protection plan the intention was always to place Child J with Father.

9.31. The Guardian discussed the Independent Social Work assessment and came to the view that Father had potential as a carer for Child J, if his paternity was confirmed. The Independent Social Work report influenced her thinking regarding Father in that she thought that Father should be given a chance of further assessment. The Guardian said Father had presented well in court and that she had sat next to him and said she *"felt Father was pleasant".*

9.32. The community-based assessment, rather than a residential assessment recommended by the Independent Social Work took place between the August 2013 and October 2013. It was supported by the Guardian because the drive was to place Child J with his father and it was felt that it would be more supportive to Child J and would enable Father to demonstrate what community support he had. However, with the information known, but not all fully explored at the time, including the extent of Father's learning difficulties, previous violence, his own experience of being cared for, his age, immaturity and level of understanding, it carried high levels of risk.

9.33. The local authority's response to 1-2-1 Social Care, the private provider who undertook the community based assessment, indicates the intention to place Child J with his father, despite the warning signs and risk indicators. *''We are fully aware of the issues raised in the assessment by 1-2-1 and in the professional's meetings in September 2013 and October 2013 and have explored the issues they have raised. However, these issues are not insurmountable and we believe that it is* ***right*** *that Child J lives with his father at this stage and that we work consistently with Father to develop his confidence and his insight and help him to build strategies for dealing with difficulties in parenting challenges.''*

9.34. The Social Worker was not present at the Looked After Children childcare review in September 2013 so the opportunity for multi-agency discussion was restricted. It may account for the fact that the plan for Child J's to be placed with his father altered significantly from the time of his Looked After Children review meeting, the minutes of which indicate no plan for this to happen, to the time of his return to his father's care in October 2013, without any record of contact with health professionals before this took place.

9.35. Communication from Children's Social Care to the Health Visitor and the Community Nursery Nurse was poor. Records do not indicate that Health Visitors or the Community Nursery Nurse were ever approached for any impressions regarding father's parenting capacity during the time prior to Child J's placement with him. Prior to being registered for care by a Health Visitor in Peterborough, when he was still living with foster carers, Child J was bought to a clinic based in a children centre run by the Health Visiting Service. He also attended a local post natal baby group but neither the Health Visitor nor the Community Nursery Nurse were advised to expect Child J, or given any information about why he was in foster care. The fact he was in foster care came to light on the second clinic attendance when the Community Nursery Nurse asked Father about his address. At each of these contacts, Father and Child J were accompanied by a support worker. The Community Nursery Nurse noticed that the support worker accompanied and observed Father but did not instruct Father. On one occasion, seeing Father struggling to change Child J, as the baby buggy was some distance from changing area, the Community Nursery Nurse noted the support worker did not intervene and support as would have been expected. The Community Nursery Nurse suggested father moved the pram and the difficulties were resolved. No professional shared information with the Community Nursery Nurse or the Health Visitor or asked for recommendations about the suitability of groups or requested feedback information. There was also no communication between the Health Visitor where Child J was living with his foster carers and the Peterborough Health Visitor during this time and there was no sharing of electronic information which meant that neither party had access to the health visitor information held by the other Health Visitor.

9.36. Prior to the commencement of the placement of Child J with his father, five distinct plans which had been developed during the preceding months were relevant:

- The Looked After Children Care Plan.
- The s31A care plan (the plan overseen by the Court).
- Placement with Parents Regulations (which are designed to secure the wellbeing of a child placed back with parents from local authority care).

- Plans for the work of the Direct Intervention Service.
- The Family Group Conference Plan.

9.37. If a local authority is looking after a child, the law says that there must be a clear Looked After Children Care Plan about how that child is cared for. It must include arrangements for all aspects of the child's care. It is subject to review by an Independent Reviewing Officer who should be told of any significant changes so that they can decide whether a meeting which includes relevant professionals should be held. In this case the Social Worker advised the Independent Reviewing Officer office by email that Child J was to be placed with his father however, there is no record that a review took place at this point so multi-agency consideration of the plan did not occur which is an omission.

9.38. The S31A Care Plan valid in October 2013 is a distinct and separate formal Court document that enables the court to have oversight of the arrangements and intentions for the child. No order can be made in respect of a child until the court has considered a S31A Care Plan. While the application is pending, as in this case, the local authority must keep any care plans prepared by them under review and, if they are of the opinion that change is required, revise the plan, or make a new one.

9.39. Placement with Parents Regulations require Children's Social Care to be satisfied that a child who is the subject of a Care Order and is placed with his parent/s is the most suitable way of safeguarding and promoting his welfare and will undertake appropriate enquiries and assessments to assist the decision making process. There is some confusion around how these duties were discharged in this case. What is not disputed is that a document was agreed, very early on in the process, between a Team Manager within Children's Social Care and the Assistant Director of Children's Social Care. The view of the Assistant Director was that the plan would have needed to come back to her should the level of contact intensify but that expectation was not formally recorded. It is the responsibility of the operational staff to hold the signed document and to incorporate it into the electronic social care record. This document cannot be found and very sadly the Team Manager died shortly afterwards so the review has not been able to elicit his views. The Assistant Director has also left the Department. There is however, an unsigned Placement with Parents Plan dated November 2013 which, on the balance of probability, can reasonably be assumed to be the document that was considered. This is not in accordance with the regulations which require the plan to be agreed prior to the placement.

9.40. The Direct Intervention Service plan valid in October 2013 was agreed with the Social Worker approximately two weeks before Child J moved to live with his father which was sound practice. This Direct Intervention Service work was designed to augment the work of 1-2-1 Social Care who were undertaking the Community Based Assessment as the time Father spent with his son stepped up from three hours three times a week to 9 to 5, five days a week, in anticipation of a move to the full time care of his father in two weeks' time. This arrangement was in-line with Children's Social Care's commitment to provide considerable on-going support for Father in recognition of his inexperience and risks.

Summary

9.41. Child J's experience during this period were largely positive, he thrived and developed and appeared contented. The plans for Child J were developed with expediency and delivered without delay. Services during this period were well co-ordinated and promptly delivered. Appropriate accommodation was provided to support contact between Child J and Father and he received practical and financial help. Professionals were clear about their respective roles and carried these out well. Staff appear to have been well qualified, experience, supervised and supported. There is evidence of effective communication between Children's Social Care, the Guardian and the support and assessment services provided.

9.42. However, there were some significant areas of poor practice. It is clear that, at the outset, there was an intention to place Child J with his father with little consideration of alternative care arrangements. As has been previously said, there was a lack of exploration of some of Father's significant difficulties and what these might have meant in terms of risk. The need to cross-reference the risk issues with external evidence appeared to lack urgency, with delay in the cannabis tests and limited follow up of the enhanced Police information. Once acquired, little significance appeared to be paid to the content of the Police reports. The outcome of a cannabis test was not known before Child J started contact with Father and the question of whether Father was Child J's father seems to indicate that this was not confirmed at the time contact began. Father's health records do not appear to have been obtained or included in reports to the court. In the absence of a pre-birth conference or the parenting assessments being made available, it is not possible to know on what basis the decision was made to return Child J to his father's care.

9.43. Communication with Health Visitors and Community Nursery Nurse services was very poor. The lack of information sharing between the local authority Social Worker and health visiting prevented there being a multi agency decision making process. Staff within the Health Visiting team expressed concern that no multi-agency meeting was planned before or following the placement of Child J with Father. The outcomes from the parenting assessments were not shared with Health Visitors. Given that Health Visitors provide a core universal service to support parenting this was regrettable as the information of a parenting assessment may significantly impact the learning styles that a parent may best respond to and also the resources that health professionals use. Significantly, prior to Child J's placement with his father on a full-time basis there were no occasions when all the professionals and partner agencies were brought together to exchange information and discuss the static and dynamic risk.

9.44. The local authority plans that were in place at the commencement of the placement with Father were designed to support the development of good care for Child J. They were however, predicated on an optimistic view of the chances of a successful placement and a confidence that Child J was not at any immediate or ongoing risk of harm.

9.45. This confidence was underpinned by reports from several practitioners and the foster carers, who reported that Child J was contented and thriving and the fact that Father's family were

committed to providing support and Father was largely compliant with all that was asked of him also underpinned their view.

9.46. However, as has been previously stated above the risks of Father caring for his son fulltime with limited experience and past personal problems had been insufficiently considered; risk management and contingency planning was somewhat overshadowed by a focus on supporting a successful placement and some important procedural actions such as reviewing the Looked After Children plan and authorising the Placement with Parents Plan had not been undertaken.

The period during which Child J lived with his father until the incident that led to his removal

9.47. When Child J was just over four months old and with the support of the court, he began to live on a full-time basis with his father, the Individual Management Reviews do not describe how well he adjusted to this or whether he missed his foster carers but recorded observations do not indicate any significant signs of unhappiness or distress. He continued to thrive, had had his immunisations, had good attachment to his foster carers and was familiar with a number of consistent adults.

9.48. It was the foster carers, not the Social Worker, who informed the Health Visitor in their area that Child J had gone to live with his birth father. It was three days after he moved to be with his father that the Peterborough Health Visitor was formally informed by her colleague. More significantly, the Peterborough Health Visitor was not made aware of any particular potential concerns regarding Father's ability to parent and does not recall being advised of a paternal learning disability. Due to administrative delays Child J's records were not open to the Peterborough Health Visitor until several days after Child J was seen in the clinic. At the time the Health Visitor was not aware that she could access the records of the Health Visitor in the previous authority. In addition, at the time of this incident, child health administration did not have clear guidelines about prioritising children to be registered onto their electronic system when requested by health visiting. Consequentially this process could be delayed until a child was formally registered with a GP. The lack of Health Visitor support at this critical time was a failing.

9.49. The Community Nursery Nurse visited Child J at home almost two weeks after he began living with his father but did not see Child J as he was asleep in the bedroom, as this was not a 'transfer in' assessment or development check and she had seen him seen six times in the previous two months during contact sessions in the clinic and baby group this was not unusual, she recorded that she did not see him. What is significant is that the Community Nursery Nurse was still not aware that there were any concerns about Father or his care of the baby. In November 2013 the Health Visitor was unable to see Child J for a transfer in assessment as his father did not answer the door or was not at home. Had she known about the safeguarding concerns, she would have been more persistent but unfortunately there was a lack of highlighted level of concern from other agencies. A new assessment was arranged but it did not take place before the incidents that led to this review took place. Child J had therefore not had health visiting services during the time he lived with his father and the Community

Nursery Nurse and Health Visitor were not aware of the concerns about Father's capacity to look after his son.

9.50. During the month that Child J was at home with his father there was frequent and consistent visiting by the Direct Intervention Service. At times they reported that the flat was untidy and Father sometimes resented being told what to do, but overall, he was seen as a pleasant young man and Child J appeared well. There were however, a number of significant events during this period relating to Child J's welfare:

- In October 2013 (a week after he began living with his father) a red mark was noticed on Child J's leg by a Direct Intervention Service worker. Father said he thought it was an insect bite. Although this looked to be a reasonable explanation and the mark was superficial it was properly recorded and shared with the Social Worker. It is not known what action was subsequently taken.
- In October 2013 in a summary note from Key 2, scratches were noted on Child J's forehead were recorded. Advice was given about cutting his nails. It is not known what action was subsequently taken,
- In November 2013 a mark was seen on Child J's cheek. The explanation was that he had flung himself forward and hit Father's chin. The incident was recorded and backed up with a telephone call to the Social Worker. No medical examination took place.
- In November 2013 a particularly concerning event occurred, Child J was seen to have a bruise to his forehead and chin. Father's explanation was that Child J had fallen out of his swing chair. A Children's Social Care Team Manager was informed and passed the information on to the Social Worker. Concern had been expressed previously about Child J moving about within the swing chair and the risk that it might topple over. No medical examination took place.
- It later transpired that, according to father, in November his hand slipped when he was bathing Child J and Child J hit his head on the bottom of the bath and on the same date father was too heavy handed when he was changing Child J who was kicking.
- In November, 24 hours prior to the observations of the final incident, Father had rung Children's Social Care to say that he had no food. When the Social Worker arrived Child J was seen in the bedroom which was said to be unusual and he was asleep. It is not known how closely the Social Worker looked at the baby.

9.51. In November 2013 the support worker noted grazing to Child J's forehead. The Social Worker arrived during this visit and instructed Father to seek medical attention from his GP. Father followed this instruction. Child J was at first seen by the Practice Nurse but was subsequently fully examined by the GP who found injuries that led to Child J being admitted to hospital for a child protection examination and, due to paediatric concerns a strategy discussion was then convened. The Social Worker, instead of advising Father to take Child J to the GP, should have accompanied them rather than allowing the support worker to do so.

9.52. In November 2013, the hospital paediatricians informed the Police of their concerns and a forensic medical examination was completed by a paediatric Forensic Medical Examiner at the hospital and reported abnormal genital findings and bruising on Child J's body and head. The hospital paediatrician made arrangements to complete a second skeletal survey and screening for sexually transmitted infections was arranged. The Looked After Children Team Manager received a telephone call from a Team Manager in Children's Social Care to advise that Child J was the subject of a child protection (section 47) enquiry. The dates of a strategy meeting

were shared and arrangements were agreed for the Health Visitor to attend. Following the strategy meeting held in November 2013, the Health Visitor shared information with the Looked After Children team manager, safeguarding team and the Health Visitor in the neighbouring area as Child J was to return to his previous foster carers the following day.

9.53. In November a second strategy meeting was held, the Police informed the meeting that Father had been charged and remanded in custody. Forensic evidence had been taken from the flat. The police reported that they found that the flat was filthy and untidy with very little food in the cupboards; evidence of alcohol use and a very small amount of cannabis. They reported that there were no clean clothes for either Child J or his father and when questioned about the state of the flat, Father admitted that he used to hide the mess in cupboards when he knew professionals were visiting. Father maintained his original account of how the injuries to his son were caused and denied sexually abusing him. The paediatrician reported that the injuries were not consistent with the explanations given. The Health Visitor did not receive a copy of the minutes of this meeting.

9.54. What can we understand about Child J's experience of this period? Professionals observed that the care afforded to him was acceptable, the flat was sometimes untidy but they were never prevented from seeing him and usually found him in the sitting room or the kitchen. The occasion when he was found asleep in the bedroom was remarked upon by practitioners at the meeting with them when they commented this was unusual. Given the conditions found by the Police and the fact that just before the abuse occurred his father reported having no money for food, it is probable that at times he was hungry, was fed with unsanitary bottles and was inadequately clothed. His father was at times under the influence of alcohol.

9.55. The best indication of how Child J was affected by the abuse and the few weeks he spent with his father comes from the foster carer I met. She described to me going to the hospital to collect him and finding a sad looking child. On returning to her care the foster mother described how wary Child J had become and how upset he became if people got too close to him physically. She described how difficult he initially found the open days which enable potential adopters to meet children who are available.

Summary

9.56. During the few weeks that Child J was with his father support services were in place to monitor his safety. It is known that professionals visited without an appointment and they visited in the evenings, early in the morning and at weekends. Cupboards were checked to see whether there was food in the flat and no concerns were raised. The Social Worker visited regularly but had no contact with paternal grandparents. Father's family visited or provided the support they had offered. Due to the difficulties described above no Health Visiting service was offered. The evidence from the Police and the admission from Father indicate that the conditions in the flat and the care of Child J may not have been as it appeared.

9.57. There was a failure to follow inter-agency procedures in relation to bruising on non-mobile babies when Child J had a bruise, said to have been caused by banging his head on his father

and when he fell out of the swing chair. Instead of referring Father to the GP Child J should have been taken to hospital for examination by a paediatrician.

9.58. The practice of the Practice Nurse and the GP was exemplary in following procedures and fully examining Child J.

9.59. Following the abuse effective inter-agency processes were put in place with two strategy meetings and appropriate Police actions. However, the minutes of the strategy meeting appear not to have been appropriately distributed.

10. Themes

10.1. During the course of this review several themes emerged which are summarised here for completeness, although most are covered in answering the above key questions.

A premature intention to place Child J with his father on a permanent basis and 'the rule of optimism'.

10.2. This drove the plans for Child J to the exclusion of a thorough exploration and weighing up of risk. There appear to be no points at which a reflection of all that was known was undertaken; the aim was always to place him with his father.

10.3. Plans were predicated on an insufficient understanding of risk and a tendency to be over-optimistic that with support Father would be able to safely care for his son.

A lack of compliance with procedures

10.4. There were several occasions when child protection procedures, that play a key role in protecting children, were not followed. These included:

- The earliest possible referral of Mother as a vulnerable mother to be.
- The lack of an Initial Child Protection Conference which would have enabled early information sharing, discussion an assessment of risk and opinions about the plans.
- An early review of the Looked After Children plan.
- The failure to obtain appropriately authorised Placement with Parent Plans.
- The failure to follow child protection procedures on bruising to non-mobile babies.

Disguised compliance

10.5. Families can find the involvement of professionals extremely positive and helpful, but some find it difficult requiring, as it does, changes in their behaviour with which they may not agree or be unwilling to address. Professionals should always be alert to the possibility that families will appear to be compliant with plans but in fact be avoiding doing so. The reality of what they say should be supported or disputed by a robust examination of the evidence

Holistic assessments

10.6. Professionals are constantly "assessing" families throughout their work. This helps to form their opinions and the way they work. Formal written assessments are a critical factor in planning for children; in this case there was no holistic assessment of the family. Whilst a core assessment was undertaken it did not look fully at Father's history of a range of difficulties. His motivation for wanting to care for his son and the reality of what this would actually mean also does not appear to have been explored.

10.7. There were also several types of assessment most of which raised concerns and the need for further assessment.

10.8. Some information such as Father's health information were not sought nor was there any discussion with Learning Disability or Mental health Services.

10.9. Overall, there was an unacceptable evaluation of risk based on the above information being sought and evaluated.

10.10. The result of this was that the information placed before the court to enable them to reach a decision as to where Child J should live, was incomplete.

Information sharing and communication

10.11. Information sharing appears to have been confined to communication between Children's Social Care, the Guardian and support services. There was no early communication with the Police or any request for them to provide information. Communication between Health Visitors was flawed and there was very little communication between Children's Social Care and community health professionals.

Good Practice

10.12. The decision by the GP Practice Nurse to draw the injuries to the attention of the GP and his decision to fully examine the baby was good practice. When the GP was asked why he had done so he cited the training he had received following a previous Serious Case Review.

10.13. It is commendable that following the abuse to this child the Director of Children's Services immediately issued new child protection instructions regarding the requirement to report at the very earliest stage and convene a Child Protection Conference for vulnerable pre-birth babies.

11. Conclusion

11.1. This was not a particularly complex or challenging case for professionals although it did require the co-ordination of a number of services, there were also some changes of circumstances such as Father's willingness and entitlement to be involved.

11.2. Father presented no particular difficulties for professionals in their working with him; his interactions with his son were observed to be gentle and appropriate. He appeared "a nice young man" he appeared to want to care for his son and appeared to be largely compliant with the advice of a range of professionals, apart from occasionally resenting their advice and being disorganised. However, this apparent compliance was not rigorously evidenced or challenged.

11.3. There were no particular organisational difficulties by any agency in providing support and the amount of this was extensive. The majority of the professionals involved were highly experienced and committed, they took their responsibilities seriously.

11.4. There were clear indicators of risk including Father being an immature young adult with special needs, a history of committing domestic abuse, criminal activities with minor convictions, mental health and behavioural difficulties, drug and alcohol use and experience of some difficulties with his Step-father. Despite this his willingness to care for his fragile and totally dependent baby was supported.

11.5. There was insufficient sharing of information held by all agencies, and when written reports followed verbal reports they were sometimes inconsistent with what had been said. There was an inadequate risk based assessment that was not amended over time, as new information became known.

11.6. The drive to place Child J with his father, almost despite what became known-the rule of optimism over evidence. There was a lack of scrutiny of compliance and challenge and practitioners being deceived by a pleasant personality.

11.7. The plan for Child J was under the scrutiny of the Court who made a number of decisions and directed various courses of action such as assessments. The Court had all the evidence that was made available and could have been more challenging of the plan, given the history of concerns.

11.8. There is evidence of some ineffective management oversight; there was a lack of reflection as to whether the plan was correct and continued to be based on the information that was becoming evident. The Independent Reviewing Officer was not in a position to challenge the plan as she was not appropriately informed of the placement of Child J with his father however the Independent Reviewing Officer could have escalated her concerns, when she was informed.

12. Recommendations

12.1. It is tempting, but of no added value, to include recommendations about the need for ensuring there is compliance with procedures, to share information and to address the above themes, all of which are well known to child protection professionals.

12.2. Individual agencies have identified a number of recommendations and the implementation of these will be monitored by the Peterborough Safeguarding Children Board.

12.3. In addition the following recommendations are suggested for the Board to address.

Peterborough Safeguarding Children Board should:

1. Discuss with Peterborough City Council Legal Services the most appropriate way to contribute to future Serious Case Reviews where appropriate.

2. Monitor the use of the revised pre-birth protocol to ensure it is being adhered to and is delivering improved safeguarding, through better risk assessment and planning.

3. Monitor the lack of use of escalation procedures and ensure any issues are addressed as this has been identified in other Serious Case Reviews.

4. Given the similar findings in a recent Serious Case Review in Peterborough, where poor communication between Health and Children's Social Care was identified, the Board should undertake a review of communication between Health Visitors and Children's Social Care, identify any difficulties or resistance and address these.

5. Seek assurance that plans made at Family Group Conferences are appropriately monitored by Children's Social Care.

6. The LSCB chair should draw this Serious Case Review to the attention of Lincolnshire LSCB so that they can ensure that the records of their partners are informed by the above information so that if Father becomes involved with another child, they can appropriately consider any risks.

Appendix 1

The Genogram