Warwickshire Safeguarding Children Board

Serious Case Review in respect of 'John'

16.4.15

Contents

1. Introduction

1.1 Why this case was chosen to be reviewed

1.2 This case was taken to the serious case review subgroup on 12th December 2013. Not all agencies thought this case met the serious case review criteria as child protection issues were not a causative factor. There was also concern around the serious case review label for the family and other child because John did not die as a result of maltreatment. John had been sleeping on a sofa with a parent and when the parent woke in the morning John had died. HM Coroner recorded an Open Verdict with cause of death Not Ascertained.

1.3 On 7th January 2014 WSCB independent chair made the decision the circumstances of the child's death fully met the criteria for a serious case review, as set out in Chapter 4 of Working Together to Safeguard Children (2013). This was because the children were receiving child in need services from social care, who, with health colleagues, were concerned about neglect. The independent chair believed this met the first part of the threshold criteria for undertaking a serious case review "'child abuse or neglect is known or suspected and a child has died".

1.4 Succinct summary of the case

1.5 The parents, Mark and Susan, moved into their new home in May 2012 with their daughter Amber?, who was three months old. They had no history of involvement with social care. Within two months of moving into their new home they had fallen into rent arrears and in September 2012 the housing provider made an application to the court to evict the family. The eviction order was suspended on a number of occasions over the next year and the family was not finally evicted until September 2013. Social care had become involved and

agreed to undertake an initial assessment under the category of "child in need" in July 2013 following the birth of John on 23rd June 2013 and a referral being made by the health visitor.

1.6 When the family was evicted they moved to the paternal grandparents' home. John died tragically the following day. In the autumn of 2013 HM Coroner recorded an Open Verdict with cause of death Not Ascertained.

1.7 Family Composition

Subject – John. Ten weeks old at time of death.

Sibling – Amber. Under two at the time of John's death

Mother – Susan

Father – Mark

Paternal grandparents - PGP

2. Timeframe under review

2.1 Systems reviews consider how safeguarding systems and practices within a local authority area operate and we test out how safe and effective they are. Therefore, when considering where to start the review we do not go back many years because systems will have changed. This does not mean that family history is overlooked but what is relevant is whether the professionals working with the family during the period under review know about the family history.

2.2 In this case it was agreed that we would start the review from the date the housing provider closed their tenancy support.

2.3 Usually the review stops at the time of the child's death but in this case the review team wanted to also test how effective the rapid response system, the immediate multi-agency response to a child's death, is in Warwickshire. For that reason it was agreed the period under review would conclude four days after John's tragic death.

3. Timeline of events

Date	Event/Circumstance
14.7.12	The housing provider closed tenancy support.
18.7.12	1st letter re rent arrears sent to the parents.
12.8.12	Amber seen at clinic. Weight on 98th centile. Feeding discussed
31.9.12	Notice of Seeking Possession of the property sent to the parents from housing provider
24.11.12	Amber 9 month review. Weight on 99th centile.
15.2.13	Suspended Order for Possession of the property.
1.4.13	Susan attended GP seeking termination of pregnancy.
20.4.13	Susan saw midwife for booking. 25 weeks gestation.
23.5.13	Citizens Advice Bureau provided advice and support in making application to the court to suspend the warranty.
2.6.13	Warrant suspension hearing.
17.6.13	Susan told a hospital midwife she was facing possible eviction and was due in court soon.

23.6.13	John born at 34 weeks gestation. Admitted to Special Care Baby Unit.
25.6.13	Susan discharged from the hospital.
26.6.13	Family seen by community midwife at paternal grandmother's.
30.6.13	Referral from student health visitor (1) to Children's Centre. Family support worker allocated.
1.7.13	Susan seen at clinic by community midwife.
5.7.13	John discharged home from hospital.
6.7.13	Attempted unannounced home visit by student health visitor (1). Family not there.
7.7.13	Established family staying with paternal grandparents. Visit made there by Health Visitor One.
11.7.13	Home visit by Health Visitor Two (HV2) and Nursery Nurse Two (NN2). Safety needs identified including safe sleeping.
12.7.13	HV2 made referral to social care, concerns included no Moses basket. Decision made by social care to undertake initial assessment. Social care contacted Susan to arrange home visit. HV2 asked family support worker to prioritise the family.
12.7.13	Family received a letter with notice of eviction date, 1.9.13. Housing provider informed the Local Housing Authority Homeless Options Team.
13.7.13	Social care attempted visit to family at 9.30am. No answer. Spoke to Susan on the telephone, she said they had been locked out and had gone to maternal grandmother's home for the day. Visit rearranged for 19.7.13. Social worker then went to maternal grandmother's home at 6pm but was told the family had returned home.
14.7.13	NN2 attempted planned home visit. No answer. On the telephone the family said they had been locked out.
17.7.13	Social care contacted the family to confirm the home visit for 19.7.13.
18.7.13	John seen at eye clinic. No concerns. Discharged. Missed appointment with paediatrician.
19.7.13	Social worker visited the home. Susan and the children were seen, in the presence of the maternal grandmother and maternal aunt. Susan agreed to Child in Need support. Parents had obtained a Moses basket. Later on 19.7.13 SHV2 and HV2 visited Susan and the children at their home.
20.7.13	Family support worker attempted planned home visit. No answer. On the telephone Susan said she was unaware of the visit and not at home. Visit rearranged for 27.6.13.
21.7.13	Susan, Amber and John seen at home by NN2.
24.7.13	HV2 and social worker agreed joint home visit for 25.7.13.
25.7.13	Joint home visit by HV2 attempted. (This was supposed to be a joint visit with the social worker but she was unable to attend due to an urgent commitment). No answer. Later that day HV2 succeeded in seeing Susan and the children at home. Portage referral discussed. Amber referred to paediatrician and dietician regarding her weight.
27.7.13	Family support worker attempted planned home visit. No answer. Calling card and voicemail left
1.8.13	HV2 undertook home visit. Social worker agreed to visit 2.8.13
2.8.13	Social worker attempted home visit. No answer. No response to telephone calls.

4.8.13	Social worker undertook home visit to complete initial assessment. Susan, Amber and John seen.
8.8.13	Susan cancelled planned visit by HV2. She was unwell. Susan agreed to attend baby clinic on 10.8.13. Social care left a message for Susan saying there needed to be a meeting to look at support required by the family.
10.8.13	Susan did not attend baby clinic. HV2 and the family support worker attempted to contact Susan by telephone.
11.8.13	SHV2 attempted home visit but Susan unwilling to let her in. She said she was embarrassed by the mess. Susan seen to have dried blood in both nostrils and enflamed veins in her nostrils. She said she was fine. HV2 and social worker agreed joint home visit for 16.8.13.
16.8.13	HV2 and social worker did joint home visit. Susan initially refused entry but was advised by social worker that she would seek advice from her manager about returning with the police if entry refused. All the family were seen. (This was the first time Mark had been seen since John left the hospital). Child in Need plan agreed. Further visit arranged for 19.8.13. Social worker left telephone message for housing provider to gain information for initial assessment.
18.8.13	Housing provider requested reissue of the warrant for eviction. The accounts manager and housing officer attempted to visit the family. Susan was at a neighbour's. She said she had been locked out.
18.8.13	John and Susan seen by GP for 6 week check. No concerns.
18.8.13	HV2 and family support worker agreed to do joint home visit on 24.8.13.
19.8.13	Social worker attempted planned home visit. No answer. On the telephone Susan advised she had gone to the shops and the children were staying with relatives for a couple of days. Home visit arranged for 23.8.13.
22.8.13	Parents receive notice of hearing for warrant to be suspended from the court.
22.8.13	Amber missed appointment with paediatrician.
23.8.13	John did not attend immunisations appointment.
23.8.13	Social worker undertook home visit and made it clear of what changes needed to take place. During the visit telephone call to housing provider. Advised of court date 29.8.13. Hope that payment plan could be agreed. Home visit arranged for 29.8.13.
24.8.13	Joint visit by family support worker and HV2.
25.8.13	John had immunisations.
29.8.13	Mark and Susan met with the Local Housing Authority to discuss eviction. Based on the information they provided the family was advised they would be likely to be seen as intentionally homeless. B&B offered but declined. Advised to ask relatives for accommodation or seek private rental.
29.8.13	Court granted the eviction. Date for eviction remained 1.9.13.
30.8.13	Susan contacted GP by telephone, concerned Amber unwell. Susan then took Amber to the surgery. No sign of ill-heath.
30.8.13	Social care reviewed initial assessment and allocated as Child in Need case, with view to transfer to a CAF.
30.8.13	HV2 undertook a home visit. The mother spoke of the eviction.
31.8.13	Family support worker attempted planned home visit. No answer.

1.9.13	Family evicted from their home. Went to stay with paternal grandparents
1.9.13	John died. Family were at paternal grandparents' home. Ambulance attended. Police attended. Telephone discussion between police and social care. Consultant paediatrician and Detective Inspector from police child protection team visited the grandparents' home. Strategy discussion arranged for 8.9.13.
3.9.13	HV2 attempted to make contact with Susan.
5.9.13	Susan telephoned HV2 requesting visit. Arranged for 6.9.13.
6.9.13	Home visit to paternal grandparents' home by HV2.
8.9.13	Strategy discussion.

4. Organisational learning and improvement

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

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

4.3 Warwickshire Safeguarding Children Board identified that this serious case review held the potential to shed light on particular areas of practice including addressing the following questions:

- How effectively we in Warwickshire understand levels of risk and the interface between different agencies, particularly in the context of when a family with young children may become homeless.
- How the professionals respond when a family is being assessed by social care under child in need, as opposed to child protection and the level of scrutiny required.

5. Methodology

5.1 Statutory guidance requires serious case reviews to be conducted in such in a way which:

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

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

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

5.2 In order to comply with these requirements Warwickshire LSCB has used the Social Care Institute for Excellence (SCIE) Learning Together systems model (Fish, Munro & Bairstow 2010). The serious case review has been quality assured by SCIE.

5.3 Reviewing expertise and independence

5.4 The serious case review has been led by two people independent of the case under review and of the organisations whose actions are being reviewed. Deborah Jeremiah and Joanna Nicolas are both accredited to carry out SCIE reviews, and have extensive experience in serious case reviews. Neither had any previous involvement with this case, or any previous or current relationship with Warwickshire Council or partner agencies.

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

5.6 Statutory guidance requires that serious case review reports be written in plain English and in a way that can be easily understood by professionals and the public alike. Writing for multiple audiences is always challenging. In the Appendix we provide a section on terminology. Our aim is to support readers who are not familiar with the processes and language of safeguarding and child protection work.

5.7 LSCBs and SCIE are both keen to improve the accessibility of serious case review reports and welcome feedback and suggestions for how this might be improved.

5.8 Participation of professionals

5.9 The review consisted of two groups of professionals, the review team which consisted of a senior manager from each of the agencies involved during the period under review, none of whom had had line management of the case, and the two independent lead reviewers.

5.10 Review Team

Deborah Jeremiah	Independent lead reviewer.
Joanna Nicolas	Independent lead reviewer.
Service Manager	Early Help and Targeted Support. Warwickshire County Council.

Service Manager for Safeguarding	Children's social care. Warwickshire County Council.
Housing Manager	Local Housing Authority.
Area Community Manager	Housing provider.
Development manager	WSCB.
Professional Lead for Health Visiting for Warwickshire	South Warwickshire NHS Foundation Trust.
Named GP for Safeguarding	Clinical Commissioning Group.
Modern Matron, Midwifery	University Hospitals Coventry and Warwickshire NHS Trust.
Detective Inspector	West Mercia and Warwickshire Police.

5.11 The case group was made up of the key frontline professionals who had been working with the family during the period under review.

5.12 The case group

Social Worker	Children's social care. Warwickshire County Council.
Practice Leader	Children's social care. Warwickshire County Council.
Operations Manager	Children's social care. Warwickshire County Council.
Health Visitor (2)	South Warwickshire NHS Foundation Trust.
Student Health Visitor (1)	South Warwickshire NHS Foundation Trust.
Student Health Visitor (2)	South Warwickshire NHS Foundation Trust.
Community Nursery Nurse	South Warwickshire NHS Foundation Trust.
Community Midwife	University Hospitals Coventry and Warwickshire NHS Trust.
Hospital Midwife	University Hospitals Coventry and Warwickshire NHS Trust.
Neo-natal Care Manager	University Hospitals Coventry and Warwickshire NHS Trust.
GP	Family's GP Practice.
Tenancy Support Worker	Housing provider.
Accounts Manager	Housing provider.
Housing Officer	Housing provider.
Interim Supervisor	Children's centre.
Consultant Paediatrician	University Hospitals Coventry and Warwickshire NHS Trust.
Detective Inspector	Child protection team. West Mercia and Warwickshire Police.
Detective Constable	Child protection team. West Mercia and Warwickshire Police.
Family support worker	Children's Centre.

There was ongoing interaction between the two groups to test out accuracy, developing analysis and findings.

Perspectives of the family

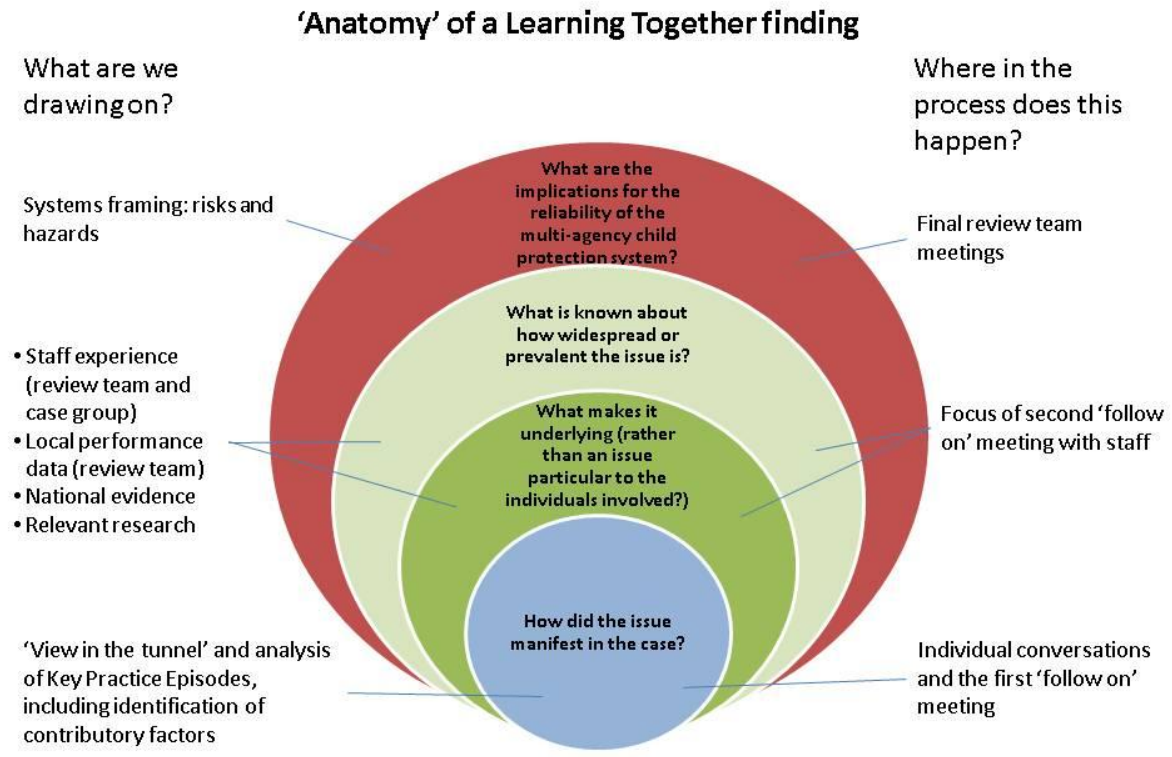
5.13 In this case the mother met with two members of the review team. Her views are woven throughout the report. The father and the paternal grandmother were given a number of opportunities to meet with us, so we could hear their views, but both declined to be part of the serious case review.

Methodological comment and limitations

5.14 It is a family's choice whether they contribute to a serious case review. Every effort is made to engage with the family because their contribution is recognised as extremely important and makes for a much richer review.

5.15 The review team acknowledges that our understanding of what happened, from the family's perspective is limited by the father and paternal grandmother being unwilling to contribute to the review.

6 The findings:



6.1 Introduction

6.1.1 Statutory guidance requires that serious case reviews provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of reoccurrence. These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong.

6.1.2 This section contains five priority findings that have emerged from the serious case review. The findings explain why professional practice was not more effective in protecting John in this case. Each finding also lays out the evidence identified by the review team that indicates that these are not one-off issues but systemic within Warwickshire. Many of these findings will resonate with other local authorities and London boroughs. Evidence is provided to show how each finding creates risks to other children and families in future cases, because they undermine the reliability with which professionals can do their jobs.

6.1.3 First, an overview is provided of professional practice in this case. This clarifies the view of the review team about how timely and effective the help that was given to John and his family was, including where practice was below expected standards.

6.1.4 A transition section reiterates the ways in which features of this particular case are common to other work that professionals conduct with other families and therefore provides useful organisational learning to underpin improvement.

6.2 Appraisal of professional practice in this case: a synopsis

6.2.1 When Susan became pregnant with her second child she and Mark were already in rent arrears as joint tenants. Amber was under one when Susan became pregnant. Her ante natal needs had to be met within a reduced timescale because of the late presentation of the pregnancy and then the premature birth. The pregnancy was past 24 weeks and there was no choice but to carry on the pregnancy. There was timely management of her medical needs which is positive but the family's social situation or social needs were not considered and that would have provided a wider picture. The focus was on the medical needs given that Susan had presented late into pregnancy and it was becoming apparent that the pregnancy was complicated. In an uncomplicated pregnancy there would have been a midwife leading the care, getting to know the mother more holistically, in this case it was medically driven only. There was no consideration of the impact upon Susan of the unplanned pregnancy, or if there could possibly be any safeguarding issues to consider. The medical care took primacy but the consideration of this and social factors should not present as an either/or. Sound ante natal care should include a more holistic approach not a superficial response, considering one aspect of care only. Agencies working in a superficial manner is considered in **Finding Two**.

6.2.2 A lack of consideration of social context continued when Susan was in hospital and gave birth prematurely by caesarean section. One hospital midwife knew that Susan was facing eviction and was due to go to court soon and yet this did not trigger any risk assessment or further enquiry. This was because Susan was cared for by a number of hospital midwives over a short space of time and hospital midwives would expect issues such as these to be addressed by community health professionals. Susan left hospital

before John. The fact of a possible eviction was not considered and did not feature on discharge. This was because the hospital discharge form addresses the clinical aspects of the mother and baby and the hospital had no concerns about the family because the mother, father and grandparents had been regular visitors to the hospital and had raised no concerns for the staff. The usual timescale for a mother to be discharged post caesarean is one to three days. Susan had remained in hospital for three days, which gave the hospital staff time to see John's family with her but because of shift work no professional had the overview of Susan and Mark's social situation.

6.2.3 It takes around six weeks to fully recover from a caesarean section. Susan was being helped for a few days by the paternal grandmother who later expressed concerns to a professional about Susan being able to cope with a second child. The expectation of the review team was that this information would have been captured and considered inter and cross agency to inform risk to the new-born and also consider what support may be required to Susan in these early days of caring for John who was vulnerable, having been born prematurely. The agencies involved were not effectively communicating with each other. Disparate information sharing is considered in **Finding Five.**

6.2.4 John stayed in hospital as he required neonatal care and was cared for by many different nurses on the neonatal unit. The shift system means continuity of care is difficult to achieve. John's condition progressed and he was medically fit to be discharged. There was no consideration of any potential social needs, as Susan and Mark had been coming in to visit John. The health professionals did not raise any social concerns nor were the parents asked about any concerns. The discharging nurse for John did not know about any possible eviction facing the family. The lack of consideration of social needs was influenced by the discharge form which primarily focuses on clinical needs. Disparate information sharing is considered in **Finding Five.**

6.2.5 Susan was seen by a community midwife but this was before John came home and did not take place in the family home. When the health visitor became involved as per routine, they had to make numerous enquiries to find where the family was located. The discharge information given did not indicate accurately where the family were staying. After a failed attempt to see the family at the family home and following extensive enquiries the family were located and seen some days later in the family home by HV2. Immediate concerns were expressed around the state of the home, and Susan's health and ability to cope. HV2 made a referral to social care. Susan did have some parenting experience with her first child. She was not already known to social care. It was noted that there was also a sibling toddler with developmental delay. Mark was absent and seemingly at work. The communication between the various health professionals was however, disparate and reflects the numerous and at times disjointed components of health as Susan and John's care passed from one part of the health service to another. The one constant should have been the GP but he was left out of the loop altogether and when he saw Susan for her six week check post birth he had no idea of other professionals' concerns or that HV2 considered this family to be in their top three families of concerns and had alerted social care. However, HV2 had a positive communication line into social care reinforced by knowing the allocated social worker and having worked together before. Disparate information sharing is explored more widely at **Finding Five**.

6.2.6 HV2 made great effort to work with the family but this was done in the context of no formal plan as yet being in place and there was a lengthy delay in conclusion of the initial assessment, for legitimate reasons including heavy workloads and the need to prioritise child protection cases. HV2 made a care plan for her involvement. However, the situation left HV2 managing the risks with no formal safeguarding plan in place and there was a strong reliance upon the health professionals to hold the case while social care sought to progress the initial assessment and make key decisions. The concerns included Susan's ability to care for a premature baby and a toddler who also had additional needs with developmental delay. The other identified risks centred around the home not being a clean and safe environment for two young children and Susan's ability to cope. She was noted to be "flat" in mood and "like a rabbit in headlights". Susan's mental health was not further probed or discussed with the GP as it should have been. HV2 did set up a good rapport with Susan. HV2 also obtained some further support within her team to provide additional support to Susan though to do so she had to take that colleague away from her core work. Formal planning and co-ordination of services is explored more widely in **Finding Three.**

6.2.7 HV2's honesty and openness with Susan meant their relationship was not affected when HV2 told Susan she would have to make a referral to social care. Susan understood why the health visitor had done this because the health visitor explained it to her. Notably Susan continued to engage with HV2 and HV2 was able to provide advice for the baby around safe sleeping, feeding, and also support around health matters for the sibling. There were some improvements in the home environment making it cleaner and safer but Susan was unable to sustain the improvements. It later became apparent that eviction was a real threat to the family and HV2 was reporting into social care almost on a daily basis as she was so concerned. Agency working in the absence of a formal plan is explored at **Finding Three**.

6.2.8 HV2 became aware of the eviction but was being told by Susan that they had secured a loan to pay off the arrears. The family had in fact had their eviction suspended already before on the premise that they would pay the arrears. However this was not happening as income was not regular and Susan was reliant on Mark paying as she was not working. It then transpired that the loan was not going to materialise and therefore eviction was a very real risk. This review shows very clearly that professionals supporting the family outside housing did not understand the eviction process. The lack of understanding by professionals across all agencies of both the impact of eviction on a family and the eviction process is explored in **Finding One**.

6.2.9 This case also highlights the complexities of the interface between the various aspects of housing, the housing provider, the Local Housing Authority's (LHA's) homeless prevention unit and social care and the legal process, when managing a family who are facing the very real prospect of being evicted from their home. The lack of understanding by professionals across all agencies of both the impact of eviction on a family and the eviction process is explored in **Finding One**. All this was happening in the context of an unplanned premature baby, a sibling with developmental delay and a mother about whom there were health concerns. Social care was seeking to engage but HV2 was more successful in getting into the home. Susan told a number of professionals she was locked out on occasions and so they could not always see inside the family home. Accepting what families tell us without testing it out is explored more widely in **Finding Two.**

6.2.10 At the beginning of their involvement the housing provider provided excellent support and assistance to the family, which enabled the family to take up the tenancy however the family's ongoing support needs were not recognised because there was a lack of intra (the housing provider) and inter-agency communication and the focus became centred on eviction and not support and the vulnerability of the children and the family was not appreciated. Further, there was an assumption by other professionals that social care were supporting and helping the family manage their housing issues but this was not the case. The response therefore to the risk of eviction was superficial cross agency and this is explored further in **Finding One** and **Finding Two**.

6.2.11 The family was eventually evicted from their home with just a few days to move out. They had limited options as to where to go with a toddler and a very young baby and they went to stay with the paternal grandmother but there was not enough room so it was going to be overcrowded. They had to leave numerous things behind in the flat including a travel cot, nappies, children's clothes and toys as there would not be enough room for them at the grandmother's home. Susan told social care that is where they would have to go and Mark wanted them to stay with his mother, rather than Susan's. Social care thought it the best option in all the circumstances. The arrangements were discussed with the social worker. The plan was that the children sleep in travel cots in their grandmother's bedroom, Susan would sleep on the sofa, with Mark in a bed as one family member was away. The grandmother already had additional travel cots in the house for the children. The reason for these sleeping arrangements was because Mark needed his sleep because he had to get up for work. The agreement was that if the children woke they would have to be taken downstairs.

6.2.12 Health professionals had spoken to Susan about safe sleeping and the risks of co-sleeping in the context of the environment in the home they had just been evicted from, and generally. The sleeping arrangements planned while staying at Mark's mother's included two key risk factors for SIDs (Sudden Infant Death Syndrome) – a premature baby and high likelihood of mum falling asleep with him on the sofa. We therefore would have expected social care professionals to discuss this and alternative possibilities that would be safer. However, the social worker was focused on the fact that they did have somewhere to stay, and had planned sleeping arrangements, so did not critique them at this time. It was on the first night after the eviction that John died after he was brought downstairs for a feed and slept on the sofa with Susan after Mark went to bed. Superficial responses and accepting information from families at face value is explored more widely in **Finding Two.** The National Institute for Health and Care Excellence (NICE) updated its guidance to clarify the association between co-sleeping and Sudden Infant Death Syndrome (SIDS) in December, 2014[1]. The guidance says that the association between co-sleeping and SIDS is likely to be greater when a woman, or their partner, smoke, there is parental or carer recent alcohol consumption, or parental or carer drug use, or low birth weight or premature infants.

6.2.13 Two of the main concerns with this family were the impending eviction and the state of the home. Susan was not supported by professionals she would engage with in either of these areas. Susan was told what she had to do, but not offered practical assistance by them. The professional who would have offered the most practical support was the family support worker but despite her best efforts Susan would not work with her. The family

[1] http://www.nice.org.uk/guidance/CG37

support worker only met with Susan on one occasion. The initial visit is to ascertain the situation and then to set out what support the service can offer. Despite several attempts the family support worker was unable to engage Susan further.

6.2.14 In terms of safeguarding, the health visitor was in a supporting role. It is not the health visitor's responsibility to drive forward any co-ordinated plan with defined outcomes and objectives for a child in need case. The frontline professionals were not able to see that a pattern of engagement emerged early on with the mother. She met frequently with the health visitor but remained consistently unavailable to social care and the children centre worker. Susan told the review that she liked the health visitor. She did not like the social worker because she was "constantly on my back". Although it was explained to her at the time, by a number of professionals, Susan said she did not understand the role of the family support worker and Susan just wanted to be alone with the children. Superficial working is explored more widely in **Finding Two.**

6.2.15 There was a considerable amount of activity by a number of professionals in this case despite the key professionals having high volume caseloads, for example the health visitor, who was part time, had around 250 children she was working with. (It is the view of the Professional Lead for Health Visiting for Warwickshire and their colleagues that an average case load at that time would have been 370 children per full time health visitor, with no more than five children subject to a child protection plan). Professionals went to great lengths to attempt to meet with the family. The health visitor was extremely proactive and carried the case for some time but actually the lead agency for decision making was social care. The fact that until the initial assessment is completed there is no formal multi-agency plan and no formal co-ordination of services, which may leave children vulnerable, is explored in **Finding Two**.

6.2.16 Having considered the perspectives of both professionals and the mother there are indications that the professionals although constantly questioning, did accept at face value information given to them by the family. This was arguably inhibited by Susan's reluctance to be open and honest with professionals and her pattern of engaging with some professionals but not others. If the professionals had tested out information they would have gained a more in-depth and accurate picture as to the family's troubles and struggles. This issue of superficial working cross agency is explored further in **Finding Two**.

6.2.17 There is no evidence in this case that agencies' involvement reduced the risk factors significantly. There was correct advice given around feeding and the importance of a clean and safe environment for the children. John did gain weight. Whilst some improvements were made within the household also, these improvements were not sustained. Nor were agencies seeking clarity from social care as to why they were involved and what their involvement was. The identifying risk factors were known to be an initially unwanted pregnancy followed by a premature birth set in the context of an impending eviction, the parents were struggling to sustain a clean and safe home environment and a young sibling also with additional needs, as well as clear evidence of concerns of the mother's emotional wellbeing and the father's role in the family. The issue of superficial working cross agency is explored further in **Finding Two.**

6.2.18 The immediate management of John's death as a rapid response is an example of good practice in this case even though social care and police files did not record an initial

information sharing and planning meeting chaired by the paediatrician, as required by the procedures. Despite this there was an early and thorough consideration by all the relevant professionals, the police, social care and health, around the possible cause of death and any potential risk to the sibling.

6.2.19 Throughout the focus of professionals was on Susan rather than her and Mark equally as parents. Mark was out working and also Susan tended to be the one to speak with professionals as well as looking after the children. This meant that a crucial part of the picture was not fully understood, which was that Mark was not working regularly and therefore would have not have the money to pay for the rent. This meant that the main focus of responsibility was upon Susan and that is explored at **Finding Four**.

7. Findings

In what ways does this case provide a useful window on our systems?

7.1 When considering this question we consider 6 typologies as lines of enquires. These are:-

1. Tools - what have we learnt about the tools and their use by professionals?

2. Responses to incidents/crises - are there particular patterns we have identified about how professionals respond to incidents?

3. Longer term work - are there particular patterns we have identified about ways of working over a longer period with children and families?

4. Management systems - are any elements of management systems a routine cause for concern in any particular ways?

5. Family-professional interaction - what patterns of ways that professionals are interacting with different family members are discernible, and do they introduce risk into our systems?

6. Innate human biases - are there common errors of human reasoning and judgement evident that are not being picked up through current set ups?

7.2 Our findings in this case fit into three of the categories of the typology, responses to incidents/crises, longer term work and management systems.

7.3 Reviewing the way that professionals responded in this case is a useful test for how effectively we in Warwickshire understand levels of risk and the interface between different agencies, particularly in the context of when a family with young children may become homeless.

7.4 This case has also provided us with a useful window on the system to see how the professionals respond when a family is being assessed by social care under child in need, as opposed to child protection and the level of scrutiny required.

7.5 The case can provide a useful window onto ways we may be working well and any underlying weaknesses in our set ups, practice and arrangements. In this case the difficulties being experienced by the family were dealt with as single issues.

7.6 This case has also highlighted to the non-housing team and the case group members their lack of knowledge of the eviction process, of which they now have a much greater understanding.

7.7 This case has also highlighted that whilst the professionals that were involved in this rapid response had a high level of experience, the same is not true across the county.

8. Summary of findings

The review team has prioritised five finding for WSCB to consider. They are:-

Finding One In Warwickshire the lack of understanding by professionals across all agencies of both the impact of eviction on a family and the eviction process which increases the chance that children in these circumstances will be left vulnerable.
Finding Two In Warwickshire there are underlying indicators that suggest agencies' responses can be superficial and do not always get to the heart of what the issues, and therefore do not fully address risk.
Finding Three In child in need cases in Warwickshire until social care complete their assessment there is no formal multi-agency plan and social care do not see their role as co-ordinator of services during the assessment period.
Finding Four A wealth of experience and expertise within this rapid response multi-agency team enables a pattern of effective rapid response within this team.
Finding Five In Warwickshire there is a pattern of disparate information sharing across agencies, increasing the risk that important information relevant to keeping children safe will be overlooked.

Management Systems - are any elements of management systems a routine cause for concern in any particular ways?

Finding One

In Warwickshire the lack of understanding by professionals across all agencies of both the impact of eviction on a family and the eviction process which increases the chance that children in these circumstances will be left vulnerable.

8.1 When there is an impending eviction the expectation is that the housing provider informs the LHA's Homeless Options Team. In every eviction involving children the council will make a referral to children's social care to advise them of the action taken. This is emailed over secure email and from housing's perspective is a referral into children's social care. The council will look at their statutory duty to rehouse a family under the legalisation and as part of this they would consider whether the family has made themselves intentionally homeless. The LHA's Homeless Options Team will always refer intentionally homeless families to children's social care, if there are children involved.

How did the issue manifest in this case?

8.2 A factor in this case was why the seemingly evident vulnerabilities of a mother recovering from caesarean section, with both a premature baby and a toddler to look after did not impact at all on the process or outcome of eviction. Once they became involved social care, as the lead agency, should have worked closely with the family and with the housing association to prevent the eviction.

8.3 The housing provider knew prior to John's birth that the eviction was imminent. The hospital midwifery service knew of the impending eviction before John was discharged. Neither considered the impact on Susan's mental health of having recently had a premature baby by caesarean and now being about to lose her home and, because they did not talk to other agencies, neither knew that there were already concerns about Amber.

8.4 Within the housing provider there were three different workers involved, from each of the relevant sections of the provider, a tenancy support worker, whose role it is to provide short term tenancy advice for customers needing additional support to maintain their tenancy, the accounts officer, whose role it is to pursue rent arrears and the housing officer, whose job it is to manage the tenancy all of whom were involved with the family. The tenancy support worker ended her involvement shortly after the family moved to the property because she was unaware the family was already in rent areas, she had fulfilled her remit and did not consider this case more widely in the face of a family not appearing at the time to have any vulnerability.

8.5 When it was identified that the family was in rent arrears, which was around the time the tenancy support was closed, there was a first attempt to evict. This involved an application by the housing provider to the court. It is the court that will ultimately make the decision to evict upon the information put before them by the housing provider and the tenant can also make representations though this is often done with no or little legal support. On the first occasion of the eviction coming before the court, the court suspended the eviction on the basis that the family would pay the rent arrears. There were two further attempts by the housing provider to evict for non-payment and an eviction date was set by the court. At no time throughout did the family make any payment of any amount to pay off their arrears and in that situation the housing provider has to take legal action because of non payment of rent. By the time of the eviction Susan had given birth to John prematurely and John had recently been discharged home from the neo-natal unit. There was no liaison between the housing provider, the Local Housing Authority and any of the other agencies involved with the family about the impending eviction and the impact this might have on the family.

8.6 A week before the eviction when Susan told the social worker she could get £200 to pay towards the rent, having had a brief conversation with the housing provider, the social worker assumed the eviction would not happen. This was an incorrect assumption.

8.7 Once the eviction had happened there was no support for Susan, professional involvement was only in terms of where everyone was going to sleep.

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

8.8 When this issue was explored further during the review, it became evident that the housing provider workers did not understand the impact of the eviction on the family because they did not have knowledge that social care were involved when they made their application to the court and therefore there was no liaison as the eviction loomed. The social worker only considered where the family would move to in terms of the practicalities, rather than exploring with Susan what may have been better for her emotionally. Susan had wanted to go to her mother's but Mark had said they were going to his mother's. The health visitor did not see herself as having a supportive role in the eviction process.

8.9 None of the other professionals understood how the eviction process works, including all of the non-housing members of the review team and the two independent lead reviewers. The review team and the case group have confirmed that there is a lack of understanding about the eviction process and the impact on the family of the process across all agencies.

How widespread is the issue?

8.10 Local data does not exist across all of the housing providers across Warwickshire as to how effectively they engage with other agencies around eviction and how effectively other agencies engage with them around the process.

8.11 It is highly likely that a lack of understanding of how the eviction process works by professionals other than housing will not be unique to Warwickshire.

How prevalent is the issue?

8.12 In the eighteen months prior to the serious case review, the housing provider involved in this case evicted twelve families. The Local Housing Authority has evicted twenty seven families since 2012, of these three had children under 18. This is therefore a rare occurrence and therefore not something that professionals across all agencies are coming across and working with regularly.

8.13 The NSPCC has recently produced a report "Housing services: learning from case reviews,Summary of risk factors and learning for improved practice around the housing sector".[2]

8.14 Amongst its learning the report states "Many housing issues are warning signs of child protection concerns. Housing services should consider the impact that tenants' lifestyles and behaviour are having on their children".

[2] http://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/housing/#

Why does it matter? What are the implications for the reliability of the safeguarding system?

8.15 If professionals do not understand how the eviction process works and do not understand the impact on children they will not consider the added vulnerability of children in these situations. The implications of this are that these children are not recognised as vulnerable by professionals in Warwickshire.

Finding One

In Warwickshire the lack of understanding by professionals across all agencies of both the impact of eviction on a family and the eviction process which increases the chance that children in these circumstances will be left vulnerable.

A safe system must be able to deal with all sorts of unexpected and unplanned developments in families' lives, where they have implications for the safety and welfare of children. Evictions do not come out of the blue. We should therefore be able to be confident that professionals across agencies are routinely working effectively together in cases of possible eviction relating to families, to ascertain and assess the extra vulnerability that eviction would entail for any babies and children involved. Instead, this case review has highlighted poor quality working together within a housing provider, and between the housing provider and other professionals. Trying to understand what lay behind this, the case review has identified a basic lack of understanding of either what is involved in the eviction process, and a lack of routine consideration of the potential impact on babies or children. Without this, we should not be surprised when some children are put at risk as a result.

Questions for Consideration by the Board

1. What action would WSCB like housing providers to take when they are planning to evict a family? E.g. notify housing, refer to social care, do a CAF, ask housing or someone else to do a CAF?
2. How can the board be assured that agencies can recognise and anticipate when eviction is a probability, not just a possibility and risk assess appropriately for that eventuality.
3. How confident is the board that all agencies have adequate knowledge of each other's roles and responsibilities in order that they can effectively support families potentially facing eviction.

Finding Two

In Warwickshire there are underlying indicators that suggest agencies' responses can be superficial and do not always get to the heart of what the issues are, and therefore do not fully address risk.

How did the issue manifest in this case?

8.16 There were numerous examples in this case of relatively superficial working. We have selected two here, as illustrations. The first relates to the discussion had with the family about sleeping arrangements at the paternal grandmother's house after they had been evicted. As stated in the appraisal above, the issue is not that none of the professionals

discussed the sleeping arrangements with the parents; the social worker did discuss what the plans were with the mother and the social worker was told that each child had a cot, in the paternal grandmother's bedroom and that is where the children would sleep. The social worker was also told that if either child woke in the night the plan was for the mother to take the child downstairs because the paternal grandmother had to get her sleep because she had to get up for work. What none of the professionals discussed with the parents was that in reality, with a baby and a toddler, it was inevitable the children would be waking every night and would therefore have to be brought downstairs to their mother, who was sleeping on the sofa. None of the professionals discussed what was likely to happen in this inevitable situation or thought through the risks to the premature baby and sibling. So the issue of sleeping arrangements was dealt with but on a superficial level, which meant that the risks were not ascertained. Professionals simply ascertained that each child had a cot to sleep in.

8.17 In this case the majority of professional contact was with the mother and many examples of superficial working relate to the way in which information she gave professionals was accepted, without scrutiny, when there was often evidence to the contrary. For example, she told social care she could pay £200 towards her rent arrears and this was accepted when the evidence was she and her partner had made no attempts to pay off their rent arrears over many months. If the evidence had been considered, rather than just accepting what the mother was saying, it would have been quite clear that no payment had ever been made and there could have been further discussion as to why that was.

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

8.18 The primary source of information about a child, their family and their circumstances will come from the family itself, usually the mother. Input from the review teams and the case group suggests that because of work/time pressures and particularly in cases that are not identified as child protection, information given by families may not be subject to the same level of scrutiny by the professionals. Information is more likely to be taken at face value, which can result in a more superficial response.

8.19 WSCB have undertaken two other reviews recently, one of which found that a young person's needs were not fully understood by social care and police and her mental health deteriorated catastrophically before her death. In the other review there were some similar patterns from the family nurse partnership, midwifery and social care about working superficially and this review identified the need to promote 'professional curiosity' and 'respectful uncertainty' in safeguarding practice.

How widespread is the issue?

8.20 It is not possible to collect data around superficial working. We only record it when there is a case review. This is the third example in Warwickshire in recent times.

How prevalent is the issue?

8.21 'Respectful uncertainty' should be inherent in all our work but we know that the reality is too often that the parents' word is accepted, without being tested.

8.22 It is a common feature of serious case reviews nationally that in these situations some information provided by families is not reliable. It is also a common feature that professionals

working with the family have had little understanding of what is really happening within the family and this is often as a result of work/time pressures.

Why does it matter? What are the implications for the reliability of the safegaurding system?

8.23 A safe system requires professionals to develop relationships with family members and other professionals which would then help them develop a deeper understanding of what the issues are, how they are being addressed and by whom. This would make it more likely that professionals put in place the right balance of support and scrutiny. If we only skim the surface we will not understand what the issues are and may then work with that family for many months, and in some cases years, without getting to the heart of what is actually happening in that family. Not only will this impact negatively on the child, if the maltreatment and the potential for change are not understood and therefore that child continues to live with abuse but it is also an ineffectual use of staff time.

8.24 Professionals having more time and less pressure may increase the quality of the interactions between themselves and families. We would then be more likely to see professionals working with 'respectful uncertainty' which should always be part of the relationship between a professional and a family.

8.25 Risks to children cannot be effectively assessed if the child's world is not fully understood by all professionals working with the family. If families are allowed to be selective about with whom they will engage and who they avoid it hinders effective multi-agency working and allows the response to be driven solely by the family, as opposed to the professionals working alongside the family. Professionals need to understand why a family will engage with some professionals and not others.

8.26 If we do not get to the heart of what the issues really are we will respond to the symptoms, not the cause.

Finding Two

In Warwickshire there are underlying indicators that suggest agencies' responses can be superficial and do not always get to the heart of what the issues, and therefore do not fully address risk.

Safe systems rely on professionals understanding what is happening within a family. If we do not have that understanding we cannot effectively assess risk. There has to be a balance between accepting information that families give us and checking out that information is accurate. It would have taken very little for social care to have ascertained that the family had paid nothing towards their rent arrears and were unlikely to do so, or that the sleeping arrangements the parents made were not practicable.

Both professional curiosity and respectful uncertainty are essential components of safeguarding.

Questions for Consideration by the Board

1. Is supervision effective at enabling practitioners to recognise when they need to probe further or escalate a response?

2. Are staff properly supported to probe for, and hear, difficult information? Do the measures agreed to promote ‘professional curiosity’ and 'respectful uncertainty' in WSCB’s most recent serious case review action plan need to be reconsidered in the light of this finding?

Communication and collaboration in response to incidents/crises

Are there particular good or bad aspects to the patterns of how professionals respond to specific incidents?

8.27 Under this category, the review found some systems of practice suggesting improvements are required but also good practice around the rapid response to a child's death process. Both are detailed below.

Finding Three

In child in need cases in Warwickshire, until social care complete their assessment there is no formal multi-agency plan and social care do not see their role as co-ordinator of services during the assessment period.

How did these issues manifest in this case?

8.28 In this case, following the referral from the health visitor due to concerns about the family's vulnerability, in the context of their impending eviction, social care proceeded with an assessment under the provisional category of child in need. This took much longer than is required because of high caseloads and the necessity to prioritise child protection cases – it was not completed and signed off for five weeks, instead of within the timescale of ten working days. It is important to note that it has not been the view of any of those reviewing this case that it met the threshold for child protection, as opposed to child in need.

8.29 During this time the concerns included Susan's ability to care for a premature baby and a toddler who also had additional needs with developmental delay. The other identified risks centred around the home not being a clean and safe environment for two young children and Susan's ability to cope. She was noted to be "flat" in mood and "like a rabbit in headlights". Yet over the five weeks that the assessment process was underway, there was no formal plan made or agreed between professionals.

8.30 The situation left HV2 making valiant efforts to obtain further support for Susan, but only being partly successful because her role and team are not set up for this purpose.

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

8.31 When we explored this issue further with professionals during the course of the review, a mismatch of understanding of roles emerged. Non-social care agencies assumed that once a referral is made to social care, social care lead and own the risk assessment around the child and family and co-ordinate services. Agencies therefore look to social care to be the decision maker. For this reason, agencies feel a sense of assurance, once social care have accepted the referral. However social care do not see their role as leading and co-ordinating a formal plan during the assessment period. This leaves families in the kind of service void that we saw John's family in, depending on chance as to how willing or able other agencies are to step in to help them.

How widespread is the issue?

8.32 Input from the review team indicates that this mismatch in expectation about who leads and what happens during the process of the initial assessment, occurs across Warwickshire.

It is generally accepted that as soon as social care accept a referral they become the lead professional and therefore co-ordinate the multi-agency response. Working Together to Safeguard Children(2013) the statutory guidance in place during the period under review, set out clearly that the lead professional role fell to the social worker once social care accepted a referral from another agency. The statutory guidance has recently been updated and now states that "Following acceptance of a referral by the local authority children's social care, a social worker should lead a multi-agency assessment under section 17 of the Children Act 1989[3]" The assessment must be done within 45 working days. Social care do not actively take the lead or consider developing a formal child in need, or child protection, plan or start co-ordinating services until they have concluded their assessment.

How prevalent is the issue?

8.33 All cases subject to an initial assessment are potentially affected by this temporary void in leadership of a case and arrangement of timely help, those where there is a delay in the completion of the assessment even more so. Between April and September 2013, which was in the period under review, social care completed 2,544 initial assessments. Of those 24% were completed with the required ten day period, and 76% took longer. This is the number of families then that are potentially affected by this finding.

Why does it matter? What are the implications for the reliability of the safeguarding system?

8.34 It is imperative that there is a clear and co-ordinated plan in place during social care's assessment period, this becomes particularly relevant if assessments are delayed for whatever reason.

8.35 The system is unsafe if there is a significant period of time when there is no formal, co-ordinated plan in place. The fact that social care become the lead professional from the moment they accept a referral creates an illusion that there is a co-ordination of services at this point. Social care do not see their role as bringing agencies together and developing a formal plan during the assessment period, unless they are undertaking a child protection investigation under s.47, Children Act 1989.

Finding Three **In child in need cases in Warwickshire until social care complete their assessment there is no formal multi-agency plan and social care do not see their role as co-ordinator of services during the assessment period.**
A safe system requires clarity about whom, if anyone, is leading and coordinating services. This is especially important at points of change and transition in the case management, such as when a referral has been made and accepted by social care, but the outcome is as yet unknown. This case has revealed that instead, other agencies assume that social care will immediately take over the co-ordination of services. Social Care do not take on this role in child in need cases until the conclusion of the initial assessment, nor do they develop a formal plan. This lack of clarity around process increases the risk that a child, and possibly their family, will be left vulnerable during the assessment period.

[3] Following acceptance of a referral by the local authority children's social care, a social worker should lead a multi-agency assessment under section 17 of the Children Act 1989.

Questions for consideration by the Board

1. How is the Board going to resolve the lack of clarity for professionals as to who is co-ordinating the multi-agency response from the point that social care accept a referral until they conclude their statutory assessment.
2. This finding will become even more pertinent as Warwickshire decides how the single assessment will look. The requirement of *Working Together to Safeguard Children (2013)* and subsequently *Working Together to Safeguard Children(2015)* is that social care undertake a single assessment within 45 working days and the requirement for an initial assessment to be done within ten working days has been removed. How can the Board seek assurance on how best all agencies can be involved in thinking through implications of new arrangements?

Finding Four

A wealth of experience and expertise within this rapid response multi-agency team enables a pattern of effective rapid response in this team.

8.36 Each Local Safeguarding Children Board has a responsibility to review the death of each child that normally resides in their area. This work is undertaken by the Child Death Overview Panel. Each Local Safeguarding Children Board also has to put in place procedures for ensuring there is a co-ordinated response by the authority, their Board partners and other relevant persons.

8.37 There is a process to follow with the death of every child but in some circumstances it is deemed to be an unexpected or unexplained death. An unexpected or unexplained death is defined as a death that was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death. If this is the case the “rapid response” process to the unexpected or unexplained death of a child procedure must be followed, which is more detailed that the more general process to be followed for all child deaths.

8.38 The prime purpose of the rapid response procedure is to ensure that all relevant information is captured in order to be able to explain the death and the aim is that the response is safe, consistent and sensitive to those concerned.

8.39 The rapid response process sets out what must be done within the first 2-4 hours, then 24-28 hours, then within 1-6 months.

How did these issues manifest in this case?

8.40 Because of the experience and expertise within the rapid response multi-agency team that responded in this case the system worked effectively, including the consideration of the safety and protection of the sibling, which is one of the main components of rapid response.

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

8.41 According to the review team, within this team there is considerable expertise and their response is consistently effective. The rapid response process used in Warwickshire has been developed by a consultant paediatrician with considerable experience, who is one of the leaders in the field. He has built on the statutory requirements and developed an enhanced multi-agency system response. Within this rapid response team all agencies demonstrate that each knows its respective role in this regard and works well together in these circumstances. This is due to regular updates and multi-agency training and also strong links with the national child death working group and regional child protection forums.

How prevalent is the issue?

8.42 Professionals report that there is not the same level of expertise, as well as capacity, in other aligned localities and parts of the child death review process, particularly in terms of the paediatrician routinely undertaking a home visit. In some areas this is not happening.

How widespread is the issue?

8.43 There are different rapid response arrangements in each locality and it is only in the police and paediatric teams which responded in this case that this excellent practice is seen.

8.44 Between 1.4.11 and 31.12.14 there were 32 sudden and unexpected or unexplained child deaths in Warwickshire. Of these, 16 deaths met the requirement for a rapid response. Most, if not all of the elements were carried out in nine of the cases. In the four cases where the joint home visit was not carried out with a consultant paediatrician within 24 hours, as is set out in the protocol, the child had not been taken to the hospital John was taken to. In all of the cases of the children being taken to the hospital that John was taken to, the home visit with the consultant paediatrician was undertaken within the required 24 hours.

8.45 In the other seven child deaths some of the requirements of the protocol were not adhered to. Problems have arisen when acute health staff at other hospitals are not been conversant with the rapid response SUDC Protocol on the admission of a child, or have been unwilling to undertake the home visit element of the process. The police teams which respond out of operational hours are less familiar with the process and may not initiate it or initiate it fully.

8.46 Conducting joint home visits between the police and a paediatrician has also proved to be problematic in Warwickshire. This is due to there only being an informal arrangement for South Warwickshire Foundation Trust where there are only two specialist community practitioners paediatricians (one a consultant paediatrician and the other a nurse), who conduct rapid response investigations. If neither is available then the police conduct the home visit on their own. All six deaths where a paediatrician was not available occurred during a weekday evening or over a weekend which identifies a need for an on-call agreement. The two deaths where a joint home visit was conducted (cases 2 and 32) occurred in the morning of a weekday, where availability is more likely. Not all paediatricians fully appreciate the importance of a home visit.

Why does it matter? What are the implications for the reliability of the safeguarding system?

8.47 The rapid response process is central to the immediate multi-agency response where there is a child death both in terms of the protection of siblings and possible criminal culpability. If surviving siblings are to be safe it has to ascertained as quickly as possible how a child has died and whether surviving siblings are at risk, either in the short term, or the long term. If crucial information is missed because the process has not been followed potential risks to others may not be ascertained and cause of death may not be accurate.

Finding Four

A wealth of experience and expertise within this rapid response multi-agency team enables a pattern of effective rapid response in this team

The rapid response team is crucial both in terms of determining possible criminal culpability but also the protection of surviving siblings in the immediate aftermath of a sudden or unexpected or unexplained child death. It is the responsibility of a serious case review to capture effective working. This was an example of agencies in Warwickshire working positively together.
The significance of this finding is that whilst this was an effective rapid response team, there is not the same level of expertise across the locality.

Questions for Consideration by the Board

1. To maintain this wealth of experience and expertise within the rapid response team into the future and to ensure consistency in the response across the locality, there will need to be sound succession planning and development of process across all areas. Is the Board confident these structures are in place?

Communication and collaboration in longer term work.

Were any good or bad patterns identified about ways of working over a longer period with child or adult service users, carer(s) and family members?

Finding Five

In Warwickshire there is a pattern of disparate information sharing across agencies increasing the risk that important information relevant to keeping children safe will be overlooked

How did the issue manifest in this case?

8.48 Within the health components there was limited communication between agencies. There was no liaison between the GP and the health visitor, or the GP and the social worker, which resulted in the GP working in isolation, with no understanding of any of the wider issues. There was also no communication between the midwifery service and the health visiting service. As a result of this, of the numerous professionals involved including health

professionals in the community and in the hospital, social care, housing and the children's centre, none had the complete picture as to what was happening with this family.

8.49 An example of this was when Susan attended the GP for the six week post-delivery check. The GP was not able to assess Susan effectively because none of the professionals had advised the GP of the other risk factors for the family, or that social care was involved. The GP was not aware that there were concerns about Susan's coping or her being "emotionless", which was the way another health professional had described her. Susan did not volunteer any information either.

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

8.50 The challenge of information sharing between professionals is a common one according to both the review team and the case group.

8.51 This is particularly demonstrated by the complex structure of the health service and the multiple strands of health provision who can be involved with children and their families, making intra-agency as well as inter-agency information sharing more difficult.

How widespread is the issue

8.52 A previous serious case review in Warwickshire identified that professionals worked in isolation from each other, sharing some information bi-laterally but not sharing uniformly across the multi-agency network. There is a widespread problem in information sharing between hospital and community midwives, which has been evident in another case review recently completed by WSCB. WSCB has requested the review of a further case where it appears that practitioners in a GP practice may have been repeatedly presented with a child showing indicators of neglect, but these were not communicated to other agencies who may have been well placed to assess and intervene.

8.53 There is also evidence of good information sharing in the county. Health visitors are now located in children's centres and that has led to good communication between those two agencies. There is also anecdotal evidence that housing services are working more closely with health.

8.54 The challenges of information sharing are experienced on a national level. The Government has recently updated its advice on information sharing[4].

How prevalent is the issue?

8.55 This finding has the potential to affect all families because in a family with a new-born baby there will always be more than one agency involved, at the very least a GP and health visitor. A recent report commissioned by the Department for Education entitled "A Study to Investigate the Barriers to Learning from Serious Case Reviews and Identify ways of Overcoming these Barriers"[5] concluded that "Generally information sharing is an issue which appears in all cases and has appeared consistently for many years". This is a national issue,

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf

[5] http://www.lscbchairs.org.uk/sitedata/files/RR340.pdf

as well as a local one.

Why does it matter? What are the implications for the reliability of the safeguarding system?

8.56 If all the agencies working with a family are effectively sharing information, as appropriate, the child's world will be better understood and consideration of risks will be more effective. This will create a safer world for the child.

8.57 Just as with other professionals, if there are a number of health professionals involved services need to be coordinated, if we are to optimise the safety and wellbeing of the child.

8.58 This case review indicates that effective information sharing in Warwickshire is more a matter of chance than of safe, reliable systems and practices; increasing the risk significantly that important information relevant to keeping children safe will be overlooked.

Finding Five

In Warwickshire there is a pattern of disparate information sharing across agencies increasing the risk that important information relevant to keeping children safe will be overlooked

Our greatest opportunity to reduce risk and improve outcomes for children is through effective multi-agency working. One of the cornerstones of effective multi-agency working is information sharing. If this is not happening, the system is unsafe. Yet this case review indicates that effective information sharing in Warwickshire is more a matter of chance than of safe, reliable systems and practices; increasing the risk significantly that important information relevant to keeping children safe will be overlooked.

Questions for Consideration by the Board

1. Does the Board know what work is currently underway to support multi-agency working within health and between all agencies?
2. Does the Board understand the main barriers to good multi-agency working? Are any of these barriers currently being tackled by the Board?
3. How can the Board and its partner agencies help frontline professionals in this area?
4. What does the Board consider the role of the GP to be in multi-agency safeguarding working?
5. Does the Board understand what the barriers are to timely notification from midwifery services to health visiting services about expectant women?

Appendix One

Glossary of Terms and Acronyms

Common Assessment Framework (CAF) - The CAF should be offered to children who have additional needs to those being met by universal services. The practitioner assesses needs using the CAF.

Child in Need - Under Section 17 (10) of the Children Act 1989, a child is a Child in Need if:

- He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or
- He/she is a Disabled Child.

Child protection – Section 47(1) of the Children Act 1989 states that: Where a local authority have reasonable cause to suspect that a child who lives, or is found, in the area and is suffering, or is likely to suffer, significant harm, the authority shall make such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

LHA – Local Housing Authority

LSCB - Local Safeguarding Children Board

Rapid response – as set out in Working Together, 2013, each LSCB must have a rapid response protocol when a child dies suddenly or unexpectedly.

Safeguarding - Safeguarding is defined within Working Together, 2015 as

• protecting children from maltreatment;

• preventing impairment of children's health or development;

• ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and

• taking action to enable all children to have the best outcomes

SCIE – Social Care Institute for Excellence

SUDC – Sudden Unexpected or Unexplained Death of a Child

Working Together to Safeguard Children, 2013, updated 2015. The statutory guidance for inter-agency working to safeguard and promote the welfare of children.

WSCB – Warwickshire Safeguarding Children Board