Croydon and Lambeth Safeguarding Children Boards

Serious Case Review

Child L

August 2018

Contents

1. Introduction

1.1 The purpose of a Serious Case Review (SCR), is to seek to understand what happened and why it happened in the context of local safeguarding systems, rather than to view solely the actions of individuals relating to a single case. The case under review is an example of local working arrangements in several areas of London at the time that the work was undertaken.

1.2 The lessons learned should be used to seek to improve the protection of children and multi-agency safeguarding systems.

1.3 Where possible a review should be informed by the experiences, views and perspectives of the family and practitioners at the time, rather than just from agency records in the light of hindsight. Judgements and lessons should follow from what was known to practitioners at the time or which could or should have been known at the time, but not using information which could not have been known.

1.4 The review is to ensure that agencies are held accountable for their services, systems and processes in safeguarding children and how they work together as a multi-disciplinary team. A SCR aims to enable the Local Safeguarding Children Board and its partner Agencies, through the single case, to test the wider effectiveness of local and national safeguarding children procedures, protocols and working arrangements.

1.5 A review should be proportionate and seek to understand, explain and evaluate what happened through a systems framework, but not to blame.

1.6 The Croydon and Lambeth Safeguarding Children Boards each endorsed this report in the Autumn of 2017 and agreed the recommendations within it. The Review could not be published at that time as the criminal investigation into the harm to Child L was not complete.

1.7 Both Parents were charged with **causing or allowing serious physical harm to a child, contrary to section 5 of the Domestic Violence, Crime and Victims Act 2004**. This was on the basis that they were persons who were members of the same household and had frequent contact with Child L and there being a significant risk of serious physical harm to L from the unlawful act of one of them; and that either (i) caused serious physical harm to L by an unlawful act, or, (ii) as someone who was or ought to have been aware of the risk of serious physical harm to L from the unlawful act of the other, failed to take reasonable steps to protect L from that risk, the unlawful act having occurred in circumstances of the kind that he/she foresaw or ought to have foreseen.

1.8 The case came to trial at the end of May 2018. The Jury found both parents Not Guilty.

1.9 The Review and the lessons from it can now be published as all legal proceedings from this case have been concluded. The Croydon and Lambeth Safeguarding Children Boards have been progressing the actions arising from the agreed recommendations and monitoring their impact; and will continue to do so.

2. Background and reason for the review

2.1 In July 2016, L (age 11 months) was taken to Hospital 2 by his parents. He was in cardiac arrest, as a result of ingestion of cocaine, which appeared to have been hidden in his cot. At the time of this review this was under investigation as a crime. L survived the ingestion and was later made subject of Care Proceedings[1].

2.2 L had been a subject of Child Protection Plans since before his birth, in July 2015. This level of safeguarding arose from concerns about his Mother's behaviour, emotional state and possible self-harm (or harm to the foetus) and apparent mental ill-health during and after pregnancy; ongoing domestic abuse, including allegations and counter-allegations of assault between the parents; a background of cultural tension between the Mother's and Father's families, including an allegation of forced-marriage; and reluctance by the parents to follow through agreed actions and Child Protection Plans. The case was complicated by homelessness and temporary moves across borough boundaries in London. Previous drug use by Father was known, but not seen to be a safeguarding issue. A later allegation that Father was a drug dealer, was denied by him.

2.3 Information gained from enquiries after the critical incident, but not previously known to practitioners, showed that L had ingested cocaine over several months, from January 2016. The view formed was that on a balance of probability he had ingested it by coming into contact with cocaine powder/residue left lying on surfaces and that he had transferred it to his mouth on his fingers, by accident. Mother also had evidence of cocaine in her system from before the critical event. The SCR Panel considered whether one of the parents may have given L cocaine deliberately, but there was no evidence to support this view. Mother had breastfed L briefly, but there was no evidence of transmission through breast milk, and the traces found in his system were from some months after she ceased breast-feeding. It was alleged that Father snorted cocaine rather than smoked it, there is no evidence, therefore, that ingestion could be through passive inhalation.

2.4 Agencies involved were Midwifery, Acute Hospital Services, Perinatal Mental Health Services, Primary Health Care, Children's Social Care, Health Visiting Services, Police, Housing, Domestic Violence Services and a Children's Centre. These were across three London boroughs.

2.5 Lambeth agencies had initially worked with L's parents as his Mother was temporarily resident in Lambeth, with members of the Father's family. At the time of the critical incident, L was permanently resident in Croydon and had been transferred to a Child Protection Plan there. Because of the harm and public agencies' involvement with L since before his birth, the Independent Chairs of Croydon and Lambeth Safeguarding Children Boards jointly agreed that the case met the criteria for a Serious Case Review (SCR)[2].

2.6 It was agreed that Croydon Safeguarding Children Board would lead the SCR. A joint SCR Panel was convened and Terms of Reference for the review and its Scope were agreed. An Independent Chair

[1] The meaning of technical terms relating to safeguarding children law or guidance can be searched in the London Child Protection Procedures http://www.londoncp.co.uk/search/search.html

[2] Working Together to Safeguard Children 2015, Chapter 4 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

(the newly appointed Chair of Lambeth Safeguarding Children Board, independent of this case) and an Independent Reviewer were appointed to lead the SCR. The methodology is the Extended Child Practice Review Model. Details of the Panel and Terms of Reference are set out in Appendix 1.

3. Executive Summary and Key Lessons

3.1 The case concerns a young couple in a volatile relationship. There were concerns about domestic violence, possible mental ill-health – including alleged self-harm (with risk to the foetus in pregnancy), homelessness, temporary housing and moves across local authority boundaries. There were also suggestions of drug use and dealing, which were denied. The concerns about the Mother's alleged self-harm and domestic violence in pregnancy led to a pre-birth assessment which resulted in the unborn Baby, L, being made subject of a Child Protection Plan from birth.

3.2 The Parents agreed to, but did not co-operate with the Child Protection Plan. This prevented essential perinatal assessments being completed. At times, the couple separated making counter-claims against each other. They often retracted the claims and re-united.

3.3 The case originated in Lambeth, where the Mother was living temporarily with Father's family. Lambeth took the case responsibility and placed L on the Child Protection Plan. However, she was later accepted as homeless by Croydon Council on two occasions. Opportunities to transfer the case to Croydon, and later Camden, were missed, when, first Mother and subsequently Mother and L were resident there.

3.4 The complications of cross-borough co-ordination led by Lambeth, where L never lived, led to difficulties within the work to ensure the completion of the Child Protection Plan, particularly the completion of the mental health assessment for Mother and work on the marital relationship and domestic violence. It also led to problems in establishing an effective Core Group process. There were also difficulties for the Lambeth Social Workers in seeing Mother and L since Mother often did not stay in the Camden accommodation but moved at times to relatives.

3.5 When L was seen by Practitioners he was seen to be developing normally and there were no immediate concerns about his welfare. As a result, consideration of legal proceedings was stepped down, even though there was minimal co-operation, and it was thought that Mother and Father had separated.

3.6 Mother and L were permanently re-housed in Croydon after six months, during which time they had been allocated temporary accommodation in a hostel in north London. Following a delay, Croydon Children's Services accepted the case at a Transfer-in Child Protection Conference, at which key professionals were not present. Because of the ongoing concerns L was retained on a Child Protection Plan. However, little work was done with the family from this point and the co-ordination of the Core Group was ineffective. It is understood that Father was regularly present at the accommodation in Croydon.

3.7 L collapsed in cardiac arrest six weeks later, having ingested cocaine. He survived the collapse. Care Proceedings and a criminal investigation were initiated. As a result of these enquiries it came to light that L had been exposed to and ingested cocaine over the preceding six months.

3.8 The Review of the case has highlighted lessons about the operation of the safeguarding systems in Lambeth, Croydon and Camden. They are discussed in the analysis of the work in Section 8. The priority lessons are summarised here, in section 3, and discussed in greater detail in Section 9 of the Report. Section 10 sets out recommendations resulting from those lessons.

Key Lessons See section 9 for fuller discussion of these lessons

3.9 **Keeping the child's lived experience at the centre of safeguarding children practice**

3.10 **Knowledge and Skills in Working with Drug Using Parents**

3.11 **Homelessness and Temporary Accommodation and their impact on child protection**

3.12 **Cross-Borough Working**

3.13 **Getting the basics right, adherence to Procedures, and supporting Frontline Practitioners with guidance and reflective supervision**

4. Case History

4.1 **Background** Mother and Father had known each other as teenagers. They had met at college but had not remained in contact. Father was said to have married and divorced, by Islamic custom. The couple resumed their relationship after a chance encounter in 2013.

4.1.1 They came from different cultural backgrounds (Kurdish-Turkish and Turkish-Cypriot); their families were initially reluctant to accept the relationship and it is alleged that they sought to stop it, with arguments and harassment and threats to kill, to which the Police were sometimes called.

4.1.2 In November 2014 Father was cautioned for possession of cannabis, found in his car, in which Mother was also travelling. It was accepted that the cannabis was for his own use and that Mother was not involved.

4.1.3 In Autumn 2014, Mother became pregnant with L.

4.1.4 The couple married, Mother has said that this was both an Islamic marriage, in November 2014, and a registered marriage, in January 2015. An allegation was made, by Father, that this was a forced marriage to prevent any shame to Mother resulting from the pregnancy, but this was not substantiated, or followed through by him.

4.1.5 Their relationship was volatile. Father continued an on-off relationship with his previous wife and at times sought to leave Mother or did leave Mother; Mother was jealous. This led to aggression, allegations and counter-allegations, often involving the Police. The allegations included aggression initiated by Mother and by Father.

4.2 **December 2014 – April 2015**

4.2.1 Mother was, at times, described or seen to be hysterical or alleged to be threatening self-harm or harm to the foetus. In late December 2014 and January 2015, Mother was seen at Hospital 1 Emergency Department. There were concerns about her emotional state and that she may have

mental ill-health (depression and suicidal thoughts) and a suggestion of 'personality disorder traits.' Mother did not co-operate with further attempts to assess her mental state and denied that she had mental ill-health.

4.2.2 In March, Mother was conveyed to Hospital 1 by ambulance. It was alleged that she had self-harmed and sought to harm the foetus by punching her abdomen. Father alleged that she was depressed and that Mother had not co-operated with an assessment by the GP. Hospital 1 referred Mother to Lambeth Children's Services, as she was then resident in Lambeth in the home of Father's Mother.

4.2.3 A Section 47 Child Protection Enquiry was agreed and multi-agency assessment was started. This resulted in a Pre-Birth Child Protection Conference, in April, where unborn Baby L was made the subject of a Child Protection Plan.

4.2.4 Mother was living with Father's family in Lambeth but made an application as homeless to Croydon where she had grown up. In April, she was offered temporary accommodation in Croydon but did not fully use this.

4.3 May – July 2015

4.3.1 The volatile relationship between Mother and Father continued. On three further occasions Mother was conveyed to Hospital 1 by ambulance with concerns about her emotional health and risk to the baby. Police were also involved in allegations of domestic abuse between the couple, and allegations of threats involving Father's previous wife.

4.3.2 Mother did not attend planned mental health assessments with the Perinatal Services or the GP.

4.3.3 As Mother had left the temporary accommodation provided by Croydon Housing she was informed that Croydon Council had discharged its duty to her as a vulnerable homeless person.

4.3.4 A further Pre-Birth Child Protection Conference was held in July, where it was noted that the concerns continued and that there had been little progress in completing assessments, as parents had not co-operated. It was confirmed that unborn Baby L should be subject of a Child Protection Plan for risk of physical abuse.

4.4 End of July – end of August 2015

4.4.1 L was born two weeks later, at Hospital 2, and after a few days discharged with his Mother to her Mother's home in Croydon, as part of the Discharge Plan agreed by Children's Services with the Mother, Father and the grandparents. Health visiting responsibility was transferred from Lambeth to Croydon, but the social work case responsibility remained with Lambeth. The outstanding mental health assessment was referred to the Croydon Perinatal Team from the Lambeth Team within the same Mental Health Trust.

4.4.2 Midwifery Services, Health Visiting and Lambeth Children's Services visited Mother and Baby L appropriately throughout August. Good care and bonding between L and Mother were noted. It was noted that the Parents were back together and were considering renting a private flat in East London.

4.4.3 The Review Child Protection Conference was held at the end of August. Perinatal Services and

Croydon Housing were invited to the Review Child Protection Conference but did not attend. Good care of, and good bonding with, Baby L were noted; but as there had been little progress of the Child Protection Plan and Parents had not co-operated with assessments it was agreed that L should remain subject of a Plan, under the changed category of risk of Emotional Abuse. The Plan was revised. Lambeth Children's Services continued to hold lead case responsibility, although Mother and L were now living in Croydon.

4.5 September – end of November 2015

4.5.1 At the Core Group meeting in early September, it was noted that Mother and Father were planning to separate (he was reported to have returned to his previous wife) and that Mother could not stay longer with her parents, in Croydon. The perinatal mental health assessment was noted as still not done.

4.5.2 Two days later, Police stopped Father in his car. He was in possession of a large quantity of cash which was unaccounted for, but no offence was detected and Police took no further action. As no child was in the car there was no requirement for the Police to notify children's services. The amount of cash was below the threshold for seizure or other action.

4.5.3 Later in September, the Parents were said to be 'back together', though not living together. Care of Baby L was observed to be good.

4.5.4 In the third week of September, Mother alleged to the Police that Father had assaulted her and threatened to bomb her home. A few days later she withdrew the allegation. Police informed Croydon Children's Services, which passed the information on to Lambeth Children's Services.

4.5.5 At the end of September, following a Legal Panning Meeting, Lambeth Children's Services asked Croydon Children's Services to convene a Transfer-in Child Protection conference to take over the responsibility for safeguarding Baby L, as he was resident in their area.

4.5.6 The following day Croydon Housing accepted Mother and Baby L as homeless and provided temporary accommodation in a hostel in Camden. Lambeth Children's Services expressed concerns about Mother and Baby L being rehoused so far away from family support.

4.5.7 At the beginning of October, Baby L was registered at and seen for the eight-week development check at a local GP Practice in Croydon. This was the GP Practice for the Mother's Family, although Mother was no longer registered there herself and continued to be registered with the Lambeth GP. This Practice was unaware that L was subject of a Child Protection Plan until April 2016. From this point, all his immunisations and GP care were at this Practice, even when he was living in Camden. The registration of Mother and L with different GPs and differing levels of awareness by other health workers of Mother's and L's moves led to complications in information sharing and key Practitioners being unaware that either L was subject of a Child Protection Plan or was resident in their area. (Adoption of the NHS electronic Child Protection Information Sharing System (CPIS)[3] may help mitigate against this.)

4.5.8 In early October, Croydon Children's Services declined to accept the case on the basis that Mother

[3] https://digital.nhs.uk/child-protection-information-sharing

and Baby L's residence in Croydon was temporary. They were unaware that Croydon Housing had accepted responsibility to assess Mother as homeless.

4.5.9 Croydon Health Visiting Services transferred the case to the Camden Health Visiting Service. The Lambeth Social Worker had difficulty in visiting Mother in Camden, as at times Mother was staying with a sister in Enfield, or with a friend in Hackney, or she was visiting family in South London.

4.5.10 In early-October, Mother alleged to the Police that Father had assaulted her in Lambeth and dragged her out of his car. She alleged that he had not wanted her to be in his car as he was mentally ill and dealing in drugs. Police informed Lambeth Children's Services of the assault. A few days later Father was arrested. He denied the allegations and claimed that Mother had a history of self-harm and caused the injuries herself. He was charged with assault and bailed to have no contact with Mother, pending appearance at court.

4.5.11 The Lambeth Social Worker visited Mother and Baby L at her sister's home in Enfield. Mother was staying there as she felt safer than being alone in the accommodation in Camden. Mother stated that Father had texted her to say he wanted to divorce her.

4.5.12 It was alleged that Father injected steroids.

4.5.13 The Croydon Perinatal Services, in following up the referral for an assessment of Mother's mental health, learned that she had moved to Camden, and discharged her back to the care of her Lambeth GP.

4.5.14 There was liaison between the Camden Health Visitor and the Lambeth Social Worker; the Health Visitor was concerned about Mother's emotional state and unrealistic expectations. She was concerned about unsuitable sleeping arrangements for Baby L. The Social Worker visited and found the care of Baby L to be good. Lambeth Children's Services provided a new mattress for the cot.

4.5.15 The Core Group was cancelled as Mother had moved to Camden. The Social Worker contacted Camden Children's Services to ask them to convene a Transfer-In Child Protection Conference. The Social Worker also liaised with Croydon Housing, raising the need for housing local to Mother's family in Croydon.

4.5.16 The day before the court hearing regarding the alleged assault by Father, at the end of October, Mother withdrew her allegation saying that she had lied and that the injury seen by Police was historical, and not previously reported. The charge was withdrawn.

4.5.17 At the end of October, Baby L was seen at the GP Practice in Croydon with diarrhoea. A few days later Mother contacted an Out-of-Hours GP Service saying that L was not breathing. An ambulance took L from the Temporary Housing to a hospital in North London. He had had several days of diarrhoea and vomiting after feeds and one day of running nose and cough. He was alert, had a clear chest, cough, white sputum and had a strong heart rate. *There was no evidence from the hospital records that he had been in a state of collapse and breathing was said to be normal.* The hospital was unaware that L was subject of a Child Protection Plan but was told by Mother that he had a social worker. The hospital contacted Lambeth Children's Services later the same day and advised that Baby L had been seen, had been suffering with a stomach bug, had been monitored and was well enough to be discharged. His Mother was described as caring and L appeared well-cared for.

4.5.18 The Croydon GP Practice for Baby L was alerted to the out of hours GP call, by routine notification, stating that L had collapsed and was not breathing, but not to the later hospital assessment. The GP Practice sought to follow this up by ringing Mother, but not the hospital. Mother did not respond to the phone call. When seen in the GP Practice the following week L was well enough for an immunisation. The matter of L's reported collapse was not raised again with Mother.

4.5.19 In early November Mother was staying with a friend in Hackney as she was fearful of being on her own in the homeless accommodation in Camden. The Lambeth Social Worker visited her in Hackney and noted the care of Baby L to be good.

4.5.20 Camden Children's Services declined to accept responsibility for safeguarding Baby L as he and his Mother were only temporarily resident in Camden.

4.5.21 The Social Worker saw Mother and Baby L at the Maternal Grand Mother's home in Croydon and noted no concerns about the care of Baby L. Mother was also noted to show understanding of the possible impact of domestic violence on Baby L. A week later in mid-November the Social Worker contacted Croydon Housing and asked for Mother and Baby L to be moved back to Croydon.

4.5.22 At the end of November, the Social Work Supervisor noted variable progress of the Child Protection Plan and that Mother's mental health appeared more stable, but that Mother was not using the accommodation in Camden and was staying with family or friends in other boroughs. It was agreed that Lambeth would continue to hold the case to prevent Baby L falling through the net and would convene a further Legal Planning Meeting if circumstances did not stabilise. The Social Worker contacted Croydon Housing again, asking for Mother and Baby L to be moved closer to her family; Housing was also asked to attend the planned Core Group Meeting to be held in Camden.

4.6 December 2015 – end of February 2016

4.6.1 The Social Worker saw Mother, Father and Baby L, who was observed to be fine. They had rowed as Mother alleged she had found another woman's hair in his bed, she had assaulted him and he had slapped her in return. Alternative contact arrangements were agreed for Father with Baby L and Father agreed to have no contact with Mother. The Social Work Supervisor asked for the Public Law Outline process to be reviewed.

4.6.2 The Social Worker had regular contact with Mother to support her in separating from Father and shared up-to-date information with the Camden Health Visitor and Camden Independent Domestic Violence Advisor. There was difficulty visiting Mother and Baby L in Camden as she was not always there. They were seen in the third week of December at the Grandmother's home in Croydon. No concerns about Baby L's welfare were noted on that visit; observation was of good physical care and a close emotional bond with Baby L. These observations were reported to the Supervisor in early January.

4.6.3 Baby L had the third immunisation at the GP Practice in early December.

4.6.4 In early January, the Social Worker contacted Mother to arrange to visit in Camden, but Mother was with her sister in Enfield. Mother reported that Father was being supportive. Mother was staying in Enfield as there was reported to be no heating at the homeless persons' accommodation in Camden. A few days later Mother and Baby L were visited in Enfield and Baby L was fine. As Mother and Baby L were in Enfield a planned Core Group Meeting was cancelled.

4.6.5 In social work supervision, at the end of January, it was noted that Baby L's care was good, that Mother was engaging with the Child Protection Plan, and there was an improvement in the parents' relationship. There was no report of significant domestic violence since the end of October. It was thought to be too soon to step the case down from child protection to child in need status.

4.6.6 The Social Worker visited Mother in Camden and noted Baby L was fine; and that at times Father was also staying in the accommodation.

4.6.7 The Child Protection Review Conference planned in Lambeth, at the end of January, was inquorate and had to be reconvened.

4.6.8 In early February and mid-February, Father reported to the Police that he had been trying to end his relationship with Mother, describing her as his 'ex-girlfriend'. He said that he had rung her to tell her and he alleged that she had reacted badly threatening to report him to the Police as having assaulted her to get him arrested. On the second occasion, he alleged that she was threatening to damage his car. He was worried that it may affect his contact arrangements to see Baby L.

4.6.9 Croydon Housing informed Mother and Lambeth Children's Services that they had accepted a duty for her long-term housing needs. In mid-February Mother cancelled meetings with the Lambeth Social Worker as she was preparing to move back to Croydon. She was offered a tenancy in Croydon in the third week of February; but it was not deemed suitable.

4.6.10 The reconvened Review Child Protection Conference was held at the end of February, in Lambeth. It was believed that Mother and Baby L had now moved back to Croydon, but that was not the case, as the property she had been offered in mid-February was unsuitable, which was not made known to the Child Protection Conference. Baby L was to remain subject of a Child Protection Plan as the required assessments had not been completed and there were still concerns about domestic violence. Croydon Children's Services was to be asked to convene a Transfer Child Protection Conference to accept responsibility for the case. The request for transfer was made to Croydon at the end of February.

4.7 March to May 2016

4.7.1 In early March, L was seen at the Croydon GP Practice with diarrhoea and vomiting. The Practice was not yet aware that L had been subject of a Child Protection Plan from birth.

4.7.2 A Women's Refuge in North London received a referral about Mother and long term domestic violence with Father, from a Camden domestic violence advice agency. The referral also noted that it had been alleged that Father was a drug dealer. The refuge sought to contact Mother on six occasions with no response and referred the case back to the Camden Agency.

4.7.3 The Core Group Meeting (in Lambeth) was cancelled, as it was inquorate.

4.7.4 Mother was offered alternative accommodation in Croydon, as the first tenancy was unsuitable.

4.7.5 Mother cancelled visits from the Lambeth Social Worker because of her planned move back to Croydon.

4.7.6 The Social Worker saw Mother and Baby L at the Mother's new accommodation in Croydon at the beginning of April. Baby L was happy and well. Mother reported that she and Father 'were a couple'.

4.7.7 The Social Work Team Manager contacted Croydon Children's Services to expedite the request for a Transfer-in Child Protection Conference and two days later relevant documents were sent to Croydon. A week later Croydon Children's Services requested additional information. In the third week of April, Croydon Children's Services also asked Lambeth Children's Services to complete a referral form.

4.7.8 In mid-April, the Lambeth Social Worker visited Mother and Father in their new accommodation in Croydon. They saw themselves as a couple again. Parents said they were working on their relationship.

4.7.9 Four days after the visit to Mother and Father in the new accommodation, the Father contacted the Lambeth Social Worker to say that Mother was 'mad and aggressive' and that he wanted contact with Baby L, without being threatened by her. A week later, they visited the Lambeth Children's Services office together to say that their relationship was over and that they would seek support with counselling. Baby L was seen and was fine.

4.7.10 Towards the end of April, L was seen twice at the GP Surgery, once with an ear infection and a week later with fever. The Practice also received information from the Camden Health Visiting Services that they were ceasing their involvement as L and Mother had moved back to Croydon, and that Lambeth Children's Services was transferring the case to Croydon Children's services. This was the first time that the Practice knew that L was the subject of a Child Protection Plan.

4.7.11 In early May, in social work supervision it was noted that Mother was not engaging with local services in Croydon, there were concerns about her mental health. A further Legal Planning Meeting was to be sought and the referral to Croydon Children's Services was to be chased up. The following day Croydon Children's Services agreed to the Transfer-In Child Protection Conference.

4.7.12 The Lambeth Social Worker referred Mother and Baby L to the Lambeth Children's Centre, which was located on the borough boundary between Croydon and Lambeth.

4.7.13 In the second week of May, Mother and Baby L were seen at home by the Lambeth Social Worker. Baby L was fine. A Core Group meeting was held the same day. The Parents stated that they would work on their relationship, although they had previously told the Social Worker that the relationship had ended. They agreed to access domestic violence services in Croydon; but there was concern that Mother had no insight into domestic violence and its impact. It was agreed to escalate the concern about delay in arranging the Transfer-In Conference to senior management.

4.7.14 The Transfer-In Child Protection conference was held at the end of May. Baby L was made subject of a Child Protection Plan in Croydon, under the category of risk of emotional abuse. A social worker was to be allocated by Croydon Children's Services and Lambeth's responsibility came to an end. The Croydon Health Visiting Services and L's GP Practice were not invited to the Conference.

4.7.15 At the end of May, a few days after the Conference, there was liaison between Camden Health Visiting Service and the Croydon Health Visiting Service to transfer responsibility back to Croydon. Mother and Baby L had been seen on three occasions in Camden and there had been telephone contacts, but Mother had not engaged with health visiting services in Camden. Mother had reported to the Camden Health Visitor that Father was seeing Baby L every day. The Croydon Health Visitor had been unaware that a Transfer-In Conference had already been held and sought information from the Lambeth Social Worker.

4.7.16 Mother and Father attended a Parenting Course session at the Children's Centre which they had 'enjoyed'; but Father said that he would not be able to attend again, because of work.

4.8 June to July 2016

4.8.1 In early June, the Croydon Health Visitor sought to visit Mother and Baby L but Mother did not respond to contact. The Mother visited the new GP with Baby L and shared the information that Baby L was on a Child Protection Plan to Croydon and the history of a turbulent relationship with Father, as well as worries about her mental health and post-natal depression. She stated that she had no current worries about mental health. The GP noted good bonding between Mother and Baby L and that Baby L appeared well. Croydon Children's Services was not yet aware of who L's new GP was.

4.8.2 In the second week of June both the GP and the Children's Centre asked Croydon Children's Services for information about the identity of the new allocated Social Worker. Mother attended a planned Core Group Meeting, but no professionals were present, not even the new Social Worker, and the meeting did not go ahead.

4.8.3 In the third week of June, the Health Visitor visited Mother and Baby L at home. The home was clean and tidy and positive interaction was noted between Mother and Baby L. Baby L was assessed and was up to developmental milestones. Mother was to continue attending the Children's Centre. Father was said to be living elsewhere, but visiting regularly.

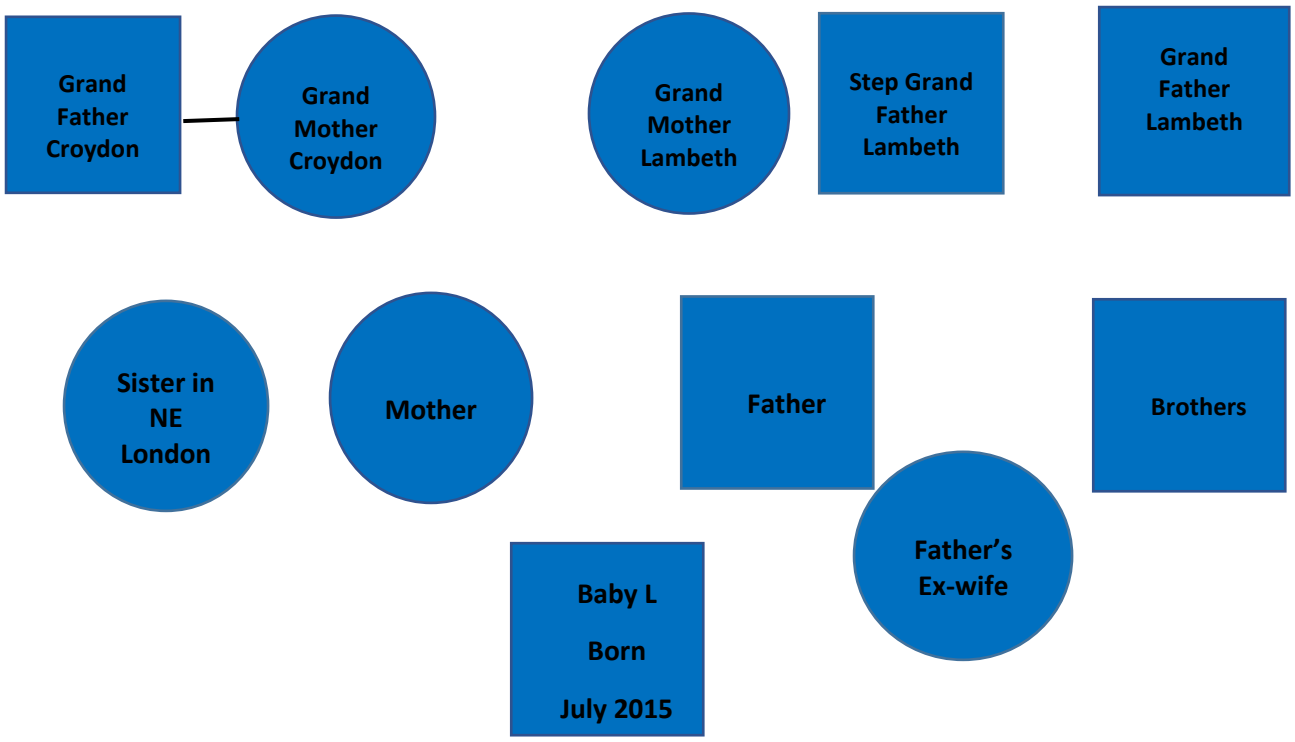
4.8.4 In the third week of June, the Children's Centre contacted the Croydon Social Worker to say that Mother had not been attending. The Social Worker agreed to follow this up.

4.8.5 In early July, the Croydon Social Worker contacted the GP to share the history of concern about Mother's mental health and to ask for mental health support for Mother, now that she was resident in Croydon.

4.8.6 In the second week of July, Baby L was taken to Hospital by his parents in cardiac arrest, as a result of ingestion of cocaine. The investigation into this showed that Father had been resident in the property for a week.

5. L's Family

5.1 Genogram



5.2 Background

5.2.1 Both Mother and Father are Muslim.

5.2.2 Mother is of Turkish-Kurdish heritage, born in Istanbul, she came to London as a toddler. Her family lived in Croydon. She had several siblings. She had lived with her mother and father in Croydon but during the initial period of this review was at times resident with Father's Mother in Lambeth.

5.2.3 Father is of Turkish-Cypriot heritage. His mother and father separated and for a period he lived in his Father's home in Lambeth with brothers. He alleged a difficult childhood and some use of drugs and alcohol, as an adolescent. Father worked as a security guard in the leisure industry, mainly at night. Father was said to have married his first partner by Islamic custom, Nikah[4]. There is no evidence that

[4] **Nikah** or **Nikkah** derives from the Quran and refers to the Muslim marriage contract or agreement between a man and woman, in front of at least two witnesses, under Sharia law. It may take a variety of forms in different Islamic cultures. It is not clear whether the marriages referred to in this case were witnessed or contracts signed. Both the man and woman must consent. It can also be used sometimes to refer to the ceremony in which the contract is agreed. In the UK, such an arrangement would be regarded as co-habitation and would not confer the

this marriage was formally registered in the UK or any other jurisdiction. He was said to have 'divorced' his first 'wife' by Islamic tradition.

5.2.4 The couple met when they were teenagers at college. They lost contact with each other for a year, re-met by chance in 2013 and started a relationship, their families were unhappy about this and sought to stop it. There was animosity and some reported aggression between the families, said to arise from cultural differences.

5.2.5 Mother reported that she was very much in love with him after this, and that this clouded her views of him and her emotional reactions when he continued a relationship with his former partner. She said that they married in November 2014, by Nikah, 'between themselves' and later in January 2015 they registered their marriage formally. The information about the Muslim marriage in November, was not shared when agencies were working with them and when there were allegations of forced marriage in January 2016.

6. Family Perspectives on the Services offered to them

6.1 Both Mother and Father were informed in writing of this Review and invited to contribute. They were advised that this was to get an understanding of their views about L's care and what they thought about support or services that were offered; and to know if there was anything else that they thought would have helped, at that time. Parents' perspectives are important.

6.2 The Independent Author and a Panel Member met with Mother and Father separately to explain the SCR process and to seek and learn from their views about the services provided. Their comments have been summarised. They were given in retrospect, and have not been verified. Mother's comments were given at the time when Care Proceedings in relation to L were still ongoing and the Police had not completed the investigation into the ingestion of drugs. Mother was hopeful of having L returned to her care. Father's comments were obtained after the Care Proceedings and when both Parents were facing trial. He said he had been 'traumatised' by what had happened to L.

6.3 Mother

6.3.1 Mother maintained that the allegations of her threatening her abdomen with a butter knife and hitting herself, while pregnant, were not true. She saw someone at Hospital 1 (in Lambeth) but despite calling back she was never offered a follow up appointment. Mother was clear that she did not have a mental health problem.

6.3.2 Mother said she was very much in love with Father and did not want the relationship to end. She did not want Baby L to be without a dad. Even when people, including professionals, strongly encouraged her to separate from him she did not wish to do so. She continued to hope that they could be reconciled and work it out. Mother now realises that as she loved him she had unrealistic expectations of him; but at the time she hoped that they would be able to resolve the issues.

legal rights or responsibilities of marriage; unless it had been conducted in a country where it also met civil law requirements, and was accepted as such by the UK.

Mother's views about the services Baby L and the family received

6.3.3 Mother was positive about the services she received from hospitals, antenatally and at the time of L's birth. The hospital and community Midwives were good.

6.3.4 The Health Visitors were 'really helpful'. Mother felt able to talk with them.

6.3.5 Mother accepted that the Social Workers were trying to help her. But each time there was a change of social worker it was stressful to have to explain things from the beginning again. Mother was positive about the relationships with the Social Workers in Lambeth (but had not met the Croydon Social Worker before the critical incident).

6.3.6 The Children's Centre was seen to be good.

6.3.7 Mother had mixed feelings about the Housing Service. She had wanted the best for Baby L. She accepted that she did not properly use the hotel accommodation provided initially in Croydon. She accepted that she had to go to Camden when she could not stay at her Mother's home for longer after L's birth. However, the Camden accommodation was not good and Mother was clear that 'she could not stay there for a year'. She felt that she needed to be closer to family. For this reason, occasionally, she stayed with relatives in north London. She was grateful when Croydon Housing offered a flat in Croydon and then provided a better flat.

6.3.8 Mother felt that she was treated unfairly by the Police who, in her view, did not take her point of view into consideration. She felt that other agencies believed the Police too readily.

6.3.9 **Child Protection Conferences and Core Groups** Mother said: 'There were so many meetings'. She understood why they were needed and that professionals had worries and were trying to help and to advise her. She thought that her wanting the relationship with Father to work clouded her response to the Plans and the advice she was given. The advice made sense to her, even though she did not follow it. She was treated fairly in the meetings, and was always able to give her point of view. However, she 'never' felt believed, for example when she said that Father was not committed and was cheating on her. When she was in Camden it might have been better if the meetings were held there.

6.4 Father

6.4.1 Father said that he met Mother when he was 18 but they lost contact. When they re-met by accident he was 21 and just coming out of a relationship with his first wife (by Islamic marriage). The relationship with Mother progressed to becoming serious more quickly than he had anticipated.

6.4.2 Father acknowledged that this was a testing time for each of them as they had different expectations of each other. He was used to having his own space and felt that she was jealous and wanted to keep close tabs on him.

6.4.3 When Mother became pregnant he felt pressured by both families to marry, even though he did not feel ready to do so. He saw this as a 'forced marriage'. He said this made him depressed; but he was happy about the pregnancy and hoped it might bring them closer.

6.4.4 When L was born Father 'fell in love with him'. He was very pleased to have a son and wanted to take responsibility for him. The family tensions made it uncomfortable for Father to have contact with L. Father said that this depressed him. Later after Mother and L moved to Camden and later back to Croydon he stayed with them most of the time and his clothes were there.

Father's views about the services Baby L and the family received

6.4.5 Father was worried about Mother's mental health and called ambulances and went with her to hospital when she threatened to harm herself or shouted in the street when was pregnant. He thought the ambulance and hospital responses were helpful. In his view she needed help with her mental health, but she denied that she had a problem and would not accept help. He felt pressured to lie and say that things were 'okay' in meetings with professionals.

6.4.6 Father thought that the Police response of arresting him was not helpful and that what was needed was a solution, such as mediation in their relationship. He said that he tried to arrange mediation himself, but Mother refused to attend. One Police Officer had advised him that things would probably not change.

6.4.7 In terms of the social work he felt excluded at times, not all the workers returned his calls, but one was helpful. He didn't think that they saw how aggressive Mother could be and why he left her on occasions. He said that he told workers that 'everything was okay' in order to pacify Mother.

6.4.8 He did not think that he had seen all the reports to meetings. He understood the Child Protection Conferences he attended but thought more help was needed. He had not understood that the incidents which led to the police being called were treated as possible domestic abuse and that Mother was being encouraged to leave him.

6.4.9 Father thought that what may have helped was some work, including with the wider families, to help them bond and accept the relationship and also see things from his point of view as well as Mother's.

7 Practitioners' and Managers' Perspectives

7.1 Lessons arising from the Practitioners' Learning Events

As part of this Review the Practitioners who had worked with L and his family were identified and invited to two Practitioners' Learning Events, led by the Independent Author with members of the SCR Panel.

Croydon and Lambeth Safeguarding Children Boards are grateful to the Practitioners and Managers who attended, including those from Camden.

In the first Event, the Practitioners were given a summary of the case timeline and a summary of the emerging lessons identified by the SCR Panel. The purpose of the Learning Event was to obtain the Practitioners' experience of the case and the operation of local systems at the time it was being

managed to assist with understanding what happened and why. The value of their comments is that they show more of the emotional content of the direct work with the family than can be recorded in agency databases.

In the second Event, the SCR Panel's final analysis and draft priority lessons were presented.

The Practitioners responded in a child-focused, open, reflective and honest way, sharing their insights and experiences. They commented on how helpful it was to be involved in this way in the review process.

7.2 Practitioners noted the following:

7.2.1 **Focus on Baby L** Despite all the problems practitioners kept a focus on L and his welfare.

7.2.2 **Information sharing** Initially this was very good between services but later as Mother and Baby L moved around professionals were less aware of which other professionals were involved. The transfers across boroughs meant that information sharing was hampered. At times Practitioners coming new to the case had to rely on the family as the informants. Problems with different client recording systems and databases hampered effective information sharing.

7.2.3 **Family engagement** It is challenging to engage with parents who do not wish to engage. Mother did engage superficially, but there was a question about her insight and commitment. Mother's overwhelming wish was to remain in the relationship with Father, when he did not want this. This impacted on her willingness to accept advice. To several Practitioners, Mother seemed immature and to lack understanding. It seemed clear, initially, that Mother had mental health concerns and there were attempts to refer these on for fuller specialist assessment and help. Mother did not engage with these. At times workers found her telephone contacts tiring. Mother could also be quite assertive and able to put her point of view. She could also be controlling of Father, silencing him.

7.2.4 Father appeared to have insight but minimised the concerns. Initially, he was seen as a protective factor. At times, including in Child Protection Conferences, a view was formed of Father, that he often sought to appease Mother.

7.2.5 Both Parents minimised the concerns. Initially they both wished to remain together in the chaotic relationship.

7.2.6 Practitioners wondered if there was 'disguised compliance'

7.2.7 **Wider family** Father's family was understood as being more 'liberal' and open to inter-relationships with other cultures or lifestyles. The Maternal Grandmother was seen as a protective factor and gave strong support after L was born.

7.2.8 **The issue of homelessness and case responsibility across boroughs** The case should have been allocated in Croydon sooner. The issue should have been escalated through senior management sooner. The cross-borough issues meant that key professional staff were not invited to essential meetings – e.g. the Health Visitor was not invited to the Transfer-In Child Protection Conference in

Croydon. The importance of involving Housing fully in the child protection conference process was noted. This also prevented continuity of care within services.

7.2.9 **Assessments** There were unanswered questions about Mother having emotionally unstable personality traits.

7.2.10 **Use of protocols** More use should have been made of the agreed local protocols[5] relating to drug use, mental ill-health and domestic violence. Domestic violence was being dealt with. There was thought to be little evidence of drug usage, and when it was raised it was denied.

7.2.11 **Systems issues** Work across borough boundaries hampered effective multi-agency safeguarding**.**

At the Second Practice Learning Event the following points and questions were noted:

7.2.12 With very young children the focus of the work is mostly with the parents. Good reflective supervision can help keep the impact on the child in mind.

7.2.13 The importance of informing and involving the child's GP, especially where the child is subject of a Child Protection Plan; and the importance of the communication between the child's Health Visitor, the GP Practice and any liaison Health Visitor who works alongside the GP Practice on safeguarding.

7.2.14 The challenges where parents choose to have a different GP for the child to the GP for the parent; leading to information being held in different places and more complex communication for Partner Agencies.

7.2.15 Different Practitioners have different levels of awareness and experience of dealing with drug misuse. There is therefore a need for access to specialist advice as well as any generic training.

7.2.16 How can Practitioners learn to discuss possible drug use in an advisory way, such as the way Practitioners can be more confident about advising or querying risks associated with alcohol use or smoking, in a public health way? It was agreed that some drug use, such as cannabis use, may not always be seen as a serious issue; even though cannabis use may make parents unavailable to children and their needs.

7.2.17 Worry about how to manage any adverse reaction from service users if drug usage is raised with them.

7.2.18 Communication is hampered between professionals by a lack of commonality in IT Systems.

7.2.19 It is important to consider other ways of working together through telephony and IT – not just face to face meetings.

[5] LSCB Protocols https://www.lambethscb.org.uk/professionals

7.2.20 The importance of identifying the key professionals around a child, including the GP, and keeping the network, not just the Core Group advised of moves and changes. Some families can be chaotic and so it is important that the Practitioners are supported to work hard to stay connected and prevent gaps. Some Agencies feel that they are not kept informed about what is happening, even when they raise concerns. There was a view that Agencies are not always told in a timely way when children, whom they are working with, are made subject of a Child Protection Plan or there are significant changes.

7.2.21 How is the lack of progress of a Child Protection Plan monitored over time? L was subject of a Plan for over 15 months. What is the role of the Child Protection Conference Chair in escalating lack of progress?

7.2.22 Practitioners experience is that it is not easy to escalate concern when things are not working well.

7.2.23 It was agreed that problems of accessing social housing and temporary housing in London are major systemic issues. This underlined the importance of close liaison between Housing and Social Care in case management. The recent changes in Croydon were seen to be seeking to address this issue.

7.2.24 There was broad agreement by the Practitioners with the analysis and lessons from this case. Practitioners also believed that the findings were not unique to this case.

8 Discussion and Evaluation

8.1 What worked well?

8.1.1 Police and midwifery staff appropriately recognised the concerns about the volatility in the parental relationship and Mother's emotional well-being and referred on to social care for antenatal safeguarding assessments.

8.1.2 When the concern was referred to Lambeth Children's Services it was appropriately recognised as a safeguarding matter and a section 47 inquiry was initiated. This resulted in a Child Protection Conference, which agreed that L should be subject of a pre-birth Child Protection Plan.

8.1.3 It was appropriate to consider that the case may require legal intervention and to initiate the Pre-Legal processes.

8.1.4 L was born at a hospital where the background of concern was unknown. But immediate enquiries to the hospital, where Mother had been seen for antenatal care and emergency appointments, showed the concern and information was shared quickly and appropriately to confirm the history and the Child Protection Plan.

8.1.5 When Mother and Baby L were transferred to temporary accommodation in Camden there was a timely transfer of responsibility from one Health Visiting Service to the other.

8.1.6 Good attempts were made to counsel Mother on domestic abuse and to refer her to specialist agencies, but she did not follow this up.

8.1.7 Lambeth Children's Services was clear that the case should remain with Lambeth until secure housing was found, despite the complexities of working across boroughs. However, there were missed opportunities to get the case transferred to where it should have been held.

8.1.8 The Lambeth social work visits followed Mother and L, wherever they were staying in different parts of London, not just the temporary accommodation in Camden.

8.2 Cross-Borough Issues Impacting on the Effectiveness of the Child Protection Plan

8.2.1 The geographical issues in this case gave rise to some of the biggest challenges. Mother was not normally a Lambeth resident. Her residence rights were in Croydon. She was temporarily and inconsistently staying in Lambeth with Father's family. This was not a permanent arrangement. She made her housing application to Croydon on the grounds that she and her unborn child could not stay at her family home in Croydon and she was accepted, from there, as potentially homeless, twice.

8.2.2 The initial pre-birth child protection concerns arose from a Lambeth address and were appropriately referred by the hospital and Police to Lambeth Children's Services. Fuller enquiry about Mother's housing history might have established that her housing 'rights' were in Croydon and might have led to earlier co-ordination between social care and housing.

8.2.3 The London Child Protection Procedures (section 6: **Children and Families moving across Local Authority Boundaries[6])** are clear about the additional vulnerability 'as a consequence of homelessness and the dislocation that is likely to occur as a result of moving between local authority areas'.

8.2.4 Lambeth Children's Services acted appropriately in accepting the **section 47** referral. However, more should have been done to liaise with Croydon Housing, or even Lambeth Housing when it became clear that the Father's Mother's home was not a viable alternative as accommodation for Mother and the expected baby. This was particularly so when it seemed clear that the parental relationship was turbulent and possibly characterised by frequent arguments and / or domestic violence, leading to a question about the viability of the relationship.

8.2.5 Mother made her first 'homeless' application to Croydon from her parental family home address in November 2014 but was not accepted as having proved homelessness at that point. She might already have been staying in Lambeth at the Father's Mother's address, at that time. In December 2014, she alleged to the Housing Department that she had been excluded from the family home in Croydon and had been sleeping rough but discontinued the call when asked for evidence of this. In February 2015, the Maternal Grandmother confirmed to Croydon Housing that she had asked Mother to leave the Croydon address; and in March, Housing confirmed through a health agency that Mother had been staying in Lambeth at the Father's Mother's house. In the second week of

[6] London Child Protection Procedures section 6: **Children and Families moving across Local Authority Boundaries** 5th Edition 2016 http://www.londoncp.co.uk/chapters/chi_fam_bound.html

April, Mother denied this and said that she had not been resident in Lambeth for over a month. A few days later she was offered homeless person's accommodation at a hotel in Croydon. Lambeth Children's Services was unaware of this.

8.2.6 Housing was not invited to the Pre-Birth Child Protection Conference held in Lambeth, even though Lambeth Children's Services was aware that Mother had made a housing application; but not that she had been offered the temporary accommodation.

8.2.7 Under the London Child Protection Procedures, the case responsibility should have been transferred to Croydon Children's Services as the unborn baby was then clearly resident in Croydon, and Croydon Housing had accepted responsibility to assess for homelessness. Section 6.1.14 is clear that responsibility lies with the Local Authority where the child (in this case unborn child) is to be found. No application to transfer the case to Croydon was made and the issue was not considered at the Initial Child Protection Conference held in Lambeth later in April, when unborn Baby L was made the subject of a Child Protection Plan.

8.2.8 Mother later left the homeless accommodation voluntarily. Croydon Housing rightly judged that it had met its responsibilities to Mother and unborn baby. For a period before Baby L's birth Mother lived with Father at his Father's home, also in Lambeth. At that point, it was appropriate for Lambeth Children's Services to continue to hold the case accountability as the unborn baby was again resident in their area.

8.2.9 A further opportunity to transfer the case to Croydon Children's Services arose when Baby L was born and discharged from hospital to be placed with Mother in her Mother's home in Croydon. It is puzzling that Lambeth Children's Services did not then transfer the case to Croydon as Mother and Baby were now fully resident there and had no call on any other housing. Managers and the Review Pre-Birth Child Protection Conference held before Baby L's birth missed the need to consider and plan for this. Thus, complications arose in the inter-agency management of the case led by Lambeth when no other Lambeth agencies continued to be involved. The key worker had to work with unfamiliar services and colleagues, out of borough.

8.2.10 Lambeth Children's Services formally notified Croydon Children's Services that Baby L was a child subject to a CP Plan to Lambeth and was in their area, but received no response.

8.2.11 In the third week of September, Lambeth Children's Services was given legal advice that Baby L's case should be transferred to Croydon Children's Services, as he was resident there. A referral was made to Croydon Children's Services, which was correct, but overdue, under the London Child Protection Procedures. Croydon did not accept the transfer on the basis that Baby L was not resident in the borough at the time it made the decision even though he had been resident at the time of the referral; and it was Croydon Housing that had transferred him to Camden, thereby another section of the Local Authority was accepting residency – albeit temporarily. This may be a systemic issue of Social Care Departments, under bombardment, seeking to limit the volume of work, which is understandable. However, Croydon Children's Services did not consider all the facts of the case.

8.2.12 Lambeth did not challenge this decision, which it should have done, using the London Child Protection Procedures and, if necessary, seeking legal assistance or senior management involvement. Baby L was a 'Croydon resident', even though Lambeth was holding case responsibility

through a Child Protection Plan, which should have transferred to Croydon within 15 days of the formal request. Although court action was being considered as part of the protection plan there was no immediate risk or need to seek an order and so no reason for Croydon to refuse the request.

8.2.13 Mother had made a further application to Croydon Housing, while resident at her Mother's home in Croydon, on the grounds that she could no longer reside there; and at the end of September 2015 was offered homeless accommodation in a hostel in Camden for herself and Baby L. Baby L's move to Camden raised a fundamental question about the safeguarding system as relationships had been formed with Mother by local health services which were monitoring Baby L and Mother's care of him. The Croydon Health Visiting service appropriately transferred the responsibility to Camden Health Visitors after the move.

8.2.14 The responsibility for the overdue perinatal mental health assessment had been transferred within the Mental Health Trust to the Croydon team from the Lambeth team and now had to be transferred to Camden services.

8.2.15 There were questions about the quality and suitability of the accommodation provided in Camden; and it is understood that Camden Children's Services and Camden health services would not advise use of this accommodation. Croydon Housing subsequently agreed not to use this facility.

8.2.16 This is a systemic issue in terms of emergency and short-term homeless accommodation in London, which is wider than any one local authority and beyond the capacity of any social worker to resolve. Had the case been held by Croydon Children's Services, as it should have been from the time of L's birth, it may have been possible to use local working arrangements within Croydon to require that Baby L, as a child subject to a Child Protection Plan, was housed within or very close to the borough. In this case although domestic violence was a factor it was not sufficiently risky to warrant a geographical move away from extended family and known local services for Mother and Baby L's safety.

8.2.17 The placement of Mother and Baby L in Camden led to systemic issues affecting the co-ordination and quality of multi-agency work and the engagement with Mother across London. It was also an additional burden on the Lambeth Social Worker having to travel across London and engage with Mother to ensure the completion of the Child Protection Plan, especially when Mother also opted to stay in different parts of north London to escape the unpleasant temporary accommodation and her sense of isolation. There was also an impact on the functioning of formal Child Protection Conferences and Core Groups (essential mechanisms in safeguarding processes) which will be discussed below.

8.2.18 The Lambeth Social Worker contacted Croydon Housing in early October, a few days after Baby L's move to express concern about the placement in Camden and was advised that this would be referred to senior management within Housing.

8.2.19 At the end of October, the Lambeth Social Worker made a formal request to Camden Children's Services to accept case responsibility for Baby L given that he was now resident in their area. Camden refused this request, in early November, because Baby L was only temporarily resident, placed by Croydon. The London Child Protection Procedures are clear on this point, saying that the grounds for refusal are: section 6.2.7 'If the child and their family have been placed in temporary

accommodation in the receiving authority for a specified period of time, which is less than 4 weeks, after which they will be located elsewhere'. The intention at that time was that Mother and Baby L may be in Camden 'for up to a year', therefore, there were grounds to challenge this decision not to accept the case made by Camden.

8.2.20 This type of 'gatekeeping' is understandable systemically, when, because of shortage of suitable local temporary housing, local authorities may be resentful of out-of-borough children in need of protection being placed in their area. This is hard territory for a social worker alone to negotiate, when they have busy caseloads; and in this case the worker had now to cross London, arrange practical items for Mother and Baby L's new accommodation and seek to re-establish a Core Group and re-build the Child Protection Plan, which was already faltering as a result of the parental behaviours. Housing and transferring case responsibility had become imperatives over the issues of incomplete assessments, concerns about the volatile, on-off parental relationship and monitoring Baby L's welfare.

8.2.21 Two weeks later, the Social Worker contacted Croydon Housing, again, to ask for Baby L to be moved closer to Croydon, nearer to her family, and followed this up in writing a week later. It is not clear why this was not escalated at that time, as the request had originally been made for Baby L to be placed close to family, in early October. Croydon Housing was invited to the next Core Group Meeting but did not attend. At the time, there was no safeguarding protocol for Housing in Croydon. Now there is an agreement that a Housing Manager will attend Child Protection Conferences and Housing Caseworkers will attend Core Groups. Lambeth Housing and Lambeth Children's Services were reviewing their local arrangements at the time of this review.

8.2.22 At the Core Group Meeting, held at the end of November, it was noted that neither Croydon nor Camden would accept case responsibility and that Lambeth would therefore would retain it. This was laudable in the face of the failure to get the case transferred but was outside the London Child Protection Procedures and should have been escalated to senior management to make representation across Local Authorities. It is the view of this Review Panel that Croydon should have accepted the case responsibility and worked with Croydon Housing to bring Baby L back (closer) to Croydon.

8.2.23 As noted previously, Mother being placed in Camden, but not always residing there impacted negatively on the Child Protection Plan and the working of the Core Group over the next few months.

8.2.24 In the middle of February, Mother was offered accommodation in Croydon. The Lambeth Social Worker asked for a Transfer-In Child Protection Conference at the end of the month. This should normally be convened within 15 days. In early April, the Lambeth Team Manager followed up this request for a transfer conference and ensured that all the documents required were sent as Croydon queried that they had been given all the correct documentation. At the beginning of May, the request was made again; in the middle of May Croydon responded saying that it would provide a date for the Conference, which was held at the end of May, several weeks outside the agreed timescale. Lead case responsibility then transferred to Croydon Children's Services and the multi-agency arrangements under the Croydon Safeguarding Children Board. The delay in arranging the Transfer-In Conference was poor practice.

8.2.25 The complications arising from the moves across borough boundaries by Mother and Baby L, led to challenges to completing the Child Protection Plan and possible escalation to legal proceedings when this was required. It also contributed to the difficulty of gaining full co-operation by Mother and impeded an effective multi-agency core group. These are discussed further below.

8.2.26 The SCR Panel queried how big a system issue this may be, as families are housed in temporary accommodation across London and outside London, and not always for reasons of protection from domestic violence. The known cases in Croydon and Lambeth where this was an issue were low in number, but significant in management terms. It is a matter that may benefit from discussion by the London Safeguarding Children Board, to establish if this is a London-wide problem.

8.3 Focus on Baby L

8.3.1 The child should be central to the work. In the pre-birth phase, there is no doubt that there was appropriate professional concern about the possible risks to the foetus by police and antenatal services, often as a result about Mother's own reported behaviour and emotional state. Appropriate referrals were made and at times of crisis antenatal checks and scans were done.

8.3.2 A Midwife noticed that Baby L was not falling asleep after feeds and queried whether he was 'over-stimulated through maternal substance misuse'. The Social Worker was advised that Baby L was monitored for withdrawal symptoms but there was no further evidence to suggest substance misuse.

8.3.3 After discharge home with Mother to the Maternal Grandparents' home. Midwifery services, Health Visiting and Social Work services visited appropriately and Baby L was observed and assessed to be developing normally and there was noted to be a good relationship with his Mother.

8.3.4 Later in the work, although Baby L was seen often, there was greater focus on the Mother, the overdue mental health assessment, the relationship problems with Father, and the need to resolve appropriate housing.

8.3.5 Overall the view, despite the original concerns, was that Baby L was developing normally and that his Mother was caring for him well. There was no evidence of impact on Baby L of the original worries resulting from Mother's mental state or domestic violence.

8.3.6 However, information made available to this Review, from hair strand tests undertaken after the critical incident, show that Baby L had been exposed to cocaine continuously from January 2016, and that it had metabolised in his body. Assessment was that the cocaine levels were too high to have been ingested through breast milk or inhalation.

8.3.7 **Direct observation of Baby L** – Child protection research and enquiries show that it is important for professionals 'to see the world through the eyes of the child'. In such young infants, their 'voice' is heard through good observations, over time, and attention to their emotional state and their responses to care-giving and attachment seeking behaviour. Concern about Baby L was a focus of the antenatal work. In the eleven months after birth, up to the critical incident, L was seen with his Mother, and occasionally with Father, 36 times by Practitioners; not including occasional attendance with Mother at the Lambeth Children's Centre on their return to Croydon in March 2016. Midwives in the early post-birth visits assessed Mother mainly and observed but expressed no concerns for L.

Health Visitors saw Baby L five times, twice in Croydon before the family move and twice in Camden, with one additional contact where the Health Visitor was unable to see him as Mother was going out; and one contact after their re-housing in Croydon. He was also seen several times by the GP Practice for a development check, immunisations and for what appeared to be minor illnesses. L was taken to hospital once with a stomach bug. Lambeth Social Workers saw him 22 times, with Mother; other attempted visits were prevented, either by Mother staying in different parts of London or Mother postponing visits on the grounds that it was not convenient with her impending move back to Croydon. All the workers noted that the care was good and that there was a close bond between Mother and Baby L, with Mother looking after him well, and there was good mother-child interaction; at times, he was described as 'happy'. The Health Visitors undertook development checks and noted good development. Workers thought he was thriving.

8.3.8 The Lambeth Social Worker discussed L in supervision on several occasions in November 2015, and January 2016. It was noted that Mother 'was managing L's care well' and 'L was thriving and well-presented'. There was a 'close bond' and 'good physical care'.

8.3.9 There were no social work visits, observations of Baby L, or Core Groups after the case was accepted by Croydon Children's Services at the end of May up to the critical incident in July 2016. This did not meet agreed standards for monitoring.

8.3.10 The Croydon Health Visitor saw Baby L in mid-June 2016 she noted 'good mother-child interaction' and 'L was developing well'.

8.3.11 Although there are some gaps in observations of Baby L and the move across London prevented health visitor contact at the frequency a child subject to a plan would expect, professionals were observing Baby L for signs of harm, in both planned and unannounced visits. The anticipated harm that had resulted in him being subject of a Child Protection Plan was not being evidenced; there were continuing, but diminishing, concerns about Mother's instability and the volatile parental relationship.

8.3.12 Parental drug misuse had been raised as a possibility historically, and there had been suggestions and queries during the period, but these had not been substantiated. Practitioners were not, therefore, holding in mind that Baby L might have been or may be being exposed to drugs. This was not part of the Child Protection Plan. Workers tend to be more vigilant when there is known parental drug use. This case raises questions about whether the local safeguarding systems sufficiently equip practitioners to consider the possibility of hidden drug use and its possible impact on children.

8.3.13 There is little research into the impact of cocaine on healthy infants and how it would be manifested, except in neonates where the transmission has been in utero and the baby shows withdrawal symptoms or where it is ingested through breast milk; or inhaled through smoke. Such literature as there is derives from clinicians attending to crises where a child has been adversely affected[7] or a

[7] **Cocaine Toxicity in Toddlers**; J D Dinnies, et al; The Pediatric Forum; American Journal of Diseases of Childhood Vol 144, July 1990

1991 prevalence study in Boston, USA.[8] It is not thought that Baby L ingested cocaine in utero, through breast milk or passive smoking. Dinnies, et al describe a very small sample of cases of accidental ingestion or indirect exposure, which would appear to be the case with Baby L. Pagliaro and Pagliaro, 2012[9] briefly note the possibility of exposure by unintentional childhood poisonings which, unless there is a severe adverse reaction will probably not come to clinical attention. Parents may not seek help, drawing attention to the ingestion unless the effects are serious. Adverse symptoms which may be recognised are seizures, arrhythmias and hypertension.

8.3.14 Clinical advice to the Review Panel is that ingestion of cocaine in a baby may be noted by the following symptoms:
Tremors (trembling)
Sleep problems
High-pitched crying
Tight muscle tone
Hyperactive reflexes
Seizures
Yawning, stuffy nose and sneezing
Poor feeding and suck
Vomiting
Diarrhoea
Dehydration
Sweating
Fever or unstable temperature
It should also be noted that the impact on a baby would be short-lived. A Practitioner would have to see a baby who had ingested cocaine soon after the event to note any symptoms.

Caution should be taken in considering such a list, as such symptoms are common in babies and are not a clear indicator of cocaine ingestion but may be as a result of other causes, requiring a differential diagnosis, in context and over time.

8.3.15 Father had reported that Baby L was sometimes agitated but that was not witnessed by Practitioners.

8.3.16 The query about whether he was over-stimulated as a neonate, possibly through breast milk and any substances Mother may have used was not substantiated and the hyperactivity was not noted again.

8.3.17 On some of the occasions when L was seen by the GP and at hospital, in October 2015, diarrhoea, vomiting and fever were noted. Those services were unaware of the child protection concerns.

[8] **Unsuspected Cocaine Exposure in Young Children**; SJ Kharasch, et al; American Journal of Diseases of Childhood; Vol 145, pages 204-206, February 1991

[9] See also Chapter 5 **Exposure to the Drugs and Substances of Abuse From Conception Through Adulthood** in Handbook of Child and Adolescent Drug and Substance Abuse: Pharmacological, Development, ad Clinical Considerations; Pagliaro and Pagliaro; John Wiley and Sons; 2012

8.3.18 Other Practitioners did not note any such symptoms. It should be noted, however, that most of them would not have had training in what to look for. As there was no active concern about the possibility of drug misuse such symptoms were not being looked for.

8.4 Lessons from research into parental drug use, mental ill-health and domestic violence and the relevance

8.4.1 The impact of these three factors in child maltreatment is well-publicised, particularly from analyses of lessons from Serious Case Reviews, where the phrase 'toxic trio'[10] has been coined to alert workers and managers to the specific risks where one of more of them is present as a dynamic in parenting. All three dynamics were present in this case. Lambeth Safeguarding Children Board had published Protocols for each of the toxic trio in the past. A revised combined Protocol was agreed by the Lambeth Safeguarding Children Board with the Safeguarding Adults Board in March 2014, ***Lambeth Joint Service Protocol to Safeguard and Support Families where the adults have additional needs Protocol***. The Safeguarding Children Board had provided multi-agency briefings on the Protocol. Although other agencies were using this protocol it was unknown to Lambeth Children's Services Practitioners working with this case; and it was no longer on the Lambeth SCB website, which was being re-designed.

8.4.2 **Parental Mental Ill Health** Mother's reported behaviour and emotional responses gave rise in the early phase to a question about Mother's mental state, which was unresolved throughout the work as no psychiatric assessment was possible, because of a range of systemic issues; including Mother herself, moves across London, and who can commission such assessments. A 'view' was given in December 2014, at Hospital 1, without a formal assessment or diagnosis that she may have 'emotionally unstable personality traits'. This view probably clouded later judgements of her and was never confirmed.

8.4.3 Given Mother's observed behaviour, it was appropriate that a perinatal mental health assessment should be sought. This was a key but unresolved part of the Child Protection Plan, throughout. At times, Father described her as 'mad'. She was clear that she did not have a mental health problem and although she agreed to an assessment, both Mother and circumstances prevented it. Sometime after L's birth, Mother told a worker seeking to understand the previous concern about her mental state that she had had some depression but that it had cleared up.

8.4.4 The Mental Health Trust was commissioned to provide services in both Lambeth and Croydon. There was confusion about who could refer Mother to the Trust for a perinatal assessment. The Social Worker tried to make a referral but was advised that the GP must do this; but this is not the Trust's policy, a social worker is able to make a referral. Mother did not attend a planned Multi-Agency Perinatal Team Meeting. After unsuccessful attempts, the Lambeth Perinatal Team spoke with

[10] **Working with families where there is domestic violence, parent substance misuse and/or parent mental health problems. A rapid research review**: Oxford Brookes University. Institute of Public Care; 2015 http://www.scie-socialcareonline.org.uk/working-with-families-where-there-is-domestic-violence-parent-substance-misuse-andor-parent-mental-health-problems-a-rapid-research-review

Mother and agreed a home visit for the end of June. However, Mother was not at home for the visit and did not respond to phone calls.

8.4.5 In early August, the responsibility for assessment was transferred within the Mental Health Trust to the Croydon Perinatal Team as Mother and Baby L were resident in Croydon. The Perinatal Psychiatrist based at Hospital 1 suggested that a worker from the Croydon Team should visit Mother with a Midwife. This was not arranged. In mid-August, the Social Worker contacted the Perinatal Team for information about the assessment and was asked if the needs were social or mental health; the Social Worker agreed to speak to the Social Work Manager about whether the assessment was still needed. This is puzzling on two levels; the Social Worker could have made clear that the assessment was part of the Child Protection Plan; and the Practitioner who had requested the perinatal assessment was, in fact, the GP. If the Trust needed to have confirmation that an assessment was still required it should have gone back to the referring GP. There is no information that the Trust was advised that an assessment was still required. The Trust took no further action until September.

8.4.6 It is not clear why the Trust was not invited to the next Review Child Protection Conference or Core Groups as this was a key part of the Child Protection Plan.

8.4.7 In late September, the Trust contacted the Social Worker to check whether a (late assessment was still required and was advised that it was. After unsuccessful attempts to contact Mother at her Mother's home, the Team was told by Grandmother in mid-October that Mother and Baby L had moved to temporary accommodation in Camden. The Trust discharged Mother's care back to the GP; the Social Worker was not informed.

8.4.8 Mother was later referred to a Camden Mental Health Service but did not attend appointments offered to her.

8.4.9 Workers across the system were aware of the risks from parental mental ill-health and worked to get to the bottom of it. This case shows that the practitioners understood the significance of parental mental ill-health in safeguarding and that on this, the local system was robust.

8.4.10 Psychiatric assessment after the critical incident (and therefore with hindsight) showed that Mother had no major mental illness, at that time, and questioned whether her behaviour arose from the volatile parental relationship, immaturity and possibly from drug use.

8.4.11 Father was not thought to have any mental illness. It was acknowledged that he had anger management problems and in August 2015 he told the Social Worker about adverse childhood experiences and how he thought that these had affected him. He agreed to a referral being made to work on his anger management.

Parental Drug Misuse

8.4.12 Drug use by parents is a challenge for all workers in health and child care agencies; especially, where there is denial and there are no apparent signs of its use or negative impact, such as chaotic lifestyle, impaired thinking or behaviours; or signs of addiction and its physical and mental side-effects. For a

safeguarding system, this raises questions about how well workers are equipped to assess and work with parents who conceal use of cannabis, cocaine or other drugs and apparently do not display ill-effect. As noted above, it also raises questions about Practitioners' awareness of the possible secondary effects of parental drug use through smoke or 'accidental' ingestion. Would workers know to look for drug residue, with which a mobile infant or child may be able to contaminate / poison himself? [11]

8.4.13 In the antenatal phase, there was no evidence of drug use by Mother. There were known concerns about her emotional state and questions about her mental health; but, it is not clear whether thought was given to whether these may have been as a result (or partial result) of any concealed drug use.

8.4.14 Mother told this Review that she was not and never had been a drug user. She accepted that, after the critical incident, tests showed that she had had cocaine in her system. She said that the cocaine metabolites in her and in Baby L were from passive reception. Expert advice refutes this.

8.4.15 Father's possession of cannabis, in Mother's presence, was known to the Police. He was charged with possession of cannabis for personal use; he stated that he was a regular smoker of cannabis, as it helped him with his anxiety. Mother was present when the drugs were found, but her denial of use was accepted. Father was found on another occasion to be in possession of a large amount of money, which could be suggestive of drug dealing (or another crime); but there was no evidence of drugs at the time, nor supporting intelligence. The possibility of drug use being a factor was discussed at the first Child Protection Conference but there was no evidence to show that it was significant, chaotic or problematic; or that Mother was using. Historic parental substance use was noted; but was not seen as an issue for the Child Protection Plan.

8.4.16 When Mother alleged that Father was a 'drug dealer', the allegation was put to Father, but he denied it. In the absence of clear corroborated evidence or other signs or symptoms suggestive of drug use or dealing, it was proportionate to raise the issue with the Parents but there were no grounds to insist on tests or searches. Her allegation was also made in the context of her having made allegations against Father and then later retracting them; she was not a reliable witness. A second allegation to domestic violence services in Camden, that Father was a drug dealer, was not passed to Children's Services or followed up.

8.4.17 It has been noted above (8.3.6) that there was a question raised about whether new born Baby L was being impacted by possible maternal drug use. The Social Worker was advised that Baby L had been monitored and that there were no signs of withdrawal.

8.4.18 There was also a question about whether Mother's emotional and mental presentation and mood may have been signs of drug use.

8.4.19 As new allegations of possible drug use or drug dealing were made, there should have been a multi-agency conversation to consider how to assess this and if it met the threshold for higher level action;

[11] See Merton Safeguarding Children Board SCR Child A (2013) on issues relating to parental use of cannabis and its impact on parenting.

if not in a Strategy Discussion the allegations should have been discussed in a Core Group. The allegations about Father's drug use should have been considered as part of the regular and ongoing re-assessments as part of the Child Protection Plan.

8.4.20 Clinical advice to the Panel is that the effects of cocaine ingestion are short lived, unless serious, and that Practitioners would not easily have noticed any ill-effects of small amounts of cocaine ingestion by a child, by simple observation (even if they had been alerted to the risk of it?)

8.4.21 Given that there were possible indicators and that drug use had been raised at the Child Protection Conference the multi-agency network should have had a continuing curiosity about the possibility that drug use was a dynamic in the parenting. The NSPCC **Summary of Lessons from SCRs** where parental drug and alcohol misuse had been a factor[12] shows the need to treat with caution a parent's account of how much and how often they drink alcohol or take drugs; and remain alert to risks of drug or alcohol use, even if parents seem to be complying. Practitioners must also be confident in challenging carers about the risks to which they may be exposing their children.[13] There was, however, insufficient evidence to take any further action in this case despite several suggestions of drug use, as there were also retractions and denials.

8.4.22 In the legal discussions, there was no consideration of whether to seek drug-testing as the alleged drug use was not substantiated and was not seen as problematic and so there was no reason to challenge it.

Domestic Violence

8.4.23 The volatility of the Parental Relationship was a continuing concern throughout the period of the safeguarding work. There were arguments, shouting, allegations and counter-allegations, jealousy, unrealistic expectations and at times physical encounters which gave rise to worry about domestic violence and its possible future impact on Baby L. The risks were noted early on and with the worry about Mother's emotional state led to the safeguarding referral which initiated the work. The recognition and referral part of the multi-agency safeguarding system worked well. Ongoing concern about domestic violence was central to Child Protection Plans.

8.4.24 The Child Protection Plans sought to address the parental behaviour and actions were put in place at various times to help the Parents work on the 'abusive' aspects of their behaviour. However, this was not a classic case of male violence to a woman. At times, Mother through her possessiveness and perhaps unrealistic expectations of Father also appeared to initiate abusive behaviour. It was also noted by practitioners that she could be assertive and controlling of him. She was offered counselling, specialist work by an Independent Domestic Violence Advisor, and they were both

[12] **Parents who misuse substances: learning from case reviews:** Summary of risk factors and learning for improved practice around parents with substance misuse problems https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/parents-misuse-substances/

[13] See BASW Alcohol and Drugs A Pocket Guide, University of Bedfordshire, 2012 https://www.basw.co.uk/pocket-guides/

offered training in understanding domestic violence. They were both offered support when they wished to end the relationship.

8.4.25 When there was believed to be evidence of physical violence by Father the Police took this seriously and put conditions in place to protect Mother and charged him, but Mother later retracted, maintaining that she had fabricated the allegation of assault (also retracting at the same time the allegation that he was a drug dealer). Father also later claimed that she had threatened to make false allegations against him on another occasion.

8.4.26 The Police appropriately completed DASH assessments[14] when domestic disputes were brought to their attention. It should be noted that the number of times that this volatile behaviour came to Police attention warranted consideration of the need for referral to MARAC[15] to review the level of risk and what actions should be considered to prevent harm to adults or child. The reasons why it was not decided to refer to MARAC were not recorded. Other agencies could also have referred the case to MARAC for multi-agency review. A question arises, therefore, as to whether practitioners were not seeing the parental behaviour as serious enough to warrant a full domestic violence response. Agencies may need to ask if there is sufficient awareness of when to consider MARAC as the 'trigger of repeat incidents' had been reached in this case and no evidence has been found that there was active consideration and a proper decision not to refer. The volatile behaviour remained central to the case throughout.

8.4.27 The Police, the Lambeth Community Safety Unit and Camden Safety Net referred the case to Refuge[16] on three separate occasions to support Mother with the alleged domestic violence by Father. Mother did not respond to the specialist Domestic Violence Agency's attempts to engage her.

8.4.28 The Social Worker undertook direct work with Mother and Father, together and separately, on the domestic violence and its impact; and worked with Paternal Grandmother to supervise contact with Baby L when Mother and Father could not safely manage being together.

8.4.29 Practitioners, and Mother, noted the intensity of her emotional feelings towards him and her difficulty in following through plans for separation. At times, he appeared more resolute but then he returned to her; sometimes, his concern was about losing his relationship and contact with Baby L. A question which should perhaps have been asked is whether her having accommodation of her own was perhaps an attraction to him; as he, too, was ostensibly 'homeless'.

8.4.30 The attempts within Child Protection Plans to work on the abusive aspects of their relationship were appropriate and sought to protect Baby L. Mother and Father lacked insight, about their behaviours and motivation. They agreed to work on this, but did not do so or carry through agreed actions. As there was no evidence of harm to L and he was seen to be developing well there were no grounds to

[14] DASH Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model www.dashriskchecklist.co.uk

[15] MARAC Multi-Agency Risk and Assessment Conference

[16] Refuge is an agency which supports women affected by domestic violence www.refuge.org.uk

consider Care Proceedings and work on their relationship or alleged domestic violence could not, therefore, be required.

8.5 Engaging the Parents and Working with Them

8.5.1 **Mother** There were good attempts to work with Mother by a range of Practitioners from across services and to make clear to her what the concerns were arising from her perceived unusual and erratic behaviour and her allegations about Father. Although at times she agreed to work on issues she did not follow these through, and at times also made it clear that she did not agree with them – particularly concerns in relation to her emotional and mental health. Practitioners queried whether there was 'disguised compliance'[17] but there was also clear evidence of avoidance and misleading Practitioners when she made allegations and then later denied or retracted them; e.g. Mother worked with the Lambeth Social Worker and an Independent Domestic Violence Advisor in Camden on how she would manage giving evidence in court against Father knowing that she had already retracted the statement to the Police about the alleged assault with which Father had been charged.

8.5.2 Mother's priorities were a home for herself and Baby L and maintaining her relationship with Father. At times, she accepted advice and assistance on separating from Father but her strong wish to be with him meant that she did not follow through actions to separate from him. The moves across London meant that it was difficult to create supportive professional relationships with her where her behaviour could be monitored and worked with in a constructive and challenging helping relationship.

8.5.3 **Father** Research from serious case reviews and other sources shows a long history of challenge in safeguarding work to engage Fathers. The Social Worker spoke with him alone on two occasions, in August and October 2015, about his relationship with Mother and about his anger/behaviour which may contribute to the emotional abuse of Baby L. On the latter occasion, it was suspected that he may have been under the influence of cannabis. In August 2105, Father explained his volatile behaviour stemming from what he saw as adverse childhood experiences and as reactions to Mother's behaviour. He agreed to a referral to work on anger management; he was not referred for such work.

8.5.4 He was ambivalent about his wish to be with her; declaring on several occasions that he had left her – only 'to feel sorry' for her and to return to her. It was not possible to build a clear picture of when they were together in the homeless accommodation. He was not part of the housing application. Housing recognised him as her partner, but was unaware that they were married. It was understood that they were no longer a couple but it is clear that he was a frequent visitor and probably stayed regularly.

8.5.5 Father's attendance at formal child protection meetings was sporadic. His statements to Police and Social Workers contributed to the understanding that he no longer wished to be with Mother, but that he wished to have contact with Baby L.

[17] **Disguised compliance: learning from case reviews** , NSPCC, 2014 https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/disguised-compliance/

8.5.6 In the late February 2016 Child Protection Conference, it was noted that both parents had agreed to access Domestic Abuse Services. In May, both parents again agreed to attend Domestic Violence Services in Croydon, however, nothing was arranged for them.

8.5.7 The Police and Social Worker tried to work with Father on his part of abusive behaviour. It is not clear that he took part in any formal programme to manage his anger or reactions, however. It is not clear how much his behaviour may have been impacted by drug use; but that may be hindsight, as considering him as a possible drug user and the impact of drug use on his behaviour and thinking were not part of the work or its supervision.

8.6 Information sharing, thresholds and referrals

8.6.1 The review has shown that information sharing was mixed in its quality. Initial concerns were appropriately noted by antenatal services and Police and were appropriately shared as a need to consider safeguarding. Hospital 1 advised the GP of the initial concerns when Mother was seen in late December 2014 and recommended that she may need counselling, it was questioned whether she may have a personality disorder. At that time, her behaviour was not seen as reaching the threshold for pre-birth child protection assessment.

8.6.2 As concerns increased they were appropriately shared with Lambeth Children's Services and led to a Strategy Discussion with the Police and the agreement that an assessment should be undertaken. Given the nature of the concerns and Mother's pregnancy health services (Hospital 1 and GP) should have been involved in the discussion. The assessment led to the Initial Child Protection Conference.

8.6.3 The Lambeth Social Workers regularly shared information with other professionals. However, L's GP (a different GP to Mother) was not aware that L was subject of a Child Protection Plan from birth.

8.6.4 The Lambeth Social Worker sought information from the local Mental Health Trust on several occasions and was told that Mother was not known to their service, despite information that Trust staff had been involved and that she had been referred.

8.6.5 At the end of September, Baby L and Mother moved to temporary accommodation in Camden, disrupting the Core Group. Her parents had asked her to leave. Croydon Housing did not liaise with Lambeth Children's Services about this.

8.6.6 When Mother returned to live in Croydon in 2016 the Croydon Health Visiting Service was not advised of her return to the area and was not invited to the Transfer-In Child Protection Conference. This was an oversight.

8.6.7 After Baby L was made subject of a Child Protection Plan in Croydon in May 2016, key agencies requested information about who the allocated Social Worker was, but were not informed in a timely way.

8.7 Pre-birth section 47 assessment

8.7.1 The pre-birth section 47 assessment was thorough and appropriately sought information from relevant agencies. Given that the reported concern had been about domestic violence it was appropriately sceptical of the united front that Mother and Father were displaying and took into account the recent episodes and concerns as well as family history. It noted concerns about Mother's emotional health, self-reported depression and thoughts of self-harm. It was right that the assessment led to the convening of a Pre-Birth Child Protection Conference.

8.8 Child Protection Conferences, Child Protection Plans and Core Groups

8.8.1 Child Protection Conferences, Plans and Core Groups and their effectiveness are a measure of how well a local safeguarding system is working. Conferences were held appropriately from April 2015 to May 2016 given the concerns which professionals had noted and the lack of progress in being able to properly assess or diminish the assessed risk to Baby L.

8.8.2 The **Initial/Pre-Birth Conference** held at the end of April 2015 before Baby L was born rightly noted the concerns and strengths in the family dynamics and that more information was needed about Mother's emotional and mental health and the nature the volatile relationship. Both Mother and Father attended this conference which meant that the concerns could be put to them directly. Father was seen as showing more insight into why Practitioners were concerned; Mother showed little insight and was seen not to recognise the concerns or to be minimising them. Police and Health Visiting Services were present. Maternity Services and Mother's GP were not present in the Meeting. Given the nature of the worries it would have been helpful to have had them, or their views, represented. It was right to make the unborn baby subject of a Child Protection Plan.

8.8.3 The **Child Protection Plan** was agreed in outline at the Conference and confirmed at the **Core Group** in early May. It appears that by the time of the **May Core Group** Mother and Father had separated. Mother agreed to be referred to the Perinatal Service for an assessment. Father agreed to attend with her. The Parents were to agree a safety plan with wider family members regarding the Baby's welfare. The risk of domestic violence was to be addressed in the Family's safety plan. The new Social Worker was to collate a fuller family history, including childhood experiences, to provide a better understanding of the Parental behaviours and wider family dynamics. The Parents agreed to attend antenatal classes. A Discharge Plan was to be agreed and in place before the Baby was born, including who would care for the Baby, should Mother become unwell.

8.8.4 It was noted that Mother was placed in temporary accommodation in Croydon but no action was agreed regarding this, which was a missed opportunity to transfer the case to Croydon where support could be more easily offered, given that Mother was resident there and the Baby may be born or live there.

8.8.5 **Review Pre-birth Conference July 2015** – held a week before Baby L was born. Mother was no longer living in temporary accommodation in Croydon. Mother had attended antenatal appointments and there were no concerns about the Baby's development in-utero. Mother had been receptive to the Social Worker's visits. There had been continued examples of altercations and allegations between the couple, involving Father's 'ex-wife'. A report of self-harm by Mother was denied by Mother and

Father. Mother had not attended the Perinatal Service for an assessment, as agreed. The plan was for the couple to stay with Mother's Parents in Croydon after the birth. The Child Protection Plan had not progressed. It was agreed that Unborn Baby L should remain subject of a Child Protection Plan for risk of Physical Abuse. The Conference was robust in noting the unchanged and possibly increased risk.

8.8.6 The **Child Protection Plan** was revised to include the need for an urgent Legal Planning Meeting, which was seen to be overdue. A parenting assessment was to be completed. A new urgent referral was to be made to Perinatal Service, to which the Parents agreed. A safety plan involving the family was to be in place before the Baby's, imminent, birth. The work with both parents on domestic violence was not completed and was required. The Plan was to be firmed up at a Core Group meeting at Hospital 1 in early August.

The Conference was robust and appropriately addressed the continued concerns and lack of progress.

8.8.7 Baby L was born at the end of July in Hospital 2.

8.8.8 The **Core Group** met shortly after Baby L had been discharged with Mother from Hospital 2 to the Maternal Grandparents' home. The Maternal Family was unhappy about Father staying overnight. Mother and Father were present in the meeting. A new Social Worker was allocated on the day that Baby L was born, as a result of staff turnover, but meaning that the social worker and Mother were new to each other. The Perinatal Assessment was transferred to the Croydon Perinatal Service and assessed as non-urgent as Mother was showing no sign of urgent need, or mental instability. The Parents and Maternal Family had agreed to and signed a Safeguarding Agreement; Baby L and Mother were resident with them. Parents were denying the previous levels of domestic violence and were optimistic that now that Baby L was born there would be no more incidents. They agreed to work with domestic violence services; an agency was to be identified to work with them. The fuller family history was still to be completed. Parents had attended antenatal classes. A discharge meeting had taken place in Hospital 2 and it was agreed that Mother and Baby L would stay with the Maternal Grand Parents in Croydon until housing was offered. It was noted that housing was an important factor and that the Parents could not stay long-term with the Maternal Grandparents. Housing was to be asked to prioritise this; it was not stated that this was Croydon Housing. There were positive signs that Mother and Father were bonding with Baby L. Mother was encouraged to work with the Croydon Health Visitor.

8.8.9 The case should have been transferred to Croydon at this time as Baby L was resident there and the network of Agencies were Croydon agencies. This is not noted in the revised Child Protection Plan and was a missed opportunity.

8.8.10 A **Review Child Protection Conference** was held at the end of August. There was a different Chair Person. Mother, but not Father attended; Mother and Father had argued on their way to the meeting and, as a result, he had decided not to attend (He spoke with the Conference Chair the following day). Only the Mother, Lambeth Social Worker and Manager, Croydon health visiting representative (in place of the allocated Health Visitor) and Chair were present**.** The Perinatal Team and Croydon Housing had been invited but did not attend.

8.8.11 The report to the Conference was positive in that care of Baby L was good and that there were signs of attachment. Mother was said to be following advice. Father was said to be taking an active role in caring. There were also fewer arguments reported between the Parents. It was Father's view that these were caused by Mother's instability, but he had also been unfaithful. The Parents had agreed to work with Domestic Violence Services and for Mother to attend the Perinatal Service. It was of concern that the Legal Planning Meeting had not been convened. It was agreed that Baby L should remain subject of a Child Protection Plan under the changed category of Emotional Abuse. This was appropriate.

8.8.12 The Plan was formally revised at the **Core Group** at the beginning of September and timescales set for the previously agreed bur incomplete actions. Domestic violence services were to be identified in Croydon by the Health Visitor. The case was to be transferred to Croydon now that Mother and Baby L were living there. The Social Worker was to support Mother in expediting housing, and had provided a letter for Mother to take to Croydon Housing. It is right that the case should have been transferred as Baby L was resident in Croydon, but at that point Croydon Housing had discharged its responsibility to Mother as a homeless person.

8.8.13 At the end of September, Baby L and Mother moved to temporary accommodation in Camden, disrupting the **Core Group**.

8.8.14 In late October, the scheduled **Core Group** was cancelled as Mother had moved to Camden. This was not appropriate.

8.8.15 A Core group planned for early November in Camden was postponed as the Mother was staying in Croydon, as she was unwell.

8.8.16 The next **Core Group** was held at the end of November, in Camden. Mother, Social Worker and an Independent Domestic Violence Advisor from Camden were present. Croydon Housing had been invited to attend a few days before hand, but was not present. The Perinatal Assessment had not been assessed as urgent by Croydon Mental Health Service and had not been completed. The Legal Planning Meeting had been held at the end of September and had recommended that the case should be transferred to Croydon. Croydon had declined to accept the case. The Camden Health Visitor, in absentia, expressed grave concerns about the temporary accommodation. There had been further incidents of domestic violence. The Health Visitor had agreed to refer Mother to local parenting programme and a Children's Centre. A new domestic violence service for Mother was to be located in Camden. The Social Worker was waiting to hear from Croydon Housing about the request to move Mother back to Croydon.

8.8.17 The **Core Group** scheduled for early January was cancelled as Mother was staying with a family member in another part of London.

8.8.18 The **Child Protection Conference** scheduled for the end of January 2016 was inquorate and had to be reconvened, as no other professionals were present.

8.8.19 The **Review Conference** was held in the third week of February. Croydon Housing had agreed to transfer Mother back to Croydon, although this had not happened at the time of the review conference. The Social Worker, Line Manager, Mother and Conference Chair were present. The

Camden Health Visitor, the Lambeth GP for Mother, Police and Camden Children's Centre were unable to attend; L's GP was not invited. The Perinatal Assessment had still not been achieved. The Parental relationship continued to be volatile and there was confusion about whether it had been ended by Mother, or not. There had also been allegations of assault by Father, later retracted by Mother and the allegation that Father was a drug dealer; which he had denied.

8.8.20 Baby L remained subject of a **Child Protection Plan** for Emotional Abuse. The referral to the Perinatal service was to be referred back to Croydon Mental Health Team as Mother had moved (in fact, she had not yet moved). A new safety Plan was to be devised as Mother had moved to Croydon. The case was to be transferred to Croydon Children's Services. Mother had done some minimal work in Camden on domestic violence and separating from Father; and was now to be referred to a domestic violence service in Croydon; Father was to work with a project for men and domestic violence. A request was to be made for a Child Protection Conference in Croydon, as Mother was now thought to be living there. A **Family Group Conference** was to be considered but Mother did not want Father's family to be involved. The Parenting Assessment had been completed. There had been a change of Social Worker.

8.8.21 The **Core Group** scheduled for early March was cancelled as only the Parents and Social Worker attended.

8.8.22 There were no more **Core Groups** held before the critical incident. This was not acceptable practice.

8.8.23 The **Transfer Child Protection Conference** was held in Croydon at the end of May. Key local agencies were not invited. Croydon accepted the case and agreed that Baby L should remain subject of a Child Protection Plan under Emotional Abuse. It was noted that in April, Father had informed Children's Services that he had ended his relationship with Mother. Several of the actions for the Child Protection Plan agreed in February were incomplete.

8.8.24 In summary, it can be noted that it was right to make and keep Baby L subject of a Child Protection Plan given the parental behaviour and lack of change. Attendances at Conferences and Core groups was seriously impacted by the cross-borough issues and retention of the case responsibility by Lambeth. It is to be noted that there were no formal contingency plans. When there was continued lack of progress on the tasks agreed with parents the case should have been escalated to consider whether there were grounds for legal action. However, it should be noted that, despite repeated domestic disputes and alleged violence, lack of co-operation and parents failing to complete agreed tasks, there was no evidence of the impact of the anticipated harm to Baby L.

8.8.25 **Legal Planning** There was drift in seeking legal advice and arranging a Pre-Legal Planning Meeting**,** in two phases. The original decision to seek legal advice was made in mid-May 2015 before Baby L's birth but had not been achieved by the Second Pre-Birth Conference in late July. A referral was made a week later. At the Review Conference in late August, the legal planning meeting had not happened and the need was escalated to a manager. It was a further three weeks before a meeting was held, with advice that the case should be transferred to Croydon as Baby L was resident there. When Croydon refused to accept the case, it is not clear why further legal advice was not sought about what could be done, including a legal or escalated senior management challenge to Croydon's decision.

8.8.26 In late November 2015, Lambeth decided to continue to hold the case as neither Croydon nor Camden would accept it, although there were grounds to challenge both decisions as they were outside the London Child Protection Procedures. As there was still no progress, it was agreed to convene a further Legal Planning Meeting, which was held a few days later. The advice was that the threshold for legal proceedings was probably met but that the case should be transferred to Croydon. The Management decision was to continue to hold the case. This was a missed opportunity to consider with legal assistance how the Croydon (or Camden) decision could be challenged.

8.8.27 At the **Review Conference** in February 2016, it was again recommended that legal advice should be sought with a view to using the Public Law Outline, this was included in the Child Protection Plan. Action to progress this was not taken until early May as effort had been put into transferring the case to Croydon. As the case was transferred at the end of May the Legal Planning Meeting in Lambeth did not go ahead.

8.8.28 It has been noted that during the period there were changes in the way that Legal Planning Meetings were requested and arranged in Lambeth, which may have had some small systemic impact. However, the delays were unacceptable.

8.8.29 It is not clear whether Parents were ever advised that Legal Action was being considered as a prompt to helping them realise how serious their non-co-operation was. The use of a Public Law Outline meeting or legal letter and formal recommendation to the Parents to seek legal advice as the Council was considering Family Proceedings may have helped the parents realise the seriousness of non-co-operation.

Written Agreements

8.9 There was one written agreement with Mother, Father and L's Maternal Grandmother. This was completed following a Discharge Planning Meeting at the hospital after L was born and covered arrangements for Mother and L to stay with the Maternal Grandparents; and for Father to visit. Mother, Father, Maternal Grandparents and Paternal Grandmother were present, with an interpreter, plus the Social Worker and Safeguarding Midwife. The concerns about family animosity and the reasons for the Child Protection Plan, resulting from Mother's and Father's behaviour, were clearly set out in the meeting and the arrangements for accommodation, support and supervision were agreed. Not all family members were happy with the agreed arrangements.

Family Group Conference

8.10 The Initial Child Protection Plan (April 2015) included that there should be a Family Group Conference. This was never arranged. It is not clear why. This would have been an opportunity for Practitioners to put to the wider family what the concerns were and what actions were expected, and to seek family support and solutions to act on the perceived risks. It would have been difficult to bring Mother's and Father's Families together given the history of animosity and mistrust between them. Alternative arrangements were not considered, even though this action was part of the Plan.

Race and Culture

8.11 The Review has shown that cultural and religious factors were explored in depth by the Lambeth Social Worker; and the Police in relation to the allegation of forced marriage. The cultural differences between the two extended families were seen to be a part of the dynamics; and were discussed with Mother and Father and their families. Interpreters were used, when needed with Grandparents.

8.12 Case Supervision and Management

8.12.1 The importance of reflective thinking in child protection work has been recognised for some time. Assessments can be impacted by a range of dynamics, thought processes and biases[18]. For social work, the safeguarding system has built in case supervision with an experienced line manager, as a way of supporting the social worker and helping them stand back and think critically about the case and the hypotheses being developed through assessments and attempted interventions. Supervision is also the place where the line-manager can support the worker in unsticking complex issues and resources.

8.12.2 The Social Worker discussed the case and its progress with managers in supervision on several occasions. In March 2015, the Social Work Manager noted the case to be of high risk. In July 2015, the Child Protection Conference Chair escalated the drift in the case to the Team Manager, noting that the Legal Planning Meeting which was part of the Child Protection Plan had not been convened. In supervision in late August, it was noted that the case would continue to be managed under a Child Protection Plan as the Legal Planning Meeting had not yet been convened. This was further delay. It is not clear what the Manager did to expedite this.

8.12.3 Staying with the Maternal Grandparents was part of the safety arrangements for L. It is not clear how Managers reviewed this when the Maternal Grandmother stated that Mother and L could not stay longer and would need to leave the home. The actions in the Plan had not been progressed.

8.12.4 In November 2015, the Supervisor noted that progress had been variable. L was said to be thriving and Mother was managing his care, and her mental health was said to be stable, although Mother was 'low' when she had to stay in the temporary accommodation in Camden. The Management view was that Lambeth would retain the case, as there was a risk that professional networks may keep changing, with a negative impact on L. A Legal Planning Meeting was to be convened if circumstances did not stabilise. As noted above, by not escalating the case for transfer to Croydon (or Camden) this decision failed to grasp the issues and to ensure that the right network was able to support Mother and L. Within a week it was agreed in Supervision that the Legal Planning process should be reviewed. But this did not happen.

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[18] **Clinical Judgement and Decision-Making in Children's Social Work: An Analysis of the 'front door' system** Research report, Apr 2014; Elspeth Kirkman & Karen Melrose, The Behavioural Insights Team; https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/305516/RR337_-Clinical_Judgement_and_Decision-Making_in_Childrens_Social_Work.pdf

8.12.5 In early January 2016, the Supervisor noted good physical care and that there was a close bond between Mother and baby L. It is not noted what was happening with regard to the Child Protection Plan or the agreement to review legal advice.

8.12.6 In late January, it was stated that Baby L was developing appropriately and that Mother had now engaged with the Child Protection Plan**.** Consideration was given to stepping down the case to Child in Need – but it was agreed that this would be premature as improvements were too recent.

8.12.7 In late February, the Supervisor and Social Worker noted Mother's distressed presentation at the Review Conference and Mother's unrealistic view of the state of the marriage and her denial that Father was saying that the relationship was over. It was also noted in this discussion that it had been alleged that Father was a drug dealer. No action appears to have been agreed in relation to this allegation, which was a missed opportunity. The Supervisor could have helped the Social Worker to think what could be done to explore the allegation further and whether a strategy discussion or referral for Legal Advice was required.

8.12.8 In early April, the Team Manager contacted Croydon Children's Services and asked them to accept the case. In early May, it was noted in supervision that Mother was not co-operating or accessing local services. There was a question about Mother's mental state. The request for transfer to Croydon was to be followed up and a Review Legal Planning Meeting was to be convened. A few days later the case was escalated to a Service Manager in Croydon to progress the transfer of the case.

8.12.9 There is no record that the case was discussed in Supervision after this, in either Lambeth or Croydon, before the critical incident, two months later. This did not meet social work standards.

8.12.10 Management and reflective supervision should have been a place where the case would be kept under review and the worker/s should have been assisted in working with any obstacles, resistance or disguised compliance. The issues of cross-borough dynamics have been noted as part of the cause for delays and drift in the case, but supervision and management should have addressed the drift and considered how to support the workers in challenging Mother and Father to undertake the agreed tasks. Failing that there should have been escalation to legal processes, such as the Public Law Outline, with clear setting out to both Parents and their lawyers of the consequences of not undertaking the agreed actions. Child Protection Conferences and Core Groups should also allow reflective consideration of the changes and reasons for lack of change. The systems issue, in this case, of not having a stable and consistent Core Group, because of working across boroughs, meant that there was not reflective challenge from Partner Agencies to the lack of progress.

8.12.11 There is no available information for this case about how Practitioners in other Agencies were supervised and supported in their thinking. This raises a question about management and supervisory processes in safeguarding in non-social work agencies.

8.13 Systems dynamics outside the case which may have impacted on the multi-agency case work

8.13.1 The second Practitioners' Learning Event highlighted that at the time of the case there were a number of systemic issues within Lambeth Children's Services. These included frequent changes in Social Workers and Managers.

8.13.2 During the period of the transfer of case responsibility between Lambeth and Croydon from February to the end of May 2016, Croydon Children's Social Care was subject of a Joint Targeted Area Inspection (JTAI). It has been stated that this may have affected the management and timing of the transfer of this case.

8.13.3 There were systemic issues relating to homelessness and the availability of local temporary accommodation for families being assessed where there are also concerns about the parenting. This is known to be a London-wide and national issue.

8.13.4 The case has also raised a question about how common drug use is in society, how it is hidden or accepted as 'normal' if it is not assessed as 'problematic', and questions about the possible impact on children of regular use by parents if drugs. This raises a question about whether a public health awareness approach may be needed to warn of the risks of parental drug use; like smoking and alcohol.

8.13.5 It has been noted as part of this review that an added systemic complication was that Mother and Baby L had different GPs, in different GP Practices. This was not understood at the time and assumptions were made that child protection information and invitations given to one of the GPs (Mother's) also applied to the welfare of L. L's GP Practice was unaware for several months that L was subject of a Child Protection Plan. This raises questions about the co-ordination of child protection information across the health economy and the role of information sharing between GPs and Health Visitors, as well as Social Workers. Key members of Core groups should be confirmed at each Conference and Core Group to identify any such discrepancy and agree how to manage this.

9 Lessons

Only the most important lessons as agreed by the Panel are discussed in this section. Other lessons have been noted in the analysis and discussion above. These lessons were shared and agreed with the Practitioners and Managers at the second Practitioners' Learning Event.

Keeping the child's lived experience at the centre of safeguarding children practice

9.1 **There is a challenge for practitioners in holding the child's lived experience in mind and at the centre of the work. Professional and Agency Systems should support practitioners in contemplating the 'child's journey' from the child's point of view, and any possible adverse impact from parenting or the context in which the child is living. Practitioners can be easily diverted from holding the child's experience in mind by parental behaviours or other complicating or systemic factors.**

9.1.1 The problems of housing, domestic violence, and non-co-operation with the perinatal mental health assessment, exacerbated by the cross-borough moves and changes in personnel or responsibility, meant that consideration of L's own experience of the world appears to have been lost, as Practitioners sought to negotiate with the Parents or with each other.

9.1.2 It is not clear to this Review how the Practitioners, their Supervisors or the safeguarding system of Child Protection Conferences and Core Groups assessed L's needs and development and the impact of parental behaviour, and several changes of home and environments in a short space of time.

9.1.3 An additional challenge was L's age; for the period under review he was a pre-verbal baby and infant. Physical developmental checks and observations by those practitioners who saw him suggested that all was 'fine', that he was thriving, and the expected harm had not transpired. It raises questions about how Practitioners assess pre-verbal children's experience and what they should look out for.

9.1.4 A question is, therefore, how Practitioners are supported in keeping a focus on the child and the child's experience, especially through reflective supervision and pro-active consideration as part of the agenda of Core Groups and Conferences. This case suggests a focus on process and that, as in other cases, Core Groups and Conferences may concentrate on challenges in achieving Plans and Tasks and may lose sight of the child's experience, over time.

9.1.5 The absence of social work visits and case co-ordination from the point of transfer to Croydon at the end of May 2016 meant that there was no focus on L, at all. This was unacceptable practice.

9.1.6 It has come to light that probably there were times that one parent, or possibly both, were unavailable to him emotionally through drug use. While this is hindsight for this case, it needs to be borne in mind for learning in future cases where there is a suggestion of drug use.

Knowledge and Skills in Working with Drug Using Parents

9.2 **Illicit, and, or denied, parental drug use is a challenging area for safeguarding systems, practitioners and managers. Local safeguarding systems should be confident in the levels of awareness and skills of frontline staff to assess and work with the potential risks of illicit drug use, including possible signs of ingestion in children to look out for.**

9.2.1 The Review has raised important questions about the level of knowledge and skills of front-line practitioners and their managers in working with parents who use drugs; particularly where the drug use is not 'problematic' or not fully apparent. This view is supported by Prof Sarah Galvani[19]: *'In spite of a growing evidence base, social work has struggled to respond adequately to substance use within its service user groups although evidence shows that some social work educators and local authority workforce and development training departments have attempted to respond with training on substance use topics (Allnock and Hutchinson 2014, Galvani and Allnock 2014). However, this is inconsistent across English social work qualifying programmes and Local Authority employers.*

[19] Alcohol and other Drug Use: The Roles and Capabilities of Social Workers; Prof Sarah Galvani, Manchester Metropolitan University, March 2015. Research Funded by Public Health England http://cdn.basw.co.uk/upload/basw_25925-3.pdf

The evidence also shows that many social work and social care professionals are not clear what they should be doing in relation to substance use and their role expectations vary according to their specialist area of practice, their knowledge of substance use, and their levels of confidence (Dance and Galvani 2014; Galvani et al. 2011, Hutchinson et al. 2013, Loughran et al. 2010). For the profession of social work to engage fully with substance use, it needs clarity over the roles and function its social workers should fulfil along with the capabilities they need to do so effectively. This clarity needs to begin at qualifying training level and extend into continuing professional development.'

The Panel's view is that this is not just an issue for social work.

9.2.2 Given what is understood to be the widespread prevalence of drug use,[20] this is an important finding; as it suggests local safeguarding systems lack assurance in both competence and confidence to tackle hidden parental substance misuse and its potential harmful impact on children.

9.2.3 Tests undertaken after the critical incident, when Baby L (aged 11 months) collapsed after he had ingested cocaine, show that he had, in fact, been exposed to and ingested cocaine continually over, at least, the preceding six months. This is, of course, hindsight not available to the Practitioners at the time. However, during the period of safeguarding under review there were occasions when drugs were found or parental drug misuse was suggested.

9.2.4 The Review Panel's view is that Practitioners are more able to challenge and work with drug use where it is known to be problematic rather than hidden, usually through chaotic lifestyle, conviction or known addiction, or where an adult shows clear signs of the effects of drug misuse.

9.2.5 If practitioners were better educated in understanding hidden drug misuse, denial about it, and the risk of secondary or accidental ingestion by toddlers or children, it could have led to more curiosity and openness to disguised compliance. This in turn would have enabled potential parental drug use to be included in Child Protection Plans, Public Law Outline consideration and direct work with these Parents, including educating them in the possible accidental or secondary risks to children of hidden parental drug use. Working with parental drug use is seen as a specialist skill but needs to be seen as core to all frontline practitioners.

9.2.6 The London Child Protection Procedures Section, Section 29, **Parents who use misuse drugs**[21] sets out the requirement on LSCBs to have a local multi-disciplinary protocol on parental drug misuse. Lambeth Safeguarding Children Board had previously issued such multi-agency guidance in 2010 and revised it in 2014; but, by the time of this case it had fallen into disuse, was no longer available on

[20] Health and Social Care Information Centre, Statistics on Drug Misuse, England 2016, National Statistics, July 2016: 1 in 12 16-59 year olds had used drugs, this increases to 1 in 5 for 16-24 year olds; More men than women were users; cannabis was used more than other drugs

[21] **London Child Protection Procedures**, section 29.4 6: Local Safeguarding Children Boards are responsible for taking full account of the challenges and complexities of work in this area by ensuring that inter-disciplinary / agency protocols and training are in place for the co-ordination of assessment and support and for close collaboration between all local children's and adult's services.

the LSCB's website and was not promoted in the multi-agency training on parental drug misuse. Lambeth Children's Services Practitioners advised this Review that they had been unaware of such guidance, but it was still available to the staff of the Health Trust. Croydon LSCB had such guidance in place.

9.2.7 However, such guidance as is available rarely alerts practitioners to the risk of accidental ingestion. The 2011, Advisory Council on the Misuse of Drugs inquiry: 'Hidden harm'[22] reporting impact on the children of drug users briefly mentions risk of accidental ingestion, but not of drugs in powder or residue form.

9.2.8 Literature reviewed for this enquiry rarely covers signs or symptoms of possible drug ingestion in toddlers or children, except when in clinical collapse, through withdrawal from *in utero* addiction, or the impact of ingestion through breast milk. Non-specialist practitioners are not aware what to look out for, in terms of possible signs and symptoms of ingestion in children. In a case, such as this one, where drug misuse has been suggested on more than one occasion, this was a potential shortcoming.

Homelessness and Temporary Accommodation and their impact on child protection

9.3 **A systems lesson highlighted by this case is that of the (national and London) shortage of suitable social housing and local temporary accommodation for homeless families, and within that, the prioritising of children subject of Child Protection Plans.**

9.3.1 A lack of sufficient suitable social housing stock is a national issue and, in particular, a problem for London authorities. Temporarily housing children who have been identified as being **in need** (under the Children Act 1989) outside the local authority area causes systemic problems in the co-ordination of multi-agency work, particularly for cases where a child has been assessed as being at risk of significant harm and made subject of a child protection plan.

9.3.2 Croydon Housing placed Mother and Baby L in temporary hostel accommodation in Camden, intending that they may reside there for up to a year, as there was no suitable local provision. At the time of this case Croydon did not give additional priority to families with children subject to Child Protection Plans. It has been stated that as Baby L was a 'Lambeth child' no additional priority would have been given. The Lambeth Social Worker asked Croydon Housing twice to give priority and move Mother and Baby L closer to her family in south London. However, there was no action on this request for six months.

9.3.3 The review has raised the question of how well homelessness and housing law is understood by non-housing professionals, particularly social workers, and the strategic relationships between Local Authority Children's Services Departments and Housing Departments in working together to prioritise the most vulnerable children and families. Are social workers (and others) aware of the rules and powers governing Local Authorities in relation to homelessness, security of tenure and why it may be necessary to place families outside the borough, temporarily?

[22] https://www.gov.uk/government/publications/amcd-inquiry-hidden-harm-report-on-children-of-drug-users

9.3.4 It also raises the question about how well housing workers understand safeguarding children, and safeguarding children processes, such as Core Groups. As a result of another local SCR, Croydon has introduced a Joint Protocol to deal with this and now provides Single Points of Contact in Housing Sections for safeguarding advice, and tracks cases where children are known to be subject of Child Protection Plans; a Housing Safeguarding Co-ordinator post has also been created. Lambeth Children's Services and Lambeth Housing are in the process of agreeing a joint protocol on this issue.

9.3.5 Where a family's housing has a negative impact on a child's welfare or safety this should be assessed as part of the ongoing re-assessments as part of the Child Protection Plan and relevant Housing Staff should be engaged in the Core Group.

9.3.6 During the review, the use and the effectiveness of the London Councils' 'notify2' System was raised. This is an online notification system for tracking the movement of vulnerable homeless families, across London Boroughs. *'Notify2 enables London boroughs to continue supporting homeless households moving to a new address. The scheme can help families and vulnerable people access schools, NHS and social care services. With the consent of service-users' borough Housing Departments provide information about homeless households to notify2, which issues notifications to education, social care and health detailing households placed, moving between or leaving temporary accommodation. Notify2 is provided by London Councils and used by all 33 London Local Authorities.'*[23]

9.3.7 London Councils informed this review (July 2017) that an analysis of the effectiveness of the notify2 arrangements had led to a decision to change the purpose of the database to be for notification of the moves of homeless families to Housing Departments only, and no longer to Social Care, Education or Health, which should, henceforth, use the London Child Protection Procedures for guidance.

9.3.8 In this case, Croydon Children's Services were not directly advised when Mother (pregnant) and, then later, Mother and Baby L were placed in temporary accommodation by Croydon Housing. It was not common practice for the Multi-Agency Strategic Hub (MASH) to enquire of the notify2 database, if that had happened in this case Croydon would have seen earlier that Mother and Baby L had been accepted as Croydon's responsibility by Croydon Housing while being assessed for eligibility for permanent housing. It is not clear, however, that this would have altered their view that Baby L was a Lambeth case, until he was permanently re-housed in Croydon.

9.3.9 Camden services had strong reservations about the quality of the temporary accommodation and its suitability for children. This raised a systems issue about how this concern about the suitability of such accommodation is made known across other placing authorities.

[23] London Councils' website: http://www.londoncouncils.gov.uk/services/welcome-notify

Cross-Borough Working

9.4 **Strong safeguarding systems require local networks of professionals (Core Groups) who can work closely together as a multidisciplinary team with parents to minimise risk, support Child Protection through parental change, and challenge parental non-compliance or drift. When those networks are disrupted by Cross-Borough working, systems must work harder to ensure effective safeguarding.**

9.4.1 As noted above, a key systems dynamic impacting on this case was having to work across several boroughs and agencies, as the Mother (and Father) moved several times, as Core Groups had to be re-formed several times; and proved to be ineffective as a result.

9.4.2 Lambeth Children's Services decisions to continue to hold the case, for fear that Baby L may fall through the net when Croydon and Camden declined to take it, exacerbated the problem of securing the right network of people across social care, health, mental health and domestic violence services, when some of those services were based in north London.

9.4.3 The majority of key meetings were held in south London, rather than local to Mother and Baby L in Camden, this resulted in non-attendance of key professionals. Consideration should have been given to both the location of key meetings and to creative and modern ways of involving more geographically remote professionals, such as teleconferencing for Core Groups or Child Protection Conferences.

9.4.4 There was a lack of awareness of, or adherence to, the agreed London child protection procedures[24] on this issue see 9.5.1 below.

Getting the basics right, adherence to Procedures, and supporting Frontline Practitioners with guidance and reflective supervision

9.5 **There were several examples in this case of lack of awareness of, or lack of adherence to, statutory guidance or local protocols. On occasions, timescales were not followed. From this one case, it cannot be assumed that this is common. It raises questions, however, about how Agencies monitor the use of safeguarding guidance, track adherence to requirements, use escalation and support Practitioners in critical and reflective thinking.**

The effectiveness of Core groups and their management in this is important.

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[24] London Child Protection Procedures section 6: **Children and Families moving across Local Authority Boundaries** 5th Edition 2016 http://www.londoncp.co.uk/chapters/chi_fam_bound.html

Note that a revised draft edition of the London Child Protection Procedures was published in March 2017 for consultation http://www.londoncp.co.uk

9.5.1 The case history, discussion and evaluation above show that on several occasions the basics of safeguarding were not right. Key agencies did not have the information that they needed. Protocols and procedures were unknown or not followed. Child Protection Conferences were not well attended and at times the right professionals were not invited. Core Groups, an essential tool in safeguarding were ineffective; not just because of the geographical problems. This raises questions about the co-ordination, chairing and quality of Core Groups in implementing Child Protection Plans, ensuring compliance, monitoring drift and ensuring that higher thresholds are considered when there is non-compliance by parents or insufficient change.

9.5.2 From the point of transfer of case responsibility to Croydon child protection standards were not met, in terms of visits to observe Baby L and check on his welfare and there was no systematic co-ordination of the multi-agency child protection work; despite requests from some professionals. This gap was not picked up by a management monitoring system.

9.5.3 Changes in workers, sometimes at key points, impeded the ability to form good working relationships with Mother and Father, as a foundation for bringing about change.

9.5.4 The work was task-focused and did not have sufficient professional curiosity to get behind what were the causes of the parental behaviour, and the reasons for lack of change. When it was thought that there might be 'disguised compliance' there was no plan to tackle this.

9.5.5 The Review has not been able to obtain a clear picture of the use of reflective supervision in the case, by all agencies. Agencies confirmed that systems were in place but some could not give a clear account of how supervision or management was used, or how effective it was, in this case. Critical refection and management oversight are important in work with stuck or resistant families; particularly in supporting professional curiosity and hypothesising about causes for behaviour as well as monitoring tasks. This raises a question for the LSCBs about how this is monitored and quality assured across all safeguarding work.

9.5.6 There was a lack of awareness of when and where to escalate concerns about insufficient progress, especially in the cross-borough work. The case should have been escalated to senior managers when frontline practitioners were stuck because of decisions by senior managers in other places e.g. transfer of case responsibility across boroughs.

9.5.7 It is acknowledged that this case was seriously impacted by the cross-borough issues. However, the view of the Panel is, that had the right quality assurance and management oversight been in place the cross-borough issues would have been resolved sooner. Greater attention was also needed to ensure that the right people were advised of the case, as a child protection case, and invited to key meetings and that their attendance or involvement was monitored.

9.5.8 Within this there were particular concerns about the management of transfers of responsibility, for a child subject of a Child Protection Plan, across boroughs and the need to ensure the effective handover of the multiagency responsibility between Core Groups. Such transitions present a risk that the focus and momentum may become lost as practitioners new to the case must catch up and make new relationships with the family. This suggests that more attention needs to be paid to the transfer of such cases between the old Core Group and the new Core Group and the tracking of key tasks;

including consideration of the need for a re-assessment in the new and permanent housing and community.

10 Recommendations

Croydon and Lambeth Safeguarding Children Boards and their Partner Agencies should consider the following recommendations and, if endorsed, agree an Action Plan to address them.

10.1 Ensuring that the child's experience is central to the work

Croydon and Lambeth Safeguarding Children Boards should satisfy themselves that their Partner Agencies seek to ensure that the safeguarding practice and supervisory systems in place keep the child's lived experience at the core of all safeguarding work.

The purpose of such a review will be to make the needs of children paramount, particularly where the needs or actions of parents may divert from this.

10.2 Knowledge and Skills in Working with Drug Using Parents

Croydon and Lambeth Safeguarding Children Boards and their Partner Agencies should review Practitioner Knowledge and Skills in understanding, assessing and responding to hidden substance misuse by parents, such as use of cannabis and other common drugs but where there is no clear sign of addiction or problematic life-style. This should include awareness of the possible clinical signs and impact of (accidental) drug ingestion or exposure by children. As part of this Agencies should review any practice guidance on recognising and working with drug use which is hidden or not deemed 'problematic'.

Consideration should also be given to how front-line practitioners can raise questions about drug use and the risks of drug-taking in a general and more 'universal or public health' way to ensure that parents are aware of the risks to babies and children.

This will ensure a more confident and competent workforce able to enquire about and challenge the use of drugs, which parents may deem to be acceptable or common and non-problematic.

10.3 Cross Borough Working, Homelessness and Temporary Accommodation

Croydon and Lambeth Safeguarding Children Boards, with their Children's Services and Housing Departments, should ensure that suitable arrangements are in place for prioritising the needs of children who are the subject of Child Protection Plans and who are in families placed in temporary accommodation. Such arrangements, including local guidance, should seek to ensure that where a child is transferred in or out, across borough boundaries the transition of multi-agency responsibility is timely. There should be full transfer of information and handover to a new Core Group of essential Practitioners, able to continue the Plan. As part of this, there should be clarity of the respective roles

and responsibilities of housing officers and social workers and a sufficient understanding by non-housing practitioners of homelessness rules; with access to specialist advice.

Such arrangements will provide the necessary additional knowledge and strong transition arrangements where there is no alternative to moving a child out of the home area.

10.4 Getting the basics right, adherence to Procedures, and supporting Frontline Practitioners with guidance and reflective supervision

Croydon and Lambeth Safeguarding Children Boards should review the Agency systems in place for quality assuring the safeguarding processes, including awareness of and use of multi-agency procedures, specialist guidance and reflective supervision or management. This should include how data and tracking are used to monitor cases, timescales and possible drift or non-adherence to Plans.

Through this the Boards should have a view of how frontline practice is overseen and an exception reporting system can be put in place to alert the Boards to any systemic issues which require attention.

10.5 Single Agency Recommendations / Actions

10.5.1 **The Metropolitan Police**, as part of their review of this case, has agreed that the Senior Leadership Teams of the Lambeth and Croydon Borough Operational Command Units (BOCU) carry out a dip-sample of Domestic Abuse cases to establish compliance with the current MARAC referral thresholds.

It is recommended as part of this review that the BOCUs report to their home LSCB on the findings and any actions to be taken as a result of those audits.

10.5.2 **Croydon and Lambeth Health Services and Children's Services and the NHS Child Protection Information System (CPIS)[25]**

Croydon and Lambeth CCGs and Croydon and Lambeth Children's Services should review progress on the adoption of the CPIS and report to their respective LSCBs on this. Adoption of CPIS will not act as a full substitute for information sharing about children subject of Child Protection Plans but it will assist in ensuring that children about whom there are concerns may be identified within the health economy; including any discrepancies in identifying data.

10.5.3 **Lambeth Children's Services and Lambeth Housing – Joint Protocol**

Lambeth Children's Services and Lambeth Housing should agree the Joint Protocol on Child Welfare, Child Protection and Housing (does it have a particular name?) and inform the Lambeth Safeguarding Children Board of the agreed arrangements.

[25] https://digital.nhs.uk/child-protection-information-sharing

The Lambeth SCB should ensure that the Protocol is on the Board's website.

This will assist in ensuring that where temporary housing is a key issue in a child's welfare and protection that there is effective co-ordination and understanding between Practitioners and that the Child Protection Plan can take this into account.

Malcolm Ward

Independent Reviewer

August 2018

Appendices Appendix 1 Terms of Reference

Serious Case Review Child L

Following discussion with the two Serious Case Review Sub Groups of Croydon and Lambeth Safeguarding Children Boards, in accordance with Working Together to Safeguard Children (2015), we have decided that a Serious Case Review should be undertaken on the above child.

1. CRITERIA FOR SERIOUS CASE REVIEW

The case meets the two criteria below set out in Working Together 2015[26]

5(2)(a)	Abuse or neglect of a child is known or suspected

And

5(2)(b)	(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

2. The Purpose of a Serious Case Review

The Boards have adopted the principles of the SCIE NSPCC SCR Quality Markers[27] which confirm the purpose of the SCR should be organisational learning and improvement and, where relevant, the prevention of the reoccurrence of similar incidents. The framework accepts that errors are inevitable and, where they are identified, they become the starting point of an investigation. Individual and organisational accountability is manifest through being open and transparent about any problems identified in the way the case was handled, and demonstrating a commitment to seek to address the causes

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.

[26] HM Government Working together to safeguard children. A guide to inter-agency working to safeguard and promote the welfare of children. March 2015

[27] SCIE NSPCC Serious Case Review Quality Markers 2016

SCRs and other case reviews should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children (using a systems analysis);
- 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.

SCRs should:

- be proportionate
- involve the professionals fully and invite them to contribute their perspectives without fear of being blamed for actions they took in good faith;
- involve families, including children, where possible. 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;

3. Methodology

The methodology being used for this review is the Welsh Model; Extended Child Practice Review a nationally recognised model which ensures that all the core elements of a high quality learning review are in place.

The methodology incorporates:-

- Oversight by a Serious Case Review Panel
- Agencies to provide:
    - A short summary report describing agency involvement with the family prior to the period under review.
    - A detailed chronology for the period under review:1 October 2014 to 31 July 2016
    - A brief analysis of relevant context, emerging issues and concerns –this may be in the form of bullet points
    - A note of any actions already taken or recommendations for future improvements in systems practice as a result of the critical incident.
    - List of all practitioners and their immediate Line-Managers who were significantly involved in the case
- Engagement with family members
- Practitioner Learning Event
- Child Practice Review Report written by the Independent Author, Malcolm Ward
- Debrief event to all participants
- Learning events for all with dissemination of the SCR

4. SCR Panel

An SCR Panel of senior managers from agencies involved in the provision of services to the family but independent of the management of the case is being appointed to oversee the SCR.

Andrew Christie (Chair of Lambeth SCB) will chair the Panel. The Independent Reviewer/Author will be Malcolm Ward. Panel Membership will be drawn from services in Croydon and Lambeth. It will not be proportionate for every agency to be involved directly in the Panel

Sarah Baker is the commissioner of the review and Croydon LSCB will take the lead for the review process, and the review will be funded 50:50 by Lambeth and Croydon LSCBs.

5. Practice Learning Event

Agencies should identify all Practitioners and their immediate Line-Managers who were significantly involved in the case (i.e. involved in the direct practice, planning or decision-making), including those who may have left the agency; and ensure that they are invited to and supported in attending the Practice Learning Event/s.

Both Croydon and Lambeth LSCBs expect these practitioners to be released and to attend the Events as an essential part of the methodology. Dates will be agreed in advance to give as much warning as possible to ensure attendance.

The Police and CPS will be consulted about any professional staff who may be required to give statements or have a role as a witness in any possible criminal proceedings.

6. Documentation

The SCR will request direct access to some agency documents, for example:-

- agency reports to child protection conferences
- minutes of child protection conference,
- Child Protection Plans
- any written agreements
- notes of Core Groups
- transfer documentation between local authorities
- any other documents identified by the SCR Panel

7. Scope of This Review

As a minimum, the review should cover the period from:

1 October 2014 to 31 July 2016

Agencies are asked to provide information during this period within their chronologies, using the Chronolator Tool and provide a summary of any relevant information that falls outside of this period.

8. Family Involvement

The independent chairs of the LSCB will inform the parents about the SCR and invite them to take part should they wish to do so. Family views about the SCR will be sought prior to publication.

9. Consent

In order to obtain the best possible understanding of the child's circumstances we need to consider information about his parents and carers. The parents will be advised that medical information about them, relevant to the care of their son will be shared for the purpose of the SCR.

10. Agencies requested to provide chronology and summary

1. NHS England (GPs)
2. Croydon Health Services (including Croydon University Hospital, Health Visitors and School Nurses and Family Nurse Partnership)
3. Kings College Hospital
4. Guys & St Thomas' Hospital
5. St George's Hospital
6. South London and Maudsley NHS Foundation Trust (SLAM),
7. Metropolitan Police, SCR Team
8. LB Croydon Children's Social Care
9. LB Lambeth Children's Social Care
10. LB Croydon Housing Dept.
11. LB Lambeth Housing Dept.
12. London Ambulance Service
13. National Probation Service/London CRC
14. Crown Lane Children's Centre
15. GAIA

11. Terms of Reference for this review

The circumstances of this SCR contain a number of issues which we expect to be explored by the SCR Panel and within the summary reports, as follows:-

What did the practitioners know or could they have known at the time and what knowledge, skills and values did they base their judgements on?

How did agencies and their practitioners take account of any specific cultural or religious needs of the parents or child?

How was the allegation of forced marriage assessed?

How was the risk of domestic abuse assessed?

How was the parent/s' drug possession and possible use assessed?

How were concerns about the mother's mental health and possible self-harm assessed?

Was it considered that the father may have mental health issues?

What history was taken from the parents about their own childhoods? And how did they come to meet?

How well did the pre-birth assessment work?

How effective was the child protection plan and the work of the Core Group?

The transfer of case responsibility ad recognition of risk to the child?

Was there appropriate information sharing across services and geographical areas?

Was there appropriate challenge to the parents? Together and individually?

How were policies and procedures used in relation to the work undertaken at the time?

What was the good practice? Are there any gaps? If either what led to these?

Systems and context

In terms of a systemic analysis were there things happening in the wider family which impacted on this case?

Were there any processes in the professional teams working on this case at the time which impacted on the case – resources, staffing, professional knowledge and skills, workloads, changes etc.

Appendix 2 SCR Panel Membership

Andrew Christie	Independent Review Chair (Chair Lambeth SCB)
Malcolm Ward	Independent Review Author / Lead Reviewer
Maureen Floyd	Croydon Safeguarding Children Board Manager
Sian Foley	Manager, Croydon Housing
Tina Hickson	Associate Director of Nursing, Croydon University Hospital NHS Trust
Moira Keen	Head of Service, Children in Need, Croydon Children's Services
Sally Innis	Designated Nurse, Croydon CCG
Ann Lorek	Designated Doctor, Lambeth CCG / Guys & St Thomas's NHS Hospital and Community Trust
Sabina Malique	Lambeth Safeguarding Children Board Manager
Chris McCree	Safeguarding Lead for Children, South London and Maudsley NHS Mental Health Trust
Russell Pearson	Metropolitan Police, Specialist Crime Review Group
Naeema Sarkar	Assistant Director Quality Assurance, Lambeth Children's Social Care
Debbie Saunders	Named Nurse for Safeguarding Children, Guys & St Thomas's NHS Hospital and Community Trust
Avis Williams-McKoy	Designated Nurse, Lambeth CCG
Nia Lewis	Croydon Safeguarding Children Board Administrator

The Panel is very grateful to Nia Lewis for her careful administration of the review process.

October 2017