Medway Safeguarding Children Board

Safeguarding Medway's children together

MEDWAY SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

'GEORGE'

INDEPENDENT REVIEWER: FERGUS SMITH

MARCH 2020

1 INTRODUCTION

1.1 TRIGGER EVENT & RESPONSES OF RELEVANT LOCAL SAFEGUARDING CHILDREN BOARDS

1.1.1 On 01.02.18 the London Ambulance Service (LAS) was called to a street in Croydon where George (a White British male nearing his 4th birthday) was found unresponsive. The child, having suffered a cardiac arrest, was resuscitated, taken to hospital and given intensive care. George subsequently developed multi-organ failure and ischemic brain injury and died 3 days after the incident.

1.1.2 Following a criminal investigation, it was established that George had been alive and well when he entered the car and had been in the rear passenger foot well when the front passenger (his mother's partner 'A') twice pushed his seat back and crushed him. Post mortem examination recorded the cause of death as 'ischaemic brain injury and compression asphyxia'. George's mother subsequently received a custodial sentence for child cruelty, perverting the course of Justice and assault and 'A' was more recently found guilty and imprisoned for manslaughter, perverting the course of Justice and witness intimidation.

1.1.3 It was established that mother and child had moved to Croydon only 2 days before the trigger incident and that George remained registered with Medway health services (GP and health visiting). Medway's designated doctor for child deaths subsequently chaired a 'multi-agency rapid review' and Croydon completed the required 'serious incident notification' to the regulatory body Ofsted.

1.1.4 In March 2018 the Metropolitan Police Service (MPS) proposed to the Croydon Safeguarding Children Board (CSCB) that it commission a serious case review (SCR)[1]. It declined to do so citing insufficient evidence that George was ordinarily resident in that borough. On the advice of its 'screening panel', the independent chairperson of Medway Safeguarding Children Board (MSCB) agreed that Medway would commission this SCR.

1.1.5 The prime purpose of this review has been to identify learning opportunities and to enable agencies and professionals to improve the way in which they work individually and collectively to safeguard and promote the welfare of children.

[1] Regulation 5 Local Safeguarding Children Boards Regulations 2006 required Local Safeguarding Children Boards (LSCBs) to undertake reviews of 'serious cases' in accordance with Working Together to Safeguard Children HM Government 2015 (since replaced by a 2018 equivalent) . A 'serious case' is one in which, with respect to a child in its area, 'abuse or neglect is known or suspected and the child has died' [including cases of suicide] or been 'seriously harmed and there is cause for concern as to the way in which the local authority, LSCB partners or other relevant persons have worked together to safeguard her/him'.

1.1.6 An independent report was commissioned from CAE Ltd (www.caeuk.org) and Fergus Smith was asked to:

- Collate and evaluate material supplied
- Draft for consideration by the SCR panel and subsequent publication, an overview report identifying opportunities for organisational and individual learning
- Formulate any justifiable recommendations for the Safeguarding Children Boards (or member agencies) in any of the involved local authorities

1.1.7 In February and April 2019 letters had been sent to mother and the man assumed to be George's father ('B') to inform them that the SCR was being undertaken and to invite them to contribute to it. No response was received. By November, relevant criminal proceedings had been completed and further invitations were sent. Personal encouragement and support was also provided by the probation officer working with her and a meeting with the author of this report subsequently held at mother's current location.

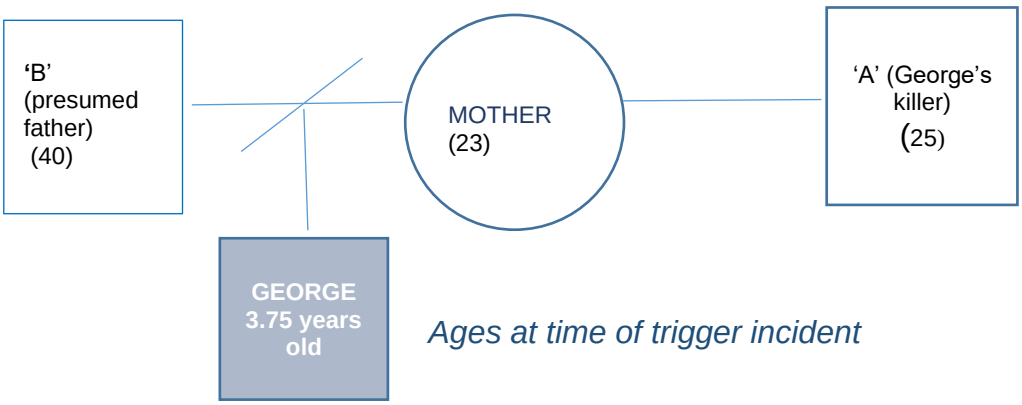
1.1.8 In spite of her ongoing distress at the loss of her son, mother was able to confirm the accuracy of much of the narrative that had been drafted and on occasions to add her own perspectives. The author and panel members are grateful that George's mother contributed in the hope that the learning emerging from this review might better safeguard other vulnerable children.

1.1.9 This SCR has addressed the following:

- **Family History**: Mother's background and relationship with George's maternal grandmother (MGM); understanding of mother as victim of domestic abuse including coercive control; agencies' knowledge of father's background including offending history, domestic abuse and substance misuse and level of interaction; knowledge of mother's partner, their relationship and his contact with George
- **Quality of Assessments:** How was family history taken into account? What assessments were made of mother's parenting and cognitive ability? Were assessments made in an informed and timely way? Were assessments child-focused? What was the quality of analysis of risk and protective factors? Did assessments appropriately consider mother and George's housing needs and moves? Was he identified as a missing / invisible child? Did recommendations reflect the levels of perceived risk to George? How well understood and managed was the mental health of mother and father and what was its impact? What was the role of management oversight and supervision in assessments ?

- **Child Protection and Pre-birth Planning:** Was the pre-birth child protection timely, effective, robust and compliant with procedures? Did the child protection plan appropriately reflect known risks within the family? Was the plan child-focused? How well were agencies engaged in the child protection process; Quality of managerial oversight / supervision? Opportunity for reflection? Was the agency's supervision policy adhered to ?; Effectiveness of the core group process?
- **Multi-agency Working and Information Sharing**: Did agencies communicate effectively and share information? Opportunities for agencies to safeguard and promote welfare of George? Any opportunities missed? Was the 'challenge and escalation process' considered or used ?

GEORGE's 'SIGNIFICANT OTHERS'



SCR PANEL, MATERIAL EVALUATED & REPORT STRUCTURE

1.1.10 The panel overseeing the SCR met on 8 occasions over 12 months from December 2018 and comprised senior representatives of relevant national and local agencies (Health Services, Children's Social Care, and Police). The SCR drew on information in 'individual management reviews' (IMRs) from involved agencies and some brief reports from those with a less significant contribution.

1.1.11 George's life had been rendered more complex by the several men with whom his mother became involved and many moves of home. No complete record exists of the overlapping personal relationships and a 'calculation' of a dozen changes of home / location may be an under-estimate. By way of highlighting the risk 'A' and 'B' posed to vulnerable others, 'domestic incidents' triggering Police attendance have been counted (a minimum of 12 for 'A' and 7 relating to 'B').

1.1.12 Section 2 offers a narrative of events and agency contacts during the review period (October 2013 to George's death in February 2018). It is interspersed with emboldened comments on the quality of responses or issues emerging. Section 3 addresses the terms of reference and section 4 provides recommendations for improved service design and/or delivery.

DEVELOPMENTAL INFLUENCES IN PRE-REVIEW PERIOD

1.1.13 A good deal of collated detail associated with mother's earlier experiences may be summarised by stating that she had experienced a troubled childhood leaving her vulnerable to abuse and exploitation by others. 'B', who is assumed (though not proven to be) George's father has an extensive criminal record of dishonesty, domestic violence, arson and drugs-related offences.

1.1.14 Mother's reported partner at the time of the trigger incident ('A') had, been adopted as a young child. Having attained the age of criminal responsibility, 'A' went on to acquire an extensive juvenile criminal record, some relating to sexual offending with younger females and as a teenager, he was re-accommodated by a local authority. In adulthood, 'A' has accrued an extensive criminal record of domestic and other forms of violence.

1.1.15 Both 'A' and 'B' are known to have significant mental health difficulties, agency responses to which have been addressed within this published report *only* to the limited extent that they did, or might reasonably have been seen to impact on the safeguarding or development of George or any other child with whom either individual might be associated.

2 PERIOD UNDER REVIEW

2.1 EVENTS DURING MOTHER'S PREGNANCY WITH GEORGE IN MEDWAY (2013/14)

2.1.1 In Summer 2013 George's mother (then aged 18) booked (slightly late) and went on to make good use of available ante-natal care in Medway. No significant medical or social concerns were identified. The identity of the baby's father was not established. At her meeting with the author, mother spoke positively of the service provided.

2.1.2 During this period 'A' (then 20) was arrested in the Midlands in connection with an indecent assault. There was insufficient evidence to pursue the case. In the same week the Metropolitan Police Service (MPS) received an allegation of domestic abuse from his Croydon-based partner ('R') - the mother of their son. Enquiries made by Croydon's Children's Social Care resulted in his child being deemed a 'child in need' and a support plan formulated.

2.1.3 The *first* indication of a link between mother and 'B' was in early January 2014 when Kent Police attended a street-based altercation between them. Mother reported being 6 months pregnant and that 'B' was *not* the father. Medway Children's Social Care was appropriately notified via a 'domestic abuse notice' (DAN). A pre-birth assessment of need was attempted though thwarted by mother's disinclination to co-operate (which she does not now recall) and eventually dropped.

George's birth & Probation Referral to Children's Social Care

2.1.4 Records of George's birth in mid-May 2014 provide no indication of the presence of a partner. On the ward, mother needed to be advised about the basic care of George (feeding / maintaining adequate body warmth etc) but no concern about their relationship was recorded. George was discharged to the home of his paternal grandmother ('B's mother).

2.1.5 In late May Medway Children's Social Care received a referral from Probation which was concerned because 'B' was not allowed to have unsupervised contact with children. In addition, there were concerns about domestic abuse between mother and 'B' and a risk the paternal grandfather was believed to represent. Enquiries under s.47 Children Act 1989 were commenced and Children's Social Care funded a place for mother and George in local supported accommodation for 16-25 year olds. It was assumed she would supervise contact by 'B' (named on George's birth certificate as his father and by then in daily contact).

2.1.6 A report provided by the Unit for the purpose of this SCR provides a more elaborated, convincing and concerned view of mother's behaviours than is apparent from the records of statutory agencies. Mother speaks positively about her time in supported accommodation and of her relationship with her key-worker. **Children's Social Care completed no risk assessment of mother's ability or motivation to safeguard George during visits by 'B'**.

2.1.7 Significant concerns being expressed by the Accommodation Provider about mother's ability to manage (self-care and state of her room) were shared with health visitor HV1. She in turn sought (unsuccessfully) to engage the allocated SW3 in a discussion. **The lack of responsivity justified escalation**. Informed by the results of an 'Edinburgh Post Natal Depression Scale', HV1 put in place (an unspecified) support package and sought to alert the GP by filing a letter in her/his records. Mother did not thereafter consult the GP so the issue was not pursued.

2.1.8 'B' was involved in a further domestic incident on in mid-July 2014 (his 2nd) involving an ex-partner 'CD' and their daughter. Mother revealed to HV1 the name of an alternative man whom she thought was the biological father of her child, though later re-confirmed it to be 'B'. **Mother's genuine, confabulated or mistaken belief / assertion were never further explored or any DNA test contemplated**.

2.1.9 The child and family assessment was completed in early August and concluded that mother was *not* acknowledging the risks that 'B' posed toward George. Whilst the above events were playing out in Medway, mother's *future* partner 'A' was involved in a domestic incident at the flat he was then sharing with a new partner 'P' in the Blackpool area.

Initial Child Protection Conference (ICPC): George

2.1.10 At the ICPC in late August 2014 George was made subject of a child protection plan on the grounds of neglect with a review due in November. It was also agreed that mother should complete an assessment of her cognitive ability. A 'core group' was established. Early observations by HV1 and a newly allocated social worker SW5 were positive. Mother agreed to remain at her accommodation on specified days to enable completion of a parenting assessment.

2.1.11 Mother's future partner 'A' was involved again with the MPS in early October (3rd such episode) in connection to an allegation of his behaviours toward a then girlfriend. The investigation and the relationship ceased soon afterwards. During October, 'A' received further convictions for violence and sending offensive / indecent material to an ex-partner. Mother was remaining at her accommodation on agreed days and George's father 'B' was found to be unsuitable for an anticipated domestic abuse programme to which he had agreed.

2.1.12 Initially as a result of the death of her step-father, mother was 'temporarily' residing with MGM and still to start the 'Freedom Programme'[2] and counselling. The Accommodation Provider's report offers examples of controlling / coercive behaviour by 'B' and MGM, the impact of which was compounded by mother's inability to assert her own perspective or to prioritise George's needs. Records suggest some difficulty in *understanding* what she had been told or agreed to and reinforce doubts about mother's cognitive ability. The potential value of 2 further core groups was undermined because SW5 did not attend.

[2] The Freedom Programme is a well-established formalised approach to informing and empowering those experiencing domestic abuse to recognise and challenge their situation.

2.1.13 Mother actually moved to 'B's address in Medway in late January 2015. HV1's attempt to confirm with the social worker that she had, as asserted by mother, agreed to the early move prompted no response. **SW5's 2nd apparent failure to respond to such a message (and absence from 2 core groups) justified escalation**. Meanwhile, mother's future partner 'A' had again been involved in domestic abuse of another partner (5th such example).

2.1.14 In March 2015 the 2nd review conference determined because of co-operation and *apparent* progress (the parents had been cohabiting for only 1 month), that it was safe to step down to a 'child in need' (CIN) plan with monthly social work visits and bi-monthly health visitor contact. **The planned cognitive assessment and an evaluation of the impact of the Freedom Programme or counselling had apparently been set aside**.

2.1.15 'A' (this time using an alias) was involved in a domestic abuse incident (his 6th) with a different female. The event triggered no additional action by the Community Rehabilitation Company (CRC's) 'responsible officer' *nominally* monitoring 'A's previously imposed Community Order.

2.1.16 By chance, when a newly allocated HV2 made her first home visit to mother and George in early May 2015, SW5 was present and indicated an intention to close the case. No formal CIN plan has been located and no record of any regular CIN reviews found; it appears that SW5 may have 're-branded' this chance encounter with the health visitor as a 'CIN meeting'. During mid to late May, 'A's 'responsible officer' continued to make ineffective attempts to trace and encourage him to engage.

Arson at home of mother & George

2.1.17 In late May 2015 there had been a further domestic incident involving mother and 'B' (his 3rd). During completion of a risk assessment, mother reported having ended the relationship some 2 weeks earlier, since when 'B' had threatened suicide or seriously harming her and George. The situation was assessed as 'high risk' and child protection and MARAC[3] referrals were initiated. A fire at the Medway home address of mother and George which was empty at the time, had been deliberately started and 'B' had been seen running away. He became a suspect for 'arson with intent to endanger life'. At her meeting with the author, mother asserted that 'B' knew neither she nor George were present and that he had never (then or later) shown any aggression toward her son.

1st Multi-agency Risk Assessment Conference (MARAC) meeting: George's mother

2.1.18 A MARAC meeting in late June 2015 considered the arson and domestic incidents and confirmed additional safety-related steps e.g. referral to Children's Social Care and a suggestion for mother to consider use of a local domestic abuse charity.

[3] MARAC = Multi-agency Risk Assessment Conference

2.1.19 MGM reported to the health visitor at this time that she had not seen George or his mother for some weeks and suspected they and 'B' had fled the area. The health visitor contacted SW5 who undertook to alert Police though did not do so. It was later reported by mother that following a row with MGM's partner, she had left though 'B' (with whom she denied having resumed a relationship) was nonetheless paying for her to stay with George in a flat. **Mother's ongoing dependence on the controlling and risky individual who had tried to burn the then home down (and whose bail conditions prohibited contact with mother and George) should have been very clear**.

2.1.20 HV2 was justifiably dubious about mother's claims and subsequently emailed SW5 to advocate stepping up the case to 'child protection' status. In addition to taking the steps recommended by the health visitor, **Police *should* have been informed of the ongoing relationship and contact between mother and 'B'**.

2.1.21 By late October 2015 mother and George were back with MGM where mother reported further abusive calls from 'B'. SW5 undertook to enlist an independent domestic abuse adviser (IDVA) though did not do so. Following an allegation to Kent Police that mother was a drug addict, a 'welfare visit' did not confirm that (in breach of bail conditions) ongoing contact between the parents. In early November, 'B' was admitted to a psychiatric ward at a Kent hospital for 'suicidal and homicidal thoughts', an assurance that he had *no* contact with George was accepted at face value and neither Children's Social Care or mother alerted to the event.

2.1.22 Meanwhile, ex-partner 'CD' reported to the MPS 'A's threats to kill her, her children and a brother (his 7th such episode) though subsequently completed a 'withdrawal statement'. It was learned that 'A' had *also* had a relationship with the sister of 'CD' in South London.

George's reported head injuries

2.1.23 George (18 months old) was transported by ambulance to a Medway hospital in November 2015 having reportedly tripped, fallen and banged his head. Routine treatment was provided and overdue immunisations noted. Next day, mother re-presented George saying she had dropped a hammer which had bounced and hit him in the face. Concerned staff appropriately liaised with 'out of office hours' Children's Social Care before agreeing discharge and a discharge letter was emailed to the Health Visiting Service. It has not been possible to confirm receipt of comparable notifications by relevant GPs. The author has been assured current arrangements facilitate such notifications. No evidence has been found that a planned follow-up by Children's Social Care occurred.

2.1.24 In mid-January 2016 a 3rd party reported an incident which ex-partner 'CD' later confirmed as 'B', attending her home drunk, though not making threats (his 4th such episode). Police, on the basis of known history, assessed the risk as 'medium' and Children's Social Care was notified.

2.1.25 Soon afterwards, ex-partner 'CE' attended a South London Police station and reported further harassment and stalking by 'A' since November 2015 ('A's 8th such episode). Allegations included a report of texting a threat to use a firearm he possessed.

2.1.26 By late January 2016 SW5 reported an 'improvement' in the case and a decision was made to close it. **There had been no sustained improvement in mother's ability / motivation to protect George from the emotional and potentially physical consequences of a wholly dependent relationship with disturbed controlling men and associated rapidity of residence changes**.

2.1.27 In late March 2016 'A' (thought to be living in South East London) was arrested as a result of ex-partner 'CE's allegation that he had called her in November 2015 and threatened to shoot her brother.

2.2 MOTHER & GEORGE IN BLACKPOOL (APRIL- MAY 2016)

2nd consideration by MARAC

2.2.1 In early April 2016 Lancashire Police contacted Kent colleagues and relayed what it described a 'medium risk' event involving mother and 'B' (his 5th). It was upgraded to 'high risk' by Kent on the basis of the previous offence for which 'B' remained bailed and a MARAC referral and child protection notification initiated. Mother and George had been having a 'short break in Blackpool'. In her explanation to attending officers, mother acknowledged engaging in consensual sexual intercourse with 'B' following his arrival at the address but argued with him when he became intoxicated in front of George. In contrast to many of the other moves, mother described to the author that the move to Blackpool had been her idea.

2.2.2 A very comprehensive MARAC to MARAC transfer between Medway and Blackpool was completed on the basis that mother had indicated she would *not* be returning to Medway and had been allocated a permanent address in Blackpool. MGM left a message with Children's Social Care soon after the above indicating that mother and George were 'missing'. After 2 further reminders, SW5 called back and suggested MGM contact Blackpool. In late May, Blackpool Children's Social Care was notified via the police officer of its MASH[4] that ex-partner 'B' continued to be in contact with mother, *contrary* to defined bail conditions. A management decision was made to undertake what became the 3rd child and family assessment.

2.2.3 In early June, mother reported being back in Medway as a result of the hospitalisation of her own mother (MGM), though reported that she *would* be returning to Blackpool. She claimed that she would *not* be reconciling with 'B', accepted a referral to Women's Aid and provision of advice about obtaining a 'Child Arrangements Order' to define with whom and where George should live.

[4] MASH = A 'Multi-agency Safeguarding Hub' in which co-located professionals from Health, Social Care and Police filter incoming notifications and requests for service.

2.3 RETURN OF MOTHER & GEORGE TO MEDWAY, SUTTON & CROYDON (JUNE 2016 - JANUARY 2018)

2.3.1 Toward the end of June 2016 mother and George returned to MGM in Medway. Before her return, mother had informed a social worker that she and a 'new partner' ('A') had argued over a bank card ('A's 9th such episode). Blackpool's HV3 also confirmed the move back to the local area in a phone call to a colleague in Medway.

2.3.2 Kent Police dealt with his 6th such episode in late June when a verbal argument between 'B' and his 'ex-partner' 'CD' centred on access to their child. A fortnight later Kent Police attended a further altercation in a Gravesend street involving mother and 'B' (his 7th such episode). He admitted ongoing contact in spite of bail conditions. An initial assessment of 'high risk' was later lowered by a sergeant to 'medium'. **The incident of April 2016 remained relevant and the initial 'high risk' had been a proportionate evaluation**.

2.3.3 At the end of September 2016 during a visit to MGM, SW5 accepted a reassurance that 'B' (reported to be living in mid-Kent) was not in contact. SW5 consequently recommended case closure (enacted in early November by a 'step-down' to 'Early Help'). Health Visiting Services remained un-informed of the decision. Little account was taken of historic information especially the repeated (false) reassurances about a genuine separation from 'B'. **Hence the risk to George in consequence of mother's choice of associates and inability to safeguard him was unchanged**.

2.3.4 In late December 2016, a newly allocated HV4 arranged a home visit and on contacting Children's Social Care, was informed of the case closure. **A challenge of case closure made would have been justified**. In mid-February 2017 Kent Police were told of an assault by 'A' on MGM (10th such episode for 'A'). Subsequent attempts to trace him failed and mother (nominally still a partner) revealed only that he was 'in the North of England' and claimed an inability to contact him. Though circulated as 'wanted' on the Police National Computer (PNC) and later arrested twice by the MPS for other matters, he was never dealt with for the alleged assault of MGM.

Mother & George coming to attention of Kent Police

2.3.5 HV4 learned in late February 2017 of an altercation at a friend's house following a move from MGM's by mother and George. Attending police officers has been sufficiently concerned about the lack of a stable environment to submit a 'child protection referral' including the following …' *there is concern over George being present during regular arguments and volatile situations as was the case during this incident. Mother appeared scared and uncertain. It is a concern that she does not have stable accommodation with George as it appears her mother kicks them out after getting intoxicated and arguing with mother.'*

2.3.6 Medway Children's Social Care's response was limited to a letter which, in spite of the knowledge she had left there, was sent to MGM's home.

Imprisonment of ‘B’ / further contact with Police by or about ‘A’

2.3.7 In late April 2017, ‘B’ was sentenced for the arson attack to 3 years imprisonment with supervision in the community after release. Case management was allocated to a National Probation Service (NPS) officer PO1. At about this time, the MPS responded promptly to a request for information from Bromley Children’s Social Care which was gathering information to inform its response to an attempt by ‘A’ to gain access to his 5 year old daughter.

2.3.8 In early May 2017 ‘A’ (using an alias and an address in Sutton) reported to Police an assault by 10 men said to have been witnessed by George’s mother. The investigation was closed due to insufficient evidence. 2 weeks later Kent Police were informed by the MPS of a report that mother was carrying a gun in her purse for potential use by partner ‘A’. This prompted a standardised response on the records of both parties. **The safeguarding implications of the possible possession of a gun were insufficiently recognised**.

2.3.9 Significantly, information communicated from the prison to PO1 refers to ‘Restraining Orders’ on 2 females not previously linked to George and a prohibition on entering a named road and area. **This information suggests that ‘B’s behaviours had been impacting on more than just those known to the agencies involved in this SCR**.

Arrest of ‘A’ on suspicion of drug-related offences

2.3.10 In early June 2017 ‘A’ and 4 others were arrested on suspicion of ‘possession of drugs with intent to supply’ and possession of an imitation firearm. Records suggest without making explicit, a child/ren at home (same Sutton address again). It was later determined that there existed no realistic chance of prosecution and no charges were preferred. **The circumstances recorded indicate an under-estimated risk to associated children**. ‘A’ remained ‘wanted’ by Kent Police for common assault of MGM. As a result of an oversight, Kent Police Service was not notified.

Allegation of risk to life

2.3.11 While at a cousin’s address in Kent, mother (who reported being 4 weeks pregnant with ‘A’s child) alleged that he had issued a threat to kill her, the baby and himself (his 11th domestic episode). ‘A’ subsequently ran away from officers. The incident was assessed as ‘medium risk’ and Children’s Social Care formally notified. That evaluation was later raised to reflect known history including the recent issue of possible possession of a firearm and subsequently downgraded again by a Public Protection Unit supervisor to ‘medium’. Mother subsequently claimed to have spoken with ‘A’ but to be unaware of his whereabouts. She anyway withdrew her co-operation; the investigation was closed off and ‘A’ was never spoken to in relation to the incident. **There was scope for a more thorough investigation and potentially, the arrest of ‘A’**.

2.3.12 A complex explanation offered by Kent County Council of the arrangements then in place includes a reassurance that current responses to such notifications would ensure that *all* children present are considered (the significance of George who was present had been overlooked) by what is referred to now as its 'Front Door' Service;

2.3.13 A week later, 'A' became a suspect for criminal damage to the car of a male with whom he was familiar, though the case was dropped for lack of evidence. Kent Police received a call in late June 2017 about screaming at the well-known address of mother's cousin in Gravesend (the same address as the 'threats to kill' incident). George was present and the address was noted to be 'cramped, dirty and smelly'. A report was submitted to the Public Protection Unit though Police records do not confirm that Children's Social Care was also alerted. **Insofar as officers were often alerted to noise at this address and one person present acknowledged having a social worker, an alert to Children's Social Care would have been justified**.

Allegation of George's 'kidnap' by 'A'

2.3.14 Kent Police received a call from a female at MGM's address on a date in early August. The caller claimed to be a friend of George's mother and that a male described as an 'ex-partner 'A' had abducted the child. Efforts to locate 'A', mother or George failed. Next day both (appearing well) presented to Bromley Police Station. Mother said she had willingly stayed overnight with 'A' and George at a Travelodge. **Though closed off as a potential hoax by an officer within the Public Protection Unit, this incident should have been investigated more thoroughly and relevant extracts retained for future intelligence-related purposes**.

Alleged rape / fraud: 'A'

2.3.15 Although not reported to Lancashire Police until late March 2018, it appears that 'A' was suspected of raping a named female in September 2017. His home address was reported to be Croydon. Days after the above incident, 'A', accompanied by George's mother again defrauded a Travelodge by means of a previously used technique.

2.3.16 Within 2 weeks of his daughter's birth, 'A' was reported by 'ex-partner' 'CE' to have assaulted her by pulling her hair, sticking his fingers down her throat and throwing her to the floor (his 12th domestic episode). The allegations were later withdrawn and, following arrest and denial, the case dropped. A notification to Sutton's MASH was completed and 7 days later Children's Social Care contacted Police because it had not proved possible to make contact and neither of the older siblings had attended school.

2.3.17 A search by Police of the unoccupied premises failed to locate the family, which was at this time an open case to Sutton Children's Social Care. More extensive enquiries established that the family were staying with the maternal grandparents of 'A's daughter in Mitcham.

2.3.18 The last occasion on which Kent Police was involved and noted the presence of a child thought to be George was in mid-September when a community support officer (PCSO) attended MGM's address, *only* (she believed) in support of a local 'enforcement officer' pursuing an un-related matter. Having established the presence of a responsible adult, the officer did not record details of those present. Had the 'Force Control Room' been clearer about the reason for her deployment (the enforcement officer's earlier reported concern about a 'confused 3 year old answering the door') she would probably have been more inclined to establish more precisely the names and circumstances of *all* present.

Initial child protection conference: child of ex-partner 'CE'

2.3.19 An ICPC was convened in late October 2017 by Sutton Children's Social Care and addressed concerns about the domestic abuse that characterised the relationship of 'A' and ex-partner 'CE'. All the involved children were made subject of child protection plans under the category of 'neglect' and the case scheduled for review in mid-January 2018.

2.3.20 In early November 'A' was arrested for the alleged assault in September, which he denied. The Crown Prosecution Service (CPS) advised 'no further action' by Police. In accordance with standard procedures, the MPS responding to a 'locate and trace' request on the Police National Computer (PNC) and emailed Kent Police. On 12.11.17 'A' initiated contact with the MPS and alleged that his daughter should (in accordance with a court order) be at her maternal grandparents' home. Officers attended and the child's mother explained that a Sutton social worker had agreed her move and that she and 'A' were 'no longer partners'. There were no concerns about the home or children and a Merlin was shared via the MASH.

Anonymous referral to Sutton's Children's Social Care

2.3.21 On 05.01.18 a caller who wished to remain anonymous had alerted Sutton's Children's Social Care to her concern about an unnamed child ('child X' aged 1) staying at a house previously shared by 'CE' and 'A'. The caller was worried about the risk 'A' posed to 'child X' and her/his mother. In addition the caller referred to the criminal history of an unnamed 'adult 4'. It would seem that the caller was unaware that George was / might also be present.

Review child protection conference (RCPC) / contacts with George's last known location

2.3.22 'A' had not attended a RCPC on 15.01.18 which determined that the protection plan for his child remained necessary and the case would be further reviewed in June 2018. 2 days later it was learned that these children, 'A' and his brother were all living in a flat. Following a strategy discussion by phone next day a meeting was scheduled for 24.01.18. Police welfare visits prior to that meeting found that the property appeared empty and had elicited no response. The delay in convening a formal strategy meeting was unfortunate but welfare checks by police officers offered a robust interim safety plan.

2.3.23 The strategy meeting on 24.01.18 was well attended and informed the planning of a joint visit next day under s.47 Children Act 1989. At the visit next day by a senior and a newly qualified social worker, supported by MPS officers, mother and son (only later identified as George and his mother) were noted to be 'happy and well'. **As in earlier examples, there would have been real advantage in establishing identities and significance of all those with whom professionals have contact; had George's identity been established, a referral via MASH could have been progressed.**

2.3.24 Upon their return to the office, the assistant team manager of the MASH asked for mother and George to be invited for an office meeting at which details could be derived and a MASH referral initiated. Next day 'A' informed his daughter's social worker and offered an explanation about the various adults and children at the address, some of whom (he said) would be returning to Blackpool. The other unnamed 'adult' also attended the office that day and amongst other matters, confirmed that 'A' and George's mother were in a relationship. A further (unannounced) home visit on 30.01.18 prompted no response though there *were* people present. George's mother and unnamed friend failed to attend on 31.01.18 as requested. At interview with the author, mother could not recall agreeing to that arrangement.

2.4 TRIGGER INCIDENT IN CROYDON

2.4.1 Following the trigger incident described in para. 1.1.1, hospital staff became suspicious of the varying versions of events and differing addresses offered by mother and initiated a safeguarding referral.

2.4.2 George was transferred for paediatric intensive care to St. Thomas' Hospital and Croydon Health Services (CHS) Safeguarding Team and its 'named nurse' notified. The latter's contact with Croydon Children's Social Care revealed no knowledge of the child / family but confirmed they *were* known by Medway Children's Social Care).

2.4.3 Though there was some initial uncertainty about which local authority was primarily responsible, the safeguarding lead nurse at the Paediatric Intensive Care Unit usefully drew attention to the 'London Child Protection Procedures' which made it clear that the responsibility rested with Croydon until a 'home authority' agreed to accept responsibility.

2.4.4 An initial strategy meeting agreed the need for enquiries under s.47 Children Act 1989. There was a full exchange of known information between local authorities, and varying explanations by mother of events and relationships. The outcome of the enquiries was that concerns could not be substantiated. Following George's death on 05.02.18, a 2nd strategy meeting was convened and Sutton Children's Social Care acknowledged that it had visited a property in its borough in January 2018 at which mother, George and 'A' has been staying.

2.4.5 Sutton staff also visited on 05.02.18 (just before being notified of George's serious injuries) and formed the view that the property had been vacated. George was confirmed as having being present on 25.01.18. On the day before, 'A' had been present so as to participate in a parenting assessment with respect to daughter and her half-siblings, though the house appeared vacated. It remains uncertain whether George was present during the unsuccessful visit on 30.01.18.

2.4.6 Given continuing uncertainty about cause of death and confirmation that the last known connection was Medway, the case was closed to Croydon's Children's Social Care the rationale being that the child was 'ordinarily resident' in Medway.

2.4.7 Reported service improvements since the trigger event e.g. co-location of Police within the borough's 'Single Point of Contact' (SPOC) and completed audits of case notes (with a requirement of sufficient evidence of reflection) render recommendations for Sutton Children's Social Care (which might otherwise have been justified) unnecessary.

3 RESPONSES TO TERMS OF REFERENCE & OVERALL FINDINGS

3.1 FAMILY HISTORY

3.1.1 The significance of mother's personal history in terms of her heightened risk of domestic abuse, as well as that of her various partners with respect to the physical and emotional risk they posed toward a partner and/or a child was under-estimated to a greater or lesser degree across most involved agencies.

3.1.2 The Midwifery Service focused entirely on medical matters and seems to have had no interest in George's paternity or the circumstances into which he was to be born. Attempts by Medway Children's Social Care to complete a pre-birth assessment were frustrated by mother's reluctance to co-operate and it would seem that, although the response had been triggered by the first of what would be many domestic incidents, that there was little if any enquiry about her partner.

3.1.3 Whilst the 2nd (and completed) assessment in August 2014 was denied some (unknown) information reportedly held by Kent County Council, it was anyway limited in its exploration of the ongoing impact of mother's relationship with MGM and her partner.

3.1.4 Enquiries by midwives and health visitors about potential for domestic abuse had also been less explicit than would have been helpful. Staff of the Accommodation Provider were more attuned to and witnessed directly, coercive and controlling conduct from 'B' as well as MGM some 2 months into placement. Though staff there liaised effectively with the health visitor, the latter appeared to lack the confidence to challenge more formally the unduly optimistic view being developed by SW4 and her successor SW5 (neither of whom, according to records and mother's own recollection shared with the author) appeared to spend much time in direct contact with mother or George).

3.1.5 Following HV1's recognition of mother's lowered mood state, the absence of further engagement with the GP Practice meant that its potential value for mother or child remained unrealised.

3.1.6 Given that the law with respect to 'coercive control' changed only in late 2015, the links initiated by officers in Kent and Metropolitan Police Services prior to that date suggest a welcome awareness of the relevance of the abusive behaviours of 'B' and 'A'.

3.1.7 Blackpool's brief involvement with mother and George lacked exploration of personal history and showed minimal recognition of the relevance of male partners, existence of a Non-Molestation Order etc.

3.1.8 During George's final weeks (some of it at a Sutton address) the focus of that borough's Children's Social Care had been on 'A's daughter and other adults within the household in question. Similarly, the initial referral of the hospitalised George in February 2018 included no reference to his father 'B' and it only emerged subsequently that 'A' had been known to the agency during the period 2013 -2015.

3.2 QUALITY OF ASSESSMENTS

3.2.1 According to Medway's records, a request had been made to Kent County Council for background information that could inform the ICPC report in 2014 but none was received. Assessments completed by Medway Children' Social Care were insufficiently informed by collation and analysis (with respect to implications for George) of mother's developmental experiences, cognitive ability, latest relationship or unresolved issue of paternity.

3.2.2 Descriptions provided by the Accommodation Provider offered a well evidenced account of examples of dishonesty of mother, 'B', and MGM as well as mother's inability / unwillingness to challenge 'B'. The value of the material provided in terms of the implication for future care of George were under-estimated by Children' Social Care.

3.2.3 The risk that 'B represented to George and his mother was under-estimated by several agencies:

- Medway's Midwifery and Children's Social Care's ongoing acceptance of mother providing sufficient monitoring of 'B's near-daily visits to George when he and his mother were in the accommodation provided (late 2014)
- The Kent hospital and SW5 in November 2015 when the former accepted without question 'B's assurance of no contact with George and the latter accepted mother's admitted contact with 'B'

3.2.4 Sutton's responses to the *other* children present at George's last known address are beyond the scope of this SCR. It had though, no basis on which to formally assess the well-being of George and/or his mother.

3.3 PRE-BIRTH PLANNING & CHILD PROTECTION

3.3.1 Pre-birth planning was inevitably limited by the combination of few observed grounds for concern amongst the professionals (chiefly midwives) from whom mother accepted involvement and those (Children's Social Care) from whom she refused it. Because the pre-birth assessment was resisted and delayed, the potential for addressing the significance of 'B' and the risk he represented and mother's level of vulnerability in forming intimate relationships was lost.

3.3.2 Following George's birth, protection efforts were undermined by:

- No (recorded) conclusion of the cognitive assessment of mother agreed as needed at the ICPC in August 2014
- A failure by Children's Social Care to ensure that all parties e.g. Health Visiting Service, GP were sent copies of child protection or CIN plans or made clear about the reason for an ongoing protection plan at the RCPC in November 2014
- Relatively limited contact by SW5 with her client or her colleagues
- Insufficient recognition of the well-articulated and more cautious concern being expressed by the Accommodation Provider who had spent most time with, were trusted by and (above all) knew mother best

3.3.3 The decision to 'step-down' from child protection to a CIN status in March 2015 seems in hindsight, to have been less an evidence-based plan and more a passive acceptance of the status quo. With weeks of the decision to 'step-down', case closure was being contemplated. The arson at the home of mother and George (confirmed by mother as being also 'B's home) did not appear to have significantly amended the level of risk that he was seen to represent (though the incident *could* by definition have proved fatal).

3.3.4 An incident of domestic abuse whilst mother and George were with MGM and her partner was withheld from SW5 when she visited. Even after formal notification by Police, it did not prompt a re-evaluation of mother's intrinsic vulnerability to victimisation and a consequent diminished capacity to prioritise George's needs.

3.4 MULTI-AGENCY WORKING & INFORMATION SHARING

3.4.1 An early (and possibly only) example of an unjustified *refusal* to share information was reported by the Accommodation Provider. 'Sure Start' reportedly declined to report on mother's progress at its local Centre. The position it is said to have adopted *may* have reflected insufficient briefing or preparation by the commissioners. Children's Social Care could and should have explicitly sought mother's consent for those she trusted at her accommodation or the allocated social worker to seek such feedback in the context of a voluntary acceptance of family support under s.17 Children Act 1989.

3.4.2 The Accommodation Provider's report makes it clear such feedback *could* have been of relevance to mother's everyday 'one to one' responses to her son e.g. she was sufficiently manipulative to ensure toys were made available to George before (and *only* before) a visit by the health visitor. It is very disappointing that the insights gained by those working directly with mother e.g. lack of cleanliness with respect to the care of George or self, were diluted by the time they appear in the records of Children's Social Care. The report provided also indicates their clear and valuable evidence was latterly excluded when it was not invited to the final 'core meeting' held in January 2015.

3.4.3 It would appear that the GP Practice at which mother and George were registered had not been informed of their circumstances prior to or following his birth e.g. her placement. As described in section 2.1.7, though its potential value remained unrealised, the effort made by the health visitor to inform the GP of mother's lowered mood state represented good practice.

3.4.4 Later when George became subject of a 'child protection' plan and later still a 'child in need' plan, there is no confirmation that the relevant GP Practice was informed or sent a copy of the relevant plans. These omissions represented missed opportunities to share relevant information and in so doing, strengthen support of the vulnerable mother and child.

3.4.5 Whilst acknowledging that they were operating in an agency formally evaluated at the time by regulator Ofsted as 'inadequate', the following examples of individuals' lack of reliability or responsivity and poor multi-agency collaboration would have justified challenge or escalation by professionals in other agencies:

- SW3's failure to respond in July 2014 to the expressed concerns about mother's behaviours in placement in 2014
- SW5's unexplained absence from the core group of December 2014 (and apparent failure to respond to the health visitor's questions in January 2015 about discharge or to attend CIN meeting 1)
- Failure to alert Police when mother and George were reported 'missing' in July 2015
- Only after repeated messages about the reportedly 'missing' mother and George in 2016, initiating a phone call to MGM though not liaising with Blackpool Children's Social Care, where it was thought mother and child could be located and/or contacting Police
- An unjustified Children's Social Care case closure decision in December 2016

3.4.6 The response to the 2 successive presentations of George to A&E in November 2015 were sufficiently well-managed (albeit poorly recorded) by hospital and Medway Children's Social Care. The formal child protection and child in need processes appear to have been efficient in terms of timing and with the following exceptions reflect what appears to have been a professional consensus:

- The category under which George remained subject of a plan at the RCPC of November 2014 is unclear
- Records of the final RCPC in March 2015 have been described as confused and omitted any recorded requirement of change of the behaviour of 'B'
- The conclusion of CIN meeting 5 in February 2016 that sufficient progress had been made and the risk to George diminished (which rapidly led on to case closure) was at odds with the evidence of ongoing and uncontrolled risk from George's father and other partners

3.4.7 Case closure by Medway's Children's Social Care in late February 2016 was completed without any formal record of its (ill-informed) decision (and the later September 2016 case closure without any notification of the Health Visiting Service).

3.4.8 The communication by Blackpool Children's Social Care of the return of mother and George in Summer 2016 was well-informed, and a delay that ensued before the recommended re-assessment was completed was beyond its control. In its admittedly very time-limited involvement, that agency offers a further example of an unmet need to factor-in recorded history when assessing needs or risk.

3.4.9 The resumed contact between mother and 'B' (still on bail for arson and with a condition of 'no contact' with mother) at this time represented a greater level of risk that was evaluated at the time by the more senior of the Kent police officers who dealt with domestic episodes 6 and 7.

3.4.10 The notification by Kent Police of the assault of mother by the maternal grandmother's partner in June 2015 had been slow. Its response to the disturbance in February 2017 at the house of a friend of mother was though, a sensitive and efficient one. The response of Medway Children's Social Care (a letter sent to MGM's home even when it was known that mother and George had left there) was wholly inadequate.

3.4.11 The significance of the presence of George was overlooked by Kent Children's Social Care when in mid-June 2017, Police notified it of officers' attendance at a Gravesend address in response to an allegation by then pregnant mother that 'A' had threatened to kill her and her baby.

3.4.12 An opportunity *may* have been missed when Kent police officers' alert of the Public Protection Unit following their attendance at the 'cramped, smelly and dirty' flat in June 2017 may not have been relayed to Children's Social Care.

3.4.13 Though their immediate safety was assured, there was scope for more investigation of the alleged kidnap of George in August 2017.

3.4.14 The response of Sutton Children's Social Care to the anonymous referral of January 2018 was well planned and reasonably executed. The presence of mother and George was unknown to the informant and became apparent only after some elapse of time and effort. Though there existed some uncertainty about which borough would become case-accountable, the immediate responses of medical, Social Care and MPS to the extraordinary trigger incident on 01.02.18 appear to have been of a good standard.

3.4.15 The panel recognised that the responsible decision by Medway LSCB to complete a SCR rendered *its* agencies more visible and vulnerable to criticism than the many other that had been involved in George's life. The following additional question was subsequently formulated by the panel:

- To what extent could and should *other* agencies with which George and/or 'A' or 'B' had contact have recognised and responded to the risk those individuals represented ?

3.4.16 A summary of the most obvious missed or insufficiently exploited of such opportunities is provided below.

Opportunities to better recognise risk to George / other children presented by 'B'?

3.4.17 'B' was predominantly visible and more effective responses could have been made:

- Following a welfare visit by Kent Police in November 2015 when (contrary to bail conditions imposed after the arson attack) it was apparent that there was ongoing contact with mother and George
- By a Kent Hospital in November 2015 when 'B's assurance that he had no contact with George was accepted at face value
- Had the attempted assessment in May 2016 by Blackpool Children's Social Care been more prompt, it might have achieved contact in advance of mother and George returning to the Medway area
- By the involved GP when in January 2017 an angry 'B' walked out of a consultation

Opportunities to better recognise risk presented by 'A'

3.4.18 'A' went to greater efforts than 'B' to hide his location or identity but more robust responses would have been desirable:

- By Cumbria and Lancashire CRC in 2016 when terminating anyway inadequate involvement without checks with other relevant agencies ('re-nationalisation' of Probation Services by Government render it unnecessary to formulate recommendations for this agency)
- When a Blackpool social worker failed to follow up mother's account of a domestic episode with 'A'
- 'A's reported threat to kill (an apparently pregnant) mother in June 2017
- When in Summer 2017, Kent and MPS respectively were involved in reports of mother keeping a gun for 'A', and subsequent discovery of an imitation firearm
- By Kent Police in response to a reported (concluded to be hoax) kidnapping of George by 'A' in August 2017
- By Kent Police in September 2017 when George's (probable) presence at the address attended by a community support officer went un-recorded

3.5 OVERALL FINDINGS

CASE-RELATED

3.5.1 In addition to the emotional vulnerability generated by mother's past experiences, her cognitive ability appears to have remained un-tested i.e. to what extent was she *able* to understand the expectations of professionals in the agencies with which she had contact ?

3.5.2 The high level of mobility and significant levels of dishonesty of mother, 'B' and 'A' rendered it difficult for involved agencies to form, retain and as necessary share, accurate estimates of risks. The Parent / Child placement had been appropriate though potential value reduced in consequence of insufficient attention paid its observations. It is uncertain whether SW5's practice reflected agency weaknesses and/or insufficient supervision or management (there was significantly more evidence of supervision of involved health visitors than social workers).

3.5.3 The ongoing risk 'B' represented to George and mother was clear from initial Probation / Children's Social Care liaison. There is little evidence behaviours improved e.g. 'B' was assessed as 'unsuitable' for a domestic violence group; nor any that mother's ability or willingness to be protective grew - completing a domestic abuse course or some 'counselling' does not equate to effectiveness. That mother's physical care of George was (when observed) 'good enough' should not have diminished concern about the immediate and longer-term impact of witnessing domestic abuse and experiencing constant unpredictable changes of residence, routines and familial or wider contacts.

3.5.4 With the advantage of hindsight, 'B's typical behaviour toward agencies was controlling (at times coercively so) and mirrored that toward George's mother and other partners. In spite of a plan agreed with mother and the professional network in late 2014 that she would remain in the accommodation provided, 'B' manipulated his way back into (from early 2015) sharing an unsupervised cohabitation with mother and child. Even after being bailed for arson on condition of 'no contact', the relationship continued and episodically involved cohabitation.

3.5.5 Whilst nobody could have predicted the fatal trigger incident, George had until then endured and survived the consequences of a succession of domestic crises involving his mother and her associates. Aggregated evidence from participating agencies suggests there would have continued to be damaging events sufficient in number and magnitude to justify a reasonable suspicion that 'he was suffering or was likely to suffer significant harm'[5].

3.5.6 The rapidly changing locations of mother and son (still below compulsory school age when attendance rates would have had the value of rendering him more 'visible') made it possible for a chronic risk of harm to be rendered insufficiently apparent to professionals in any one agency and location. Whilst it might have been difficult to establish grounds for Care Proceedings, it would have been prudent to seek advice from the Legal Service as to other potential responses to deal with 'B's ongoing breach of bail conditions and mother's clear collusion and prioritisation of her relationship/s over safety of George.

3.5.7 Mother's first partnership with 'A' (a volatile and potentially dangerous individual if one aggregates available evidence) may have begun in mid-Summer 2016 and lasted up to a year. By August 2017 'A' seems to have resumed a relationship with 'CE', though was probably (with or without their knowledge or agreement) maintaining this and other intimate relationships. The limited involvement of Kent Police constrained its opportunities for evaluating the risk to mother, George and any other children. The occasional liaison with colleagues in the MPS offered opportunities that could have been better exploited to assess the risks to which George was being exposed.

3.5.8 Throughout the period of review there has been approaching a dozen contacts or referrals (the majority from professional sources as well as, some anonymous and arguably malicious). 3 family assessments were completed though only the 2nd was thorough enough to inform the child protection conference and justify its conclusion.

3.5.9 In essence, the focus of Health and Social Care agencies was on mother and child with insufficient recognition that the dangerous men with whom mother associated inevitably represented a significant risk to any dependent child.

[5] If a local authority is informed that a child who lives, or is found, in its area (i) is the subject of an Emergency Protection Order; or (ii) is in police protection or (iii) has reasonable cause to suspect that s/he is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable it to decide whether it should take any action to safeguard or promote the child's welfare.

CONTEXT-RELATED

3.5.10 Several reports supplied to the SCR describe structures, policies, systems and expectations within the relevant agency across the period of review. Some seek to make a connection between these contextual variables and the performance of the agency or individual. For Medway's Children's Social Care, the period has been characterised by a high rate of change of leadership, approach to social work, levels of supervision as well as within the systems supporting the agency. Successive inspections by regulator Ofsted found services to be 'inadequate'. Consideration of current functionality has also been provided in other agency reports supplied. Whilst welcoming several reports of improved performance, this report has, in its identification of potential improvements, avoided reliance on *any* current structure, policy or leadership. It offers in section 4 pragmatic recommendations that transcend such variables and should be of more lasting value.

LEARNING POINTS

3.5.11 It is apparent that the 'lived experience' of George was insufficiently recognised or captured in the records of most involved agencies (with the exception of the Accommodation Provider). The ongoing succession of dramatic / traumatic events experienced by his mother dominated professional responses and left little scope for recognising how emotionally damaging the constant changes of associated adult / parent figures, locations and absence of peer relationships must have been. Those who pose a danger to more vulnerable adults almost inevitably represent a risk to children .

3.5.12 On the following occasions, responses to observed or reported situations rendered George partially to wholly 'invisible':

- Medway's (anyway misdirected) response to an alert by Kent Police in February 2017
- The response of Kent Children's Social Care in June 2017 to notification of a threat to kill mother by 'A'
- The visit by social workers supported by Police to the Sutton flat at which George was present in January 2018

3.5.13 To be effective, the recording, interpretation and assessment of an incident or situation by *any* professional needs to reflect *all* available information e.g. identity and significance of all present and avoid capturing only 'presenting circumstances'. Reflecting their respective sources of anxiety (being re-victimised or held to account for their conduct) the account offered by a victim or a perpetrator of domestic abuse may be partial, confused or inaccurate. If the account is at odds with other available information, it should be explored / challenged.

3.5.14 Those assessing and seeking to mitigate risk to a child or vulnerable parent must define *explicitly* and within a time-frame, demonstrable change before concluding sufficient improvement. Reflective supervision in *all* involved agencies is of central importance to that accurate and reliable identification and management of risk.

4 RECOMMENDATIONS

MEDWAY SAFEGUARDING CHILDREN BOARD (MSCB)

4.1.1 MSCB should:

- Seek confirmation from Kent Children's Social Care that in circumstances when it receives Police notification of an incident involving a child, it reliably captures and responds to all relevant information
- Monitor progress made in implementing all recommendations in agencies' submitted reports or which were identified during the course of this SCR
- Seek confirmation that all members agencies' training and development programmes address current lawful definitions and required understanding of 'coercive and controlling conduct'

MEDWAY CHILDREN'S SOCIAL CARE

4.1.2 Any service commissioned by Children's Social Care needs to be recognised as a source of potentially valuable information and its views and must be routinely and reliably required to submit written and/or oral contributions at all relevant formal planning forums.

4.1.3 Children's Social Care should offer MSCB a written assurance that social work staff in comparable roles to those involved with George:

- Receive reliable and timely reflective supervision
- Are monitored with respect to completion of allocated tasks and decisive management action taken if under-performance is apparent

MEDWAY NHS FOUNDATION TRUST

4.1.4 Staff training programmes should emphasise the value and necessity in of exploring any indication of additional 'vulnerability' e.g. acknowledged involvement with Children's Social Care / experience of domestic abuse

MEDWAY COMMUNITY HEALTHCARE

4.1.5 The internal safeguarding policy should be reviewed to ensure it includes a requirement for staff to escalate unresolved concerns / professional disagreements to a manager and 'Safeguarding Team'.

4.1.6 Awareness levels of the above revised policy should be increased via briefing / training events and awareness levels audited within the following year.

KENT POLICE

4.1.7 Officers and staff should be reminded of:

- The necessity of considering all known information when dealing with potentially vulnerable children or adults
- Requirement to submit referrals relating to children and vulnerable adults where risk is identified

4.1.8 Force Control Room dispatchers should be reminded to highlight any potential vulnerabilities linked to calls to which officers are dispatched.

MEDWAY CLINICAL COMMISSIONING GROUP (CCG)

4.1.9 The CCG should

- Remind all GP Practice Safeguarding Leads that of the need for post-natal checks and mental health reviews for this group of vulnerable patients.
- Take steps to ensure that patients with signs of post-natal depression have a risk assessment within their records