Medway Safeguarding Children Partnership

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MEDWAY SAFEGUARDING CHILDREN PARTNERSHIP

SERIOUS CASE REVIEW

Baby Harris

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CONTENTS

1. THE CRITICAL INCIDENT THAT TRIGGERED THE REVIEW:

1.1 On the 15th June 2019 at 9.27 am emergency services were called to the home address. This was in response to a report that Baby Harris' parents thought he was dead. The parents told the ambulance staff that Baby Harris had been asleep in the parent's bed. The baby had last been fed at 3 am or 4 am and seemed "fine". He was later found unresponsive.

1.2 The home was observed by the ambulance staff as unusually warm. The home was described as "cluttered and messy". "Copious amounts of alcohol" were observed including 8 empty wine bottles, that were in the bin. Both parents smelt of alcohol and their appearance was described by the ambulance staff as "dishevelled".

1.3 Observations of Baby Harris' body indicated that he had been dead for some time before emergency services had been called.

1.4 The baby's older brother, Child A (then aged 6 years old) was in the family home at the time of the death. When the police searched the property, they found hardly any clothing or items in the home for him. The family of four were living in a one bedroomed flat.

2. THE REVIEW PROCESS

2.1 The background to the review, terms of reference and a description of how the review was carried, out are shown in the Appendices to this report.

3. SUMMARY OF FACTS

3.1 FAMILY COMPOSITION

Family member	Relationship	Ethnicity	Age at the time of the child's death
Baby Harris	Baby that died	White British	15 days
Child A	Half sibling to Baby Harris	White British	6 years
G	Mother	White British	41 years
W	Father to Baby Harris	European	22 years
Paternal grandmother	Paternal grandmother	White British	Not known
B	Father to Child A	White British	50 years

4. BACKGROUND HISTORY

4.1 The father of Baby Harris was made the subject of a child protection plan in 2008, when he was 12 years old. This was due to concerns about physical and emotional abuse. He witnessed domestic abuse between his father and mother, when they lived together. He also reported being physically harmed by his father.

4.2 Before starting a relationship with W (the father of Baby Harris), the children's mother was married to B. Together they had four children, the youngest of which is included in this review, known as Child A. Child A's older siblings were not considered as part of this review.

4.3 B and the mother separated in January 2018. She retrospectively reported to her GP that there was domestic abuse in this relationship, however, there was no history of interventions by the police or other services.

4.4 The mother had no known background history of alcohol and/or drug misuse before meeting the father of Baby Harris, in June 2018.

5. CONTEXTUAL INFORMATION AND NARRATIVE CHRONOLOGY

5.1 This section seeks to provide the story of the family from the perspective of agencies involved in providing services to the children or the parents. The terms of reference of this review span from September 2012 to June 2019. This period was chosen to try to understand events from the mother's pregnancy with Child A, to the death of Baby Harris.

5.2 There is an age difference of 18 years between the father and mother of Baby Harris, the father being the younger of the two adults. This is relevant as it helps interpret the services that were offered from 2012, when the W was a child. The mother was good friends with W's mother (i.e. the paternal grandmother) before the commencement of their relationship. The paternal grandmother deeply disapproved of their relationship. Again, this is relevant as it impacted on the support for the father's mental health issues. The narrative below shows that she had been a significant support for the father in ensuring that his mental health needs were met, before the couple started their relationship.

5.3 **The father of Baby Harris' childhood:** W experienced adverse childhood experiences[1]. From a young age, he was exposed to domestic abuse, between his mother and father, which resulted in him being the subject of a child protection plan.

5.4 In early 2012, W's mother sought help from the family's GP. Baby Harris' father was then 15 years old and his mother was concerned that he may be showing symptoms of ADHD. W's mother described his continued behavioural problems, anger and that he "smashed" the house. As a result, the GP referred W to the local Child and Adolescent Mental Health Services or CAMHS.

5.5 The then child, W, went on to receive services intermittently from the local CAMHS until he reached 18 years of age. W perpetrated some serious assaults, involving family members and on one occasion when he resisted arrest, for which he was made the subject of a 6 month Referral Order[2].

5.6 Due to violence and a serious argument in the home, W's mother requested that he be placed in voluntary accommodation, on two separate occasions. He later went on to secure some independent accommodation, when he was 17 years old.

5.7 Throughout his teenage years he suffered from depression and anxiety, he struggled to manage his anger and took an overdose in 2014.

5.8 **The mother and child A**: In August 2012, the mother registered the pregnancy of Child A with her GP. This was the fourth child of the mother and B.

[1] The term "adverse childhood experience" refers to a range of negative situations a child may face or witness while growing up. These experiences include emotional, physical, or sexual abuse; emotional or physical neglect; parental separation or divorce; or living in a household in which domestic violence occurs

[2] A referral order is the community sentence most often used by the courts when dealing with 10 to 17 year olds, particularly for first time offenders who plead guilty. Referral orders require that an offender must agree a contract of rehabilitative and restorative elements to be completed within the sentence.

5.9 In April 2013 Child A was born. The mother did not access all the expected antenatal services from the midwife. Her pregnancy was unremarkable, with no indicators of alcohol use, mental health issues or domestic abuse. She was seen 3 times by the midwife post the birth and had her new birth visit with the health visitor

5.10 In June and July 2013, Child A was seen 3 times by the health visitor and was assessed as requiring "universal plus" services due to the feeding difficulties. By the time Child A was 9 weeks old, he had not had a 6 – 8 weeks developmental check, which is usually carried out by the health visitor. The expected maternal mental health assessment was also not undertaken. Child A was last seen and assessed by a health visitor at the age of approximately 3 months.

5.11 The health visitor arranged to see Child A in July 2015 for his 2.5-year review. He was not brought to this appointment and there was no follow up by the health visitor.

5.12 In July 2017, Child A was discharged from the health visiting service by a team coordinator, as it was considered that he had "transferred to school", meaning school health nursing services. Child A was not enrolled at a school and only started school some 15 months later. Child A was not registered with a GP between June 2017 and July 2019.

5.13 **Baby Harris' mother and father's history as adults:** In September 2014, the support offered by CAMHS ceased as W turned 18 years old. He was advised to go to his GP for ongoing support from adult mental health services. There was no transition plan and his prescription for anti-depressants was not renewed.

5.14 In December 2015 there was an entry of malicious calls and stalking behaviour to W's then ex-girlfriend. No further action was taken by the police in respect of these calls. This was not recognised as stalking behaviour, despite the harassment legislation have been in place since 1997[3].

5.15 A further incident occurred between W and his ex-girlfriend in April 2016. She had gone to his home, W had initially refused to let her leave the property and then threatened to take an overdose.

5.16 The next month, in May 2016, a community nurse from Think Action made a referral to the community mental health team[4]. When they made contact, W described problems with anger and anxiety. He spoke of "fearing leaving his home" and a worry that his fear and social interaction contributed to feelings of anger. He disclosed having used cannabis in the past and was experiencing some suicidal ideation[5]. He shared that he struggled to understand and deal with his anger. He spoke of experiencing 'paranoia', believing others were watching him and making negative comments about him. He felt that this fed into his anxiety and anger.

[3] Protection from Harassment Act 1997

[4] Think Action is a charity based in Medway, offering one to one therapies, group work and other interventions for people suffering from anxiety, low mood, panic attacks or obsessive thoughts or behaviours.

[5] Thoughts of ending one's own life

5.17 The mental health consultant concluded that, based on his history, W had an emotionally unstable personality disorder. The plan from this contact was for a Care Programme Approach (CPA[6]) meeting to be held to review his medication and consider if attendance at an emotional regulation group could meet his needs.

5.18 This plan was reviewed at a CPA meeting in August 2016 where it was noted that he had "a history of violence and impulsivity and it seems that there is ongoing risk of harm to others". On this basis, he was not offered group work due to the potential risk to others and was not considered able to "tolerate" one to one therapy.

5.19 Due to the risk of harm to others, a forensic assessment was recommended however, this assessment was not undertaken.

5.20 He was later reviewed by a psychiatrist in November 2016. The Doctor observed that W suffered from an emotionally unstable personality disorder, a mental and behavioural disorder due to cannabis use and queried a mixed personality disorder.

5.21 Between January and April 2017 W was involved in three assaults. The third assault resulted in him being arrested for an assault in a public house, where the victim had been hit to the head, using a brick. W told officers that he suffered from anxiety and depression and had taken overdoses in the past. He was assessed by the Criminal Liaison and Diversion Service (CJLDS) who concluded that W did not have an acute mental health illness which would have required him to be diverted from the criminal justice system. He was provided with information about services, but no contact was made with the community mental health services by the CJLDS. There were no charges brought in respect of the alleged assault in the public house.

5.22 In August 2017 a further referral was made for a forensic assessment for W. This was triggered after a review was undertaken of all unallocated clients open to the community mental health team.

5.23 The request for the assessment was not accepted due to the amount of time that had elapsed since the original request for the assessment and the fact that W had not been seen for almost a year. The community mental health team were advised to see W and link any request for a forensic assessment to the criminal proceedings.

5.24 W was offered an appointment by the community mental health service in October 2017. He did not attend due to a serious motorbike accident.

5.25 W was offered another appointment with a psychiatrist in December 2017. He described that he was having "problems trusting people, regulating his mood, establishing long term relationships & managing anger". He told the consultant that he did not have a "problem" with alcohol or drugs. He had stopped using cannabis and only drank occasionally. W requested to be referred to a talking therapy.

5.26 The plan following this appointment was for him to continue with the anti-depressant medication. He was also to be referred to the Support Time and Recovery service for the allocation of a Support Time Recovery worker or STR worker[7] . The purpose of this intervention was to encourage structure in W's days. The previously assessed need for a forensic assessment was never revisited.

5.27 In the same month W was convicted of drink driving and was stabbed by his brother during a fight.

[6] CPA, or Care Program Approach, is a technique that mental health care workers use to facilitate effective care for individuals with serious mental health problems. CPA is administered to assess individual needs, plan care, organize planned care and monitor and review care process.

[7] These are unqualified positions offering services for those with mental health disorder or learning disabilities. They are part of a multi-disciplinary team at service level Tier 2.

5.28 On the 2nd January 2018 W was offered an appointment with the community mental health team, following a family bereavement. W said that he wanted to continue to work with the STR worker. Four attempts were made by the STR worker to get in contact with W during January 2018, with no success.

5.29 B and the mother separated in January 2018.

5.30 In February 2018 the STR worker telephoned W. He told the STR worker that he was "probably drinking too much". Unfortunately, this appointment did not go ahead due to heavy snowfall in the area.[8]

5.31 Following a further three attempts, the STR worker got to see him at home on the 16th March 2018. He reported not wanting to be around people and a plan was explored to get W enrolled in a gym and referred to a nutritionist.

5.32 In April 2018 W reported to his STR worker that he had been drinking heavily and this was linked to a lack of activity and routine. Following the weekend of the 5th May 2018, he told his STR worker that he drank a "large bottle of scotch" and stayed in at the weekend.

5.33 6 Attempts were made to engage with W, which is good practice. As a result of W not engaging, he was discharged from the service on the 18th May 2018. The STR service informed the GP that W had been discharged from the Support, Time and Recovery Service. However, W's heavy alcohol use was not shared with any other agencies.

5.34 Thereafter the only source of support available to W for his mental health needs was from his GP. His unsafe use of alcohol since February 2018 did not trigger a referral to substance misuse services.

5.35 The first domestic abuse incident happened between W and Baby Harris' mother on the 10th June 2018. A verbal altercation happened on a street. Child A was not present at this incident. This is the first time that services were aware of the relationship between W and the mother.

5.36 A DASH[9] risk assessment was completed by the attending police officers. The risk to Baby Harris' mother was assessed as "standard[10]". Despite the specific question on the risk assessment about children, neither of the adults disclosed the existence of Child A.

5.37 W's mother contacted the mental health team and his GP to try to get some support for him. The GP referred W to the community mental health in August 2018. However, this referral did not trigger a new assessment as the records incorrectly showed that he was already open to the service.

5.38 At the end of August 2018 the 2nd reported domestic abuse incident took place. W called the police to his home address advising that the mother was in his home, very intoxicated and refusing to leave. The police went to his home address and completed a DASH risk assessment. Again, neither referred to Child A when asked about having children. Child A was not present at the time of the incident.

5.39 W referred to suicidal thoughts and as a result, the police made a referral to mental health services.

[8] At this time, the UK was experiencing heavy snow fall in what was then referred to in the press as "the beast from the east".

[9] Domestic Abuse, Stalking and Harassment and Honour Based Violence - Risk Identification and Assessment and tool

[10] Standard risk is assessed as "Current evidence does not indicate likelihood of causing serious harm"

5.40 Child A became of compulsory school age on the 31st August 2018.[11]

5.41 A referral was made to Kent Police by an anonymous source on the 6th September 2018. The caller told the police that they had observed the use of crack cocaine, Child A was not in school or registered with a GP.

5.42 The police liaised with children's services and it was agreed that the police would do an unannounced home visit. On the 12th September 2018, they observed that the home was tidy and food readily available. Child A was not spoken to during the visit.

5.43 The officers were concerned that Child A did not have a bed to sleep in and was not attending school, so they shared this information with children's services.

5.44 The third domestic abuse incident happened in the early hours of the morning of 22nd September 2018. The mother called the police to W's flat where they were both living. W was holding a large knife to his chest, threatening to stab himself in front of the mother. Child A was at home at the time.

5.45 W was described as very "intoxicated" and the mother said that she was frightened that he may well kill himself. She also told officers that this had happened "a couple of times before". In a "panic" the mother ran out of the home, leaving Child A inside the one bedroomed flat. During the incident, W assaulted a police officer and was arrested.

5.46 The mother told the police that she did not consider W to pose a risk to her or Child A and that she planned to continue her relationship with him after his release from custody. Despite being asked, the mother stated that she was not pregnant.

5.47 The completed DASH assessment showed the mother to be at "medium" risk[12].

5.48 The family was allocated to a social worker for assessment on 25th October 2018 and he was visited on the 29th October 2018. During this visit, the mother told the social worker that she was pregnant. When spoken to about the referrals she said that they were malicious. She said that they were made by W's mother, who disapproved of their relationship and was unhappy about the conception of Baby Harris. She described that W and she had "minor" arguments. She told the social worker that Child A was enrolled at school. Furthermore, she told the social worker that the couple only drank "2 or 3 cans" of beer a week and that she did not drink at all, due to being pregnant.

5.49 On the same day the mother and W went to the hospital to book in with the midwife. A told the midwife that she was consuming between 14 to 20 units of alcohol per week but had not drunk alcohol in the pregnancy.

5.50 The 29th October 2018 was Child A's first day in school, 3 months after his compulsory school age.

5.51 On the 1st November 2018 a further anonymous referral was made to Kent police. Concerns were shared that a child was being exposed to drug use. Police officers made an unannounced visit to the home address and saw no evidence of drug-taking. They saw appropriate clothing and toys for Child A. The mother told the police that she and W slept on the floor in the lounge and Child A slept on the sofa.

[11] A child reaches compulsory school age on or after their fifth birthday. If they turn 5 between 1 January and 31 March, then they are of compulsory school age on 31 March; if they turn 5 between 1 April and 31 August, then they are of compulsory school age on 31 August. If they turn 5 between 1 September and 31 December, then they are of compulsory school age on 31 December.

[12] Medium risk is described as "There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse".

5.52 Following the home visit, the police went to Child A's school and spoke to him and his class. The school safeguarding lead told the two police officers that Child A always attended school and was "well presented". They shared their concern that Child A enrolled late to school, he was behind his peers in his development and was described as "small". The police officers then went to the GP surgery who confirmed that Child A was not registered at the surgery and had not been seen since October 2016, although it has subsequently been shown that this information was not accurate. The police shared the information from the school and GP with the social worker's manager on the 2nd November 2018.

5.53 The social worker's assessment was informed by information from Child A's wider family, the mother's views, the school and the police. On the 9th November, the assessment was finished and concluded that there was "no evidence of harm" to Child A. There was no assessment undertaken in respect of the unborn baby.

5.54 Later that day, the school rang to report that Child A had missed two days of school and they had not heard from the mother. This triggered a review of Child A's records and a further assessment was commenced, with a direction that the information received from the contact on the 22nd September onwards, needed to be considered. There was no direction to include unborn Baby Harris in the assessment.

5.55 The social worker made three telephone calls and one home visit in her attempts to see Child A. However, Child A was not seen before the case closure on the 28th November 2018. The case supervision acknowledges that the social worker had not seen Child A.

5.56 The school made a referral to the Attendance Advisory Service to Schools and Academies (AASSA) on the 11th December as Child A's attendance had dropped to 72%. A prompt referral was made by the school to children's services, as they were aware that Child A had also missed the whole reception year of schooling. Children's services records were checked to see if any other agencies were supporting the family. This check showed that there had been an assessment by children's services, but no further action was taken.

5.57 W attended the GP on the 30th January 2019 about his mental health. The mother was with him, she would have been approximately 5 months pregnant. There is no mention of the pregnancy, although it was noted that he was with "his girlfriend". He was advised to restart his anti-depressant medicine.

5.58 The mother was invited to a Pre-proceedings meeting at Child A's school in March 2019, due to his continued poor school attendance of 77%. She did not attend. The Attendance officer attempted to do a home visit a few days later but could not gain access, as there was no response.

5.59 In April 2019 a further referral was made to the community mental health services by W's GP. W had requested the service due to feeling depressed and low in mood. Despite the referral being reviewed by a consultant, clinical lead nurse and two team leaders, it did not result in the provision of any services from the community mental health team. The criteria for meeting the threshold for services was set out by the consultant as having "multiple, complex needs including a clinically diagnosable mental health problem that impairs functioning significantly and contributes to risks to the individual and or to others". W was not considered to be presenting with these needs.

5.60 The consultant recommended an increase in W's depression medication and a review. If the change in medication did not have any impact, the GP was invited to re-refer W. The original GP referral did not detail that W was in a relationship and due to become a father very soon.

5.61 W did not attend the follow-up appointment offered by the GP in May 2019.

5.62 Child A had commenced speech and language therapy in school in mid May 2019. The mother did not attend the session.

5.63 W went to his GP on the 20th May 2019 and reported feeling low, not motivated to leave the house, suffering from insomnia and some suicidal thoughts. He discussed with the GP the imminent arrival of Baby Harris and how he was looking forward to caring for him. His anti-depressant medication was increased.

5.64 A few days later the mother was seen at home by a midwife. This was due to having missed 5 antenatal contacts. W was not seen on this visit. The midwife telephoned the health visitor and left a message, consulted children's services by email and completed the DNA[13] checklist which is designed to highlight risks. The DNA checklist was shared with the mother's GP and the health visiting team.

5.65 A final Court warning letter was sent to A on the 22nd May 2019. Child A had missed a further 20 sessions of school time in the preceding month.

5.66 Baby Harris was born on the 31st May 2019 in hospital. The mother and Baby Harris were seen by a midwife three times. The mother was advised against co-sleeping with Baby Harris. No concerns were noted about the home conditions or the care of Baby Harris.

5.67 The care of Baby Harris was handed over to the health visitor on the 13th June 2019. Baby Harris was reported to be sleeping in his Moses basket in the lounge with the parents, due to dampness in the bedroom. W was not seen as part of this visit as he was asleep in the lounge. When asked about alcohol or drug use and domestic abuse, the mother did not disclose any information to indicate these factors were present. Child A was reported to be well and in school.

5.68 On the 15th June 2019 Baby Harris died. After his half sibling's death, Child A made disclosures of assaults on himself and his mother.

6. THE VIEWS OF THE FAMILY

6.1 Baby Harris' mother and father contributed to the review. Both parents read that report following the final drafting and shared their observations.

6.2 There were aspects of the report that Baby Harris' father felt were inaccurate. Where possible these have been addressed and changed in the main body of the report.

6.3 Some other parts of the report were disputed, where the agency's descriptions of events were recalled differently by the father. These disputed areas are set out below:

- W disputed ever stalking or making malicious calls as described in the police entry in para 5.14
- W disputed ever feeling that he presented a risk to himself or others as described by mental health professionals in para 5.19
- W reported not being aware of the mental health appointment offered to him, referred to in para 5.24
- Regarding para 5.30, W disputes drinking heavily at this point and reported that he had only told his STR worker that he had been drinking to get access to services e.g., talking therapies.
- W strongly disputes that there was a knife involved in the domestic abuse incident in September of 2018, as described in para 5.44
- W felt that the anonymous referrals were made maliciously by neighbours, that he had arguments with

[13] DNA stands for Did not attend

6.4 W felt that he did not have an 'alcohol problem', in that, he did not drink daily or feel dependent on alcohol. Although he did accept that when he had drunk alcohol this had resulted in "situations where it hadn't ended well".

6.5 W shared his insight into the difficulty he and his mother experienced in trying to get help for him from CAMHS[14], when he was experiencing depression and anxiety, as a child. He felt that he didn't get any help other than medication and that his mother felt the need to exaggerate his symptoms, to try to get access to services.

6.6 W also shared his frustration about the lack of services for adults who may on the surface, appear to be functioning well, but who are actually struggling. He shared his view that, in his experience, doctors[15] had formed a view that he was in better health than he was, as his appearance was good. W felt that having pride in his appearance resulted in assumptions being made that he was well.

6.7 W's view was that he actively sought help for his depression and anxiety, but that he had been offered only medication to help him manage this. These medications often entailed drugs that had sedative effects. This made W reluctant to take these medications.

6.8 W shared that, in the past, he wanted someone to talk to, meaning access to some form of talking therapy. He felt frustrated that there appeared only to be services for adults that are acutely mentally unwell, had substance misuse issues and could not function on a day to day basis. His view was that there appears to be a gap in services between adults that were very mentally unwell and those that are well.

6.9 The mother and father of Baby Harris disagreed with the term "dishevelled" used by the attending ambulance staff, as described in paragraph 1.2. They also disagreed that there was hardly any clothing or items in the home for Child A, as described in para 1.4.

6.10 The mother of Baby Harris and Child A explained that she did take active steps to get Child A into school. She described that her first application for a school place for Child A was not accepted. She was offered a place at another school, which she declined as she felt this wasn't a good school. She felt that her school preference was not considered and thereafter there was no follow up from the school or Local Authority after Child A didn't start school.

6.11 She also described that it took a long time to get registered at the new GP surgery and that she and her children had been removed from the family's previous GP without her knowledge. She reports that it took a while to get registered with the new GP and this explained the gap in registration. Records show that Child A was not registered with a GP between June 2017 to July 2019.

6.12 Child A's mother shared that the missed appointments pre-February 2018 were due to transport issues. Child A's father drove and the mother didn't. When he was unwell and unable to leave the home, this meant that she and the children did not have transport for appointments and attending school.

6.13 The birth father of Child A also contributed to this review. Child A's father had regular weekend contact with Child A from September 2018 onwards. He was asked for his views on what agencies could learn from this review. He shared his view that if he had been made aware of the referrals into children's services and police attendances, he would have been better able to interpret Child A's behaviours, before and after his weekend

[14] Child and Family Mental Health Services

[15] GPs and Psychiatrists

contact. He also stated, had information been shared with him as the parent with shared parental responsibility, he would have been able to have contributed to keeping Child A safe.

7. ANALYSIS

7.1 How well was the family history understood:

7.2 ***Community Mental health services:*** Mental health services were aware of W's childhood abuse and violent behaviour. There were references in his records to the use of cannabis between 2016 and 2018 and alcohol use in 2018. They, therefore, had a good understanding of his history. However, due to W's disengagement and the subsequent discharge, the mental health service was not able to consider W's relationship, Child A, or the unborn Baby Harris.

7.3 ***Outreach or STR worker:*** The STR worker was aware that W had significant mental health issues and was drinking excessively. However, she was unaware of the relationship between W and the mother or the subsequent pregnancy, as the relationship and pregnancy were not disclosed.

7.4 ***The GPs****:* W's GP held a full history of his childhood abuse, the violence and aggression in his teenage years and his mental health issues. W was seen by a locum GP in May 2019. The record of this visit referred to the pregnancy with Baby Harris and his imminent birth. The Locum GP did not know W from previous consultations and therefore did not link W's mental health needs and violence with the risk to Child A and the unborn Baby Harris.

7.5 W was seen by his GP on three occasions before Baby Harris' death. The recording of these is extremely limited. At no time did the GP link the known family history of W and the potential link to the unborn child.

7.6 The mother changed GP in April 2017. The mother's GP held a full history of her childhood, her separation from her ex-husband B and her medical conditions. The GP was under the impression that the mother had successfully fought for the custody of her children. This was not a truthful account. The GP was not aware of the anonymous referrals to children's services or the police. The mother's GP was aware of the birth of Baby Harris but did not hold any information on the antenatal care offered concerning this pregnancy, other than the DNA checklist completed by the midwife.

7.7 The mother and W were registered at two different surgeries and therefore the two GP's could not have understood the combined risks to Child A and Baby Harris from the union of the mother and W. Child A was not registered with a GP between June 2017 and July 2019.

7.8 ***Midwifery services:*** During the pregnancy with Baby Harris, the mother chose to access midwifery services at the local hospital. As a result, the midwifery services did not have access to information that could have alerted them to the family history. This meant that questions about why her other children were not living with her and the change in her alcohol use were left unquestioned.

7.9 W was not engaged in any of the antenatal care before the baby's birth. W was present during a home visit by midwifery staff but was asleep in another room. The lack of engagement of W resulted in the midwife not being able to link W's history and understand this in the context of Child A and his unborn sibling. The mother was also untruthful to the midwife when she enquired about parental substance misuse or domestic abuse.

7.10 ***Health visiting services:*** The health visiting service was told by the midwifery staff that the family had no additional needs. The health visitor only visited the home once before Baby Harris' death. The previous health visitor to Child A had left the organisation by the time Baby Harris was born. The only family history that would have been known to the health visitor, was that of the early months of Child A's life.

7.11 ***The police:*** The police were aware of W's violence and aggression in his childhood and adult life. This was available to them from interrogation of police records. Their knowledge of W's mental health needs was also restricted to his self-reporting when officers responded to domestic abuse incidents in September 2018.

7.12 In response to the incident on the 22nd September 2019, this review has highlighted that the DASH assessment completed by the attending police officers, was carried out using the relevant family history.

7.13 However, the lived experience of the child wasn't considered as part of this assessment and there was insufficient attention given to securing an immediate safety plan for the child over the weekend.

7.14 ***AASSA and the school:*** Child A joined the school in October 2018, three months after his statutory compulsory school age. He missed his reception year in school. There was no handover of information from Child A's health visitor to a school nurse and as a result, the school and attendance service did not know the family history.

7.15 The limited history that was understood by the school was used effectively and prompt action was taken by them, to address Child A's poor school attendance.

7.16 ***Children's services:*** W's history was known to children's services. At the time of the initial referral in September 2018, the following was known to children's services:

- risk of violence
- mental health issues
- suicidal ideation
- historical child protection concerns

7.17 Children's services were able to access all the information required, to understand the risk factors in the family and the family's history. However, this was not used to assess Child A and Baby Harris' needs for a range of reasons.

7.18 Firstly, the domestic abuse incidents in June and August were not notified to children's services, Child A was not present and the couple had not been open about having children. This information only came to light when the police made the initial referral in September 2018.

7.19 The social worker was not fully familiar with the children's services recording system. She had only recently joined the organisation. She had also been allocated several children at the same time. This resulted in her having to assimilate a lot of information about families, at the time that she began to work with this family.

7.20 The children's services report into this review highlighted that the management oversight did not access the full family history and therefore did not provide the social worker with direction, informed by the family's history. The social worker was told to focus on Child A's non-school attendance and the fact that he had no bed. No focus was given to the impact of the domestic abuse, paternal mental health issues and anonymous referrals received.

7.21 This missed opportunity to understand the family's history was further compounded by the late addition of details of the domestic abuse incident on the 22nd September 2018. This information and the information from the referral of the 2nd November were both added to the child's record on the 5th November, the case was reviewed and closed on the 9th November 2018.

7.22 Finally, the management oversight at closure did not make any reference to the family's history and an over-reliance was placed on the mother's account concerning the 3 domestic abuse incidents and the 2 anonymous referrals received. This impaired the assessment of risk and impacted on the outcome of the assessment.

8. Quality of Assessments:

8.1 Assessments were carried out at various points between 2012 and 2019. These were undertaken by mental health services, midwifery services, health visiting, children's services, and the police.

8.2 In 2016 it was recognised that W's mental health needs and violent behaviour required a specialist forensic assessment. The identification of the need for this assessment was good practice, however the delay in commissioning this meant that the request was later declined.

8.3 As a result, there was no clear understanding of the risk that W could present to himself or others. It has not been possible to establish why this did not happen, as both treating consultants had left the Trust at the time of this review. Responsibility for responding to W's mental health needs thereafter oscillated between the community mental health team and the GP. As a result, the treatment of W's mental health needs was reliant on self-referral, which requires a high level of insight by patients. The GP would not have been able to proactively treat W's mental health needs given the demands on the practice. There were approximately 8000 patients registered with that practice as of 1st April 2020[16].

8.4 W's mental health needs were not responded to robustly and the resultant risk remained unquantified.

8.5 Child A was not provided with his 12 months or 2.5-year review or a review of his readiness to access education. These reviews should have taken place between May 2015 and April 2018, when Child A turned 5 years old. This was a critical point of intervention in ensuring that Child A was meeting his developmental milestones, was up to date with his immunisations, his eyesight and hearing were functioning well and most critically for Child A, that he was ready for school.

8.6 The health practitioners that took part in the review felt that Child A's checks got overlooked because of three factors:

- high caseloads
- organisational changes
- fragmented service provision from a number of different sources

8.7 They shared that most missed appointments for developmental checks tend to happen in the school holidays. Child A's 2-and-a-half-year developmental check would have been due in July 2015. Thereafter, it would have been an administrative task to rebook the developmental review. It would not have been possible for the health visitor to have recalled the need to revisit this check for Child A, due to the number of children on caseloads. Practitioners' observations in this review about the impact of high caseloads echo the findings of a national survey carried out by the Institute of Health Visiting in 2016. It showed a worrying trend of high caseloads in 2016, with most health visitors describing caseloads between 500 and 1000 children[17]. The recommended average caseload is 250 children.

[16] Data sources from NHS digital found at https://app.powerbi.com/view?r=eyJrIjoiNjQxMTI5NTEtYzlkNi00MzljLWE0OGItNGVjM2QwNjAzZGQ0IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9. Access on 12.05.2020

[17] The Nursing Times, 2016 found at https://www.nursingtimes.net/news/workforce/health-visitors-warn-of-rise-in-caseload-and-fall-in-staff-07-12-2016/. Accessed on 12.05.2020

8.8 Historically, the health visitor and community nursing teams were based together which promoted information sharing and knowing the children well. These teams later got split and families that were seen to have increased levels of needs were served by the health visitors. Families with less complex needs were served by community nurses.

8.9 The provision of services to children that are assessed as having "universal" needs by community nurses is not without risk and does not consider the skills required to recognise and respond to the cumulative nature of neglect. It also adds another transition point for children and families. As this review demonstrates, information sharing between agencies had not been as effective as it could have been, and the introduction of other transition points will exacerbate this issue.

8.10 In the months leading up to Baby Harris' birth there was an opportunity for the Locum GP to explore how W would be supported to safely parent Baby Harris, given his low mood, history of violence and aggression and mental health needs. It is highly likely that being a locum GP that they would not have had time to fully access W's notes and therefore have a full history of W for the consultation. However, had the Locum GP taken a more "think family" approach this could have triggered a discussion with the safeguarding lead for the practice. Unfortunately, it has not been possible to speak to the Locum GP as part of this review.

8.11 W was also seen by his GP on three occasions before the death of Baby Harris. The recording of these consultations is extremely limited and there appears to be no assessment of the impact of a new-born baby on W's mental health issues and the potential risk to Baby Harris.

8.12 The midwives had chances to be professionally curious and provide some challenge to the mother, for example, the sudden change in her drinking. The mother told the midwife that her older children had chosen to live with their father. Again, an inquisitive approach to this would have been helpful, given that historical research shows that about 90% of children go to live with their mothers, post parental separation[18] .

8.13 Lastly, more professional curiosity could have been shown about the wellbeing of Child A. He was seen at home by a midwife. She was told by the mother that he was off school due to being unwell, but later documented in her notes that in her opinion he had not appeared to be ill. Furthermore, there are no entries by either the Baby Harris' midwives or health visitor to show that they had asked about where Child A slept or about his welfare.

8.14 Unfortunately the mother was not challenged, her explanations and accounts of events were not triangulated by testing out with other professionals. This represented a missed opportunity to have understood the family's needs more holistically.

8.15 The ongoing assessments of risk carried out by the police in respect of the domestic abuse was victim focused.

8.16 It is noted that both the mother and W were not open about the existence of any children, or the pregnancy with Baby Harris. This would have significantly impacted on the risk assessments and it is difficult to see how the attending police officers could have done anything differently.

[18] MOJ. Outcomes of applications to court for contact orders after parental separation or divorce. September 2008. P1

8.17 The police did make a referral to children's services on the 6th September 2018 following the anonymous referral, raising concerns about Child A's welfare. At this time, the children's services records showed significant risk markers concerning W.

8.18 An assessment was not triggered at this time although there was sufficient information available to do so.

8.19 Child A was allocated a social worker on the 25th October 2018.

8.20 The social worker's observations of the home were that there was "available food". No concerns were noted about the home conditions, even though Child A did not have a bed or room of his own. W had refused to take part in the assessment and the mother refuted all the concerns that had been raised. These were accepted and there is no evidence that the mother's responses were checked against the family history, or with other agencies.

8.21 A further referral was received from the police on the 2nd November 2018. This referral detailed concerns that Child A was being left alone and was being neglected. This information and the information from the incident on the 22nd September were both added to Child A's case file on the 5th November 2018.

8.22 The information contained in the children's services records was fragmented but robust assessment skills, coupled with good quality supervision could have helped piece together the information available as shown in Fig 1:

Fig 1:

Risk	**Source**
Historical risk due to W namely, mental health issues, history of domestic abuse, history of child protection plan, substance misuse	*Markers on children services records on receipt of the first referral 6th September 2018.*
Domestic abuse	*Referrals made in June, August and September 2018 from the police.* *Historical report by the mother of experiencing Domestic abuse* *W as both a perpetrator and victim of domestic abuse.*
Neglect	*X2 Anonymous referrals, Child A had no bed, not attending school*
Substance misuse	*Anonymous referrals ref exposure of Child A to adult drug misuse.* *August domestic abuse referral both the mother and W intoxicated.* *August 24th A described as very drunk was escorted home by police from W's home.* *September 2018 referral ref domestic abuse, W reported as drinking very heavily*
Adult mental health	*Police warning markers for W's mental health issues* *The incident on 22nd September W talked of wanting to harm himself.* *21.11.18 mother describes it as "a bad time for W" that he is depressed and not taking his medication.*

8.23 Despite these indicators of risk, a decision was made to close the referral and for no further action to be taken. The record shows limited professional analysis, reflection and no consideration of the presence of factors that

contribute to risk for children, namely domestic abuse, poverty, substance misuse and parental mental health issues.

8.24 Medway children's services procedures set out the expectation that children experiencing neglect have their assessment of need informed by the completion of a Graded Care Profile[19]. This was not completed to support the assessment of Child A's needs.

8.25 Lastly, the corner stone of any assessment or intervention, is listening to the voice of the child and gaining an understanding of the lived experience of the child. There is no evidence of structured direct work with the children and this affected the quality of the assessment.

8.26 Reflections from front line practitioners gave an insight into contextual factors that impacted on the quality of the assessment.

- The request for a welfare check by the police was symptomatic of the then low levels of confidence in assessing risk and applying the threshold criteria. The SPA[20] and the MASH had only recently been introduced.
- There was a delay in allocating the assessment by 6 weeks which placed additional pressure on the social worker to complete the assessment as quickly as possible, as it was due for completion 10 working days after it was allocated.
- There were capacity issues in children's services at this time which meant that the assessment of Child A's needs was allocated to a social worker in a part of the service that was not accustomed to undertaking assessments on new families to the service.
- The information was received by the social worker in a fragmented way. The concerns arising between September and November were added to the record at different times, with no alert to the social worker.
- The referral linked to the assessment was centred around Child A not being in school and not having a bed.
- The social worker's access to information was inhibited as she was new to Medway children's services and had limited knowledge of the information systems. Being new to Medway also made it harder to know how to access other agency information and who to contact.
- The social worker did not receive the amount of management oversight that would be expected when a child is first allocated for assessment.
- The social worker was not instructed to assess the risks to Baby Harris as the then policy was to only assess children who were in their third trimester of the pregnancy. The mother was only 9 weeks pregnant at the commence of the assessment and therefore was not included.

8.27 In the practitioner event the social worker also spoke of her reluctance in ending her involvement and felt compelled to end the assessment due to a drive to manage workloads at the time.

8.28 The combined impact of the above resulted in the risks to Child A and his unborn sibling remaining unassessed.

8.29 In summary, the assessments carried out by the individual agencies did not really grasp the cumulative impact of neglect. Cumulative harm is a concept adopted in child protection law in Australia. It refers to the effects of multiple adverse circumstances and events in a child's life (Bryce, 2018). Cumulative harm and the coexistence of neglect with other forms of abuse was a feature in over three-quarters of the children included in reviews considered in the UK between 2014 and 2017[21].

[19] The Graded Care Profile is a widely used assessment tool designed to help social workers identify when a child is at risk of neglect. The Graded Care Profile assists social workers to measure the quality of care being given to a child in respect of physical care, safety, love and esteem on a graded descriptive scale.

[20] Single point of access – the front door to children's services

[21] DFE, Complexity and challenge: a triennial analysis of SCRs 2014-2017. Final report. (2020) p. 66

8.30 In Baby Harris' case there was the co-existence of parental mental health issues, a history of criminal activity, domestic abuse and substance misuse. Sadly, these factors were not drawn together by any of the professionals working with the family. This resulted in a poor understanding of the level of risk present in Child A and Baby Harris' lives.

8.31 It is also notable that none of the assessments identified poverty and poor housing as an issue for the family, despite the family of 4 living in a one-bedroom flat, in an area that was well known to professionals as being deprived. The one-bedroom in the home was not being slept in, as it had damp. Again, learning from previous reviews shows that poverty is increasingly a factor in serious case reviews[22]. In this review, there was a degree of acceptance of the home conditions. Practitioners shared that the housing situation for this family is not uncommon. As a result of this ongoing exposure to overcrowded housing conditions, this resulted in a lack of acknowledgement of the poverty and the impact on Child A and the baby.

8.32 Neither Baby Harris' father or Child A's father were included in assessments undertaken by midwifery staff, health visiting staff, or children's services. There is also evidence that information was not shared with Child A's father regarding the concerns that were raised. There is a significant body of research that supports the need to ensure that new partners and fathers are included in services being provided to children and the need to assess the potential risks that adult males can present. Reviews undertaken since 2008 have highlighted the issue of professionals not identifying and/or assessing key men, such as fathers, mothers' partners, involved in the care of children and the child/ren have died.[23]

9. Multi-Agency Working and Information Sharing:

9.1 This review has shown some strong multi-agency practice between the police and children's services where referral information was shared promptly. However, the referral made by the police in September 2018 was delayed by 2 days, only arriving at children's services on the following Monday. Given the severity of this incident, this should have triggered an immediate response from the police and the out of hours children's services.

9.2 There were examples in this review where professionals believed that they had made referrals or handed over to services, where this was not the case.

9.3 The first example was the practice by the health visiting service of "transferring" Child A as he had started school. By placing Child A's name on a school nurse list this led to an impractical process that was not adequate to safeguarding children at this key transition point.

9.4 Local authorities have a duty to establish the identities of children in their area, who are not registered pupils at a school and are not receiving a suitable education. In the case of Child A, the School Admissions Service reported that they had shared Child A's details with an allocated school and placed his name on their school roll. The school reported that they did not receive this notification and therefore did not raise an alert about his non-attendance. In the absence of an alert from the school, it was assumed that Child A had started school. It has not been possible to establish why this mechanism was not effective in this review. Further consideration is given to this in the recommendations.

9.5 There appeared to be some fracture in multi-agency information sharing between adult services, namely the GP, the community mental health team, STR worker and adult substance misuse services. It is not clear if all these professionals were fully appraised of all information. For example, W's increasing alcohol use and the

[22] Opcit p.68

[23] NSPCC, Hidden Men: learning from case reviews. 2015. P1. Accessed on 11.05.2020

cessation of services to W. The assessment of W's mental health, while he was in custody, was not shared with his treating mental health consultant.

9.6 Furthermore, police efforts to gain support for W's mental health appear to have been thwarted by unclear referral pathways. The police made referrals to a mental health provision for W on the 24th August 2018 and the 22nd September 2018. Examination of the report submitted by the Kent and Medway Partnership Trust does not show any record of these referrals being received. Information provided by Kent police evidenced the fact that these referrals had been made.

9.7 The DNA checklist undertaken by the midwife in June 2019 shows another example of an unclear referral pathway. The midwife appears to have searched the children's services information system and looked for the mother's name. This revealed no information. However, a more thorough search would have shown a link to Child A or W. Had this link been established, the records would have shown there had been a recent assessment due to concerns about neglect and the risks associated with W's history. This misunderstanding resulted in a 'false positive' for the midwifery staff when completing the DNA checklist.

9.8 The AASSA service interrogated the children's services information system after the school alerted them to Child A's poor school attendance. This again gave a falsely positive impression. The recent assessment had resulted in no further action, which inferred that there were no concerns. Whilst it is good practice to gather information in this way, perhaps more contextual information could have been acquired by speaking to a MASH worker. A more detailed dialogue about the assessment could have alerted the AASSA officer to the fact that the previous assessment was in respect to neglect, there were also concerns and about domestic abuse.

10. IDENTIFIED GOOD PRACTICE

10.1 The police response to the request of a welfare visit was above and beyond that expected of a standard welfare check. The officers involved showed an excellent example of professional curiosity and child-centred approach.

10.2 Their inquisitive approach enabled them to see Child A, check on his welfare at school and triangulate the fact that T was not registered with a GP and had not been seen.

10.3 The social work assessment showed some professional curiosity by seeking information from the wider family. This is rarely seen in assessments and provided important information in understanding life for Child A pre the marital breakdown. It also offered insight into how Child A experienced contact with his mother and father and the increasing use of alcohol by the mother.

10.4 AASSA attempted to do a home visit and contacted children's services to gather information about the family. This is positive practice and had the attempt to visit the home been successful, this could have offered the opportunity to gain an insight into the lived experience of the child at home, as well as gathering other agency information.

11. LESSONS LEARNT FOR THE SAFEGUARDING PARTNERSHIP

11.1 As with all reviews there are lessons arising from this review, for both individual agencies and the wider safeguarding partnership. A significant factor, in this case, is the invisibility of the children from when Child A was approximately 3 months old to September 2018, when it became apparent that Child A had been involved in a domestic abuse incident. Critical transition points between midwifery, health visiting, school nursing, the local authority Admissions Service and school, resulted in Child A falling between services and going "under the radar". The statutory safeguards designed to ensure that children are safe, healthy and receiving education were not effective.

11.2 When Child A was seen by professionals in school and his home, this did not result in an understanding of his lived experience.

11.3 Despite his speech and language delay, he was very able to describe the assaults that he and his mother experienced, which had happened before Baby Harris' death. It is therefore extremely likely that if Child A had been engaged in structured direct work, designed to elicit his lived experience, then there would have been opportunities for professionals to understand what life was like for him. Learning from other serious case reviews continues to show the importance of hearing children's voices and understanding their "lived experience"[24] to alert professionals to risks and harm.

11.4 The Unborn Baby Harris was also invisible at times, due to the mother's inconsistent engagement with midwifery in the antenatal period. When agencies were aware of the unborn child, the risks arising from the relationship of the mother and W, between September 2018 and June 2019 were not well understood. The pre-birth assessment was a critical opportunity to enable professionals to identify and respond to the potential risks to Baby Harris.

11.5 Reports written by Brandon and her colleagues since 2012, show increased risk of harm or death to children where the following adult issues are present:

- Adult mental health issues
- Substance misuse
- Domestic abuse
- Adult criminality

11.6 Hers and the work of her colleagues also highlight the critical importance of involving fathers and/or male caregivers in assessments and safety planning.

11.7 The presence of all the above parental risk factors and the absence of engagement of W, were not identified as risk factors in this family.

11.8 The component parts of the jigsaw which showed the picture of the children's lived experience were held by midwifery staff, health visiting staff, the GP, the police, the school and adult mental health practitioners. However, these parts were never drawn together to show the full extent of the risk to the children.

11.9 There were opportunities for the GP surgery, community mental health professionals and midwifery services to have taken a more "think family" approach, thinking holistically about the needs of their 'client' in the context of their family. This would have enabled them to identify the adult risk factors and the impact of these on Child A and Baby Harris.

11.10 Equally, if the police responses to the domestic abuse incidents and the two anonymous referrals had been informed by the family's history, this would have enabled them to have undertaken a holistic assessment of the risk, as opposed to a one based on a "snapshot" in time.

11.11 This review has shown that Baby Harris' parents, W and the mother, were not always truthful with agencies. Neither volunteered the existence of Child A in the June and August domestic abuse incidents. The mother was not truthful about the amount of alcohol she was consuming pre and post the pregnancy with Baby Harris and gave a diluted account of "minor arguments" when asked about the domestic abuse reports. W reported to his psychiatrist that he was not drinking and only shortly afterwards he was arrested for drink driving. The parent's unwillingness to be open makes the importance of understanding that family history absolutely critical in assessing risk and also demonstrates the need for professionals to triangulate and test out accounts given by parents.

[24] Brandon et al (2020) Complexity and challenge: a triennial analysis of SCRs 2014-2017. Final report. DFE

11.12 The one agency that did have all the component parts of the 'jigsaw' was children's services. These were not pieced together in the assessment which was started in October 2018. Child A's lived experience, the family history, parental substance misuse, domestic abuse, mental health issues, W's criminal history, his poor engagement in the assessment and the poverty the family were experiencing, were not drawn together to show the level of risk that Child A and his sibling were exposed to. There was an over-reliance on the accounts given by the mother. There was also a lack of recognition of the needs of the unborn child, due to previous practice that delayed assessment of unborn babies until 16 weeks of the pregnancy.

11.13 The messages from research about the impact of parental risk factors on children's safety are not new. It is important therefore to understand the impact of not only the operational barriers experienced in children's services, but also the impact of the wider system on the practice and the decisions made in this case.

11.14 The report by Brazil, E (2019) described that the conditions for "good social work"[25] were not in place. In the years leading up to the publication of the report, there had been considerable changes and instability in children's services management. Also, the managers that were in place, did not have the required skills to deliver high quality services. There was widespread workforce instability, high caseloads and a lack of challenge through supervision and management oversight [26]. The overview offered by Brazil (2019[27]) provides triangulation between what front line practitioners shared in this case and findings from a range of inspections. This challenging context, coupled with the operational barriers articulated by the social worker and managers in this review, meant that "good social work" was not undertaken with this family.

11.15 A further inspection in June 2018 found that multi-agency responses to domestic abuse were "not consistently effective" and that "some children *were* left in situations of unassessed risk[28]. The inspection showed issues concerning information sharing, particularly with health and delays in the allocation of assessments. Again, the findings of this review echo that of this inspection which took place at the time of the first domestic abuse incident between the mother and W.

11.16 More recently multi-agency audits carried out by the Medway Safeguarding Children Partnership[29] have shown some common themes which were:

- Not enough consideration of the impact on all members of the family where there has been domestic abuse
- Insufficient evidence of the voice of the child
- How direct work informs decision making
- Delays for children who are experiencing neglect

11.17 It is positive that the Partnership audit activity has detected similar themes as this review. However, it will be important that actions arising from previous audits and the recommendations from this review are well aligned.

[25] Brazil, E, The Report on ways forward for Children's Services in Medway, December 2019.Found at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/857018/Medway_report.pdf. Accessed 20.05.2020

[26] LGA Safeguarding Practice Diagnostic 2- - 22 March 2018, cited from Brazil, E, The Report on ways forward for Children's Services in Medway, December 2019. P.17

[27] Brazil, E, The Report on ways forward for Children's Services in Medway, December 2019

[28] Joint Targeted Area Inspection of the multi-agency responses to domestic abuse. June 2018 cited from Brazil, E, The Report on ways forward for Children's Services in Medway, December 2019. P.17

[29] Some of the audit and scrutiny work is shared with Kent Safeguarding Children Partnership.

11.18 The commissioning and delivery of health services in Medway is extremely complex[30] and this has resulted in a professional landscape that is difficult to navigate. This review has shown that even when risks were identified and professional curiosity exercised, attempts to share concerns or gather information were thwarted by not knowing where to refer to or where to seek information from.

11.19 Services that are fragmented, insufficiently resourced and provided from a range of access points, provide a challenging context where children can get lost and professionals confused. This is especially important where some children's services teams had vacancy rates of 35% in July 2019[31], school nurse caseloads are circa 1000 children and health visitor's caseload numbers continue to exceed best practice. It will be important that going forward, professionals are given clear pathways, to ensure that they can both share and gather information, from the right services, at the right time.

11.20 Finally, key safer sleeping messages were provided to the mother, both in her previous pregnancies and around the time of Baby Harris' birth. This review has shown that the key health professionals were not aware of all the family risk factors. However, the sharing of these messages seems over-optimistic and indicative of "ticking the box, but missing the point"[32]. The family was sleeping in one room. Even for parents where substance misuse, domestic abuse and adult mental health issues were not present, it would have been a challenge for the parents to balance the need to keep the disturbance as low as possible for their school attending child, versus the need to keep Baby Harris safe from the risks brought about by co-sleeping.

11.21 The work of the Lullaby Trust, Safeguarding Children Boards and Partnerships has not resulted in a reduction of reviews undertaken, where babies have died in circumstances of sudden unidentified deaths of infants. This would suggest that the dissemination of these messages may be more effective from a multi-agency approach to identifying risk to babies.

12 CONCLUSIONS

12.1 The purpose of a serious case review is to establish whether there are lessons to be learnt about how local professionals and organisations work together, to safeguard and promote the welfare of children. It is not surprising that the learning from this review, echoes the findings of the inspections and reviews that have considered practice over the same period.

12.2 All of the practitioners that took part in this review participated with openness and transparency. They all demonstrated their wish to offer the best possible services for children. However, the intentions of individual workers were not sufficient to counter the systemic barriers which inhibited the 'conditions of success' required, to enable workers to effectively safeguard children.

12.3 In this case, the key few reachable moments, which could have facilitated a robust grasp of the risks the children were exposed to, were obscured across the Partnership by:

- high caseloads
- a lack of access to and understanding of the family's history
- a collective poor understanding of the cumulative effects of neglect
- a complex operating model of health services making it difficult for professionals to know who to ask for information or where to make referrals for services
- Barriers to effective information sharing between midwifery professionals and children's services
- A lack of "think family" approach when responding to W's mental health issues

[30] cited from Brazil, E, The Report on ways forward for Children's Services in Medway, December 2019. P31

[31] Medway Children's Services, Inspection of children's social care services. Inspection dates: 15 July 2019 to 26 July 2019. Accessed on 02.06.2020

[32] Dr Cheryll Adams CBE, Executive Director Institute of Health Visiting. Cited in Health Visiting in England: A Vision for the Future. IHV 2019

- Transitions between the health visiting and school nurse services that are not designed to 'hold' vulnerable children
- Provision of health visiting services that practitioners felt posed potential risks to vulnerable children
- Practitioner exposure to poverty and poor housing conditions that were accepted as the 'norm' for this area of Medway
- Ineffective tracking systems between the local authority Admissions Service and the school

12.4 The Improvement Board[33] will need to continue to drive the overarching practice improvements that have been identified from the inspections and practice reviews, to create the conditions for sustained multi-agency practice improvement.

12.5 The Partnership, whilst being assured of the progress made against the Improvement Plan, will need to focus on the specific learning arising from this review.

RECOMMENDATIONS

1. The Partnership to be assured that the work of the Improvement Board is addressing key core practice issues such as:
    - Improving the engagement of children and an understanding of the lived experience of children
    - Improving the quality of assessments where children and unborn children are experiencing neglect
    - Improving the understanding of the cumulative effect of neglect
    - Ensuring that there is sufficient capacity in the workforce to offer the 'conditions for good social work practice'.
    - Ensuring that there is a good induction process for new staff in Medway children's services and they are offered reflective supervision and management oversight
    - Developing the "think family" approach to generic or adult service practitioners.

2. The Partnership to seek assurance regarding how the lived experience and voices of children living in neglectful circumstances, are heard and reflected in assessments and plans - and to address any gaps in practice. This should include hearing the voices of practitioners to understand any barriers and identify how improvements can be made going forward.

3. The Medway Safeguarding Children Partnership to assure themselves that learning from this and previous reviews are embedded and well understood by professionals working with children. This learning should include the impact of risks associated with poor adult mental health, adult substance misuse, domestic abuse and the importance of engaging fathers and adult male carers in assessing risk.

4. The Medway Safeguarding Children Partnership to assure themselves about how each agency develops an understanding of the impact of the family history and how this influences the interventions that are offered to children and their families.

5. The Partnership to carry out assurance activity following the concerns raised by practitioners about the current model of the provision of health visiting services, to assure that this model does not increase or contribute to the risk to vulnerable children, who are considered to be eligible for "universal" services, especially in response to the impact on services post Covid 19.

[33] A multi- agency board which oversees improvement activity across the Partnership.

6. The Partnership to review the current transfer of children from health visiting services to that of school nursing services and assure that this critical point of transfer is as safe as possible.

7. Children and adult health (including mental health) providers to consider how it can make it easier for professionals in Medway to understand how and where to make referrals and gather/share information, where concerns are identified about children.

8. Medway Safeguarding Children Partnership to undertake a review of the current strategies and initiatives to combat the risks associated with safer sleeping and consider any changes required in line with the learning from this review and the National Panel review published in July 2020.

9. Medway Safeguarding Children Partnership to seek assurance about the availability of services for parents that are experiencing depression and anxiety, but are not presenting as suffering from acute mental health issues.

10. The Medway Admissions Service to take the learning from this review and offer assurance to the Medway Safeguarding Children Partnership of the effectiveness of processes and procedures to:

    a) ensure children are offered school places in a timely manner
       and
    b) where these children do not commence education this is effectively followed up.

Appendix 1

BACKGROUND TO THE REVIEW

This review was commissioned by the Medway Safeguarding Children Partnership (MSCP) as a Serious Case Review (SCR) following recommendations to the Board's Independent Chair that the circumstances met the statutory criteria for an SCR. The criteria being:

(a) abuse or neglect of a child is known or suspected; and
(b) the child has died[34]

Baby Harris' death and the circumstances of his sibling was reported to the National Panel 24th June 2019. The recommendation to carry out a Serious Case Review was confirmed by the Chair on12th July 2019. The National Panel confirmed their agreement to the decision on the 31st July 2019.

THE TERMS OF REFERENCE

The specific terms of reference are attached as Appendix 2. In addition to the requirements in the Terms of Reference, all agencies were asked to report on their work under the following headings:

- Family history
- Quality of assessment
- Child protection and Pre-birth planning
- Multi agency working and Information Sharing

The time frame of the review was from September 2012 to June 2019. Agencies were also asked to provide a brief background of any significant events in respect of Baby Harris and his sibling, that took place prior to this.

THE REVIEW PROCESS

The review was conducted using a systems methodology that:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings [35]

Reports were received from the following sources:

- Kent Police
- Medway Children's Services
- Medway Council Early Help and Targeted Services
- Two GP practices
- Medway NHS Foundation Trust
- Medway Community Healthcare
- Kent and Medway NHS Partnership Trust
- AASSA (Attendance Advisory Service to Schools and Academies)
- Child A's school

[34] Working Together to Safeguard Children, 2015 © Crown copyright 2015

[35] HM Government, (2015) *Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children*. London: Crown copyright 2015.

PRACTITIONER INPUT TO THE REVIEW

One practitioner event took place involving professionals from health visiting, the school, police officers, an attendance agency and children's services.

The scheduled follow up practitioner event, or recall event, did not go ahead as planned. This was due to the outbreak of the Coronavirus (Covid 19). Measures were announced on the 23rd March 2020 which restricted the movements of individual professionals and created increased demand on agencies providing front line services. As a result, follow up discussions with the frontline practitioners took place via individual interview on the telephone.

The lead reviewer is an experienced author, with a history of leading children's services and over 20 years experience as a qualified social worker.

The lead reviewer and author was independent of Medway Safeguarding Children Partnership and the agencies that report into the Partnership.

PARALELL PROCESSES

An inquest was undertaken on the 25th September 2020. The findings were that the cause of death was unascertained.

FAMILY INPUT TO THE REVIEW

Baby Harris' parents contributed to the review. Three meetings were carried out with Baby Harris' mother and father and one meeting carried out with Child A's father. Their views have been captured in the main body of the report.

Appendix 2 – A copy of the Terms of Reference

1. Aims and objectives of the review

The prime purpose of a SCR is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. This involves a focused examination by all relevant organisations and professionals as to their involvement with the child and family concerned.

2. Methodology

Agencies involved in the Serious Case Review are:

- Medway Council – Children's Social Care
- Medway Community Healthcare
- Medway Foundation Trust
- NHS Medway CCG - GPs
- Kent and Medway NHS and Social Care Partnership Trust
- Kent Police
- Education services and settings
- Medway Youth Offending Team (YOT)

In addition, any other agencies may be involved if they are identified as having involvement with the family during the course of the review.

The agencies involved are required to prepare:

- A chronology of contacts from September 2012 until 15th June 2019.
- An analytical Individual Management Review (IMR) report, or summary report, considering agency involvement during the review period and considering any relevant information known about MM and his family.
- An action plan addressing any learning arising which has been agreed by a senior manager.

The IMR author will be separate to the agency's Serious Case Review Panel member. The Panel member should have had no previous direct operational/ managerial involvement in the case and should focus as much as on why events happened, as what events happened in this case.

The Serious Case Review panel will be chaired by the Assistant Director for Safeguarding and Quality from NHS England and NHS Improvement. An Overview Report will be produced by an independent author. The Overview Report will be published and learning from the review will be shared and a practitioners' event held. The Serious Case Review panel will act as a reference group and be responsible for developing multi-agency recommendations and pulling these into an action plan together with the single agency recommendations.

Practitioner events will be arranged to provide opportunity for front line staff to input into the review.

The family will be informed that the review is being undertaken and be invited to participate in the review, where this does not impact on any parallel processes.

The Overview Report will include:

- a brief overview of what happened and the key circumstances, background and context of the case. This should be concise but sufficient to understand the context for the learning and recommendations;
- a summary of why relevant decisions by professionals were taken;
- a critique of how agencies worked together and any shortcomings in this;
- whether any shortcomings identified are features of practice in general;
- what would need to be done differently to prevent improve practice for children in similar circumstances; and,
- what needs to happen to ensure that agencies learn from this case.

3. Scope of review

The following terms of reference should be considered by the author of the IMRs and summary reports. These are not prescriptive and should be used and addressed only where appropriate to the service. Please do not address each point in turn if they are not relevant. Consider the events that occurred, the decisions made, and the actions taken, evaluating where practice or management could be improved as well as identifying examples of good practice.

The review will focus on baby Harris, and his half-brother who lived with him, to look at how services worked with them and their family. The primary focus of the review is the period from September 2012 to June 2019.

In particular the review will consider relevant information in respect of:

3.1. Family History:

- What information is known about parent's backgrounds and relationship with their own family/older children?
- How much did we understand about mother and father as victims and/or perpetrators of domestic abuse, including coercive control?
- What information was known by agencies about father's background, including history of offending, mental health needs, domestic abuse and substance misuse?
- What was the level of agencies' interaction with father?

3.2. Quality of Assessment:

- How was the family history taken into account in any assessments?
- What assessments were made of mother's parenting ability?
- Were assessments made in an informed and timely way?
- Were assessments child focused and inclusive of all children? Did assessments reflect the lived experience of the children?
- What was the quality of the analysis of risk and protective factors?
- Did assessment appropriately consider mother and children's housing needs?
- How well understood was father's mental health, it's management and impact? What is understood about his role in the family?
- How well understood was mother's use of substances?

- What was the quality of managerial oversight/ supervision in this case? Was there the opportunity for reflection? Was the agency's supervision policy adhered to?
- What assessments, inclusive of risk and the family history, were made of domestic abuse? What was the impact of these?

3.3. Policy and procedures:

- Were processes for referrals followed appropriately?
- How effective were "did not attend" procedures?
- Have thresholds to services impacted on service responses?
- How well did professionals exercise their professional curiosity?

3.4. Multi-Agency Working and Information Sharing:

- How well were agencies engaged in the child safeguarding processes?
- Did agencies communicate effectively and share information to safeguard and promote the welfare of baby Harris and his half-brother?
- Were there opportunities for agencies to safeguard and promote the welfare of Baby Harris and his half-brother? Were any opportunities missed by any of the agencies involved?
- Were the challenge and escalation processes used or considered in this case?