LONDON BOROUGH OF GREENWICH SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CHILD U

FERGUS SMITH

22.05.17 [updated 14.01.19]

Contents

1 INTRODUCTION

1.1 EVENT TRIGGERING THIS SERIOUS CASE REVIEW

1.1.1 On 16.09.16, child U (an apparently healthy 8-week-old male) was transported by ambulance to Queen Elizabeth Hospital. The baby was in respiratory arrest and the parental account of events initially offered to attending paramedics, was that father was bathing his son who had slipped and hurt his head.

1.1.2 The South Thames Retrieval Service (STRS) (a specialist ambulance service consisting of a skilled paediatric intensive care team for transporting critically ill children) subsequently transferred child U to the Intensive Care Unit at Kings College Hospital where investigations revealed bilateral retinal eye haemorrhages with no underlying cause. Initial medical examinations were highly indicative of non-accidental injury

1.1.3 Further medical investigations completed 3 days after hospitalisation revealed sub-dural and bi-lateral sub-arachnoid haemorrhages i.e. widespread brain injuries. Child U died later that day.

1.1.4 The Metropolitan Police Service (MPS) initiated a murder enquiry and both parents (who originate from the Ivory Coast) were arrested.. In late 2018 father faced trial for murder but was subsequently found 'not guilty'.

1.1.5 Upon discovering that the father of child U had a child by another partner in a neighbouring borough, checks were completed and a confirmation received that there were no grounds for concern about child U's half-sibling.

CONSIDERATION OF A SERIOUS CASE REVIEW

1.1.6 In accordance with the Local Safeguarding Children Board Regulations 2006 and local agreed procedures, child U's death was discussed at the 'Serious Case Sub-group meeting' on 07.11.16.

1.1.7 It was concluded that the primary criterion for initiating a 'serious case review' (reproduced in paragraph 1.2.1) was satisfied and a recommendation made to the independent chairperson of Greenwich Safeguarding Children Board Nicky Pace that a serious case review be commissioned. The chairperson ratified that recommendation on 11.11.16 and the Department for Education. The regulatory body Ofsted and the 'National Panel of Independent Experts' (NPIE) were informed.

1.1.8 This serious case review was undertaken between December 2016 and March 2017 in accordance with the terms of reference appended.

1.2 PURPOSE, SCOPE & CONDUCT OF THE REVIEW

PURPOSE & SCOPE

1.2.1 Regulation 5 Local Safeguarding Children Boards Regulations 2006 requires Safeguarding Children Boards (LSCBs) to undertake reviews of 'serious cases' in accordance with procedures in *Working Together to Safeguard Children* HM Government 2015. A 'serious case' is one in which abuse or neglect is known or suspected and the child has died [as in this case] *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 the child.

1.2.2 Its purpose is to identify required improvements in service design, policy or practice amongst local or if relevant, national services. A serious case review (SCR) is *not* concerned with attribution of culpability (a matter for a criminal court), nor the cause of death (the role of a Coroner).

1.2.3 The period of review was agreed as being the first professional awareness of mother's pregnancy to the date of child U's injuries (September 2015 to September 2016). Any agency possessing relevant material pre-dating this period was invited to include it.

CONDUCT

1.2.4 An independent report was commissioned from www.caeuk.org and it was agreed that lead reviewer Fergus Smith would:

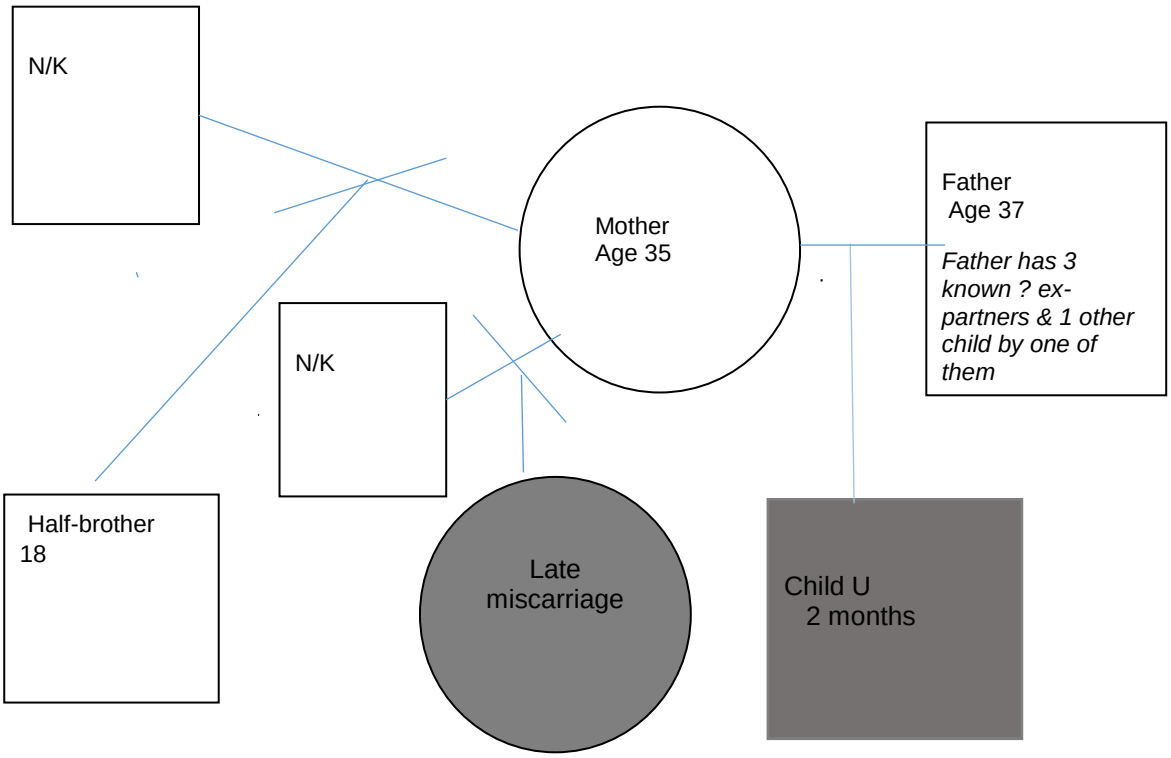
- Evaluate submitted reports, develop and conduct consultation / learning events with relevant professionals
- Draft for consideration by the serious case review panel a narrative of agencies' involvement and an evaluation of its quality, with conclusions and recommendations for action by the Royal Borough of Greenwich Safeguarding Children Board, member agencies and (if relevant) other local or national agencies

Family involvement & publication

1.2.5 A written (translated) invitation to contribute was sent to the parents at the start of this review and a second translated letter encouraging participation was sent when reports from participating agencies had been received. No response was received to either letter.

1.2.6 Publication of this report was deferred pending completion of the criminal investigation and trial though the agreed recommended improvements to local services summarised in section 4 were implemented without delay. Having been informed of the result of the completed trial, the author subsequently sent a further (translated) invitation to meet and discuss this report prior to its publication.

RELEVANT FAMILY



PANEL MEMBERSHIP

1.2.7 The SCR panel comprised:

- Director of Health & Adult Services Royal Borough of Greenwich (chairperson)
- Designated Nurse Safeguarding Children Greenwich Clinical Commissioning Group (CCG)
- Named Nurse for Safeguarding Children Oxleas NHS Foundation Trust (Greenwich)
- Service Manager Royal Borough of Greenwich Housing Options & Business Support
- Quality Improvement Service Group Leader Royal Borough of Greenwich Children's Services
- Designated Nurse Safeguarding Children Lewisham & Greenwich NHS Trust
- Representative of Metropolitan Police Service
- Learning & Improvement Co-ordinator Greenwich Safeguarding Children Board
- Independent lead reviewer

1.2.8 The report agreed by the above group was debated with relevant practitioners before being presented to and agreed by the Safeguarding Children Board. A copy is being sent to the national panel of independent experts (NPIE) and to the Department for Education (DfE).

SOURCES OF INFORMATION

1.2.9 The following agencies supplied information to the SCR panel:

- Lambeth Clinical Commissioning Group (GP care of mother and child U)
- Oxleas NHS Foundation Trust (routine health visiting)
- Greenwich Housing (accommodation)
- Guy's & St. Thomas' NHS Foundation Trust (GSTT) (initial maternity services)
- Lewisham and Greenwich NHS Trust (maternity services at University Hospital (UHL) and some ante-natal care, birth & later emergency medical treatment at Queen Elizabeth Hospital (QEH)
- Lewisham Children's Social Care (confirming welfare of child U's half-sibling)
- Metropolitan Police Service (investigation of injuries)

2 SIGNIFICANT EVENTS

2.1 PRE-REVIEW PERIOD

A PREVIOUS MISCARRIAGE

2.1.1 The most significant event known to any of the agencies submitting material to this review was in April 2014 when mother had presented (at 12 weeks gestation) to Guys & St. Thomas' Hospital.

2.1.2 Medical complications ensued and mother subsequently experienced a late miscarriage[1]. The man reported by mother to be the father of the miscarried baby accompanied her, though a midwife had previously been told that the relationship was over. The involved male was not the father of child U.

2.2 PERIOD OF REVIEW (SEPTEMBER 2015- SEPTEMBER 2016)

EARLY ANTE-NATAL CARE

2.2.1 In late December 2015 a routine referral was initiated by mother's GP to Guys & St. Thomas' Hospital. Mother was about 12 weeks pregnant and her estimated date of delivery was mid-July 2016. No social issues or communication difficulties were identified. In the GP's view, mother understood English sufficiently well, though was unable to express herself in that language. The decision that no interpreter was required was not captured in medical notes.

2.2.2 Mother reported to her GP that she was living with the father of the expected baby, though this assertion conflicts to a degree with the account father later offered the Housing Service prior to the birth of child U and differs also from what he told Police after child U died.

2.2.3 The pregnancy was recorded at Guys & St. Thomas' Hospital (presumably based upon mother's report) as being her second and routine screening identified no specific medical risks. It seems likely that the possibility of domestic abuse was not raised at any of her appointments.

Comment: *the medical history taken prior to the loss of her child in 2014 had explicitly referred to her giving birth to a son in 1998 (when she would have been only 16) i.e. this was in fact her third acknowledged pregnancy*.

[1] If a baby dies before 24 completed weeks of gestation the event is described as a miscarriage or late foetal loss: www.nhs.uk/conditions

2.2.4 Mother attended the majority of her maternity appointments during both her pregnancies. The report supplied by the Guys & St. Thomas' NHS Foundation Trust indicates that mother's ante-natal care with child U ceased at about 28 weeks' gestation when she moved to a different address.

2.2.5 In mid-April 2016 mother self-referred to the University Hospital Lewisham UHL (part of the Lewisham & Greenwich NHS Trust LGT) and was admitted and treated for 4 days for some symptoms which were causing her discomfort. The report submitted to the serious case review advises that mother's self-referral was a sensible response to her condition. UHL records do not indicate any communication issues being identified during mother's presentation.

Comment: *LGT records do not confirm that, whilst she was an in-patient, a review of social needs including information about mother's partner (identity, presence, duration of relationship or possibility of domestic abuse) was completed; this represented a missed opportunity*.

FATHER'S INITIAL HOUSING ENQUIRY

2.2.6 Father approached the Greenwich 'Customer Access Team' in mid-May 2016 and gave his address as 'address 1'. He said his partner was 8 months pregnant and her expected date of delivery (EDD) was mid to late June. He reported that they were living separately with friends and that the arrangement was temporary.

2.2.7 Father was given advice that took account of his partner's ineligibility (as an 'over-stayer'[2]) for housing assistance. Father's personal history was sought and provided. He reported arrival in the UK in 2002 and achievement of permanent residence status in 2012. He indicated that child U's mother had entered the UK on a visitor's visa which had expired.

2.2.8 Records indicate father remained at 'address 1' until early June 2016 when he and child U's mother moved together to 'address 2'.

2.2.9 At 33 weeks gestation and as a result of further symptoms, mother attended and was admitted to Maternity Services at Queen Elizabeth Hospital (QEH). She reported her ante-natal care had been booked at Guys & St. Thomas' Hospital and a notification was sent there. Mother indicated she would need an interpreter at future appointments. Records captured the fact mother had a live child who was not living with her.

Comment: *this was a missed opportunity to refer to the 'maternity safeguarding pathway' (MSP) for women who are not living with their children' for a fuller review.*

[2] S.115 Immigration and Asylum Act 1999 indicates that a 'person has no recourse to public funds if s/he is subject to 'immigration control' e.g. a visa over-stayer such as child U's mother.

2.2.10 On the day of her discharge, mother's ante-natal care was formally transferred to QEH. 'Language Line' was used. It is unclear whether her partner was present. Because of the previous miscarriage a referral was made to the obstetric consultant and an interpreter organised. Consistent with the then policy, GSTT was not sent a formal notification of mother transferring her ante-natal care to QEH (a further missed opportunity).

Comment: *the report provided by Lewisham & Greenwich NHS Trust (LGT) indicates that current best practice is to use the 'Access (Did Not Attend) Policy' to identify women transferring their care*.

ANTE-NATAL INVOLVEMENT OF HEALTH VISITING SERVICE

2.2.11 The Health Visiting Team received an ante-natal booking form from the LGT Midwifery Service. The referral included mother's country of origin, preferred language, previous (now adult) child and her need for an interpreter. Mother was noted to be still working as a hairdresser and the father as a betting office manager.

Comment: *as an 'over stayer', mother was not entitled to work in the UK*.

2.2.12 At this time father was involved in a minor road traffic accident. This was the only involvement of Police with either parent until their arrest following the death of child U. Information supplied by the Police for the purpose of this review (and unknown to professionals in touch with mother) suggests though, that father may have been cohabiting with mother only after child U's birth and may also have been sustaining another intimate relationship.

2.2.13 At a further ante-natal clinic attendance in late June the opportunity to enquire about the possibility of domestic abuse was lost in consequence of father being used as an interpreter.

Ante-natal home visit by a health visitor

2.2.14 In early July, an ante-natal visit to 'address 2' was conducted by health visitor HV1. Mother was 38 weeks pregnant. HV1's progress notes confirmed that mother spoke minimal English.

2.2.15 She had recently moved to the address (a single room with shared facilities) to be with her partner whom she said was supportive. It was noted that no cot or Moses basket had been bought.

2.2.16 The ante-natal RiO [database] assessment form was completed and information given on the role of the health visitor, contact number and clinic details, breastfeeding and support, sudden infant death syndrome (SIDS), Benefits; vitamins and supplements, healthy eating and physical activity, post-natal depression (PND), early brain development, skin to skin contact, Children Centre activities and neonatal blood screening. HV1 identified no concerns and her plan was to follow up at the new birth visit.

BIRTH OF CHILD U & FOLLOW-UP

2.2.17 On a date in late July 2016 child U was born at Queen Elizabeth Hospital (QEH). Records indicate that mother's command of English was limited and that her partner was to be used to interpret. Routine tests and check were completed and mother and baby discharged home 2 days later, following a routine 'new born' examination by a paediatrician.

Comment: *use of a family member to interpret carries with it a risk of denying an individual any voice*.

2.2.18 Mother appeared to appreciate and accept advice offered by a midwife about safe sleeping. It is uncertain whether her partner was present on this occasion but a conversation with mother at the point of discharge was apparently completed in French by a bi-lingual member of staff. The post-natal summary was sent to the GP and a discharge summary also sent to the relevant community midwifery team and health visiting service.

2.2.19 It was not possible to source a French-speaking interpreter for an immediate home visit completed by a midwifery support worker (MSW). The same individual had seen mother for a routine post-natal check in line with Trust guidelines when child U was 3 days old.

2.2.20 An interpreter was planned for a follow-up in late July though this was subsequently postponed until very early August. Meanwhile, a post-natal transfer notification was received by the Health Visiting Service and an arrangement made for a new birth visit on 01.08.16.

2.2.21 HV2's record of the visit indicates that a 'good attachment had been noted between mother and baby', who was reported to be breast-feeding well on demand. The new birth assessment for mother and baby were completed and no concerns were recorded. Leaflets (in English) were left covering cot death, domestic abuse and female genital mutilation.

2.2.22 Mother was advised on booking immunisations with the GP and was invited to attend Child Health Clinics. Health Visiting at the 'Universal Care'[3] level was offered. Next day a 'Sure Start' form was sent to the local Children's Centre.

Comment: *in the light of available evidence, 'universal care' was a reasonable evaluation of need*.

2.2.23 In response to a phone enquiry from father HV2 agreed to visit that day and did so accompanied by a nursery nurse. Both parents were present and good bonding of both was recorded with 'an appropriately dressed, clean and alert' child U who was being fed on a mixture of breast and formula milk. No concerns were identified.

[3] Health visiting services are provided at one of 3 levels: 'Universal', 'Universal Plus' and 'Universal Partnership Plus' (according to the assessed level of need / involvement of other agencies)

APPLICATION FOR SOCIAL HOUSING

2.2.24 When child U was about 4 weeks old mother and father sought accommodation from the Royal Borough of Greenwich Housing Options and Family Support Service. Father claimed that he and his partner had been asked to leave 'address 2' without any notice. An 'initial homelessness assessment' was completed and emergency overnight accommodation was agreed.

2.2.25 Next day, facilitated by a Language Line interpreter mother was interviewed and the family was allowed to remain at 'address 3' where they resided up until and following the death of child U. The completed assessment confirmed that the family met the series of statutory requirements and that there was a duty to provide accommodation. Routine checks to establish whether either parent was known to Adults or Children's Social Care revealed nothing.

2.2.26 Interviews with those who undertook and can recall the interview with parents provided reassurance that the involved staff member was sensitive to the issue of how the adults related to one another and to their baby. Because father was occasionally out of the room, mother would (via the interpreter) have had the opportunity to raise any fears of domestic abuse or other forms of exploitation.

2.2.27 The only further contact by a statutory agency was a letter sent in early September about rent arrears and a consequent phone conversation with the father of child U.

2.2.28 A week before the above contact with Housing, both parents attended breast feeding support group at a local Children's Centre. Whilst there they reported that child U was constipated and unsettled. A breast feeding assessment was completed and advice offered to consult the GP if the constipation failed to improve. Mother wished to mix-feed though father was less keen. The parents proposed to attend a further session the following week though it seems that they did not do so.

2.2.29 The same GP who had seen mother for a total of 6 times during the period under review completed the 8 week check of child U days before his hospitalisation. Nothing untoward was noted about child or mother who were accompanied by mother's partner.

INCIDENT TRIGGERING SERIOUS CASE REVIEW

2.2.30 At 21.30 on the day of the event triggering this serious case review, the Emergency Department of QEH received a call from the London Ambulance Service to report that crew were en-route with an 8 week old baby in cardiac arrest. The initial parental account offered to the crew was that the baby was being given a bath by his father who dropped him in the water. Father then apparently changed his account stating that his son was lying on a changing mat on the bed and he was cleaning him with wet wipes. His partner was reported to have been out buying baby food.

2.2.31 Father later offered the on call consultant paediatrician a further description of events preceding the child's hospitalisation viz: that child U was crying and felt hot, prompting father to sponge him with tepid water. The baby passed a lot of runny stools which went all over his clothes. Father stated that he had dropped the baby (but immediately corrected this to indicate he had placed his son on his side). Mother entered the room and noticed that child U was having difficulty breathing at which point they dialled 999.

2.2.32 Mother later spoke to the consultant alone and offered her comparable but not identical account. Staff did not immediately recognise the significance of the inconsistency of accounts.

3 ANALYSIS, CONCLUSIONS & LEARNING

3.1 ANALYSIS

3.1.1 Section 3.1 provides an evaluation of professional practice with respect to the elements of the terms of reference summarised below. It should be kept in mind that at no point before his birth nor at any following it were there indications of risk to child U. Atypically for those families ordinarily the subject of serious case reviews, his parents sought and made proper use of services offered.

3.1.2 There was no evidence of avoidant behaviours, nor of the 'disguised compliance' often discerned in retrospective analyses of service provision.

WHAT WERE THE KEY POINTS / OPPORTUNITIES FOR ASSESSMENT & DECISION-MAKING IN RELATION TO THE CHILD & FAMILY ?

3.1.3 The GP referral confirming pregnancy and seeking ante-natal care was the first opportunity and was made by a physician who knew mother reasonably well. No vulnerability was discerned.

3.1.4 Further opportunities arose within the respective Midwifery Services of both Health Trusts and later the Health Visiting Service. The assessment of housing need before and following the birth of child U provided a distinct, non-health related opportunity for the assessment of need and generated no concerns.

PROFESSIONAL AWARENESS - SUFFICIENT TO EFFECTIVELY RESPOND TO NEEDS OF THE CHILD & BOTH PARENTS; CULTURAL IDENTITY & ANY OTHER DIVERSITY ISSUES ?

3.1.5 Language-related needs of mother were inconsistently recognised and addressed. The further implication of her status as an 'over-stayer' remained unexplored though may have been of real concern to mother, serving to increase her anxiety and dependence upon casual (unlawful) work and/or dependence upon her partner.

HISTORY – WERE FACTS KNOWN OR SUFFICIENTLY TAKEN INTO ACCOUNT; MOTHER'S & FATHER'S HISTORIES? ANY OTHER PREVIOUS INVOLVEMENT OF EITHER PARENT WITH ADULTS' OR CHILDREN'S SERVICES, POLICE OR PROBATION ?

3.1.6 A little more curiosity about parental personal histories could have helped to inform responses by Maternity and Health Visiting Services. For example a better appreciation of the circumstances around mother's older non-resident son, her previous 2014 relationship and the real need for an interpreting service could have added confidence to the perception of need. At no stage was there any suggestion that either parent was known to Police or Probation Services.

POLICIES & PROCEDURES – WERE THESE EFFECTIVE IN SAFEGUARDING AN UNBORN OR NON-MOBILE BABY; DID PRACTICE ACCORD WITH *WORKING TOGETHER* 2015 &/OR THE *LONDON CHILD PROTECTION PROCEDURES ;* DID ACTIONS ACCORD WITH ASSESSMENTS & DECISIONS MADE? WERE APPROPRIATE SERVICES OFFERED/PROVIDED OR RELEVANT ENQUIRES MADE, IN LIGHT OF ASSESSMENTS? WERE RECORDS SYSTEMATICALLY REVIEWED TO EVALUATE & ASSESS RISK?

3.1.7 Insofar as no safeguarding issues were identified, statutory and London-wide safeguarding procedures were of limited relevance. Actions did all accord with assessment of need and appropriate services provided.

3.1.8 Some positive and critical comments about record keeping and review may be justified

- Hospital and health visiting records should have captured more information about child U's father (the value and risks of associated males are often overlooked) [December 2016 revised Health Visiting standards now require enquiries to be made about fathers / partners]
- Records of service delivery by Housing Options & Support Service are very clear
- It is reassuring to note that HV2 recognised the potential relevance of a change of address (a correlate of vulnerability) when she spoke by phone with father in August 2016

QUALITY OF WORK ASSESSMENTS, DECISION-MAKING, RECORD-KEEPING, FIRST-LINE MANAGEMENT OVERSIGHT INCLUDING SUPERVISION, INFORMATION-SHARING, APPROPRIATE INVOLVEMENT OF SENIOR MANAGERS AND THEIR ACCOUNTABILITY, ANY DEFICIENCIES DUE TO ORGANISATIONAL CAPACITY (RESOURCES, STAFFING PROBLEMS ETC)?

3.1.9 The assessments completed and decisions emerging from them were unremarkable across all involved agencies:

- The GP made a standard hospital referral including relevant medical information for ante-natal care
- A very thorough assessment of eligibility and need was completed by Greenwich Housing Options & Support Service
- In otherwise competent provision of maternity services in both Guys & St. Thomas and later Queen Elizabeth Hospital Lewisham, there was scope for a more robust consideration of domestic abuse

- The need to clarify mother's need for a French-speaking interpreter was missed when mother presented to the above hospital at 33 weeks' gestation (mother's admission in June 2016 to Queen Elizabeth Hospital offered a further missed opportunity to establish the existence or extent of additional social needs)
- Ante-natal and new birth assessments were completed in a timely fashion that were consistent with relevant health visiting standards
- The significance of inconsistent parental account of the event immediately preceding child U's hospitalisation could have been discerned more rapidly

3.1.10 Relevant information was appropriately shared in the following instances:

- GP to Maternity Services
- Following the birth of child U, the postnatal summary was sent in a timely manner by Queen Elizabeth hospital to mother's GP

3.1.11 The opportunity for Queen Elizabeth Hospital to notify Guys & St. Thomas' Hospital that mother was transferring her maternity care was not taken (though such a response was not a policy requirement at that time).

3.1.12 Senior staff were appropriately consulted and authorised responses with respect to allocation of temporary accommodation. There is evidence of formal supervision in the case of health visitors.

3.1.13 None of the involved agencies has identified any shortfall in resource to explain identified sub-optimal responses.

OUTCOMES - IF MORE INFORMATION HAD BEEN AVAILABLE, WOULD IT APPEAR THAT THRESHOLDS FOR INTERVENTION WOULD HAVE BEEN MET ?

3.1.14 On the basis of reported history and direct observations, nothing distinguished this couple from the many others facing homelessness.

3.1.15 Even if every issue identified above had been managed faultlessly, there are no grounds for asserting that events would have unfolded in any significantly different way, far less that the tragic outcome would have been predicted or prevented.

3.2 CONCLUSIONS

3.2.1 On the basis of the evidence emerging from the limited amount of contact with identified statutory agencies:

- The observable level of vulnerability of child U was not significantly greater than that of any other child in a family facing homelessness
- Professional responses in the majority of contacts with either parent were generally consistent with best practice
- The 'missed opportunities' identified in section 2 were not of sufficient magnitude to have impacted upon later events
- Even with a retrospective search for evidence, no indications of either parent posing a risk to child U have been found
- The injuries to and consequent death of child U were therefore wholly unpredictable and essentially unpreventable by means of any action that might reasonably have been taken by involved agencies and professionals

3.3 LEARNING

3.3.1 No significant deficits of policy, procedure or practice have been found, but the self-critical scrutiny of participating agencies and serious case review panel debate has usefully identified a number of ways in which future services and professional practice could be enhanced.

3.3.2 Whilst identified by and most applicable to the Lewisham & Greenwich NHS Trust, the following subject areas offer some opportunities for learning across the network:

- Scope for greater professional curiosity
- Greater precision in record keeping
- More consideration of the significance of birth fathers / relevant men
- Enhanced recognition of the need for interpreters

3.3.3 The recommendations for each specified agency in the following section reflect these opportunities or learning.

4 RECOMMENDATIONS

ROYAL BOROUGH OF GREENWICH SAFEGUARDING CHILDREN BOARD

4.1.1 The Board, in consultation with members agencies, should identify and support opportunities for 'evidence-based' programmes directed toward reducing the risk of head injuries in very young children [ongoing].

LEWISHAM & GREENWICH NHS TRUST

- Develop an information sharing pathway when a pregnant woman attends LGT services and is booked at another hospital [by 30.09.17]
- Develop a notification letter to advise previous maternity services when a woman books for pregnancy care at LGT [by 30.09.17]
- Training for all midwifery staff about the correct terminology when documenting 'gravida' and 'parity' of a pregnant woman [by 30.09.17]
- Remind staff of the need for compliance with Trust guidelines on use of interpreters [ongoing all opportunities]
- Review the maternity safeguarding pathway (MSP) to ensure that all women who have a child not living with them are referred to it [by 30.09.17]
- Adapt the 'special medical form' (SMF) so that it incorporates a template to support the medical teams when assessing a child who attends as a result of a critical event [30.09.17]
- GP discharge letters should be amended so as to include a 'safeguarding concerns' tick box [by 30.09.17]
- Ensure that training programmes reinforce professional curiosity and appropriate information sharing [by 30.09.17]
- Add to existing audit programme sampling of compliance with Trust record keeping guidelines [by 30.09.17]

OXLEAS NHS FOUNDATION TRUST

- Develop a process so that a requirement for an interpreter that has been identified on a Midwifery ante-natal booking form triggers a booking at the time of an ante-natal or new birth assessment [by 30.09.17] (interpreters must also be engaged if at any other contact a practitioner is aware of communication difficulties)
- Undertake an audit of completed assessments to establish the extent which details of fathers / other relevant adult males are captured [by 30.09.17]

HOUSING OPTIONS & SUPPORT SERVICE

- Review and update the temporary accommodation procedures to include the support, welfare and safeguarding of children [by 30.05.17]
- Roll out the programme of safeguarding training for temporary accommodation officers and review schedule for training for Housing Options and support officers as per the borough's *'Performance Review & Development Scheme'* (PRADS) 2014 [by 30.06.17]

4.1.2 Each of the above-mentioned agencies is formulating detailed action plans so as to ensure implementation of the respective recommendations. The Safeguarding Children Board will seek confirmation that the specified tasks have been completed in accordance with the agreed time-scales.

5 GLOSSARY: ABBREVIATIONS / PROFESSIONALS

Agency / Abbreviation	Meaning
A&E	Accident and Emergency Department
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
EDD	Estimated Date of Delivery
GSST	Guys & St. Thomas' NHS Foundation Trust
LGT	Lewisham & Greenwich NHS Trust
LSCB	Local Safeguarding Children Board
MPS	Metropolitan Police Service
MSP	Maternity Safeguarding Pathway
NPIE	National Panel of Independent Experts
PRADS	Borough's Performance Review and Development Scheme
QEH	Queen Elizabeth Hospital
SCIL	Serious Case, Improvement and Learning Sub-committee
SCR	Serious Case Review
SMF	Special Medical Form
STRS	South Thames Retrieval Service

TERMS OF REFERENCE

SCOPE OF THE REVIEW

Chronologies and agencies' reports are required to start from 16.09.15. If agencies hold records on the parents of child U which would be useful as background information, this should be included.

METHODOLOGY

A pragmatic and case-relevant methodology will be deployed which will seek to include relevant professionals and enable discussion of learning points and early implementation of any required service improvements during the course of the SCR.

We will require agencies to produce Individual Management Reviews (IMRs). Actions identified for each agency should be undertaken immediately. To enable publication of the report, it will be written with this intention. The anticipated completion of the SCR will be May 2017 but publication will be determined by any possible criminal trial.

Family involvement

Child U's parents will be informed of and invited to contribute to the process.

Staff involvement

Practitioners and line managers, who were directly involved with the family, will be met with either individually or as part of a group to share and understand practice. Staff will have access to necessary staff counselling services, if necessary. This may take the form of a multi-agency practitioner's event to promote reflective learning.

PANEL MEMBERSHIP

- Chair of Panel – Simon Pearce
- Independent Author of SCR – Fergus Smith
- Greenwich Housing
- Named GP for Safeguarding
- London Probation Service
- Metropolitan Police Service- Child Abuse Investigation Team (CAIT)
- Greenwich Safeguarding Children Board
- Greenwich Children's Services
- Oxleas NHS Foundation trust
- Lewisham and Greenwich NHS Foundation Trust
- Greenwich Clinical Commissioning Group

ANALYSIS OF INVOLVEMENT

The individual management reviews need to consider the events that occurred, the decisions made, and the actions taken, which indicate that practice or management could be improved. Consideration should be given to not only what happened but why something did or did not happen. Consider the following areas:

Events in the case

- What were the key points / opportunities for assessment and decision-making in relation to the child and family ?

Professional awareness -sufficient to effectively respond to:

- Needs of the child in their work?
- Needs of both parents?
- Cultural identity and any other diversity issues ?

History – were facts known or sufficiently taken into account

- Mother's and father's histories?
- Any other previous involvement of either parent with Adults or Children's Services, Police or Probation
- **Policies & procedures – were these** effective
- In safeguarding an unborn or pre-verbal / non-mobile baby
- Did practice accord with *Working Together* 2015 and/or the *London Child Protection Procedures ?*
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquires made, in light of assessments? Were records systematically reviewed to evaluate and assess risk?
- Should the lack of engagement and 'did not appear' (DNA) appointments have raised concerns and been escalated ?

Quality of work

- Assessments, decision-making, record-keeping, first-line management oversight including supervision, information-sharing, appropriate involvement of senior managers and their accountability, any deficiencies due to organisational capacity (resources, staffing problems etc)

Outcomes

- If more information had been available, would it appear that thresholds for intervention would have been met ?

……