



Serious Case Review

Child V

October 2017

1 Introduction

1.1 Greenwich Safeguarding Children Board (GSCB) commissioned this Serious Case Review (SCR) following the death of Child V aged 3 months in November 2016.

1.2 The case involves and pertains to;

- The sad and untimely death of Child V aged 3 months
- The vulnerability of the child's parents due to their individual mental health problems and isolation
- The challenges that arise when adults fail to engage with services designed to offer them support
- Systemic issues about how agencies worked with the mother in particular and how they responded to her lack of engagement
- Systemic issues in how vulnerable women are supported pre and post birth
- Some of the systemic matters apply more widely.

1.3 At the time of writing the report a police investigation was underway and both parents had been arrested in connection with the child's death. In December 2018, shortly before the review was published, the child's father was tried and acquitted of manslaughter and child cruelty in relation to Child V's death. No charges were brought against the mother.

1.4 The basic facts that have emerged as part of the process of the review are as follows.

1.5 Ms A (the child's mother) became pregnant in January 2016. Throughout the pregnancy she failed to engage with pre-birth services having only one scan before the baby was born in August 2016. The baby was born in a hospital outside of London as Ms A went into labour whilst visiting her sister in Kent. No concerns were noted during her labour and she was discharged soon after the birth to her sister's address before moving back to her home address in Greenwich. Her stated intention however was to move to Kent to be nearer her sister. The following paragraph gives a brief explanation of the circumstances surrounding Child V's death.

1.6 On November 4th 2016 Child V was, briefly, in the care of her father. The parents were not living together and (at the request of the mother), father had come to the home of the mother and the baby to care for the child whilst she went shopping. Mr B (the child's father) noticed that Child V appeared lifeless and he called a friend for advice. Together they took Child V to a local health centre where emergency life support commenced and the London Ambulance Service (LAS) were called.

- 1.7 Initially Child V was taken to Queen Elizabeth Hospital (Hospital 1) and then transferred to Kings College Hospital (Hospital 2). Child V underwent CT scans that diagnosed a non-accidental head injury and rib fractures. Brain stem tests were completed and medical care was withdrawn. Sadly, Child V died later that day.
- 1.8 Arrangements for the review, details of agencies that contributed and the methodology used are contained in appendices at the end of the report.

2 Family Contribution

- 2.1 In line with expectations laid down in Working Together consideration was given to involving the family in the review process. Mother and Father were advised that the review was underway and invited to contribute. The panel were however mindful of the on going police investigation and the difficult situation the family found themselves in. Several attempts were made to try and engage them in the process but at the time of writing the report they had not expressed a wish to contribute and therefore the report has been finalised without their input. Whilst this is a significant gap, panel members were satisfied that all possible avenues had been explored. Further it was agreed that the door could remain open if family members felt at a future point (prior to publication) that they did wish to contribute. Both parents were contacted following the conclusion of the trial to offer them the opportunity to see the report prior to publication, however they have not responded.

3 Background Information regarding the parents

Ms A - Background Information

- 3.1 As a teenager Ms A had some involvement with Children's Social Care (CSC) in Greenwich resulting in her being accommodated in foster care briefly when she was 15 years old. Information gleaned from CSC records indicated the relationship between her and her mother was poor. Ms A was also said to have a cannabis habit that contributed to rendering her beyond her mother's control. Ms A described domestic violence between her stepfather and mother and her school attendance was low. CSC's involvement ended soon after she returned home from foster care, on a planned basis, in 2006.
- 3.2 Between 2005 and 2008 Ms A came to the notice of police for offences of shoplifting, was the victim of an assault and was stopped by police twice on suspicion of misuse of drugs (these were not proceeded with). She received a reprimand in relation to the shoplifting and was referred to Youth Offending Services.

3.3 Ms A's early adulthood was characterised by poor mental health that was largely managed via medication and input from her GP. She described problematic relationships with her family and health professionals viewed many of her symptoms as indicative of Post Traumatic Stress Disorder (PTSD). She was referred to counselling to help her manage her symptoms but her depression remained an issue and in 2015 she reported having taken an overdose of her medication. She was referred to mental health services but was not always compliant with their offers of assistance. This was a consistent pattern. At the point at which Child V died, Ms A was not receiving any input from mental health services having not engaged with them.

Mr B - Background Information

3.4 Agencies have been unable to highlight direct contact with Mr B during the review period but the following gives a brief summary of background information to provide context to the narrative.

3.5 Mr B had some input from CSC in Greenwich as a teenager – in 2001 his mother approached CSC for support around housing. Mr B had apparently left the local area and gone to live with a relative for fear of reprisals about his gang and criminal activity. The family were open to CSC for a period of 9 months and their case was closed when Mr B returned to the family home.

3.6 Between 2001 and 2008 (as a teenager and young adult) Mr B came to the notice of police for a number of offences such as burglary and criminal damage. These offences culminated in a youth caution for criminal damage, convictions for burglary, criminal damage, driving offences, and an acquittal and no further action (NFA) being taken on other occasions. His caution and convictions resulted in a referral to the Youth Offending Services (YOS), a referral order and fine respectively.

3.7 As well as the cautions and convictions for the above offences Mr B was also involved in a number of domestic abuse incidents the most recent of which was in 2015 in relation to a previous partner.

3.8 He was known to mental health services and was managed at times as an inpatient. He had a diagnosis of borderline personality disorder and his most recent inpatient episode ended in 2015 when he was discharged back to the care of his GP. His symptoms included a history of low mood, self-harm, aggressive outbursts and substance misuse.

3.9 Mr B's last period of hospitalisation coincided with him receiving a 12 month Community Sentence under the Offender Rehabilitation Act (ORA) 2014 in 2015 for Criminal Damage. The sentence was issued with two requirements. These were 20 days Rehabilitation Activity Requirement plus 80 hours unpaid work. At the time of writing this report Mr B had not fulfilled the requirements of the order and he was still open to London Community Rehabilitation Company (LCRC). From other information gleaned from the review process it would appear that he was admitted to hospital about the same time the sentence was issued. In 2016 he experienced a period of homelessness.

Parents' relationship

3.10 The exact nature of the relationship between Ms A and Mr B is not clear. They did not live together. In contact with professionals Ms A never mentioned Mr B by name. On the occasions when she did she talk about a partner she said that she was pleased to be pregnant and that 'her partner would be too'. On another occasion she said that he was 'not around at present but would be around for the baby'. Another time when asked about whether she had a partner she replied 'sort of'. That said, he was present at the birth and became more visible to professionals after the baby was born. He attended some health appointments with Ms A and Child V and he was caring for Child V in Ms A's home the day she collapsed.

4 Summary of Professional involvement

4.1 Family Composition

NB Ms A and Mr B lived separately

Names	Age at the time of the incident	Gender	Relationship	Ethnicity
Child V	3 Months	F	Subject	White British
Ms A	26 years	F	Mother	White British
Mr B	30 years	M	Father	White British

4.2 The review concentrates on the period from December 2015 and for ease of reference for the reader significant contacts are recorded here in chronological order.

December 2015

4.3 At the end of 2015 Ms A had some telephone contact with the Adult Mental Health Social Inclusion Team (SIT)¹ as she had wanted assistance with her benefits. Ms A presented as very low and tearful. She had lost her travel card along with her employment and support allowance benefit. She was finding it hard to cope with monies she was receiving. The worker advised that she could use a food bank but Ms A reported back that she did not have the bus fare to get there. She was given assistance in filling in benefit forms to try and ensure that she received an emergency payment. Ms A was noted to be 'remarkably thin' in stature and she reported feeling tired and weak from not eating. The assistance she received resulted in her being awarded £30.

January 2016

4.4 In January 2016 Ms A presented to the GP and her pregnancy was confirmed. She was said to be very pleased and told the GP that 'her partner would be too'. The same day her GP sent the antenatal referral to Queen Elizabeth Hospital maternity services and personally made additional remarks to ensure that the midwives knew of her history of depression; the referral never arrived. **NB** Ms A had suffered with depression for which she had been prescribed Sertraline² since 2010. The GP advised her to continue with the Sertraline and also informed the community mental health team of her pregnancy. In accordance with advice, the GP issued supplements to aid the pregnancy and a repeat prescription for Sertraline.

4.5 In mid January Ms A requested an appointment with the Social Inclusion Team but had no money to get the appointment. Over the next few days, practitioners tried to arrange a meeting but Ms A did not attend. As a result, Ms A's case was closed to them in early February.

Practice Learning Point:

It was positive that the GP alerted adult mental health services but given Ms A's history of mental health it would have been good to consider accessing an Early Help Pathway for vulnerable pregnant women at this stage as well as consulting with

¹ The SIT team is based in Greenwich and run by Oxleas NHS Trust. It is a service that leads on social inclusion and ensures the promotion of socially inclusive practice across the community e.g. facilitating service user and carer involvement within the trust and the local community, developing pathways to employment by ensuring service users have the opportunity for leisure/sport pursuits, volunteering, training and paid employment by working collaboratively with external agencies and challenging stigma and discrimination.

² Sertraline is a medication used to treat depression and also sometimes panic attacks, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD)

colleagues via the practice's multi-disciplinary meeting.

March 2016

- 4.6 In March 2016 Ms A had an appointment with the GP and stated she didn't feel as though she was pregnant and would like it checked again. The maternity referral had been sent to Queen Elizabeth Hospital but Ms A had not yet booked her pregnancy. At this GP appointment she said that she would like to have the baby at Darenth Valley Hospital (Hospital 3), as she would like a water birth. The GP assessed her mood as stable but she expressed that she was not feeling like she wanted to eat and wanted to see a dietician. The GP issued a repeat prescription of Sertraline and referred to Darenth Valley Hospital for antenatal care.
- 4.7 Later in March Ms A was referred to Greenwich East Primary Care Plus Team's ADAPT service (a service for adults experiencing Anxiety, Depression, Affective disorders, Personality disorders and Trauma). Ms A was referred to this service due to concerns about her perinatal mental health.
- 4.8 Over the course of the next two weeks Ms A did not attend her scheduled appointments with either the ADAPT worker or her ante-natal appointments. The ADAPT worker contacted the GP to obtain information. The GP shared that Ms A had been seen earlier in the month and had been seen to be stable in terms of her mental health. The GP agreed to let Ms A know that ADAPT were trying to contact her.
- 4.9 It was during this month that technically Mr B's 12 month Community Sentence under the Offender Rehabilitation Act (ORA) 2014 would have come to an end. Through information obtained through the review process it would appear that the management of Mr B though his sentence was very poor and he had not fulfilled the requirements of his order. No action has been taken by CRC in respect of this and London CRC did not meet with Mr B as required by the sentence. There was little management oversight of why this had not been dealt with.

Practice Learning Point

The GP prescribed medication on a number of occasions that was not picked up by Ms A. It has become apparent through this review that there was no system within the GP practice to note this. Patients who are prescribed medication and fail to pick it up need to be assessed in terms of the impact of stopping taking it. In order for this to happen a system needs to be in place whereby this can be brought to the attention of the GP. In this case there were further opportunities down the line to assess Ms A's mental health (post birth) and the impact of her

stopping her medication but the review has highlighted a gap which may affect other service users.

Practice Learning Point

Mr B slipped through the net in terms of fulfilling the requirements of his sentence and LCRC were not proactive in managing his rehabilitation. This was a missed opportunity not only in terms of his offending behaviour but also for professionals to work together collectively and assist Mr B in terms of his mental health and housing.

April 2016

- 4.10 The GP had a telephone consultation with Ms A and advised her to book a GP surgery appointment to review her depression and medication. The review was booked for later in the month but Ms A did not attend the appointment.

May 2016

- 4.11 In early May Ms A attended Darenth Valley Hospital's Ultrasound Department (22+2 weeks) and was advised by the radiographer to have another scan in 2-3 weeks. This was her only scan. Ms A informed them she was going to have her care at Queen Elizabeth's Hospital. **NB** She had not, and never did, book her pregnancy at any hospital.
- 4.12 The ADAPT worker attempted a home visit later that month but could not gain access. A few days later however Ms A telephoned the Social Inclusion Team to request financial assistance with moving – her stated plan was to move to Kent to be with her family. She was informed that ADAPT had been trying to contact her and she agreed to contact them. She did so that day (by telephone) and made a home appointment. She told the ADAPT worker that she was well, no longer taking her medication and had stopped taking this when she became pregnant.
- 4.13 This telephone call was the only contact the ADAPT worker had with Ms A. The ADAPT worker asked Ms A whether she had a partner and whether she was supported. Ms A answered 'sort of' saying that her partner was not currently around but would be there for the baby. In keeping with a growing pattern she did not keep the home appointment.
- 4.14 In response, the ADAPT worker contacted the GP who shared the same information as previously e.g. that she had been seen early in March and seemed stable. The GP requested that ADAPT hold Ms A's case open for a further two weeks whilst the GP tried to contact her. The GP wrote to Ms A the

same day and asked her to contact the surgery. The ADAPT worker also contacted the Best Beginnings³ midwives but they had not sought to engage with Ms A as they believed that she had booked at Darenth Valley Hospital which was out of their catchment area.

Practice Learning point

There was good collaborative working between the GP and ADAPT in keeping the case open and agreeing a plan between them. However another opportunity was lost to have a more multi disciplinary discussion within the practice and develop a plan around her non-engagement.

June 2016

- 4.15 In June, the ADAPT worker again contacted the GP to see what the outcome of the surgery's communication with Ms A had been – she was informed that Ms A had not contacted the surgery. After consulting with her managers she was advised to make a referral to Children's Social Care (CSC) which she did the following day. She rated the risk as 'high' citing that she was concerned about Ms A's lack of engagement with antenatal care and mental health services and her seemingly chaotic behaviour. After making the referral and receiving an acknowledgement of its receipt by the Multi-Agency Safeguarding Hub (MASH) the ADAPT worker closed Ms A's case.
- 4.16 The referral was not logged on the Children's Social Care electronic file system, as that was not usual practice at that time, however a number of activities were completed. On the same day as receiving the referral, a MASH team coordinator completed an agency check of Children's Social Care electronic case files. The unborn child was not known. Ms A was known as a teenager and had a case file. Later that day the MASH Practice Manager emailed the referral to the Group Leader in Safeguarding who was covering the vacant post of Pre-Birth Team Leader. The Group Leader then completed further checks with the Pre-Birth Social Work Team.
- 4.17 On 13th June 2016, the Safeguarding Midwife, who chairs the Maternity Safeguarding Meeting (MSM)⁴, received an email from the Safeguarding Group Leader detailing a number of cases to be discussed at the next meeting. The

³ The Best Beginnings Midwives provide an intensive community based preventative approach to women 'in need' and their families in Greenwich, during antenatal, labour and postnatal periods

⁴ The Maternity Safeguarding Meeting is a weekly multi agency forum run by the Maternity Unit at QEH where vulnerable mothers and their unborn babies are discussed and plans put in place to support them.

Group Leader intended to include Ms A and Child V (unborn at that time) on the list but they omitted Ms A's details erroneously. The unborn baby was therefore not discussed at the MSM and professionals did not detect the error. This was further compounded by a number of factors. One is the original referral not having been logged on the CSC system; therefore there was no audit trail on the electronic records that it existed. Second, the Group Leader was unable to attend the MSM that week due to competing priorities largely brought about by an external inspection taking place in Greenwich at that time. Third, the ADAPT worker who made the referral had moved on to another job so the lack of follow up was not detected by that service either, as the case was closed.

- 4.18 Throughout the rest of June, July and most of August, Ms A failed to attend planned health appointments. These included appointments with the GP and the dietician. She should have had appointments with ante-natal care but as she had not registered for the birth, appointments were not offered.

Practice Learning Points

The ADAPT worker was persistent in trying to get to meet with Ms A but when she was unable to do so made a referral to Children's Social Care (CSC) in respect of the unborn baby. This was good practice.

The systemic issues which resulted in the referral not being dealt with were recognised before this SCR was underway.

The issue of being unable to detect when women (vulnerable or otherwise) are not receiving antenatal care is very complex, as women are not legally bound to book their pregnancy or attend any appointments. They are also free to choose where to have their babies and therefore there are very few mechanisms by which safeguarding issues can be picked up in these circumstances.

It would have been good practice for the ADAPT Service to keep the case open to them until the referral had been followed up. The worker believed it was being dealt with because she had received a notification stating that it had been received. Workers should not assume that because a referral has been received that it is being progressed. The worker had moved on and in these circumstances, it is also necessary to have a system of handover for outstanding issues when workers leave organisations.

August 2016

- 4.19 Child V was born 3 weeks prematurely at Medway Hospital (Hospital 4). Ms A had been visiting her sister in the Medway area when her labour commenced. Ms A arrived via ambulance at the hospital in the latter stages of labour, accompanied by Mr B and Ms A's sister. Ms A told staff at Medway Hospital that

she had not brought her hand held notes as she had gone into labour unexpectedly whilst out of her home area. Ms A explained that she was due to deliver at Queen Elizabeth Hospital. A midwife at Medway Hospital made a call to Queen Elizabeth Hospital to make enquiries as to Ms A's antenatal care. Queen Elizabeth Hospital provided the information that they had i.e. that Ms A had a history of depression but did not have a record of any safeguarding concerns. The exchange of information did not however establish the fact that Ms A had not registered at QEH and had not had any ante-natal care there.

4.20 Following routine post-natal recovery and examinations of both mother and baby, both were discharged to the home address of Ms A's sister. Ms A left hospital having declined a routine hearing test for Child V. A midwife from Medway Hospital saw her the following day and had no concerns about her or the baby. Another planned appointment later that month did not go ahead as the midwife called at the home but there was no one there.

4.21 At some point between the visit from the midwife and the end of August, Ms A returned to her flat in London and the Greenwich Health Visitor (HV) completed a 'New Birth Visit' at her home. Ms A's older sister was also present. Ms A reported that she had previously been known to Mental Health services but that she had been discharged, was no longer on any medication and was feeling emotionally well. She also reported that she was looking to move to Kent to be nearer her sister. The HV observed good interaction between Ms A and the baby. Child V was reported to be bottle feeding well and good weight gain was noted. Ms A told the HV that Child V had had her hearing screening in hospital and her responses were clear - this was untrue. Ms A was put onto Universal Plus pathway and the baby put onto Universal pathway. The HV arranged to call again in 6-8 weeks time.

Practice Learning Points

Ms A delivered her baby at a hospital where she did not reside, had no antenatal notes and had not been previously seen. In these situations, professionals need to be respectfully curious of the presenting facts. cursory checks were made which were not adequate given the circumstances as they failed to establish that Ms A had not had any antenatal care.

There was no handover from Medway Maternity Services to Greenwich Maternity Services when Ms A returned to London.

Both the HV and Medway Hospital staff relied too heavily on Ms A's self reporting especially in light of the fact that she had had no antenatal care. This was one of the only times when Mr B was seen by professionals and it has become clear that there was a lack of curiosity about him and who the father of the baby was.

September 2016

- 4.22 In early September, Ms A presented at a 'walk in' clinic (this was a service provided at her GP practice) requesting emergency contraception which she was prescribed. She had also wanted to discuss her depression but was asked to contact her GP in relation to this.
- 4.23 At the end of September, she registered at a local Children's Centre and attended a health advice session.

October 2016

- 4.24 Towards the end of October Ms A saw her GP for her six week health check after giving birth (post-natal review). The appointment went well but she again requested emergency contraception. This was prescribed and she was given advice to avoid needing contraception as an emergency. Ms A's mood was assessed to be good.

November 2016

- 4.25 On the 1st November the Newborn Hearing Screening Services called the HV to say that Ms A had not attended 2 appointments with Child V. Ms A had told the HV previously that this had been done prior to her discharge from hospital and had been clear. The HV responded by calling to see Ms A the next day to discuss this with her however, Ms A was not at home.
- 4.26 On the same day that the HV tried to visit mother and baby, Child V had her 6-week check conducted by GP (she was 11 weeks old). She was seen in the surgery with both parents and no concerns were noted. The baby check was satisfactory and she was given her first set of immunisations.
- 4.27 On the 4th November the events that led to this SCR unfolded and Child V died on the 10th November.

5 Parallel Processes

- 5.1 The SCR is an independent process that takes place on behalf of GSCB to inform partner agencies about the review and to learn lessons. The panel were however mindful of other processes that were conducted in relation to Child V's death. These were mainly the police investigation that was on going throughout the SCR process. The police investigation concluded in November 2019 as stated in paragraph 1.3. An inquest was opened but immediately closed as is usual practice in cases where a criminal investigation is ongoing.

6 Analysis of Practice

Recognising the impact of poor mental health on preparing for a new born baby

- 6.1 Ms A had an extensive history of depression and according to the records available this went back as far as 2008 when she disclosed that she had been sexually assaulted. She would have been in her late teens at this stage.
- 6.2 Between 2010 and the death of Child V Ms A displayed various symptoms of poor mental health presenting to the GP with poor mood, at times feeling that life was not worth living, fleeting thoughts of suicide and had deteriorating relationships with her family.
- 6.3 The treatment offered for this was medication combined with counselling from MIND (though there is no evidence that Ms A ever accessed this). In 2013 she self-referred to Greenwich Time to Talk (GTT) and was placed on the waiting list for Cognitive Behaviour Therapy (CBT). Her symptoms were indicative of Post Traumatic Stress Disorder (PTSD).
- 6.4 Ms A's mental health deteriorated further in 2015 (just prior to the start of the period under review) when she self-reported an overdose of her medication. The GP referred her to Oxleas Adult Mental Health Service and they assessed her at home and discharged her with the suggestion that she should contact GTT. A further referral to Oxleas was made later in 2015 when she again presented to the GP with low mood and suicidal thoughts but she was discharged after they were unable to contact her. It later transpired that she had lost her phone.
- 6.5 At the point at which the review period begins in December 2015 the picture emerging is of an isolated young woman who is struggling to cope with her day to day life. Further, although she was sometimes proactive at seeking help from various professionals she was not good at seeing this through. Her motivation at these times (though not exclusively) when she did seek help appeared to be around trying to get her benefits reinstated. She first mentioned this as an issue in August 2015 and reported that it had been on going for four months at that point. This had not been resolved at the time of her contact with the Social Inclusion Team in December 2015.
- 6.6 When Ms A presented to the GP in January 2016 and the pregnancy was confirmed, Ms A's history was readily available on records within the surgery in terms of how vulnerable she was at that time. The GP's practice in relation to making the booking referral and ensuring that the information relating to Ms A's mental health problems was noted on the referral was good practice. However, as time went on and the pregnancy progressed information was shared

(particularly by the ADAPT worker) that Ms A was avoiding services especially mental health and antenatal care. Given her known vulnerabilities it would have been incumbent on the GP to make a referral to MASH in respect of the unborn baby.

- 6.7 The risks associated with the lack of ante-natal care are well documented in other SCRs and a significant proportion of SCRs involve babies three months of age or under. A lack of antenatal care is known to be a risk factor in many of these. A duplication of the referral made by the ADAPT worker in the summer of 2016 may have resolved the error made at Greenwich's 'front door'. The IMR produced on behalf of the GP surgery makes the point well that there was a lack of proactive information sharing with colleagues and this was a missed opportunity to seek advice from safeguarding leads.
- 6.8 Another route open to the GPs in the initial stages of pregnancy was the Greenwich's offer under 'Early Help' services. Greenwich's Children Centres are a one-stop shop for early help advice and support for pregnant women, fathers and their children under 5. Professionals including midwives, GPs and health visitors can refer directly into their local children centre early help groups for targeted support if required. Referrals can also be sent through MASH who will redirect them if required.
- 6.9 Eileen Munro in her review in 2011 identified the challenge for professionals working with families, 'parents who voluntarily engage with support services tend to make more progress while a more coercive approach can deteriorate into an adversarial relationship which blocks progress'⁵. It is not clear that Ms A would have engaged with such a multi-agency approach but there are a number of services available for vulnerable pregnant women. The benefits of early help are that it presents an opportunity for agencies to gather information and have a more structured multi-agency response to the presenting issues and create a Team Around the Family (TAF) if necessary. This in turn may have uncovered further evidence associated with parental habits such as Ms A's disengagement from services, more information about the relationship between the parents and the impact of Ms A's mental health.

Were childcare or safeguarding concerns in respect of the unborn baby recognised and responded to appropriately?

- 6.10 This section analyses the recognition and response to general welfare or safeguarding in relation to the unborn child.

⁵ Page 21, The Munro Review of Child Protection Interim Report: The Child's Journey Professor Eileen Munro Crown Copyright 2011

- 6.11 The worker allocated from ADAPT was chosen due to her skills in perinatal mental health which was good practice in trying to target the right support for Ms A. When she became involved she tried on several occasions to meet with Ms A, but was unable to contact her. She was tenacious in trying to engage Ms A and when she was not successful she contacted colleagues to make sure that they were abreast of the situation. She did manage to speak to Ms A on the phone on one occasion and they arranged to meet face to face but Ms A did not keep the appointment. The ADAPT worker kept the GP practice updated about her progress in trying to engage Ms A and asked them to contact her when Ms A presented at the GP. She also contacted maternity services at Queen Elizabeth's Hospital each time Ms A DNA'd an appointment with her. Maternity staff at the hospital were not proactive however, believing that Ms A had booked her antenatal care elsewhere.
- 6.12 This was a good strategy on behalf of the ADAPT worker but was unsuccessful. Ms A did not engage but this was not through lack of trying on the worker's part. As a result the worker sought advice from her managers and made a referral to CSC as she was worried about both the lack of input from mental health services and antenatal care.
- 6.13 The referral pathway for contacts about pre-birth assessments within CSC at that time relied too much on individual workers rather than having a robust system in place to respond to and track individual contacts. As a result of this and pressures on the service at the time the referral got lost and the usual pathway (referral and presentation to the Maternity Safeguarding Meeting) was not followed. In any event it is important that this meeting is seen as a resource to be used by professionals who are concerned about an unborn child and not a substitute for the correct route to process a contact or referral. This issue is explored further in the following section about the Maternity Safeguarding Meeting.
- 6.14 Three issues are particularly significant in relation to the above error. One is that the systemic flaw had been noted prior to the death of Child V and a different system initiated. The current position (implemented in November 2016) is that the MASH screen all referrals, including ones relating to unborn children, and enter them on to the electronic filing system immediately. They then alert the relevant teams. In addition, a referral relating to an unborn child is emailed to a generic email address that can be accessed by the Group Leader, the Safeguarding Pre-birth Team Leader and team members should the team leader not be available. Second, in this instance the Pre-birth Team Leader post was vacant and being covered on a short term basis by the Group Leader thus creating additional pressure.

- 6.15 The third significant feature is the fact that the error was made partly due to the pressures that the agencies and services face during an external inspection that should not be underestimated. Workers focus is elsewhere and the demands on the service increase considerably. In other circumstances when the service was not so pressured, the worker would have been present at the Maternity Safeguarding Meeting and the mistake rectified.
- 6.16 In addition to the above difficulties the worker in ADAPT who made the referral felt reassured that the concerns were being dealt with as she had had an acknowledgment from the MASH team.
- 6.17 The ADAPT worker then left the service and when the referral was not followed up with their service, this was not noted. This is a systemic issue relating to handover of work and outstanding tasks when workers leave a service. It was not good practice to close the case before the outcome of the referral was known and further information had been sought. Some partnership working between ADAPT and CSC at this point may have presented an opportunity to assess Ms A jointly. This has now been rectified and a system is now in place whereby cases are not closed until the outcome of a referral is known.
- 6.18 The review has highlighted a lack of understanding about the referral pathway for vulnerable pregnant women. This was established by the review panel and confirmed at the practitioner events where different agencies' understanding and practice varied enormously. This problem is exacerbated by the lack of structured guidance for early help services that do not reflect the same level of guidance as exists for child protection services. E.g. Working Together provides very little direction for agencies in relation to early help creating inconsistencies and variations in organisations.
- 6.19 The safeguarding practice when Ms A gave birth in Medway was poor. Ms A had arrived at Medway Hospital with no hand held notes, having had no antenatal care and was in the latter stages of labour. Brief checks were made with Queen Elizabeth Hospital but they failed to establish the true nature of the situation e.g. that Ms A had not registered or received any antenatal care there. Risks and concerns associated with the pregnancy (be they general welfare, safeguarding or medical) had not been assessed. There was no formal handover process from Maternity Services in Medway when Ms A moved back to London. Much more collaborative working and professional curiosity needed to be applied in these circumstances and this is an important lesson for that organisation.

Agencies use and understanding of the Maternity Safeguarding Meeting

- 6.20 During the process of the review the panel had extensive discussions about the function and referral process to the Maternity Safeguarding Meeting (MSM). In brief, this is a long-established multi-agency meeting, held weekly, to review

women with additional needs in pregnancy or immediately after they have given birth. It is led and Chaired by Maternity Services. The women discussed may be vulnerable in their own right e.g. due to mental health needs, learning disability, drug and alcohol misuse, etc. They may be in need of early help, more targeted support or there may be safeguarding concerns for the unborn baby. Women can be referred to the meeting as part of the assessment by the Maternity Safeguarding Pathway but any agency can refer.

6.21 Health professionals refer into this meeting as part of the Maternity Safeguarding Pathway. Women are advised of the referral and requested to give written consent for the referral. Where there are significant concerns and consent is refused, women can still be referred to the meeting. In these circumstances information is shared appropriately and proportionately with action plans in place to promote the safeguarding of babies.

6.22 The review has previously noted Ms A and child V (as an unborn child) were not discussed at the MSM due to an error made at the time of the referral to Greenwich's MASH. The significance of this meeting for the review and the learning that comes from it lies in agencies' understanding of and function of the meeting. From the perspective of MASH workers, it would appear that prior to November 2016, it had become custom and practice for referrals about unborn babies referred into MASH to be immediately referred on to the MSM, therefore bypassing the usual route that referrals would take. Referrals were not entered on to the electronic records held by CSC but subject to a series of checks, followed by referral to, and discussion at, the MSM. It was usual practice for a Pre-Birth Social Worker or Team Leader to then attend the MSM to share information and make decisions about the way forward and to track cases. Agencies then would fulfill any actions requested at the meeting, including referral to CSC if that was deemed to be appropriate.

6.23 The panel were concerned that this in effect had become a parallel screening (or MASH) process rather than a systemic approach to processing referrals. In the practitioner event held in relation to the SCR it became apparent that there were differing views and expectations of this meeting and that agencies had been using the meeting in different ways.

6.24 The issue with pre-birth referrals being processed by MASH workers was recognised prior to this review commencing. Some review panel members however, were concerned that the MSM was still taking the place of the correct referral pathway when an unborn baby requires a service from CSC. GSCB therefore need to be reassured that the correct pathway for referrals in relation to pre-birth referrals is understood and followed and that there is appropriate governance, attendance or communication, and record keeping in place. The meeting's crucial link to health visiting services should be clear.

6.25 Work is currently underway to strengthen the MSM. The Terms of Reference and governance of the meeting are being revised to support tighter outcomes from the meeting. The purpose of the work is to ensure that all agencies have a shared understanding of the meeting, its purpose and remit. Further to this it should be clear that it is a resource that supports practice and promotes information sharing, rather than replacing other necessary safeguarding processes.

6.26 The issue of consent for information to be shared at this meeting was unclear for those women who had not formally given consent as well as other relatives e.g. fathers and other family members. This needs to be clear in the revised Terms of Reference.

Services' recognition and response to lack of engagement

6.27 Historically Ms A's engagement with professionals that could help her was sporadic. At times she engaged and other times she chose not to seek help. It would seem from the information provided by agencies that worked with Ms A that there were particular triggers for when she sought help in that she had often reached a crisis point and was at a low ebb. Examples of this are feeling suicidal, a self-reported overdose, losing her benefits and not having money to eat. At these times agencies did respond and she was offered a variety of services to help in both the short and the longer term. She seemed better able to accept help at the point of a crisis than she did at other times. This was despite advice from professionals who wanted to help her overcome her longer-term issues so that she could deal better with the crises when they came along.

6.28 There were a number of attempts to work with Ms A in relation to adult focused services but they closed her case after trying (and being unsuccessful) to engage her. One of the reasons for this is that Ms A was at liberty to accept services or not, she had capacity in the formal sense to make choices for herself and this was never in any doubt. Although she had some mental health difficulties she was never at a stage where professionals were worried to the extent that they considered section under mental health legislation. Further, in many ways she was not untypical of numerous clients who sought help and then did not always follow through with the help offered. However, at the point that her pregnancy became known the emphasis should have shifted from an independent young woman making her own choices, to more consideration of the impact of her lack of engagement with services, on her unborn child.

6.29 Her recent history in terms of mental health did prompt the GP to ensure that the information about her history was shared with maternity services but at the point at which it became clear that she was not engaging with anyone, a more authoritative approach was warranted.

- 6.30 Ms A (and therefore the unborn baby) was not discussed at the GP practice multi-disciplinary meeting, consequently there was a lack of collective assessment and analysis which led to insufficient consideration of the safeguarding needs of the unborn baby. Ms A should have had an antenatal visit from the health visiting team but information about the pregnancy was not shared to enable this to happen. The lack of engagement with maternity services and the number of failed encounters with general practice should have raised concerns. It would appear the lack of engagement was tolerated without assessing the risks to the unborn. This was despite information from the ADAPT worker who kept the GP practice updated about her progress about her attempts to assess Ms A. Further enquiry should have alerted the Practice to the fact that Ms A had not booked for antenatal care and was not taking her anti-depressive medication, as advised.
- 6.31 Another aspect of Ms A's disengagement was her failing to take advice about continuing to take her medication. The GP continued to prescribe Sertraline but it was not noted that the prescriptions were not picked up. Ms A clearly stated to the ADAPT worker in May 2016 that she was no longer taking her medication and that she had stopped it as soon as she found out she was pregnant and this information was passed to the GP.
- 6.32 The GP practice has made a number of changes to their monitoring of vulnerable pregnant mothers as a result of this SCR. This includes creating systems to monitor each stage of pregnancy and follow up after the child is born. A log has been developed which is populated by information provided by midwives and other professionals. This enables the practice to track antenatal referrals and check routine appointments postnatally. They have also introduced a system to track uncollected prescriptions.
- 6.33 Ms A's lack of engagement with agencies is indicative of 'disguised compliance'⁶ that was not recognised by workers. Ms A appeared to be somewhat inconsistent and chaotic in her contact with services but there is strong evidence that suggests she manipulated situations to actively avoid contact with them, especially during her pregnancy. Examples of this are making appointments but not keeping them with Maternity Services and the ADAPT worker, telling staff at Medway Hospital that she had had her antenatal care at Queen Elizabeth Hospital and telling the health visitor that Child V had had her hearing test. There are many other examples of her misleading professionals into thinking that she had booked (or at least was intending to) appointments that in hindsight she probably did not intend to book. The information held by professionals was rarely triangulated and the information (for reasons already discussed) was not shared in a multi-agency way.

⁶ Disguised compliance involves adults giving the appearance of co-operating with agencies to avoid raising suspicions and allay concerns. This regularly involves parents agreeing to meetings and changes whilst in reality doing very little to effect change.

6.34 The SCR Panel debated the issue of possible disguised compliance at every stage of the review and whilst there is evidence to suggest that this was the case it is not possible to reach firm conclusions about this. What was clear to the Panel members was Ms A's struggles with her mental health and difficult family relationships. These factors made her a vulnerable individual who would have benefitted from more targeted support to help her feel more confident about her impending parenthood.

Professional curiosity regarding fathers.

6.35 There is very little in the notes and information available to the review regarding Mr B. There is also a general lack of curiosity from professionals who came into contact with Ms A about who the baby's father was. Ms A was never asked his name and rarely was the status of their relationship questioned. He was not seen by any practitioners throughout the pregnancy (because Ms A herself was hardly seen) and Ms A was asked very few questions about relationships in general or other family support.

6.36 Lack of knowledge about the role men play in children's lives has been a feature in a number of SCRs. For reasons already discussed, the lack of knowledge about Mr B may stem largely from the fact that there were no assessments of Ms A along with her capacity to make preparations for the unborn child. The net result of this was that agencies that could have provided information about him and the wider family were never approached.

6.37 The importance of establishing a support network for vulnerable, single mothers was overlooked in this instance largely for the same reasons outlined above. Those professionals who did meet family members were reassured by their presence without having explored the dynamics of the relationships.

7 Feedback from Practitioner events

7.1 An important part of any SCR is gaining an understanding of practice from the viewpoint of the practitioners. Actions, decisions and inactions would have made sense to them at the time even if with the benefit of hindsight these were not the best decisions.

7.2 GSCB arranged a practitioner event in May 2017 that was facilitated by the two independent Lead Reviewers and supported by Panel Members. A further event was organised towards the end of the process in September 2017 where practitioners had an opportunity to comment on the findings and recommendations of the review.

7.3 The practitioners present were able to contribute well and were very reflective in their approach to the SCR and were keen to learn lessons both individually and for their agencies. The following is a summary of issues raised by the practitioners.

Summary from the event in May 2017

7.4 It was noted that very few practitioners had a face to face meeting with Ms A. From the group present only the Health Visitor and the GP had met her. The ADAPT worker had spoken to her over the phone. All agreed that she was very plausible but they also noted her vulnerability.

7.5 There were a number of missed communications particularly between different health agencies in terms of emails, faxes and letters going astray, making for incomplete records and therefore the ability to piece information together. One such example is that the original referral for antenatal care from the GP did not reach its destination. It is not clear if this was a systems issue or human error.

7.6 Practitioners also noted a number of issues where information sharing tended to rely on individuals rather than on systems. They were committed to try and rectify these within these within their own agencies.

7.7 Practitioners recognised how much reliance was placed on Ms A's self-reporting without taking a more measured approach and checking facts out with colleagues.

7.8 Finally, those present noted how little professional curiosity there had been in relation to Mr B and how much information would have been available particularly from mental health services.

Summary from September 2017

7.9 Again practitioners were able to contribute well and to reflect on their involvement. They were keen to learn the lessons from this case and implement changes to tighten the system.

7.10 Practitioners broadly agreed with the recommendations made and made the following additional comments.

7.11 They confirmed that the early help pathway was inconsistently understood and followed and they would like more multi agency training and clarity around what is available and when to apply it.

7.12 Many of the agencies recognised that they had been too adult focused and needed to think more about the needs of an unborn child. There was also a general need to rethink how maternity services engage un-booked women. Whilst the group accepted this was challenging as it was difficult to establish if a

woman was not booked they thought the key was to have a data base of referrals sent by GPs and they would be easier to trace.

7.13 Practitioners were keen to develop more of a culture of consulting their own safeguarding leads to check out thresholds and related issues. An idea that evolved from this was to devise a method of safeguarding leads from different agencies discussing complex cases in partnership with each other rather than in isolation.

7.14 Practitioners were aware that the Pre-birth Protocol needed to be revised and thought that it should include best practice for women who arrive at hospitals without having booked their pregnancy. More specifically they thought that this should include women and their new born babies to be subject to safeguarding reviews before being discharged.

7.15 The use of generic email addresses would also help ensure that communication is not lost. A suggestion in relation to this was for the GSCB to hold a list of those addresses for anyone to contact them should the need arise.

8 Lessons learnt and questions for the GSCB to consider

8.1 There are a number of lessons the GSCB can learn from this case and these are as follows:

Use of Systems

8.2 The review has demonstrated the importance of systems that do not rely on the presence of individuals. There were several examples of this in this case and they have highlighted weaknesses across the system in general. In this instance, the issue of the referral to CSC made by the ADAPT being lost was recognised before the start of the SCR. Improvements have already been made to ensure that referrals are now captured on electronic files and then dealt with through the correct channel. Adult mental health services have altered their practice and now have a system in place to deal with outstanding issues when workers leave organisations.

Better use of early help

8.3 Families are much more likely to thrive and have a positive outcome for their children if their difficulties are recognised at an early stage and they receive help. This is also true of help offered to expectant mothers. The importance of early intervention processes that are understood and owned by all agencies are crucial. No use was made of mechanisms for offering early help to Ms A and although individual agencies offered support to Ms A, this was largely adult focused and not co-ordinated. The review has highlighted a lack of understanding and application of thresholds about when to refer to early help services.

Recognition and response to non – engagement in antenatal care

8.4 There is a general recognition that a lack of engagement with antenatal services poses a potential risk to the health and wellbeing of mothers and their babies. Ms A's failure to engage in any antenatal care was not recognised by many agencies and when it was, systemic errors prevented the correct course of action being pursued. The mother's right to choose where to access antenatal services is an added dynamic in this. The safety net of universal services as a way of catching vulnerable children before they slip through the net did not work in this case. Vital routine pieces of information were not collated such as the likely impact of mother's mental health, including ceasing to take medication against advice, on her plans and preparations for the baby, family support, and relationship with her partner.

8.5 Early liaison between the HV and the midwives was lost and thus plans for support after the birth of the baby were not formulated. Coupled with this, Ms A's lack of engagement with a number of other services should have triggered a more proactive response. Plans are now in place to link pregnant mothers with known mental health problems from the antenatal (pre-birth) pathway to the maternity safeguarding pathway.

8.6 There is also a systems question about how GPs provide early signposting of vulnerable mothers to Health Visiting Services.

8.7 Within Oxleas Trust mental health services and health visiting share a database which should have made Ms A's mental health history available to health visiting. A question arises as to how routinely this background information is accessed.

Over reliance on self-report and disguised compliance

8.8 In this case Ms A repeatedly told professionals that she had accessed or would access services without this being triangulated with other professionals or checking records. Her version of events was accepted without challenge and it is important that professionals recognise a reliance on parental self-reporting and be open to the possibility of disguised compliance. Systems such as supervision and management oversight need to be in place to act as a further check and balance to practitioners' perception of events. There was very little advice or supervision sought in this case by practitioners and little use made of named professionals or other forums (e.g. multidisciplinary meetings). Professional curiosity must include some doubt about parental statements when there is no evidence to support them.

Professional curiosity about fathers and extended family

8.9 Professionals were not sufficiently curious about the father of the baby. Enquiries were made and responded to with vague responses of his promised involvement; but these statements were not explored further. The absence of curiosity probably stems from the tenuous contact with Ms A during her pregnancy but it is important that practitioners have at least a basic understanding of both parents and the nature of the relationship. Had an assessment been pursued under either the auspices of CSC or early help processes, more information may have been uncovered about father and his particular vulnerabilities assessed. This finding resonates with previous SCRs undertaken in Greenwich and the GSCB need to be assured that these lessons have been disseminated and learned.

8.10 The same lack of curiosity applies to Ms A's extended family and how much support they offered to her throughout her pregnancy and after Child V was born.

9 Recommendations for the GSCB (to be read in conjunction with agencies recommendations and action plans)

1. GSCB to review and report on the effectiveness of early intervention in relation to unborn babies and ensure that agencies are aware of the early help pathway for vulnerable women during their pregnancy.
2. GSCB should seek to reassure itself that agencies have robust systems in place to ensure that fathers are considered in assessments. This includes fathers, stepfathers and partners even where they do not reside with children.
3. GSCB should satisfy itself that staff in partner agencies in primary and universal services are adequately skilled and knowledgeable about safeguarding children procedures and vulnerability factors (including risks associated with the lack of antenatal care) in relation to unborn babies.

4. Lewisham and Greenwich NHS Trust should revise the Terms of Reference and Governance, including membership and recording of actions for the Maternity Safeguarding Meeting. A multi-agency forum of senior agency leads and GSCB Monitoring and Challenge sub group should then agree these. GSCB should oversee the final document to ensure that the governance arrangements are robust.
5. GSCB to oversee a review of the multi agency pre-birth protocol to ensure it provides clarity on best practice in cases where women do not access antenatal care.
6. GSCB to review its training programme to ensure that staff are aware of the risks associated with over reliance on self reported information, lack of engagement and disguised compliance when working with families, including work with fathers.

Additional recommendations

GP Practices

GSCB should seek assurance that there are systems in place for tracking the welfare of patients who have missed appointments in GP practices and that information is shared across the multi agency where there are safeguarding concerns

GP Practices to ensure that they have a system in place for monitoring prescriptions that are not collected by the patient so that appropriate assessment can be undertaken of the impact of non-compliance.

Medway Foundation Trust

Medway Foundation Trust to revise their 'Antenatal/Postnatal Safeguarding Risk Assessment Policy' to include a baseline of information to be established for the assessment of women from out of area who deliver babies at their hospital or unexpectedly; and to assess any lack of antenatal care.

London Community Rehabilitation Company

London CRC should undertake a management review of practice in this case and reassure themselves and GSCB that current systems are robust to avoid clients they are working with slipping through the net.

Jane Doherty
Independent Lead Reviewer
October 2017

APPENDIX 1

Arrangements for the Serious Case Review (SCR)

After the death of Child V, GSCB took the view that the criteria for an SCR had been met which are entirely consistent with the guidance in 'Working Together'⁷ (WT) 2015. In this case the following criteria is met;

- abuse of a child is either known or suspected and the child has died;

Working Together (2015) sets out how a Serious Case Review should be conducted e.g.:

- It 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.

The purpose of the review is to

- look at what happened in the case and why and what action will be taken to learn from the review findings
- identify actions that result in lasting improvements to those services working to safeguard and promote the welfare of children.
- provide a useful insight into the way organisations are working together to safeguard and protect the welfare of children.

Arrangements were made to appoint the independent people who are required to contribute to the conduct of SCRs. Mr Malcolm Ward was appointed as the Chair of the SCR panel. Malcolm Ward is an Independent Social Work Consultant. He is an experienced Serious Case Review Chair and Overview author with significant expertise in safeguarding, quality assurance and child protection. Jane Doherty was appointed to produce this overview report. Jane is an Independent Social Work Consultant with a background in Child Protection and Quality Assurance. As an independent consultant she now specialises in multi-agency learning reviews including partnership reviews and SCRs.

⁷Working Together to Safeguard Children (Working Together) is the government's overarching guidance on safeguarding. It sets out the circumstances in which SCRs should be carried out.

GSCB appointed a Review Panel to manage and oversee the review. The membership of the panel is set out below:

Agency	Representative
Independent Chair of the Panel	Malcolm Ward Independent Social Work Consultant
Independent Overview report author	Jane Doherty Independent Social Work Consultant
Greenwich Children's Social Care	Head of Quality Improvement, Children's Services
Greenwich Safeguarding Children Board	Business Manager GSCB
Lewisham and Greenwich NHS Trust	Trust Lead for Safeguarding
Metropolitan Police Service	Lead Officer, Specialist Crime Review Group
Greenwich CCG	Designated Nurse for Safeguarding and Children Looked After
Oxleas NHS Foundation Trust	Head of Safeguarding Lead Named Nurse Oxleas

It was determined through the emerging facts of the case that the following agencies had had contact with the family and should therefore contribute to the review:

Agency	Contribution
Greenwich CCG	IMR and chronology
Thamesmead Health Centre General Practitioner (GP)	IMR and chronology
Lewisham and Greenwich NHS Trust	IMR and chronology
Greenwich Children's Social Care (CSC)	IMR and chronology
Oxleas NHS Foundation Trust	IMR and chronology

Metropolitan Police Service (MPS)	Letter and chronology
London Community Rehabilitation Company	Chronology

The Terms of Reference (ToR) agreed by the Panel were that the period under detailed review would be from 2nd December 2015 – 4th November 2016 (the date the child’s injuries were noted). This included the proviso that agencies would summarise any other relevant information pre-dating this period, to add context and background to their report.

The methodology used by the GSCB in this review was a hybrid model in that each agency was asked to complete a chronology, and undertake an Independent Management Report (IMR). Those agencies that had minimal contact were asked to complete a letter and chronology setting out a brief summary of their involvement (see table above). The reports are an opportunity for individual agencies to describe and analyse their contact with the family.

The GSCB held a series of SCR Panel meetings, chaired by the Independent Chair, where all the agencies and the overview author contributed to the process of gathering and analysing the material provided.

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

‘Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children’. (Working Together to Safeguard Children 2015, 4:7)’

Consultation and learning events were held in May 2017 and September 2017 to enable those practitioners who worked with the family to contribute to the overall findings and lessons from the review. The latter event was held prior to the final publication of the report to feedback findings from the review and to ensure views from the practitioners had been captured. Feedback from the practitioners is included at Section 7

The learning will be disseminated by events planned by the GSCB. These events will target practitioners who worked with the family as well as staff from the wider children’s multi agency workforce and GSCB partners.

Board partners were asked to identify the learning from their organisations at an early stage in order to put in place an action plan that would address any practice issues.

It is important to note that the review has been conducted and written with the benefit of hindsight, which often distorts the reader's view of the predictability of events, which may not have been evident at the time. It is important to be aware as Munro (2011) states just how much hindsight distorts our judgement about the predictability of an adverse outcome. Once an outcome is known we can look back and believe we can see where practice, actions or assessments were critical in leading to that outcome. This is not necessarily the case, and information often becomes much clearer after an event has occurred. The review is therefore sensitive to this 'bias'.

With the above in mind the review is also sensitive to pressures on agencies and the demands of the work that are sometimes overwhelming for even the most capable of workers. It is therefore important to disseminate the learning and reflect on how the lessons from this review can help support better practice, rather than apportion blame to agencies or individuals.

Appendix 2

Methodology used to produce this report

9.1 This report is informed by:

- The agency chronologies, IMRs and other reports
- Background information from agencies involved in the review
- Panel discussions and analysis
- Dialogue with IMR authors
- Input from practitioners via individual consultations and the learning events held in May and September 2017

9.2 The report consists of:

- A brief factual context
- Analysis of how the agencies worked together from the information provided in their IMRs
- Commentary on the family situation
- Key themes and lessons learned
- Recommendations
- Governance via GSCB including senior managers