Cross-Borough Learning From Practice Review

Report August 2021

Child DA

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This review was jointly commissioned by Lewisham Safeguarding Children Partnership and Greenwich Safeguarding Children Partnership. Lewisham led on the review as the incident happened within the Borough, Greenwich supported as the area where the children were ordinarily resident. The independent author, Amy Richmond was appointed by Lewisham for her experience as a Quality Improvement Child Protection Manager.

Lewisham Safeguarding Children Partnership

GREENWICH Safeguarding Children PARTNERSHIP

Contents

Executive Summary

Lewisham Children's Social Care Multi-Agency Safeguarding Hub (MASH) received a telephone referral from the Metropolitan Police on 09 March 2020 regarding 3 month old DA, who was reported to be in hospital in a life-threatening condition. Police advised that the family lived in Greenwich, but had received an emergency call to the maternal grandmother's address in Lewisham. DA's mother presented with her boyfriend (Mr H, not the father of the children) and 3 daughters.

It is reported that DA's mother's boyfriend alerted DA's mother that Child DA appeared unwell, and an ambulance was called at approximately 10.30am on 9 March 2020. DA was found to be in an unresponsive state and breathing irregularly; she was taken to hospital by ambulance. She was noted to have bruising on her forehead. When the mother was spoken to she reported that earlier that day at approximately 8 am one of the other children had knocked DA while jumping and playing.

Police also advised that there was no information from the hospital at that stage to confirm whether Child DA's injuries could be non-accidental. The Hospital also sent in a referral to Lewisham MASH. This contained the following information: '*Concerns about non-accidental injury as presented unresponsive and found to have a bleed on the brain confirmed by CT head'*.

The children's case was progressed to the Lewisham Referral and Assessment team for a Strategy Meeting which took place on 11 March 2020 and a Joint S.47 investigation commenced. However, the mechanism for DA's injury could not be confirmed at that stage, and further tests were to be arranged by the hospital. A Review Strategy Meeting was convened at the Hospital on 12 March 2020. Test results confirmed that DA's head injury was consistent with a non-accidental injury. DA was reported to be in a critical but stable condition. At the time of the Rapid Review Meeting, DA had attended Kings College Hospital for paediatric intensive care and since returned to University Hospital Lewisham for further medical care.

Greenwich Children's Services accepted case responsibility on 11 March 2020 as it was established the family's address was in their area. DA's two siblings were taken into Police Protection and placed by Greenwich Children's Services with their Maternal Great Grandmother.

DA's mother and boyfriend were both arrested. At the time of writing the report both the Police investigation and care proceedings are ongoing.

Methodology and Scope of Review

The Learning from Practice Review Panel [Panel] met on 21 July 2020 to agree the focus of the review. The Panel also considered that there would be valuable learning to be gained by looking at national learning in respect of shaken babies and risks arising from stress caused by crying babies.

The scope of the review was agreed as the period 09 March 2019 – 09 March 2020. Agencies in contact with the family were asked to provide a chronology of involvement for the period and an agency report. Specialist support was provided by health partners to inform the review on areas of record sharing, commissioning and ways of working.

Family Composition and Engagement

Child DA comes from a White British Family and has two older maternal half-sisters [Child K and L].

The lead reviewer contacted the mother Ms C and father of Child DA Mr D, and father of siblings Mr F. Each was given an opportunity to speak with the lead reviewer about their experience of services in the care of Child DA.

Ms C was spoken to by the Lead Reviewer and shared her views on the report and learning identified. Ms C had a good understanding of the purpose of the report.

Ms C spoke of how well DA is doing, her health is so much better than Ms C expected, and Ms C feels she has defied the prognosis she was initially given by medical professionals after her injury. Ms C described that DA walked before she was 1, she is really chatty and has a brilliant understanding of the world around her. She described her an ‘amazing little girl and a proper character’.

Ms C reflected that she moved around a lot when she was younger and that this had an impact on her. Ms C lived with her Auntie once her children were born and then when the twins were 5 months old she moved to live with her Grandmother, which is in Greenwich. She had good support there and felt happy there. She moved between her mother, Auntie and Grandmother at times but always felt the most support at her Grandmother’s home.

Ms C told the Lead Reviewer that she has never had her own tenancy. Ms C thought that this was sometimes confusing for people as she did move a few times and tenancies weren’t in her name. She has never made an application for housing in her own right. Ms C lives at her mother’s tenancy now as part of the agreed plan in the care proceedings, although her mother does not live with her currently.

In terms of her relationships, Ms C reported that the twins father (Mr F) and then Child DA’s father (Mr D) were the only people who lived with her. Ms C felt that she was always honest with professionals about her relationships and who was having contact with her and the children. She did acknowledge however that professionals didn’t know that she was in a relationship with Mr H at the time of the incident. She has reflected that in hindsight maybe she should have noticed behaviour that

was worrying and that it wasn't always a positive relationship, and that the work she has done since has improved her understanding of risk in relationships.

Ms C couldn't think of anything that professionals could have done differently that would have prevented the incident, but she did think that it would have been helpful to have some more support around how to communicate with the children's father, particularly after they were separated and trying to co-parent the children. Ms C wanted to emphasise that stability for the children was really important to her.

Ms C felt that although she was supported well as a mum once her daughters were born, that the "system" did fail her when she was a child herself. Ms C was able to acknowledge that if different decisions had been made to safeguard her when she was younger, she might have found it easier to make safe choices in relationships when she was older.

Ms C was open and reflective in her discussions with the Lead Reviewer which was very helpful to the process and in learning more about her experiences.

Mr F did indicate that he would like to contribute to this review however unfortunately calls to him by the Lead Reviewer were not answered. Mr F had previously stated that he would like to read the final report.

Mr D did not want to contribute to this Review and therefore was not spoken to by the Lead Reviewer although was written to and offered the opportunity to share his views.

Finally, in July 2021 prior to the final report being agreed, the Lead Reviewer spoke to Child DA's mother and Mr F, on the findings of the report, the report was provided prior to publication. Both were in agreement for the report to be published.

Final contact could not be made with Mr D DA's father.

Themes arising from the review

Working with families who have moved between local authority areas, including issues of threshold and information sharing across Boroughs:

Children's Social Care:

A referral was made to Lewisham Children's Social Care (CSC) on 19 June 2019 by Bexley Children's Social Care. Mother had contacted Bexley CSC asking for information about her then partner Mr D as she was concerned he had a history of violence. In light of the information held by Bexley CSC who were involved with Mr D's older child, X, a referral was made to Lewisham CSC and the case allocated for a Child & Family (C&F) Assessment.

The C&F Assessment carried out by Lewisham CSC as a result of this referral concluded that a referral should be made to Greenwich as this was where the children were living. The analysis and conclusion of the assessment did not identify which service (if any) should continue to support the family. Case transfer is not the outcome of an assessment, but rather a professional task which needs to take place to ensure families receive support in the area in which they are living.

The C&F Assessment notes that the concerns about Mr D's history were not discussed fully with Mr D because it transpired the family were living in Greenwich and the case needed to transfer. In answer to the question on the assessment form about whether the children should be considered Children in Need under section 17 of the Children Act 1989, the Social Worker has answered "Yes" but no Child in Need Plan or services were proposed and this was not chosen as the outcome of the assessment. The assessment appears to have been ended on the basis that the family were living in another Borough. However, the document is signed off and appears on the children's records as a completed assessment and it is this which was shared with Greenwich CSC. However, the assessment did not fully address the original reason for referral as the decision was made not to discuss the concerns with Mr D in light of case responsibility needing to transfer to Greenwich.

The London Child Protection Procedures[1] Chapter 6 Children and Families Moving Across Local Authority Boundaries states that under the Children's Act 1989 the responsibility for safeguarding and promoting the welfare of children under section 17 and 47 of the Act lies with the local authority in which the child is to be 'found'. Further:

"However, case responsibility should remain with the authority in who's area they previously resided for a short period of time in specific circumstances, i.e. where the child is already the subject of a protection plan (see 6.2.1 to 6.2.3 below), child in need plan (see 6.2.2 below) or where an assessment (S17 or S47) has already commenced but is yet to be completed (see 6.3.1 below). If the outcome of the assessment is that the child should be the subject of an initial child protection conference or child in need planning meeting, then that conference / meeting should be arranged by the receiving authority, i.e. in which they are then to be found / residing,"

The procedures are clear that the borough that starts an assessment is required to complete the assessment before transferring to the borough in which the family live.

Greenwich CSC concluded from the information shared with them by Lewisham CSC that an assessment had been completed and that threshold was met to provide Early Help services to the family. However, this decision was made on the basis of what might be considered an incomplete assessment. There is no record that the outstanding piece of work of discussing the concerns with Mr D took place and so there is no clear assessment of the risk he posed or role he plays in the family. The C&F assessment carried out by Lewisham CSC was accepted by Greenwich CSC as a completed piece of work, when in fact there was a crucial piece of work not yet completed.

[1] https://www.londoncp.co.uk/chi_fam_bound.html#

There is no record of whether the recommended step down to Early Help actually happened and whether Early Help services were offered to the family. It does not appear that Early Help Services were provided to the family but it is not possible to know whether this is because they were not offered or because the family did not take up the offer of such services.

Health:

Greenwich Family Nurse Partnership (FNP) started working with the family in March 2019 until February 2020 before handing over to Health Visiting services. In February 2020, the case transferred from the Family Nurse Partnership to Oxleas Health Visiting Services and the family was allocated a Health Visitor. This transfer was primarily due to the decommissioning of the FNP Service. There was a verbal and written handover to the new Health visitor at which no safeguarding concerns were raised for Child DA or her siblings.

The chronology completed on behalf of Oxleas does confirm that FNP records were received by the Health Visitor. The Chronology notes that there was a query regarding a reference in the records to an "ICO" for Child DA. The Health Visitor attempted to contact Greenwich MASH to discuss this, but was unsuccessful. The Chronology states that this was due to the Christmas holidays, but given that this was February 2020 this seems unlikely to be the reason why Greenwich MASH was not contactable. Child DA was not the subject of an Interim Care Order at this time, but it was important for the Health Visitor to have followed this up and clarified it to be sure.

It may also have been the case that "ICO" in the records was an abbreviation for something else but as this was not followed up it is not certain what was being referred to. This was an important piece of information which would have informed professionals understanding about the level of risk and it was important that it was followed up and clarified.

Professional curiosity and risk assessment regarding roles of partners/fathers and family history:

Children's Social Care:

August 2019 Mother contacted Greenwich MASH to advise that she had received a Clare's Law disclosure in respect of her partner (Child DA's father) and as a result of the information learned, she intended to cease all contact with him. This was an opportunity to further explore this with Mother, particularly in the context of the C&F assessment which had just been carried out (although not completed) by Lewisham CSC and any further support Mother might have needed given that she was intending to separate from her partner and care for her young children as a sole parent. A Merlin was not triggered following the Clare's Law application, as the police were not informed that children were in the home the report states "Children- NONE". When the mother was spoken to by the GSCP Professional Adviser on 25 August 2021, DA's mother stated that the Clare's Law application did not return any information that was of concern.

February 2020, Mother contacted Greenwich MASH to advise that she had resumed contact with Child DA's father and felt she could manage this safely. It is not clear why Mother initiated contact with Greenwich MASH to share this information. It may have been that she simply wanted to tell professionals what was happening. Mother appeared to have a safety plan in place to manage contact although it is not clear if the reasons for Mother resuming this contact were explored with her. In any event, it was an opportunity to consider whether the risk to the children had now changed given that this relationship had resumed.

Overall, there was a lack of urgency in the attempts by professionals to find out more about Mr D, his relationship with Mother or Mother's changing attitudes towards her relationship with him. Mother's "safety plan" was taken on face value with relatively little questioning by Greenwich CSC or consideration to whether Mother was likely to need additional support to manage this. During the original assessment by Lewisham CSC, although Mr D was present during a meeting between the Social Worker and Mother and gave his consent to information about him being shared; the assessment also states that a decision was made not to discuss the concerns about his previous behaviour with Mr D as the case needed to transfer to Greenwich CSC. This means that this assessment effectively did not reach any meaningful conclusion about the level of risk posed by Mr D.

Health:

April 2019, during a home visit to Mother by her FNP worker, Mother reported that she was considering a termination of her pregnancy (she was in the early stages of her pregnancy with Child DA). Mother reported that she had made an appointment with Marie Stopes. However, by the time of the next visit by the FNP worker 2 weeks later, Mother reported that she had changed her mind about the termination and was continuing with the pregnancy. There is no evidence that this decision, the reasons for it and the impact of it was explored any further with Mother. This was a significant decision for Mother to have made (both in considering a termination and in later deciding to proceed with the pregnancy) and there was an opportunity to explore with Mother what the meaning of the pregnancy was for her in light of these decisions. When reviewing the final report, Mother spoke about having a 'really good connection with the baby' whilst pregnant. Her thoughts around termination were in response to her relationship with the father rather than the pregnancy.

Mother appropriately booked her pregnancy with Child DA with Midwifery Services when she was 8+4 weeks gestation. The notes from this Booking appointment demonstrate that information was changed regarding the details of Mother's partner from Mr D to Mr F. It is presumed that these changes were made by Mother but there does not have appear to have been any discussion with Mother about these changes, what they implied in terms of her having a new partner in the early stages of pregnancy and what impact this might have had on her support network, as well as the other children in the family home.

During a home visit to Mother and Mr F May 2019 by FNP, Mr F reported that he was now living in the family home. During the same visit, Mother referred to her previous intention to seek a termination but stated that she had not been able to go through with it after hearing the heartbeat. The notes of

this visit describe Mother using “harsh” language when talking about her unborn child, although does not detail what this language was. This raises questions which might have been helpful to explore further at the time about what the meaning of this pregnancy was to Mother, and subsequently the meaning of the baby once born and Mother’s response to her as a result.

June 2019, Mother reported to FNP that Mr F was no longer visiting the home. This was a significant change given that during the last home visit he was reported to be living in the home. There is no information to indicate whether this was discussed further with Mother.

Two weeks later Mother told FNP she was in a new relationship with Mr D and stated that she would like FNP to contact Children’s Social Care to find out if there was any information of concern about him. However Mr D was first referred to in the notes from Mother’s antenatal booking appointment in April 2019 (when she changed her partner’s details from Mr D to Mr F). This suggests that Mr D and Mother had been in contact at the very least, if not in a relationship, prior to her telling FNP about this in June 2019. It is not clear if this was noted or discussed with Mother to understand the nature and longevity of this relationship, or indeed whether it was understood at this time who the putative father of Child DA was.

The C&F Assessment was commenced by Lewisham CSC in response to the enquiries made in respect of Mr D although he was not spoken to as part of this assessment which was ended when it became apparent the family were living in Greenwich.

By August 2019, Mother appears to have resumed her relationship (or at the very least contact) with Mr F who was present during a home visit by FNP. There is no information to indicate whether this was discussed with Mother in any detail and it does not appear that information was shared or sought between Lewisham CSC and FNP as to the outcome of the assessment carried out in response to concerns about Mr D.

Child DA was born in November 2019 by Caesarean delivery. Mother told the Midwifery Team that she did not want her ex-partner to visit her or the baby. It is not recorded who this ex-partner was, no name or other details are provided although it is reported that a photograph was shown to the Ward Security. The reasons for Mother not wanting her ex-partner to visit are not explored or recorded.

The next day, Mother did receive a visit from a male who is recorded as her “partner”. It is not clear if this is the same man who was referred to as her ex-partner the previous day, or someone different. Again, no details are taken or recorded and there is no exploration with mother about whether this is a new partner or a reconciliation with a previous partner.

A new birth home visit was carried out by FNP in 4 December 2019. Mr D was present at this visit. There is no record as to whether it was understood at this visit if Mr D and Mother were currently in a relationship, whether he was the ex-partner that she did not want to visit hospital, or whether he was the man who had in fact visited. Given that Mother had had recent relationships with both Mr D and Mr F and had separated and reconciled with them both on several occasions, this lack of clarity means it is difficult to understand the family dynamics, risks and safety. The lack of detail recorded about the

male's names also makes it very difficult for professionals to understand the story of the family, the changing nature of relationships and what impact these may have had on the assessment of risk to the children.

Greenwich Children's Social Care had not pursued any further assessment or intervention with the family on the basis that Mother had ended her relationship with Mr D and had a safety plan in place to manage contact between him and the children. By the time of Child DA's birth it was clear that this relationship was not over, and that Mr D was having contact with the children but it does not appear that this triggered any discussion with Children's Social Care or updated assessment.

This confusion is further evidenced by the recording of the next FNP visit in December 2019 where Mr F is present. The notes of this visit suggest that he was the father of Child DA. It is not clear whether professionals working with the family did actually know who the father of Child DA definitively was, and whether this was ever discussed clearly with Mother.

On 26 December 2019, Mother took Child DA to Lewisham A&E with breathing difficulties. Mother informed staff that she had no history of Social Care involvement which was not true. Hospital staff made appropriate checks with Greenwich CSC to clarify that Mother was in fact known to them. She also told staff that the father of Child DA should not be allowed to visit but again it is not clear if the name and details of Child DA's father were recorded clearly or the reasons for her not wanting him to visit.

Given that both Mr F and Mr D had been present at recent home visits, the fact that Mother was now reporting that she did not want Child DA's father to visit Child DA should have prompted more professional curiosity about who exactly she was referring to, and why she did not want him to have contact with Child DA.

At the time of Child DA being admitted to hospital on 19 March 2020 following the serious incident, Mother was in a relationship with a new partner, Mr H. There is however no record that FNP met Mr H or were aware of this relationship.

Understanding and analysing impact of family history of trauma, and inter-agency communication about family history and associated risks:

Mother, Child DA, Child K and Child L moved between Lewisham and Greenwich on several occasions. There is information in the Chronologies from FNP as well as Children's Social Care to indicate that professionals understood that Mother and the children were living with Maternal Grandmother at various points and that she was part of Mother's support network.

What is less clear, is how much was known by these agencies, and in particular by the individual practitioners working with the family, about Maternal Grandmother's own parenting history and the reasons for her children (Child M and Child N) being the subject of Child Protection Planning and safeguarding interventions by Lewisham CSC.

The assessment that was carried out by Lewisham CSC in 2019 has as its focus, the possible risk posed by Mr D in light of the information held by Bexley CSC and reported by Mother. Whilst it was appropriate to focus on this as the reason for referral, the assessment contains minimal information regarding Maternal Grandmother's parenting and the impact this might have had on Mother's parenting capacity and ability to recognise risk and safety in her own relationships. This lack of detail in the assessment is surprising given that Maternal grandmother's own children were at the time the subject of Child Protection Plans in the Lewisham Family Support & Safeguarding Service and this information would have been readily available to the assessing social worker on Lewisham children's database. Where children are the subjects of a Child Protection Plan, this is immediately evident by way of a "flag" on the child's record which is clearly visible to any Social Worker reading the record.

When it became clear the family were living in Greenwich, Lewisham CSC appropriately sought to refer the case and this was accepted. The referral however contained relatively brief information about the family history as contained in the social work assessment.

Greenwich MASH acknowledged the referral from Lewisham on 21 August 2019 with the outcome of signposting to Early Help Services.

Records provided to this Review by South London and Maudsley NHS Foundation Trust [SLAM] refer to the Maternal Grandmother presenting to Lewisham Hospital in August 2019 when she was recorded as being 11 days post-partum and reporting feeling suicidal. However, this date may not be accurate as there are no records of children born to her in or around August 2019. This date has not been able to be confirmed. There was however clearly some concern around Maternal Grandmother's mental health which may have impacted on the Mother and extended family but the lack of clarity about this means it is difficult to understand exactly what impact this had.

In any event, following the Maternal Grandmother's presentation, there is no evidence that this was shared with Children's Social Care in respect of Mother, Child K, Child L or Child DA. When professionals learned that Mother and the children were staying with Maternal Grandmother, there is very little evidence of professional curiosity or challenge around this given the concerns for Maternal Grandmother and the care of her own young children.

In December 2019, Lewisham Hospital contacted Greenwich MASH after Mother attended with Bronchitis. Information was shared in light of the fact Mother had self-reported a history of domestic abuse to hospital staff. Information was appropriately shared between agencies from the Lewisham CSC assessment and no further action taken by Greenwich CSC. It is not clear if it was explored with the hospital where Mother and the children were currently living in light of the fact she had attended Lewisham Hospital. This may have indicated that the family were living in Lewisham, perhaps with Maternal Grandmother, and might have triggered some professional curiosity had that been known, given the concerns about Maternal Grandmother's own parenting.

Related Wider Learning Opportunities:

Impact of caring for a young baby with Reflux:

In January 2020, Mother sought support from the GP regarding Child DA's reflux. She was prescribed anti-reflux milk and later baby Gaviscon. There is no reference in the GP chronology to any discussion with Mother about how she was managing with the care of DA, and in particular the additional challenges of caring for a baby with reflux, who is likely to be harder to settle, cry more and perhaps be more challenging to feed.

Very limited information provided to fully answer this; the support Mother was receiving from extended family was largely from Maternal Grandmother about whose parenting capacity there were significant safeguarding concerns and resulting CSC intervention.

Ms C when spoken to by the Lead Reviewer felt that she managed the care of her daughters well and didn't think there was any specific additional support she had needed.

Further work is currently ongoing across the partnership around risks associated with crying babies or babies who are harder to care for and it would be helpful for the learning from this review to feed into that where appropriate.

Summary of Findings and Learning

Finding 1: Understanding of the impact of family history:

The Assessment by Children's Social Care contains very little exploration of Mother's experience of being parented and the impact of this on her own parenting and ability to recognise safe relationships.

Maternal Grandmother's parenting history, its impact on Mother and therefore possible concerns about her own parenting were well known by Children's Social Care. There is however minimal evidence that this story of family trauma, parenting concerns and safeguarding concerns travelled with Mother as she became a parent and moved between Local Authorities. The FNP and Health records demonstrate that Mother's support network included Maternal Grandmother but there was little exploration of what this support looked like, how it was utilised or what impact Mother's own experience of parenting may have had.

Mother herself was clear that the impact of her family history was significant and that it did make it harder for her to recognise risks in relationships when she was an adult. It is not clear that the assessments explored this with her in any depth or what impact it had on planning or decision making by agencies.

Learning Recommendation 1: Consideration should be given to exploring family history by way of a genogram or ecomap at the first visit by a new service/professional and this kept on the child's record and referred to frequently and updated where necessary. When the case transfers to a new service/worker this should be referred to and discussed with the family to ensure it remains accurate. Agency records should always include up to date chronologies, which include information about a parents' own childhood experiences. It is appropriate for practitioners to consider whether these childhood experiences are referenced dependent on the type of case or the remit of the work with each particular family.

All case holding agencies

Finding 2. Lack of professional curiosity about fathers and male partners in the family: Throughout the records of agencies working with the family, there is a lack of clarity, detail and significant confusion about who Mother was in a relationship with at a particular time, and in particular who the father of Child DA was. Mother was in frequent contact with both Mr F and Mr D and despite often telling professionals that she did not want her partner or ex-partner to visit, it is not at all clear who she was referring to on each occasion. It may have been that the individual practitioner Mother spoke to each time had a clear understanding of who Mother was referring to, but this was never recorded and information was not passed between professionals or agencies. This meant that there was no shared understanding of who the significant male adults were in the children's lives, what role they played, and what impact they had on Mother's parenting capacity as well as any possible risk to the children. At the time of the serious incident, Mother was in a new relationship with Mr H but very little information is recorded about him on the records of FNP who were working with Mother at the time.

Mother has clarified, after reading this report, that she has only had three partners; two of which are the fathers of her children and the third being Mr H.

There are numerous occasions where Mother herself raising concerns about her male partners. She seeks information from Children's Social Care about their history, and on more than one occasion tells professionals she does not want an ex-partner to visit or have contact with the children. The fact that Mother was raising these concerns herself should have prompted greater curiosity as to what was happening in these relationships, what the impact on the children was and a greater understanding of what risks were posed, if any.

It may be useful for agencies to give consideration to a model of assessment which prompts this professional curiosity. It is generally agreed that professional curiosity is important but in order to be curious and questioning, professionals benefit from prompts to help them think about how to ask the right questions of the right people at the right time. Steve Farnfield's model of assessment is one which gives particular attention to curiosity about the parental relationship. This would help enable professional curiosity.

Learning Recommendation 2: Names and details of fathers (and other significant adults in the child's life) should always be accurately recorded.

Family members should not simply be recorded on case notes/records as "father" or "partner" but rather their full names and dates of birth should be recorded so that there is clarity about who is being referred to. This is particularly important where a Mother's current partner and the father of the children may not be the same person.

In this case, it has been difficult to ascertain which father or male partner is being referred to at various points in the records and indeed on at least one occasion despite Mother raising "red flags" regarding possible risk from a partner, his details are not recorded in the records and so staff attempting to manage risk or put safeguards in place were unable to do so. Where a parent changes the detail of her partner on the records, the reasons for this should be recorded clearly by the professional.

Agencies should give some consideration to models of working with support and prompt practitioners to develop and enable professional curiosity. One suggested model is that of Steve Farnham, however each agency may wish to consider this in the context of their own working model.

All agencies.

Finding 3: There was not a clear outcome or recommended Plan following the Lewisham C&F Assessment.

The conclusion of the assessment is somewhat contradictory and there is not a clear application of thresholds. The assessment raises concerns about Mr D's history of violence and appropriately notes the increased risk of domestic abuse in light of Mother being pregnant. The assessment identifies that the children are considered to be children in need under s17 of the Children Act 1989. However, it makes no recommendation that the children should be the subject of a Child in Need Plan or what this plan might look like.

Instead, the outcome of the assessment is that the case should close and be referred to Greenwich CSC. This was an appropriate decision given that the family were living in Greenwich but it was a missed opportunity to detail what services or support the assessing Social Worker considered the family may need in light of her conclusion that they met threshold to be considered children in need. Greenwich MASH came to the conclusion that CIN threshold was not met and that Early Help services were appropriate so this was in fact a different application of threshold from Lewisham CSC. However, because the outcome of the Lewisham Assessment was "closure" and "transfer" this difference of opinion was not fully understood or discussed. This decision making was not in line with pan London procedures on case transfers.

Learning Recommendation 3: If the conclusion of a Child & Family Assessment is to refer to another Borough, the originating Borough's assessment should still include a recommendation as to any future services or intervention and recommendation as to whether threshold is met for Early Help, Child in Need or Child Protection Planning.

It is not sufficient to conclude an assessment with an outcome stating merely that the case is to be transferred to another Borough. This leaves the decision as to what further support or intervention may be required to an agency who have no prior knowledge of the family other than the written records.

Consideration to be given to ensuring that the Assessment notes what the outcome would have been had the family remained in the originating Borough area, e.g. Early Help, Child in Need, Child Protection Plan. The receiving Borough can then determine whether they are in agreement with this outcome and put in place the appropriate plan. In the event that the receiving Borough do not agree with the recommendation from assessment, this should be clearly recorded along with the reasons for this.

Children's Social Care.

Finding 4: It is important to consider the impact of caring for a baby with reflux and the additional demands this may put on a parent already struggling to care for a young baby.

Mother appropriately sought medical advice when Child DA had reflux and was prescribed medication to treat this. However, there is no evidence in the records of any discussion with Mother about how she was managing the emotional impact of caring for a baby with reflux, the impact it might have been having on her sleep or ability to settle. This was perhaps even more important in the context of this being a pregnancy which Mother had given serious consideration to terminating and appropriate concern the FNP worker had raised about Mother not having an emotional connection to the baby at times during the pregnancy.

Although Mother informed the Lead Reviewer that she did not think Child DA's reflux had an impact on how she was cared for, we know from professional learning, experience and research that it can at times make babies harder to settle or care for and this should be taken into consideration by professionals working with the family.

Learning Recommendation 4: Consideration to be given to introducing an expectation that a discussion takes place between parents and health professionals regarding any additional support that is needed when a baby is prescribed medication for reflux.

This is a key opportunity for professionals to explore with a family how they are managing with the demands of caring for a young baby who may be more unsettled, crying more or be harder to care for due to the impact of reflux or digestive difficulties. When prescribing medication, consideration should be given to asking the parent questions about how often baby is crying, what does this feel like for the parent, what support strategies do they have in place to manage this, and what extra support they might need during what is a challenging time. The outcome of this conversation, the support plan and any referrals for additional services or support should be explicitly recorded.

Health Visiting/FNP/GP.

Learning Recommendation 5: Agencies to ensure that a family's housing status is clearly understood and recorded on file, and that any moves between Boroughs are clearly recorded so that any necessary support is put in place quickly.

In undertaking this review it was extremely difficult to work out what the family's housing status was. No one agency appeared to have an understanding of where Ms C and her children's main residence was and what entitlement she had to housing. From discussions with Ms C herself it is clear that in fact she had no housing or tenancy of her own. Although she was never street homeless, the lack of stable and predictable housing can create additional vulnerabilities, particularly for parents of young children. It is important that where parents do not have their own tenancy/address that the reasons for this are recorded by agencies and support to stabilise their housing situation is offered if necessary.

All Agencies.