Tower Hamlets Local Safeguarding Children Board

Executive Summary of the Serious Case Review into the services provided for the infant 'E' and her family during the period December 2005 – February 2007

Prepared for Tower Hamlets LSCB

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Executive Summary of the Serious Case Review into the services provided for young person 'E' and her family during the period December 2005 – February 2007

PREFACE

This report is the Executive Summary of the overview report containing the findings of the Serious Case Review (SCR) conducted by Tower Hamlets Local Safeguarding Children Board (LSCB).

The LSCB SCR draws on the findings of individual management reviews conducted within all of the agencies who provided services for 'E' and her family and the Serious Untoward Incident Investigations carried out by NHS Trusts.

This summary contains the following:

1. An overview of the circumstances leading to the death of 'E' and the decision to establish the SCR.

2. The terms of reference of the review

3. A list of the agencies involved

4. A list of key events

5. An evaluation of the services provided and the main findings of the review

6. A summary of the recommendations made by the individual management reviews and the LSCB.

The recommendations are set out in detail in an action plan. The LSCB is responsible for ensuring that they are implemented by the agencies concerned and by the board itself.

Copies of the SCR overview report and supporting documents are submitted to central government bodies for scrutiny.

1 INTRODUCTION

1.1 This report was produced by Tower Hamlets Safeguarding Children Board (THSCB) in order to fulfil the requirements of Chapter 8 of the *Working Together* guidance.[1] This guidance sets out the arrangements for the local inter-agency review of child protection cases where a child has died and abuse or neglect is considered to be a factor in the death and there are important lessons for the local network of agencies with child protection responsibilities. The detailed current arrangements for review of cases by authorities in London are contained in the London Child Protection Procedures.

1.2 The purpose of the report is to review the involvement of agencies with the child 'E' and her family and to highlight any significant findings with the objective of improving local child protection practice. This is the LSCB overview report on the case which is designed to summarise and complement the findings of the individual agency management reviews.

1.3 The review concerns 'E' who was born on 11 September 2006 and died at a time which cannot be determined precisely in the days prior to 19 February 2007.

1.4 E was found dead along with her mother (a woman aged 29 of Irish traveller background) and her father (a man of 49 of black Caribbean background) in her mother's flat in East London on 19 February 2007. At that time 'E' was living with her mother who had been re-housed separately from E's father following a reported incident of domestic violence in November 2006. She had told professionals that she was having no contact with him. On the morning of 19 February a local authority social worker attempted to visit 'E' and her mother at the flat. There was no reply but there were lights on and the flat appeared to be occupied. The social worker called the police who later forced entry to the flat and found three bodies.

1.5 The post mortem findings were that E's mother had suffered multiple wounds to the chest and neck and that there were minor defence wounds on her left hand. This was clearly consistent with a very violent stabbing and the Coroner's inquest found that she had been unlawfully killed. E's father's body was also found in the flat. Blood stained clothes were found in the flat and small traces of E's mother's blood was found on the body of her father. He had changed his clothes and appeared to have made some attempt to clean up the flat. No external injuries were noted but preliminary findings suggest that E's father had died of a drug overdose. The inquest in relation to his death is still to be held so the cause of death remains to be determined.

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v Department of Health, Home Office, Welsh Office, Department for Education and Employment, *Working Together to safeguard children*,*2006*

1.6 E had no external injuries. The inquest determined that her cause of death was dehydatration, caused by the fact that no one cared for her after her mother had been unlawfully killed.

1.7 Very little is known about the contact which had taken place between E's mother and father in the days before the deaths. From evidence given to the Coroner's inquest it is clear that text messages were sent between them over some period of time and that they had resumed a relationship. It is not possible to know how long this contact had lasted because of technical difficulties with the mobile phones used. However it is clear that it had included a period when E's mother had told her social worker and a police officer that she was not having contact with E's father.

2 SCOPE, FOCUS AND TERMS OF REFERENCE OF THE REVIEW

2.1 The *Working Together* guidance makes the Local Safeguarding Children Board responsible for determining the scope and terms of reference of the review in the light of the circumstances of the particular case. At its meeting on 27 February the LSCB serious cases subcommittee agreed that each agency would provide a chronology of its involvement and a management review detailing the period from its first contact with E's mother in Tower Hamlets. The social services review would also take into account the involvement which other authorities had had with E's mother, prior to her moving to live in Tower Hamlets.

2.2 The LSCB agreed that the terms of reference for the SCR would follow those set out in the London child protection procedures as follows:

- to draw together a full picture of the services provided for 'E' and her family;
- to establish whether there are lessons to be learned from a case about the way in which local professionals and agencies work together to safeguard children
- To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result, and hence improve inter-agency working and better safeguard children

2.3 The review is not an enquiry into the circumstances or causes of E's death. Although the SCR panel has some information on this, determining the cause of those events has been the focus of police investigations and a coroner's inquest. The task of the report is to examine in detail the planning, co-ordination and delivery of services provided to E, her mother Ms 'E' and the other members of the family. Its responsibility is to determine whether everything that could reasonably have been done was done to minimise risk to 'E' - regardless of the specific circumstances in which she died.

3 AGENCIES INVOLVED

3.1 The following agencies (located in Tower Hamlets or members of Tower Hamlet's Safeguarding Children Board) provided services to 'E' and her family within the period covered by the review and have provided reports:

- Tower Hamlets Council Children's Social Services
- Tower Hamlets Council Adults' Social Services
- Tower Hamlets Primary Care Trust
- Barts and the London NHS Trust
- East London and the City University NHS Mental Health Care Trust (ELCMHT)
- Metropolitan Police Service
- Tower Hamlets Council Homeless Persons Services

Social work services for children and families at the Royal London Hospital are provided and managed by Tower Hamlets Council.

3.2 The following agencies from outside Tower Hamlets were also involved and have provided reports or information for the review:

- Camden Primary Care Trust
- Harrow Children's Social Care – who were involved with the half brothers of 'E' who live in Harrow
- Hertfordshire Children, Schools and Families
- Hackney Children's Services – which provides the social work service at the Homerton Hospital
- Sure Start Children's centres in Tower Hamlets

3.3 Prior to the birth of 'E' her mother received services from Addaction, a voluntary organisation commissioned by Tower Hamlets Drug Action Team providing community drugs treatment.

4 OVERALL EVALUATION OF THE SERVICES PROVIDED FOR 'E' AND HER FAMILY

Introduction

This section provides an overview of the principal findings of the Serious Case Review (SCR) in relation to the standards of practice and the services provided for 'E' and her family. It deals with events from the perspective of the

overall provision and co-ordination of services. It must be considered in addition to the more detailed comments on practice set out in individual agency management reviews.

The SCR addresses three overall tasks.

a) The first of is to establish whether there is evidence that the deaths could have been prevented by different professional action? This is not the principal task of the SCR but in a case such as this it is clearly a matter of legitimate public interest that this should be fully evaluated.

b) The second is to establish whether the services to 'E' and her family met the professional standards that should have been expected.

c) The third is to establish what lessons must be learnt from this case so that services can be improved in future and to make relevant practical recommendations so that this can happen.

Could the deaths have been prevented by different professional action?

There have been extensive police enquiries into the deaths of 'E', 'M' and PF. Coroner's inquests have now been concluded in relation to the deaths of 'E' and M. The inquest into the death of PF will be held at a later date. As a result of the police enquiries and the evidence presented at the inquest, some basic facts are known about the deaths. The following are judged to be relevant to this question:

- The verdict of the inquest was that 'E' died of neglect as a result of the unlawful killing of her mother

- It is almost certain that PF killed E's mother and therefore was indirectly responsible for E's death - though no specific finding was made at the inquest on this, no other line of police investigation is being followed.

- The precise causes of PF's death are yet to be determined, but all the indications are that he caused it himself through a drug overdose.

- The review has no evidence at all about PF's motivation or the reasons for his actions.

Very little is presently known about the events which led up to the deaths and as both the key participants are dead these may never be fully understood. In particular:

- It is not clear what contact there was between PF and 'M' from the end of November 2006 onwards when she was moved to new accommodation as a result of her report of domestic violence

- It is known that text messages were exchanged between the two from 18 December onwards

- It is not clear when face to face contact between the couple resumed and how often the couple were in contact

- It is not clear if the contact was with the agreement of both parties or if the contact was coerced or motivated by the need for drugs, money or some other factor.

As there had been contact between the couple as early as 18 December it is clear that 'M' deceived professionals about this because she stated on a number of occasions to the police and her social worker that there was no current contact. Her reasons for lying are impossible to establish.

There is no evidence whatsoever that any of the professionals working with 'E' and her mother knew that her parents were having contact. It is clear that had either the police or children's social services known that E's parents were back in contact with one another they would have been required to respond to protect 'E' and her mother. Exactly what they would have done would have depended on the circumstances but taking into account the swift action that was taken in November to protect 'E' and her mother after the first allegation of domestic violence, it seems almost certain that the immediate response would have been an appropriate.

'E' died because she was in her mother's care at the time of her death and was not looked after following her mother's killing. Professional intervention could only have prevented E's death if she had already been removed from her mother's care before she was murdered. The SCR panel found that even taking into account all the information available now, the SCR found no instance of any failure on the part of 'M' herself to care properly for 'E'. There would have been no grounds to remove 'E' from her mother's care. The panel of course recognised that 'M' exposed her daughter to risk from PF by allowing contact, but it is clear that 'M' and PF deliberately hid this contact from all the professionals dealing with them.

Given all the circumstances described above it is clear that key events leading to E's death took place outside of the knowledge and control of professionals working with the family. The SCR panel therefore does not believe that the deaths would have been prevented by different professional action.

Did the services provided to 'E' and her family meet the standards that should have been expected? What lessons must be learnt from this case so that services can be improved in future?

The task of the SCR is to form a full and balanced overview of the involvement of professionals with the family so as to establish how services need to be improved in the future.

Many of the services which 'E' and her mother needed to meet their needs were provided in an effective and professional fashion. For example:

- the care provided by hospital antenatal services

- the services provided by midwives and health visitors in the community
- health care offered when ‘E’ suffered routine childhood illnesses
- the assessment of M’s history of drug misuse and the provision of basic treatment for her drug misuse
- the response of her social workers and the police service when ‘M’ alleged that she had been the victim of threats and a very serious assault in November 2006
- the steps provided to assess and meet the family’s housing need.

However taking into account all of the information available to it, the shared view of the SCR panel is that there were a number of points when professionals involved should have responded differently and provided a more effective service. Taking the overall pattern of events, these points usually occurred when the professionals involved failed to:

- take a full account of the complex history of the case,
- scratch beneath the surface of the initial positive presentation of events or
- work effectively across agency boundaries both within children’s services and between services for children and services for adults.

The SCR panel believes that different action at these points would have led to a far better shared understanding of the needs of ‘E’ and the risks that she might face and a better co-ordinated and more active intervention to safeguard and promote her welfare. These themes and the specific points in the case history are discussed in more detail in the paragraphs which follow.

Specific comments on practice and professional standards

1. Relevant background family information was not sufficiently taken into account when the main decisions and plans about E’s level of need were made. These relied too heavily on the favourable current impression made by her parents.

2. Social services did not share sufficient information about E’s mother’s parenting of her older children with other agencies. The assessment and plan were made by social services and agreed with the family before the main background information had been obtained from Harrow – an authority that knew E’s mother well - or there had been proper discussion with other agencies.

3. It was known that E’s father was using a false identity but this was not fully investigated, although this was said to have been the source of conflict between E’s parents.

4. The following agencies were involved in providing services during E’s

mother's pregnancy:

- Hospital social work team
- Adults social services care manager
- Specialist Addiction Unit
- Specialist Midwife Substance Misuse
- Health visiting service

Although the correct referrals were made from one team or service to another, there was insufficient co-ordinated assessment and planning. There was very little information sharing after the initial referrals and no meeting was co-ordinated until a few days before E's birth. No active consideration was given to convening a pre-birth child protection conference. The timing of the pre-birth strategy meeting was outside that required by the child protection procedures and because it was so soon before E's birth it could not significantly influence decision making.

5. Adult drug services made no substantial input into planning and decision making prior to E's birth.

6. Key professionals were absent when the strategy meeting was held.

7. Although individual workers offered a high level of service after 'E' was discharged from hospital, the level of communication between agencies was low and both of the allocated social workers failed to coordinate the input of the agencies involved. The supervisors responsible for the two social workers failed to ensure that they carried out this responsibility.

8. Given that it concerned a vulnerable new born infant, the parenting assessment at the Tower Hamlets Family Centre received too low a priority.

9. There was considerable confusion in the professional network (and on the Tower Hamlets records) about who the new social worker was. There is no evidence that the details of the transfer arrangements were notified to professionals who should have known.

10. The immediate response to the report of domestic violence on 29 November was appropriate and all of the agencies involved worked together effectively to provide immediate protection. However the longer term follow up failed to recognise that 'E' might be at a higher level of risk and to ensure that there was enough communication between all the agencies involved over this. The gravity of the attack and the fact that E's mother had not reported it for over three weeks should have caused a re-evaluation of the level of risk to 'E'. There

should have been at least a strategy meeting to consider the incident and its implications in detail.

11. Even after the first incident of domestic violence, the social worker from the Family Support and Child Protection Team took no responsibility for ensuring the overall co-ordination of service provision for 'E'. There is no written record of a plan of intervention to indicate what level of contact there should have been and what the purpose of the intervention was. The activity of the social worker seems to have been entirely a response to events as they unfolded.

12. The social worker had only four face to face contacts with E's mother and 'E' between 24 November and 19 February. Given the circumstances this was too few.

13. Throughout the period when 'E' was living in the community, agencies worked in isolation from one another. There is no evidence of collective working towards shared objectives. In the case of the health service, this meant that the case was treated as a reasonably 'routine' one, because the mother was meeting her daughter's needs and attending appointments as required. In the case of the adult drug agencies it meant that treatment for drug problems was being provided with insufficient reference to the input from social services, so there was no systematic way of sharing information about important developments. Adult social services were only seen as being involved as potential funders of a drug rehabilitation service.

14. When 'E' and her mother were moved back to Tower Hamlets from the hotel in Hackney, there was no consultation about where to rehouse her. Once the move had taken place and the social worker had been informed there was no strategy to ensure that all the key professionals knew about the change of address.

15. No one in the professional network really knew E's mother well or anything about her social network. It is striking that there is no information whatsoever about how and with whom E's mother was planning to spend the Christmas period.

16. When she was admitted to the Royal London Hospital on 15 January the admission appears to have been treated routinely and no information about it was passed to social services staff, even within the hospital.

A number of more general themes emerged throughout the case:

17. All the professionals dealing with E's mother took almost everything she said at face value, seldom challenged it or took the opportunity to verify it with other professionals or the records.

18. There were a number of examples of professionals not being clear what information they were entitled to share or taking a very long time

to share information that should have been provided routinely. For example:

- between hospital social services and housing
- between the SAU and social services
- between social services and health agencies

19. Some professionals paid little attention to the baby and the interactions between the parents and the baby. In particular:

- It is often unclear from the SAU chronology whether the baby was with E's mother during her appointments and if not where she was
- The family support and protection team social worker rarely comments on the child's health, development or on interaction with the parents.

20. The quality of record keeping in a number of agencies was below the standard required. The majority of the agency management reviews have noted instances in which key events, important decisions and the reasons for them or key conversations with service users or other professionals were not recorded.

21. Harrow Children's Social Care were providing services to E's half brothers. There were a number of occasions in the case history when the contact between E, her mother and her sons had implications for the wellbeing of both sets of children. It should have been obvious to social workers in both boroughs and their seniors that regular communication between the two social workers involved was necessary and all parties should have taken the initiative to ensure that it happened.

5 RECOMMENDATIONS

The agency management reviews made recommendations for action in the following areas:

Metropolitan Police Service (MPS)

The report sets out the steps which have been taken to ensure that specific local errors and deviations from established practice are not repeated and the discussions which have taken place with the officers and staff concerned. It makes a specific recommendation in relation to procedures in relation to the management of abandoned calls from mobile phones.

Tower Hamlets Children's Social Care

The report makes recommendations for action in relation to the following:

- practice in relation to checks made with other agencies
- completion and recording of the core assessment
- recording standards
- assessment of the significance of E's mother's care of her previous children and the evaluation of neglect
- the application of the thresholds for Section 47 child protection enquiries
- practice and management of practice around the birth of 'E' including the strategy and discharge meetings
- handover arrangements to the community based social work team
- the practice in relation the observation of children
- the decision not to complete a parenting assessment
- assessment of domestic violence and the mother's pattern of drug misuse
- use of recording systems

Tower Hamlets Council Adult Social Services

The report makes recommendations for action in relation to:

- involvement of adult services workers in pre-birth assessment and planning or in the hospital discharge arrangements for the infant
- mechanisms to co-ordinate discussions between adults and children's services about the funding of a detox. placement for the mother and her infant
- earlier consideration of joint funding.

Barts and the London NHS Trust (BLT)

The report makes recommendations for action in relation to:

- Training about domestic violence
- Procedures for gathering information about domestic violence
- Child protection training arrangements for all maternity, A&E and paediatric staff including consultants and junior doctors

- Ensuring that there are comprehensive records of child protection training received by all staff

- Management of records of discharge and children in need meetings

- Management of the Gateway Midwifery Team

- Arrangements for paediatric cases to be brought to psycho-social meetings

Tower Hamlets Primary Care Trust (PCT)

The report makes recommendations for action in relation to:

- notification to health visitors when responsibility for a patient changes because of change in GP practice

- arrangements for transfer of records via the child health department

- consistent application of the levels of risk and need set out in current risk assessment and management arrangements

- the need to give specific consideration given to ethnicity in relation to the service provided to members of the traveller community

- response to the history of domestic violence

- communication between health visitors and other agencies particularly drug agencies and social services

- training and supervision of temporary staff

- the need for staff to be proactive in communication with other agencies and to seek updates and review of work where there is known to be multi-agency involvement

East London and The City University Mental Health Trust (ELCMHT)

The report makes recommendations on:

- interagency liaison and information sharing – in particular the lack of engagement with formal interagency child protection procedures.

- quality of recording

- the need to include care of pregnancy within care planning process and documentation in drug services

- the need to ensure that the quality of risk assessments and risk management is subject to regular monitoring and audit

- supervision standards
- the need to ensure the systematic review of caseloads within the Specialist Addictions Service.
- training for staff regarding safeguarding children, domestic violence and vulnerable adults
- the need for a shared care protocol within the Specialist Addictions Service for the care of pregnant women who substance misuse.
- the need for a Domestic Abuse Strategy within the ELCMHT.

Tower Hamlets Council Homeless and Housing Advisory Service (HHAS)

The report makes recommendations on:

- the need for more extensive consultation with other agencies when making decisions about very vulnerable clients
- the need to clarify the role of the Homelessness Social Work Service which is already part of HHAS.

Additional Serious Cases Review Panel recommendations

The LSCB is recommended to make copies of the overview report available to both the Tower Hamlets Drugs Action Team and the Tower Hamlets Domestic Violence Forum so that they can consider what action to take in the light of the findings.

The LSCB was asked to consider how to secure a better understanding of domestic violence and drug misuse in services to safeguard children in Tower Hamlets, including reviewing the membership arrangements of the LSCB to include those with expertise in these fields.

The SCR panel also made recommendations in the following areas:

- policy, practice and training in relation to domestic violence
- pre-birth assessment of pregnant drug users
- the involvement of parents in assessments, even when they live away form their children
- review of current information sharing protocols and arrangements to ensure that they are effective
- review of procedures for key workers and lead professionals

- notification of other professionals when a member of staff ceases to be involved with a case

- planning and reviewing services for children in need

- the work and practice of Children's Centre and other early years resources when providing services for children in need