

Haringey Safeguarding Children Board

Serious Case Review

**Conducted under Working Together to Safeguard
Children 2015**

Child R

Overview Report

Lead Reviewer: Moira Murray

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1 Introduction and Background to the Review

- 1.1 On 23 January 2015 Child R, aged 6 months, was at home being cared for by his father. His mother and his half-sister, Sibling 1, were out shopping. At 13:40 police were requested by the London Ambulance Service (LAS) to attend the family home where Child R was in respiratory arrest. He was resuscitated and taken to Hospital 1. On arrival the paediatric team recorded they were concerned that bruising and injuries seen were consistent with physical abuse and traumatic brain injury. Child R underwent a CT scan which revealed bleeding and bruising on his brain. He was transferred to Hospital 3 where he was placed on life support. Police were in attendance. During the evening of 23 January 2015, the Paediatric Registrar informed Haringey Emergency Duty Team by telephone (followed by a written referral) that he was concerned about possible non-accidental injuries that were potentially life threatening. The Paediatric Registrar also contacted the Police Child Abuse Investigation Team and made a statement of his concerns.
- 1.2 Child R underwent a brain stem test and was subsequently pronounced dead on 26 January 2015. Life support was withdrawn on 27 January 2015.
- 1.3 The provisional cause of death was recorded as 'a traumatic head injury'. An initial police investigation was undertaken and on 25 January 2015 Child R's parents were arrested on suspicion of causing grievous bodily harm. Following a review of medical evidence post death, a number of historic fractures were discovered. Medical treatment or assistance had not been sought or received for these injuries. Father was charged with Child R's murder for which he was subsequently convicted. Although Mother was arrested, the evidence presented to the Crown Prosecution Service was deemed insufficient to secure a successful prosecution.
- 1.4 Following the care proceedings brought by Haringey Council in respect of Sibling 1 after Child R's death, the judge concluded that "*there is no shred of evidence to support the notion that the mother was responsible for any of Child R's injuries*" and also absolved mother of any responsibility for having failed to protect Child R from harm.
- 1.5 Child R was living with his parents and Sibling 1 in Haringey when the injuries occurred. There were no concerns about the parental care of Sibling 1. Mother and Father were Eastern European, and both were in their twenties. Father is said to have arrived in the UK in 2007, and Mother in July 2012. During his residence in the UK Father became known to the Metropolitan Police, and Mother was arrested in January 2014, under a European Arrest Warrant. The family had lived in a number of privately rented addresses, in both North and South London and had been in contact with health services in Haringey,

Lambeth and Enfield. The family was first referred to Haringey Children’s Social Care Screening Team by midwifery services at Hospital 1 in July 2014, following Child R’s birth. Mother had been noted to be wearing an electronic monitoring tag on arrival at the hospital in labour. A second referral was made in January 2015; however, Children’s Social Care had no direct involvement with the family prior to Child R’s death.

2 The Review Process

2.1 Haringey LSCB SCR Sub-group took the decision on 4 March 2015 that the circumstances surrounding the death of Child R met the criteria for undertaking a Serious Case Review, under Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 and according to statutory guidance in Working Together 2015.

2.2 The purpose of a SCR is to

- Establish whether there are lessons to be learned from the case about the way individual agencies work individually and together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result;
- Improve individual agency working and inter-agency working and communications in order to better safeguard and promote the welfare of children¹.

2.3 Karen Baggaley, Assistant Director of Quality Assurance & Nursing, Deputy Chair of Haringey LSCB chaired the review. Moira Murray was appointed as Lead Reviewer/Overview Report Author. Moira Murray was independently appointed to undertake the review by Haringey LSCB, and neither she nor the Review Chair had any previous involvement with the case.

2.4 A Panel of Senior Managers from each of the agencies involved was appointed to support the process. Panel members and agencies who provided reports to the review are listed in the Terms of Reference. **The Terms of Reference for the review can be found in Appendix 1**

The Scope of the Review

2.5 **1 August 2012 to 26 January 2015, from probable conception of Child R’s sibling to death of child R.**

2.6 Family Composition

Child R:	Born July 2014	Died: 26.01.15
Mother	Born 1984	
Father:	Born 1988	
Sibling:	Born April 2013	

¹ Working Together to Safeguard Children, 2015

Parallel Processes

2.7 An inquest into Child R's death was opened and adjourned at Barnet Coroner's Court on 5 February 2015. The inquest is now closed following the criminal proceedings.

2.8 Father was convicted of Child R's murder in December 2015 and is currently serving a life sentence.

2.9 Mother remains subject to a European Extradition Warrant (EAW), and proceedings continue to be heard in Westminster Magistrates Court.

2.10 Care Proceedings concerning Sibling 1 were initiated by Haringey Council in the High Court. The outcome of the proceedings was for Sibling 1 to return to Mother's care under a Supervision Order. Haringey Council sought leave to appeal this decision, in particular, the conclusion that mother had not failed to protect Child R and did not pose any risk of harm. The Court of Appeal refused permission to appeal as there was no reasonable chance of success.

2.11 **Effect of the civil proceedings in the High Court on the Serious Case Review Process**

2.12 The finding of fact judgement² in the care proceedings concerning Sibling 1 has been made available (with the permission of the High Court) to this Serious

² **Finding of Fact**

A 'finding of fact' in a judgement by the High Court is a binding **Judgement** of the Court as to which of the disputed facts in a case are true. It is made after evidence has been heard by the Judge. Once such a judgement is made, it is a binding Order of the Court on everyone unless successfully appealed to the Court of Appeal or the Supreme Court. Failure to acknowledge the binding Judgement of finding of fact by, for example a professional involved in a case, when making a recommendation, could be a contempt of Court. So, the professional could **not** say that the finding of fact is wrong, but could say, taking into account the Judgement of finding of fact, the recommendation is made.

Standard of proof

The difference between the standard of proof that a Judge has to find to make any findings of fact in family proceedings and a jury in a criminal case is:

Family Proceedings: the court has to be satisfied on the balance of probabilities before it can make a finding of fact. It is a high standard, but the court only has to be satisfied that some fact, more likely than not, happened.

Criminal Proceedings: the jury has to be satisfied beyond a reasonable doubt that something happened in order to make a finding of guilt. It could not make a finding of guilt if it thought something likely had happened but was not sure. It is a very high standard of proof.

Case Review. Such a judgement of the Court is based upon a legal finding that certain facts (on the balance of probabilities) are true and upon which the Court can then make findings. In this case the High Court found that the evidence of the mother indicated that she was not the perpetrator of the injuries to Child R, that she did not fail to protect him from harm, that she had played a lesser role in the criminal offences for which she had been sentenced in her country of origin, that she had informed her probation officer that she was moving to the UK and that she was a suitable person to care for Sibling 1. After considering the evidence presented, it was the decision of the judge that Mother should be exonerated from any involvement in the injuries which resulted in Child R's death, or any of the historic injuries found.

2.13 The Court of Appeal specifically stated that any appeal of this judgement had no merit and therefore dismissed the Local Authority's application for leave to appeal. The civil proceedings are therefore at an end.

2.14 The judgement of the Court is a binding finding of fact which this Serious Case Review has to recognise and cannot challenge. Unlike the Court, which is required to make findings of fact in a legal judgement, the purpose of the Serious Case Review is, as set out in paragraph 2.2 of this report, to learn lessons and improve multi-agency practice. The Serious Case Review, whilst recognising the binding nature of the Court judgement, necessarily has to look at what information practitioners had at the time when they were making decisions, and whether their decisions were appropriate in the light of that information. For example, this review concludes that a risk assessment should have been undertaken in July 2014 when it was discovered that Mother had been convicted of murder in 2002. Practitioners could not have known then that the judge would later exonerate Mother from any involvement in the injuries inflicted on Child R, after hearing five days of evidence in the civil proceedings. Similarly this review concludes that a more robust risk assessment should have been undertaken regarding the safety of the older sibling of Child R, during the weekend when Child R was in a critical condition, despite the sibling coming to no harm during the course of this weekend.

3 Methodology

3.1 The methodology used for this Serious Case Review has been a blended approach, incorporating: an independent chair and author and IMRs; a commitment to meetings with practitioners and their managers significantly involved with the case.

3.2 Chronologies were sought from known agencies and LSCBs notified. A set-up meeting was convened by the Chair of the Panel to brief IMR authors on the process and to meet with all professionals involved. IMR authors had conversations with all significantly involved practitioners (as far as possible),

using the Terms of Reference as a framework for discussion and to explore if there was anything they would have done differently.

3.3 A Case Group (those directly involved and their managers) meeting was held with IMR authors and panel members in July 2015 to discuss the narrative completed by the Overview Report Author to ensure accuracy. It was anticipated that a further Case Group meeting would be held to discuss the initial analysis and recommendations of the review. However, this was postponed until after completion of the criminal proceedings against Father, to ensure that the proceedings were not compromised. Following the completion of these proceedings, a Case Group meeting was held in February 2016, to discuss emerging themes and learning with practitioners, in order to inform the conclusions of the Panel.

3.4 A Health Overview Report was completed, which has reported on and informed the health elements of the Serious Case Review.

3.5 **Publication** The report was published on 21st July 2016.

4 Narrative of Key Events

Family History

4.1 Little information is known about the background of the parents before their arrival in the UK. Both Mother and Father originate from the same Eastern European country, which is part of the European Union, but arrived in the UK at separate times. It is believed that Father entered the UK in 2007. Father had a better command of English, but reports from those agencies, which came into contact with him, vary as to his degree of language competency. It was unclear to agencies as to how much English Mother spoke or understood. Information has become available to the Serious Case Review that he had fathered a child in his country of origin and that he had two criminal convictions for offences related to theft. This information was not known, however, to professionals dealing with the family during the period under review.

4.2 Between 2008 and 2013 Father came to the attention of the UK Police on ten occasions, resulting in two convictions and two cautions/penalty notices. The offences related in the main to possession of a Class B drug (cannabis), shoplifting and being drunk and abusive. Father was also subject to Police 'stop and search' because of suspicious behaviour. In 2011 he was suspected of being involved in a violent assault on a male adult, but there was insufficient evidence for him to be charged.

4.3 Mother came to the UK sometime after July 2012, although she told a number of professionals that she had entered the country in 2007, the same year as Father arrived. During the course of the period under review agencies became aware

that Mother had a murder conviction, for which she was still on licence when she arrived in the UK.

4.4 Prior to Child R's birth the parents lived at a number of different addresses in North and South London, most of which were multi-occupancy houses.

December 2012 – April 2013

4.5 In December 2012, Mother was living in Enfield and working as a 'nanny', caring for a friend's children. She came to the attention of Police when they were informed by a concerned neighbour that she had gone out leaving a child alone. The fire brigade was called, and Mother stated that she had accidentally locked herself out of the house whilst putting out the rubbish, leaving the child inside. Fire brigade officers felt that Mother was dressed as if she was about to go out and suspicions arose that a child had been left unattended. Police visited the following day, when Mother's account was supported by her employer. The local authority was informed by way of a Merlin³. The facts were uncertain, but no agency took any further action.

4.6 In January 2013, whilst still living in Enfield, Mother registered with a GP surgery, saying she was 12 weeks pregnant. On examination, however, the pregnancy was found to be much further advanced, and the GP made an urgent referral for antenatal care to Hospital 4. Due to Mother's lack of English, the original booking interview on 2 February 2012 was postponed until 13 February, when an interpreter could be present. By this time Mother was 34 weeks pregnant. She informed the midwife that this was her first pregnancy, that she worked as a cleaner and that the child's father was a chef. Mother said the reason for her late booking was because she had only just registered with a GP. On the same day as the booking interview, Police were called to the address in Enfield, where Mother was working as a 'nanny', to assist in her (and Father's) removal from the address. It subsequently became known, as part of the murder investigation, that Mother was already pregnant when she entered the UK and that Father was not the father of the child she was carrying.

4.7 It is unclear as to where the couple lived during the period immediately prior to Mother giving birth. Mother continued to attend antenatal appointments and Sibling 1 was born in April 2013 at Hospital 4. The birth was normal and the baby healthy. Father was present during the birth. Routine post-natal midwifery visits were made, with no concerns being noted.

4.8 An agency Health Visitor undertook a new birth visit on 24 April 2013 to an address in Enfield. Mother explained that this was her cousin's address, where

³ The term is used to describe the computerised notification used by MPS officers to report incidents in which there are concerns about the welfare or safety of a child, internally to the public protection unit. This unit screens all MERLINS and forwards relevant ones to local authority children's services, or more recently to the MASH. It is an expectation within MPS that all officers are familiar with the purpose of and able to complete a MERLIN

she planned to stay for a few weeks, as her cousin was going to help her with the baby. Mother told the Health Visitor that 'her husband', was living in the family home, an address in Enfield. This was a different address to that listed on Mother's Hospital Discharge notes, (which was not the cousin's address).

4.9 No concerns were noted by the Health Visitor about Mother or baby. This was the only home visit made by the Health Visiting Service in Enfield, as no additional health visiting support was deemed necessary. Mother was advised to attend the GP Surgery for any health concerns relating to her or the baby, and was given details of how to contact the Health Visitor and the whereabouts of the local child health clinic.

4.10 There is no evidence to suggest that Mother attended a local baby clinic in Enfield, following the new birth visit.

August 2013 – June 2014

4.11 Sometime between April and August 2013 the family moved to South London. In early August 2013 Mother registered Sibling 1 with a GP Practice in Lambeth. The next day, Sibling 1 was taken by Mother and Father to Hospital 2 A&E with vaginal redness. Treatment with barrier cream was advised and there were no concerns about her presentation. Sibling 1 regularly attended the GP surgery for immunisation appointments during the following months, although there is no record that Mother attended for her post-natal check.

4.12 In October 2013 Father was arrested for being drunk and disorderly at a North London tube station, and was issued with a Fixed Penalty Notice.

4.13 On 13 December 2013 Mother attended the GP surgery. She was 8 weeks pregnant, with an expected delivery date of 20 July 2014. Sibling 1 was 8 months old. Mother was referred to Hospital 2 for a booking appointment.

European Arrest Warrant (EAW):

4.14 On 20 December 2013 the Metropolitan Police Extradition Unit received a EAW from the authorities in Mother's country of origin. Police were informed that Mother, when aged 17, had been convicted of murder and sentenced to 12 years imprisonment after stabbing an acquaintance with a knife, whilst trying to steal a television. Mother, having served 9 years of the sentence, was released on licence in 2011 until December 2014. In 2012 she broke the conditions of the licence, when she left her home country and entered the UK as a fugitive. The EAW was treated as 'high risk' by the Metropolitan Police due to Mother's conviction for murder and the circumstances of the original offence, which had involved drugs and accomplices. The Finding of Fact judgement (discussed at 2.12) accepted that Mother had told her Probation Officer in her home country that she was going to travel to the UK and that this had been agreed. This information was not known to professionals at any point during the time they were

involved with the family, and has not been corroborated independently, for example, by information from the probation officer.

- 4.15 Mother was located by Police on the 8 January 2014, at an address in South London, where she was living with Father and Sibling 1. She was served with a copy of the warrant and appeared at Westminster Magistrates (Extradition) Court the following day. The Court was made aware that Mother was pregnant and had a 9 month old child. Mother was granted bail, with conditions, until 12 February 2014. A security of £1500 was lodged with the court. She was required to live and sleep at her named address, report weekly to Police and was under a night curfew. She was electronically tagged, her passport surrendered and she could not apply for international travel documents. Mother remained on bail throughout the period under review.
- 4.16 Police Officers dealing with Mother's arrest in the Extradition Unit made no Merlin notification.
- 4.17 Following her court appearance, Mother attended antenatal appointments at Hospital 2, with an interpreter, where she was seen on four occasions. When Mother attended a booking appointment for antenatal care on 17 January 2014, she said the pregnancy was unplanned. One follow up antenatal appointment and two ultrasound screening appointments were kept, but Mother did not attend for further antenatal care after March 2014. There is no record that anyone at Hospital 2, or at the GP Surgery in Lambeth, noted that Mother was wearing an electronic monitoring tag. These were the two agencies which had contact with Mother after the electronic tag had been fitted, prior to her arrival in labour at Hospital 1. Given the size and nature of an electronic tag (usually worn on the wrist or ankle) it would be entirely possible that health practitioners may not have seen the tag if it was beneath her clothing and hidden from view, particularly when seeing Mother at appointments not requiring physical examination.
- 4.18 On 15 April 2014, Police were called to the home address in South London, following a dispute involving the parents and their landlord because of unpaid rent. The accommodation consisted of one room. The family was evicted on that day and approached Lambeth Housing out of hours service for assistance. They were accommodated in a Lambeth Housing Homeless hostel for two nights, and on 17 April were provided with temporary housing in a private self-contained studio flat in Haringey, North London.
- 4.19 Mother was arrested on 17 April for breach of curfew, as a result of SERCO, (responsible for monitoring the electronic tagging) not updating their records. No Merlin notification was made by Police.
- 4.20 The family remained living at the Haringey address until Child R's admission to hospital with a traumatic head injury in January 2015. Lambeth Housing records note that a housing assessment was completed in May 2014, which

enabled the parents to start bidding for permanent housing. Bids for a number of properties were made in November 2014 and January 2015, but the family did not have a high enough priority to be shortlisted.

4.21 Although Mother was still living in North London, several contacts were made with the GP surgery in Lambeth South London during June 2014. This was in relation to a request for a 'fit to fly' letter to enable Mother to be extradited. On 6 June Mother attended the surgery and presented a letter, presumed to have been prepared by her solicitor, stating that she required confirmation that she and Sibling 1 were fit to fly to her home country; where they would be accommodated in a mother and baby prison unit. Mother was 35 weeks pregnant. Attached to the letter were copies of emails between the CPS and a solicitor in Mother's home country. The request was dealt with by the surgery's administrative staff. There is no evidence that it was brought to the attention of a clinician, or its significance recognised, given that Mother and Sibling 1 would be committed to prison if extradited. Ten days later a message was left on Mother's mobile phone by the practice administrator, telling her that she would need to see a GP before the letter could be prepared. At the end of June, Father contacted the surgery to say that the letter was no longer needed, which was subsequently confirmed by Mother.

Birth of Child R

4.22 On 21 July 2014, Mother went into labour and was brought by emergency ambulance to the Hospital 1. It was noted that Mother was not booked in for antenatal care or delivery at the hospital.

4.23 On arrival on the Labour Ward, the Midwife undertaking the initial assessment noted that Mother was wearing an electronic monitoring tag. The Safeguarding Midwifery Advisor was contacted and she spoke to Father. He said that the reason for the tag was that Mother had been accused of killing someone in her home country, but she '*didn't do it*'. He went on to say that '*she was in the wrong place at the wrong time*'. Information was sought from Hospital 2 about the tag and Mother's previous antenatal care. Hospital 2 reported that little was known about Mother and there were no safeguarding concerns on their system. The Safeguarding Midwifery Advisor telephoned Haringey Children's Social Care (with Mother's consent) and was advised that the family was not known. Children's Social Care have no record of this call, their first recorded contact being 22 July.

4.24 The account provided by Father of the reasons for the tag prompted the Safeguarding Midwifery Advisor at Hospital 1 to contact Police on the 101 telephone line, whilst Mother was in labour. Information has been provided to the review from a transcript of this telephone conversation, which details the hospital's concern for the safety of the unborn baby and the need to ascertain information as to whether the Mother had a conviction for murder. The call handler made inquiries whilst on the phone and informed the Safeguarding

Midwifery Advisor that Mother was *'someone that we are aware of and we're aware of her bail conditions.'* He then stated that Police would not need to attend the hospital, but would contact Mother at her home address after she had given birth and been discharged.

4.25 Child R was born in the early afternoon of 21 July. The delivery was normal and the baby healthy. The Named Midwife Safeguarding Children spoke to Mother, post labour, via the telephone interpreting service, to ascertain information about the tag. Mother maintained that the tag was due to unpaid debts in the UK, that she had never committed murder in her home country, and that what Father had said *'was a slip of the tongue'*. Maternity staff were still concerned about possible risk to the baby, other patients and staff, and the Named Midwife Safeguarding Children contacted Police again in the evening of 21 July 2014. Records from EMS⁴ provided to the review show that her call was put through to an EMS call handler at 19:04 via the Metropolitan Police. The notes state that the Named Midwife called: *"wanting to know what the subject was on a tag for because they have been told she committed a murder [in her home country] and she is on a children's ward as she has just had a baby. Advised that we can't disclose the details of offences but there was no mention [of] murder or child related crimes. Advise her to call the police for details."* There then followed a call from EMS staff to confirm that Mother was on the maternity unit of Hospital 1.

4.26 On 22 July 2014, whilst Mother and baby were still on the maternity ward, the Safeguarding Midwifery Advisor contacted Police once more via 101, to attempt to ascertain the reason for Mother being tagged. The transcript of the tape reveals that the Safeguarding Midwifery Advisor was still concerned that different accounts had been provided by the parents as to the reason for the tag. She informed the call handler that if Mother had a murder conviction there were concerns for both Mother and baby, and also for hospital staff. The call handler refused to disclose any information about the conviction on the grounds that if he did so it would be in breach of the Data Protection Act. The Safeguarding Midwifery Advisor was told that Police were aware of Mother's whereabouts (i.e. in hospital) and that *'they've advised the tag company that she's there. So there's no concerns.'* Despite the Safeguarding Midwifery Advisor continuing to express concern, the call handler did not divulge any further information, and the Safeguarding Midwifery Advisor stated that she would contact Children's Social Care. The Police 101 call handler passed the contact to the Duty Officer (a Police officer). A decision was made to close the contact. From a Police perspective, information concerning Mother's bail status and conditions were known, but contacts from the Safeguarding Midwifery Advisor were classified as being *'suspicious circumstances'* because of Mother being tagged. It was noted that a call had been received from *'a repeat caller from the same source'*. There was no recognition, however, on the part of Police of the significance of the concerns

⁴ EMS took over monitoring electronic tagging from Serco

raised by the Safeguarding Midwifery Advisor that the reason for Mother being electronically tagged could present a public protection/child protection concern.

4.27 Haringey Children's Social Care received a written referral from Hospital 1 on 22 July, detailing the circumstances of Mother's admission whilst in labour, without booking, and that she was tagged. The referral had been sent electronically, after office hours on 21 July, and picked up on 22 July. A telephone call from the hospital later followed on 22 July, explaining that Mother had delivered and requested clarity as to whether she and baby could be discharged. Advice was given that they should not be discharged until checks had been completed. Checks with Lambeth Children's Social Care confirmed that the family was not known, but the MASH (Multi-Agency Safeguarding Hub) Police representative had identified the involvement of the Metropolitan Police Extradition Unit. The duty social worker then made contact with the police officer responsible for Mother's case. Recording of the conversation with the police officer from the Extradition Unit on the Children's Social Care file confirmed that Mother had been convicted of murder, that she had been arrested on a European Arrest Warrant in the UK in June 2014 (this was an incorrect date), but she could not be extradited because she was heavily pregnant. Details of the offence were given to the duty social worker, who completed the findings section of the MASH information gathering episode, and concluded that although Mother had breached the conditions of being on licence for murder in her home country, "*she appears to have come to the UK and made a life for herself by having children and a partner. The Police are dealing with the extradition. The father of the children is around and there is no suggestion of any child care concerns. No further action.*" The decision taken by the duty social worker was endorsed by two team managers.

4.28 Following this conversation, the duty social worker contacted the Safeguarding Midwifery Advisor to inform her that '*there are no concerns that would prevent mother and baby from being discharged.*' Child R was discharged from Hospital 1 into the care of his parents on 24 July, with community midwifery follow up. A health visitor referral was completed.

4.29 There is a record on the maternity ward notes of a contact from EMS asking for confirmation as to when Mother had been discharged. There is no evidence that any action was taken in response to this request and the hospital safeguarding team had no knowledge of this contact.

July – December 2014

4.30 Child R was discharged on 23 July 2014 to the community midwifery service. Prior to his discharge Mother consented to him receiving a BCG vaccination, (this is offered to infants in the Borough). The vaccination was administered into his left arm. Mother and Child R received two visits from the community midwife during the days following their discharge from hospital, and Mother later attended the postnatal community clinic in August. No concerns were noted. On 24 July,

Mother registered herself, Child R and Sibling 1 with a GP Practice in Haringey. She stated when registering that she had entered the UK in September 2007.

- 4.31 On 25 July Father and Child R attended the Maternity Unit at Hospital 1. Father said he was concerned that Child R was constipated, and was worried about his cord. Child R was seen by a paediatrician and was pronounced well (he passed a large stool whilst being examined). Father was told to feed Child R 3-4 hourly. Enquires made by the Hospital 1 NHS Trust IMR author noted that the community midwife had documented in a home visit the previous day that Child R was well, his bowels had been open three times, bottle feeding on demand and that the cord was clean and dry.

Family involvement with Community Midwifery and Health Visiting Services

- 4.32 A health visitor liaison form had been sent at the time of Child R's discharge and the case was subsequently discussed with Paediatric Liaison Health Visitor at Hospital 1 and the Named Midwife on 27 July 2014. Details of Mother's lack of antenatal care were shared, as were the differing explanations given by the parents as to why she was wearing a tag. Information that a referral had been made to Children's Social Care was also shared. Because of the referral to Children's Social Care, the Locality Manager of the Health Visiting Service had planned to allocate the new birth visit to a substantive member of the health visiting team. However, due to low levels of permanent staff available and the requirement to complete the new birth visit within 14 days, the visit was allocated to a known and experienced agency Health Visitor.
- 4.33 It is recorded in the Community Health Individual Management Review (IMR) that prior to her visit to the family, the agency Health Visitor liaised with the Named Midwife at Hospital 1 about the case. It states in the IMR that the Health Visitor was informed that a social worker had visited the family and liaised with the police. She was also told that the reason for Mother being tagged was because of non-payment of debts in her home country. This discussion is not referred to in the Hospital 1 IMR, and it would appear that there is discrepancy in Health Visiting and Midwifery Services records. The agency Health Visitor arranged for an interpreter to accompany her to the home visit on 31 July 2014.
- 4.34 When the Health Visitor called, Child R was seen with his mother, father and Sibling 1. There were no concerns about the health, growth or development of Child R or his sibling. Mother was observed as responding to the needs of both children appropriately and no parenting capacity issues were identified. Mother said she did not attend antenatal care during the last stages of her pregnancy because the family had moved to North London and Hospital 2 was too far away. She had also suffered a family bereavement and was feeling upset. Mother reiterated that the reason for the tag was due to unpaid debts in her own country and that she was due back in court on 18 August 2014.

- 4.35 Domestic violence was not discussed as Father was present. The health visiting notes described the accommodation as consisting of a one room studio flat where Mother and Sibling 1 slept on a mattress on the floor, the baby in a cot and Father on a two-seater sofa. The room was damp with cockroaches, but clean and well organised despite its cramped nature.
- 4.36 The agency Health Visitor assessed the family's needs as suitable for universal services, but also indicated that they required follow up support due to concerns as to the stability of the family because of Mother's impending court appearance. Given this assessment, the family should have been allocated to a permanent member of the staff, as agency health visitors did not routinely hold cases. The case was put on a 'monthly team planner' for allocation, but remained with the agency Health Visitor.
- 4.37 Following the new birth visit the agency Health Visitor spoke to a social worker in Haringey Children's Services First Response Team, who stated that further checks had been made and no further action was required by Children's Social Care. As suggested by the agency Health Visitor, Mother attended the health centre clinic on 11 August and no concerns were identified. Both parents attended a session at the clinic and watched the 'Coping with Crying' video, in their first language.
- 4.38 A second home visit was arranged, with an interpreter in attendance, for 3 September 2014. The agency Health Visitor had no concerns about Mother's care of the baby or his sibling. Child R was feeding well and arrangements were made for his 6 week check and first immunisations. Mother reported that there was a possibility that she may be returned to her home country, with Child R and his sibling, to serve the remainder of her prison sentence in a Mother and Children Unit. She showed photographs of a prison apartment where they might be housed, and appeared quite relaxed at this potential outcome of her extradition case.
- 4.39 Mother brought Child R for an eight week check with the GP on 16 September 2014. Child R was a large baby at birth, weighing 4.37kg (between the ninety first and ninety-eighth centile). The GP weighed Child R, but did not plot his birth weight and his weight on 16 September, as per expected practice.⁵ However, Child R was clean and well-presented, had been brought for his primary immunisations, had a normal examination and appeared to be thriving; the differentiation in weight would not necessarily have given rise to concern, though should have been noted. During this visit Child R received his first set of immunisations from the Practice Nurse.
- 4.40 The Haringey Agency Health Visitor was, however, concerned a month later, at a clinic appointment on 23 October 2014, when Child R's weight had dropped

⁵ As focused on within GP Level 3 Safeguarding Children training (2014-15) (This issue had arisen in a previous Serious Case Review within the borough).

to below the fiftieth centile. Mother reported that he had had a cold two weeks previously and had not fed well. The Agency Health Visitor was aware of the health visiting protocol, which advised that follow up was required when two centiles were crossed. Given Child R's weight was below the fiftieth centile on 23 October, having been on the ninety-eighth centile three months earlier at birth in July 2014, the Agency Health Visitor advised Mother to take Child R to the GP for a general health check. Mother did not do this. The Family Health Care Centre (GP surgery) was not alerted to the Agency Health Visitor's concern or the advice given to Mother to take Child R to a GP follow-up appointment.

4.41 During the clinic appointment on 23 October, Sibling 1 was weighed and was found to be on the 91st centile.

4.42 Mother attended a re-arranged post-natal appointment on 28 October, after she failed to attend for her six-week post-natal check, with her GP. Mother did attend the weighing clinic with the Health Visitor on 6 November and Child R's weight had stabilised on the 50th centile, which was less concerning.

4.43 As the agency Health Visitor was due to leave her employment, the case was allocated to a Community Staff Nurse (within the Health Visiting Team) on 16 December 2014 to follow up on Child R's weight. The Staff Nurse was new in post. She wrote to the parents and invited them to attend a clinic at the health centre on 7 January 2015. When they did not attend, she spoke to Father on the telephone. He said that they had not received the letter, but reported that Child R was well and he had no concerns about his health and development. The Staff Nurse advised Father to attend the clinic if either parent had concerns and contact details and clinic times were given. The case was then allocated to universal services and there was no further contact with the Health Visiting Team.

Family involvement with the GP Surgery

4.44 The GP surgery received a discharge summary from the Hospital 1, which was scanned into Mother's notes on 11 August 2014. A letter from the hospital Safeguarding Team was also sent to the surgery on 22 August, notifying them that a referral had been made to Children's Social Care. On 27 August Father telephoned the GP surgery requesting a 'fit to fly' letter for the court. The following day, contact was made with what she thought was the MASH by the Health Care Assistant at the Surgery, who had administrative responsibility for safeguarding. The Surgery was concerned that Mother may be leaving the UK for her home country. She was advised that the case was closed and advised to contact the Extradition Unit at Scotland Yard. GP1 contacted the Extradition Unit and explained the Surgery's concerns. Child R's medical notes were flagged as '*child is cause for concern.*'

- 4.45 Both parents arrived at the Surgery on 2 September 2014 requesting a 'fit to fly' letter. GP1 refused the request as she did not know Mother well enough. This was subsequently confirmed by letter to the Mother's solicitor.
- 4.46 Mother missed her postnatal check appointment in September, and the GP asked for the Health Visitor to be contacted to ask Mother to rebook. This she did and was seen on 28 October 2014, when no concerns were noted.
- 4.47 Child R was taken for his eight week check with the GP on 16 September 2014, when the Practice Nurse also administered his first immunisations. This was the only occasion that Child R was seen by a GP. (see paragraph 5.7 below.)
- 4.48 Father's involvement with the Surgery related to him accompanying Mother to appointments (possibly to interpret?). He registered as a patient on 17 September 2014, stating on his registration form that he did not drink alcohol or smoke.
- 4.49 Father accompanied Mother to the Surgery on 1 December 2014 with a benefits advisor, seeking a Sure Start grant form. It was noted that Father became agitated, but the GP did not consider him to be threatening.
- 4.50 Child R had his second immunisations at the Surgery on 11 December 2014. These were administered to his thighs.

Police and Children's Social Care involvement December 2014 – 23 January 2015

- 4.51 On 25 December 2014 Police were called to the family home by a neighbour who was concerned about a heated argument between the parents. Mother was crying, but made no allegation of violence against Father. The couple stated that they had been celebrating Christmas and then argued. The children were recorded as being '*happy and jolly*'. Although the flat was very small, it was noted as being clean and tidy, and there was food in the fridge and cupboards. There were no concerns about the children. It was agreed that Father would remove himself and stay overnight with friends. Police deemed Mother fit enough to look after the children, and the neighbour said she would look in on Mother. Because of the presence of children, Police Officers carried out a domestic violence risk assessment (Merlin), and rated the incident 'green' which was the lowest level.
- 4.52 Due to the Christmas holiday, the Merlin related to the visit on 25 December 2014 did not reach the local authority until 2 January 2015. It detailed Father's criminal history and included Mother's bail conditions. The Screening Manager 1 evaluated the referral, and taking into account a review of the information about Mother in July 2014, decided that a single assessment was required. The Screening Manager also requested that the Metropolitan Police Extradition Unit

send a copy of the European Arrest Warrant to a member of the Haringey MASH Police Protection Desk. The referral was then passed electronically to the First Response Team, with a recommendation that the murder allegation should be reviewed to ascertain which police officer was monitoring Mother in the community, as well as consulting other professionals in contact with the family.

- 4.53 The case was initially dealt with on 2 January 2015 (a Friday) by First Response Team Manager 1, who as Duty Manager was responsible for distributing incoming work requiring assessment. He sent the details of the case to his colleague, First Response Team Manager 2 for allocation and assessment. The assessment teams were particularly busy due to a large number of referrals received during and immediately after the Christmas holiday. These included a significant number of Section 47 enquiries/investigations and Section 17 assessments. As a result, the incoming work was divided between the two First Response Teams.
- 4.54 On Monday, 5 January, a copy of the European Arrest Warrant, which contained the full detail of Mother's offence, dated 19 December 2014, was emailed to Haringey MASH Police Protection Desk. The email and attached EAW was sent by DC1, Extradition Unit. The warrant provided details about the murder and robbery, for which Mother had been convicted in her home country. It documented that Mother had been 17 years old when the crimes were committed and that the events leading to them had been fuelled by alcohol and amphetamine consumption. Although Mother had been with others at the time, she was reported to have played a significant role in the murder. It is important to note that this document had to be obtained from the National Crime Agency (NCA) and would not be searchable or accessible by police officers on ordinary police record systems. Thus, the officer completing the Merlin following the Police visit to the family on 25 December 2014 would have been unaware of these details.
- 4.55 The European Arrest Warrant confirmed that Mother had received a twelve-year prison sentence for these offences, of which she served 9 years, having been released on parole in March 2011. A summons was issued for Mother to be returned to prison; however, it is believed that Mother entered the UK in July 2012. The EAW required her to be extradited in order to serve the remainder of her custodial sentence. The covering email from DC1 stated that when Mother initially appeared at Westminster Magistrates Court in January 2014 she was heavily pregnant, which was presumed to be one of the reasons she '*managed to get bail*'. This supposition was incorrect as Mother was not heavily pregnant in January, but was approximately three months pregnant.
- 4.56 The email, with attachment was immediately passed by the MASH Police Protection Desk to Screening Manager 1, who then forwarded it via email to both First Response Managers, 1 and 2. The email, with attachment, was not uploaded onto the Children's Social Care electronic recording system (MOSAIC)

and there is no evidence that it was read by any of the managers or social workers who considered the case thereafter.

4.57 The First Response Team, managed by Team Manager 2, worked on the duty desk for the week commencing 5 January 2014. No work was undertaken to allocate cases that week and it was not until 12 January that First Response Team Manager 2 convened an allocation meeting. Child R was allocated to First Response Team Social Worker 1 in the team, who was not present at the allocation meeting. The next day, First Response Team Social Worker 1 spoke to First Response Team Manager 2 and questioned the need for the case to be allocated, on the basis that the Merlin was 'Green' and had assessed the children as being well cared for and there were no other new concerns. First Response Team Manager 2 agreed to discuss the case with First Response Team Social Worker in supervision, scheduled for 22 January 2015. Neither had seen the email and attachment detailing the reasons for the European Arrest Warrant.

4.58 The case was discussed in supervision on 22 January. The record of the supervision noted that it was agreed that there had been a non-crime domestic violence argument, where no concerns had been expressed about the care of the children. The murder issue had been addressed by Children's Social Care in July 2014, and "*at this stage it seems there was no reason for an assessment. Team Manager to review the case with a view to close.*" At no point prior to 23 January 2015 was Child R or any other members of the family visited, communicated with, seen or assessed by Haringey Children's Social Care staff.

Events 23 – 26 January 2015: Involvement of Out of Hours Services

4.59 On 23 January 2015 Child R was taken by emergency ambulance to Hospital 1 following a cardiac arrest whilst at home in the care of Father. On arrival at hospital, the paediatric team was concerned that bruising and injuries seen were consistent with physical abuse and traumatic brain injury. Later that day he was transferred to Hospital 3 where his condition was critical. Child R died on 26 January 2015.

4.60 The London Ambulance Service contacted the local authority Emergency Duty Team (EDT) at 17:08 on 23 January 2015. The call was responded to by EDT Social Worker 2 at 17:36 to take details of the referral. The LAS caller explained that they had received a call from Father at 13:34 who reported that Child R was not breathing and was unresponsive. A further call was received by the EDT Social Worker at 19:17 from the Paediatric Registrar, in A&E at Hospital 1, who reported that the cause of Child R's cardiac arrest had not been established and that he was being transferred to Hospital 3. Paediatric Registrar Hospital 1 confirmed that he had provided a statement to the Police Child Investigations Team (CAIT). Police records show that Paediatric Registrar Hospital 1 had requested that a member of the CAIT attend the hospital, as only uniform officers were present at the time. EDT Social Worker 2 then spoke with DC1, CAIT, who was at Hospital 1.

4.61 The EDT Social Worker 2 was told that the medical staff were “*unsure of the cause of his collapse and cannot rule out the possibility of non-accidental injury*”. The Police Homicide Team was attending Hospital 3 to take statements from the parents and the home address would most likely be identified as a crime scene. Child R’s older sibling had accompanied Mother to Hospital 1, but was reported to be with an aunt, at an address unknown to the officer. DC1 CAIT agreed to try and ascertain relevant details of the whereabouts of the older sibling.

4.62 At 20:17 EDT Social Worker 2 updated CSC Senior Manager 1, Tier 3, on call senior manager, of the situation. No specific details of this discussion were recorded on Haringey Children’s Services electronic recording system.

4.63 At 22.14 on 23 January 2015, Paediatric Registrar Hospital 1 sent an Interagency Early Help Form via email to Haringey First Response Team. The form detailed his involvement in the case and stated the following:

“[Child R’s] heart wasn’t beating for a total of at least 50mins (two separate episodes). Myself and Dr (X) have told parents that [Child R] is extremely unwell and is likely to have suffered a large brain injury due to lack of oxygen. We have told them that it is likely that [Child R] will die as a result of his illness.

In summary we have a child who is apparently fit and well normally who was found in cardiac arrest by parents. He was resuscitated but has a poor prognosis. We are unsure as to the cause of his collapse and cannot rule out the possibility of NAI”.

4.64 The referral email was not seen by anyone from the EDT, as out of hours social workers have no access to the First Response inbox. The information would not have been seen until Monday morning, 26 January 2015, when it would have been accessed by the First Response Team administrator.

4.65 Throughout the night and early hours of 24 January 2015 there were a number of calls between the EDT Social Worker 2, officers from the CAIT, Police Homicide Team and Hospital 3 staff. The purpose of the calls was to share information held by Children’s Social Care about the family and for updates on Child R’s condition, which remained critical.

4.66 On 24 January at 03:11 hours, an acting Detective Inspector from CAIT reviewed the investigation and arranged for a welfare check to be undertaken of the address where Sibling 1 had been accommodated with relatives. A CAIT officer attended the address where Sibling 1 was found sleeping. The aunt, when asked for details of her identity, provided the officer with an incorrect date of birth. A check of the Police National Computer (PNC) showed no trace. The CAIT Officer also ascertained from the EDT that the ‘aunt’ was not known to Children’s Social Care. Following this visit, DS1, CAIT informed EDT Social Worker 2 of the whereabouts of Sibling 1. Police stated that Sibling 1 was safe and well and that

neither parent was present at the property. The address and contact telephone number were given to EDT Social Worker 2.

4.67 It subsequently emerged that the 'aunt' and the Paternal Uncle were known to Police. This related to her possession of class B drugs in 2007 and in the same incident a member of the public called Police to report that a female was being hit by her male partner. The aunt denied this allegation and the matter was closed. Because of the false date of birth provided to the officer, this information was not known to Police or to the EDT at the time of the visit.

4.68 On 24 January, EDT Social Worker 2 went off shift at 7:00 hours and updated Children's Social Care (CSC) Tier 3 Manager 1 of the situation. EDT Social Worker 3 took over.

4.69 The review has been informed that the officer in charge of the CAIT during that weekend experienced considerable difficulty in making contact with the EDT. This culminated, on 24 January, in her requesting the intervention of senior police officers in Haringey Borough and the Head of Community Safety and Regulatory Services in Haringey Council, who in turn contacted a senior manager in CSC to request assistance in contacting the EDT. The response from the senior manager was that CSC had been notified of the incident and that any further information should go through the appropriate Emergency Duty system.

4.70 The next significant involvement of EDT came on the afternoon of Sunday, 25 January, when Consultant 1 Hospital 3 contacted EDT Social Worker 4. Consultant 1 Hospital 3 stated that in the absence of any alternative explanation non accidental injury was a likely cause of Child R's injuries. Given this situation, he was concerned for Sibling 1, who was at the hospital with her parents. The Consultant Paediatrician, Hospital 1 also contacted the EDT later that afternoon to express his concerns about the safety and wellbeing of Sibling 1.

4.71 Police in attendance at Hospital 3 were being updated about Child R's condition, and the PICU registrar informed DS2 CAIT that the likely cause was a result of inflicted injuries, however it was not possible to rule out other blood disorders. There was liaison between DI CAIT and the EDT Social Worker 4 as to the appropriateness of Sibling 1 remaining with her parents. However, it is apparent that doctors at Hospital 3 felt unable to say that non-accidental injury was a very real possibility until Sunday evening, when Consultant Paediatric Neurologist Hospital 3 provided a statement to Police that Child R's injuries may be non-accidental. It was at that point that the parents were arrested and Police then took Power of Protection in respect of Sibling 1.

4.72 A foster placement was found for Sibling 1 from a list of emergency placements and arranged by the EDT. Sibling 1 was taken to the foster home by

Police as the EDT had no resources to assist with transport. CSC Senior Manager 1 was updated of the continuing situation.

4.73 By late evening of 25 January, EDT Social Worker 2 was back on shift and was told by Camden EDT that Hospital 3 staff had unsuccessfully been trying to contact Haringey EDT. EDT Team Manager has scrutinised the record of calls made to the EDT at that time and can find no trace of a call from Hospital 3. Hospital 3 records show that staff from the Paediatric Intensive Care Unit (PICU) attempted to call the EDT Social Worker 1/First Response Team Manager 3, who had been the EDT back up social worker on Friday evening, 23 January. It would appear that the calls were made to EDT Social Worker 1/First Response Team Manager mobile phone, as messages were left. When these calls were not returned, Hospital 3 staff contacted Camden EDT, who then contacted Haringey EDT.

4.74 On making contact with the PICU Sister at Hospital 3, EDT Social Worker 2 was informed that Child R was due to undergo brain stem testing at 10 am the next day, Monday 26 January. It was highly likely that the life support would be withdrawn. PICU Sister also told EDT Social Worker 2 that Father had self-harmed in the toilets at Hospital 3 and had been admitted to hospital. He and Mother were likely to be arrested. Having received this information, EDT Social Worker 2 updated CSC Senior Manager 1, Tier 3. No detail of the discussion was recorded.

4.75 At no time during the period from 23 to 25 January 2015 did any agency consider calling a Strategy Meeting/Discussion, to share information and decide on appropriate actions. It was not until Monday, 26 January 2015 that a Strategy Meeting was convened by EDT Social Worker 1/First Response Team Manager 3 in her substantive role as First Response Team Manager. CSC Senior Manager 1, Tier 3, chaired the meeting. Child R died later that day.

5 Voice of the Children: the children's experience of living in the family

5.1 As is evident from the narrative, the children had limited contact with professionals, and thus little is known about their experience of living in the family. Information has, however, come to light during the course of the criminal proceedings pertaining to Child R's death, which has provided some insight into the home environment and the experiences of Child R and Sibling 1 whilst living with the parents.

5.2 During the period under review, professionals believed, and the couple maintained, that Father had fathered both children. However, following Child R's death Mother disclosed that she was already pregnant when she entered the UK in 2012, and that Father was not the father of Sibling 1. It seems however that Father treated Sibling 1 as his own child. Sibling 1 and Child R seemingly had

little interaction with other children, as there is no documentation to indicate that either attended a children's centre, pre-school playgroup or parent and baby group. Given Mother's lack of English (and fugitive status) this is perhaps unsurprising. Although the couple did enquire about a Sure Start Children's Centre at the GP Surgery, there is no evidence that this inquiry was pursued.

5.3 Although Mother did not regularly attend health clinics for the children to be weighed, she did take Child R and Sibling 1 for their immunisations. However, the second immunisation for Child R was late, at 20 weeks instead of 12, and he was not taken for his third immunisation.

5.4 From what is known, the family had a transient lifestyle, in the main occupying one roomed accommodation in multi-occupancy houses in North and South London. They were asked to leave at least two addresses, and on one occasion Police were called when they were evicted. Sibling 1 also experienced a short period of homelessness when Mother was pregnant with Child R. Father had relatives in the North London area, and after Mother had given birth to Sibling 1 she stayed with 'a cousin' in North London. Mother said this was so that she could have support after giving birth, but in fact the couple had recently been evicted for non-payment of rent. There is no further information about this relative and little was known by professionals as to what engagement the family had with extended family members. Following Child R's critical injury, Sibling 1 went to stay with an 'aunt', the partner of Child R's paternal uncle, of whom at the time little was known, although Police later discovered that the aunt had a criminal record. When giving evidence at Father's criminal trial, the paternal uncle and his partner stated that they had a close relationship with the family, who lived near to them in North London.

5.5 Following the death of Child R, it emerged during post mortem examination that, in addition to his severe head trauma, he had incurred a series of fractures to his left arm over a period of 4 months prior to the catastrophic head injury. In total there was evidence of at least three episodes of trauma to his left arm, occurring at various times prior to Child R's death, which have been estimated to have occurred as follows:

- 2 – 4 months before death (Between end of September and end of November 2014)
- 3 - 5 weeks before death (Between end of December 2014 and January 2015)
- 3 - 6 days before death (middle of January 2015). This appears to be a re-fracture.

5.6 When considering the timescale of these fractures and the dates when Child R was seen by Health professionals and Police Officers, it is possible that Child R may have been in pain resulting from non-accidental injuries to his left arm.

5.7 Between August and December 2014, Child R was seen as follows by Health professionals:

21/07/2014	Birth of Child R at Hospital 1. Mother requested he had a BCG vaccination. Vaccination administered on 23/07/2014
11/08/2014	Mother took Child R to the health centre clinic to be weighed. No concerns noted.
3/09/2014	Home visit by agency Health Visitor. No concerns noted.
16/09/2014	<p>Child R taken for his 8 week check and was seen by the GP. Child R weight was recorded but not plotted on a centile chart. He was also seen by the Practice Nurse, for his immunisations. The immunisations were administered to his right and left thigh. No concerns were noted about Child R's presentation.</p> <p>This was the only time Child R was seen by a GP at the surgery. It does not fall within the timeframe when non-accidental injuries to Child R may have occurred.</p>
25/09/2014	<p>The GP Surgery contacted the health visiting team to inform them that Mother had not attended for her post-natal check. The Agency Health Visitor contacted the family, and was informed by Father that Mother had made an appointment with the GP.</p> <p>Following this conversation, the Agency Health Visitor made a clinic appointment for 23/10/2014, to see Child R with an interpreter for Mother.</p>
23/10/2014	<p>Child R was taken to the clinic appointment by Mother. Sibling 1 was also in attendance. Child R was clean and well-presented. Child R's birth weight was on the 98th centile, but when weighed at the clinic, Child R's weight was below the fiftieth centile. Mother reported that he had a cold and fever two weeks previously and had not fed well. When a baby's weight crosses two centile spaces it is correct health visiting protocol to refer for medical assessment. The Health Visitor asked Mother to return to the weighing clinic on 6 November 2014 for Child R to be weighed. She was also asked to make an appointment with the GP for Child R to have a general health check.</p> <p>The appointment with the GP was not made, and the GP was not informed by the Health Visitor that Mother had been requested to make one. Because of Mother's criminal history and the possibility of her being deported, Child R had already been flagged in the GP notes as a '<i>child of concern.</i>'</p> <p>The GP surgery was not alerted to the Agency Health Visitor's concern or the advice given to Mother to take Child R to a GP follow-up appointment.</p> <p>This visit falls within the timeframe when non-accidental injuries to Child R may have occurred.</p>
6/11/2014	<p>Child R seen in the health centre clinic. His weight had stabilised on the 50th centile.</p> <p>This visit falls within the timeframe when non-accidental injuries to Child R may have occurred.</p>
11/12/2014	<p>Seen by the Practice Nurse for second set of immunisations. These immunisations were administered to his left and right thigh.</p>

	This visit falls within the timeframe when non-accidental injuries to Child R may have occurred.
25/12/2014	Police Officers were called to the home address by a neighbour concerned about the parents arguing. The children were described as 'happy and jolly'. Code Green Merlin completed. This visit falls within the timeframe when non-accidental injuries to Child R may have occurred.
7/01/2015	Child R was not brought to an appointment with the Staff Nurse at the health centre clinic to be weighed. Father said the appointment letter had not been received. Child R was not seen again by health professionals until an emergency ambulance was called on 23/01/2014. This appointment falls within the timeframe when non-accidental injuries to Child R may have occurred.

5.8 Fractures to pre-mobile babies are often difficult to diagnose even when X-rayed. It would have been highly unlikely that professionals could have recognised that Child R had suffered such injuries, unless he displayed signs of obvious pain/discomfort and had been medically examined at the time. During the course of Father's trial for murder, evidence was given by the paternal uncle and his partner that they had noticed that when they saw the family on New Year's Eve 2014 Child R had difficulty raising his left arm and cried when he did so. During the course of the Care Proceedings hearing in respect of Sibling 1, the court was told that Mother believed this was due to Child R still being in pain from his BCG vaccination, given two days after his birth. From this description, however, it would appear this could have been the fracture identified post mortem, thought to have occurred 3 – 5 weeks before Child R died.

5.9 It is now known that although Child R appeared well cared for, he had been subject to ill-treatment. At the time of his death it became apparent that he had suffered not only a catastrophic head injury, but also multiple fractures, which happened within 3 months of his death. Both parents have maintained Child R was a much loved child, however it is evident that he suffered abuse for much of his short lifetime, for which Father has been found guilty of being the perpetrator.

6 Engagement of the Parents in the Review Process

6.1 Neither parent has been involved in the review. Father is serving a prison sentence following his conviction for murder.

6.2 Both parents were written to on behalf of the LSCB to ascertain whether they wished to participate in the SCR. Mother has responded and said that she does not wish to be involved in the review. No response has been received from Father.

7 Evaluation of the way in which agencies worked together

7.1 This section will evaluate the way in which agencies worked together by referring to the specific Terms of Reference for the review, as well as the requirements concerning Serious Case Reviews, as set down in Working Together to Safeguard Children, 2015.

What did each agency know: about the parents' history and at what stage? About each of the children and at what stage?

7.2 It is believed Father entered the UK in 2007. Prior to the birth of Sibling 1 in April 2013, the only agency known to have had contact with him was the Metropolitan Police. By that time, Father had come to Police attention on at least eight occasions, mainly for shop lifting, possession of cannabis and being drunk and disorderly. In 2011, however, Father was suspected of being involved in a violent assault on an adult, but no charges were brought.

7.3 Mother had first come to the notice of the London Fire Brigade and Police in December 2012, when she would have been approximately five months pregnant. This was in relation to her being locked out of the house, whilst working as a nanny in Enfield. Police informed the local authority of this incident by way of a Merlin, but no further action was deemed necessary by Children's Social Care.

7.4 Father attended Sibling 1's birth; however, little information was available to maternity staff at Hospital 4 about either parent, except that they were from the same Eastern European country, Mother had accessed maternity services late in the pregnancy and Father spoke some English but Mother did not. Following the birth of Sibling 1 there was some limited engagement with Midwifery and Health Visiting Services, but no concerns were apparent.

Bearing in mind the knowledge about the parents, were appropriate risks and needs assessments completed and acted on?

7.5 On 13 December 2013 Mother attended the GP Surgery in South London and was told she was pregnant with Child R. She was referred to Hospital 2. Days later, on 20 December the Metropolitan Police Extradition Unit via the National Crime Agency, received a European Arrest Warrant (EAW) in respect of Mother. Mother was located by Police on 8 January 2014, at the address in South London, which she shared with Father and Sibling 1. Mother appeared at Westminster Magistrates Court the following day.

7.6 All EAW cases are heard at the Westminster Magistrates Court. It would appear that, given Mother's conviction for murder in her home country, and the fact that she had breached the terms of her licence by fleeing to the UK, it was appropriate on the face of it for the authorities in her country of origin to seek a EAW.

7.7 A note of the hearing from the Court file has been made available to the review. It shows that Mother was represented and that the Extradition Judge was made aware that she had been convicted of murdering a person in her home country by stabbing them in the neck. The Court was also told that she had received a 12 year prison sentence, was released on parole but had then breached her parole after committing two further offences (of a dissimilar nature). Mother had a nine month old child and was pregnant with Child R. It was stated that she lived with Father, who was working, and that he supported her and the child. Mother sought to argue that she should not be extradited because it would be a breach of Article 8, Human Rights Act 1998, her right to family life. The argument seemed to be that if deported, she would be separated from her child and partner at a time when she was pregnant. There was no history of Mother offending whilst she had been in the UK. On hearing the application for bail, the Judge decided that bail should be granted, with conditions (as set out at para 4.15). No objection was raised to bail. Police were present at the hearing.

7.8 The Court at this first hearing would normally have set a date for the final Extradition hearing date. It would appear that because Human Rights Act issues were raised, the Court adjourned the matter without setting a final date. There then followed a number of adjournments as the Court and the parties seemed to have been concerned to ensure that a mother and baby unit was available in Mother's home country and whether she and the children would be fit to fly. At the stage of writing this report, there has been no final adjudication on the application for a EAW and Mother remains on bail.

7.9 It is important to note that when granting bail, the Court had to consider the Bail Act 1976 which requires it to consider a number of factors set out in the schedules to the Act. Clearly the Court considered that Mother was a risk but that such risk could be dealt with by way of the conditions imposed. In deciding whether she should be granted bail, the Bail Act 1976 does not specify that the safeguarding of children is a specific consideration to be taken into account. The Children Act 2004 equally does not impose a safeguarding duty under section 11 in respect of the Court or the Crown Prosecution Service (CPS). However, the Bail Act 1976 does require the Court to consider, for example, whether the Defendant may commit an offence while on bail. This latter consideration could be considered relevant to whether, given Mother's history of violence, she was a safeguarding threat to her child or others.

7.10 From the Court notes supplied, it is unclear as to whether this was a matter raised by the Court or the CPS. It would appear that it was not. Although the Court is not subject to a specific requirement under the Children Act 2004, the Police do, however, have a duty under section 11 of the Children Act 2004 to ensure that their functions '*...are discharged having regard to the need to safeguard and promote the welfare of children...*' The Police should therefore

have considered raising this matter, by way of Merlin procedures, when bail was granted.

7.11 It would appear that there is no reason as to why the Court and the CPS should not be subject to a similar duty to ensure that their functions '*....are discharged having regard to the need to safeguard and promote the welfare of children...*'.

7.12 Whether this duty would have prevented the death of Child R is doubtful given that the perpetrator was Father. However, it would have served to put the case into context for Children's Social Care and other agencies to make an assessment of risk, and enabled professionals to identify their responsibilities with greater vigour.

Once agencies were aware of the mother wearing a tag, what enquiries were made and actions taken and were these appropriate?

7.13 It was not until Mother arrived at Hospital 1 in labour with Child R in July 2014 that health professionals became aware that she was being electronically monitored by a tag. The Safeguarding Midwifery Advisor and the Named Midwife for Safeguarding were both alerted. Staff on the maternity unit acted appropriately in trying to ascertain from Father the reasons for the tag and were alarmed when he responded that it was because Mother had been involved in a murder in their home country. Mother then gave a different account as to the reason for the tag. As documented in the narrative section of this report, contact was made with Police via the 101 service. The Named Midwife was also advised to speak with Serco, to ascertain the reason for Mother's tag. Hospital records state that Serco advised that there were '*no concerns regarding adults or children*' and that Serco had '*no information to suggest that they were monitoring [the mother] for a murder*'.

7.14 This information only compounded the limited information and wrong advice, which was given to the Midwifery Safeguarding Advisor by the 101 call handlers who dealt with her calls. Given the serious nature of Mother's conviction, together with the fact that she was a fugitive from her country of origin, the calls should have been given a much higher priority. It is evident from reading the transcript of the two telephone calls between the Safeguarding Midwifery Advisor and the call handlers that her concerns were not sufficiently understood, nor were they given the priority they deserved. The midwifery staff are to be commended for their persistence in trying to ascertain information about the circumstances for Mother being electronically tagged. It may have been that more information could have been elicited if the Named Safeguarding Midwife and the Safeguarding Midwifery Advisor, rather than calling 101 in the first instance, had contacted their colleagues in the Haringey MASH. However, when they did send in a written referral and in their later contact with the Social Worker in the screening team,

similar assurance was given that Mother and baby could be discharged (see below).

7.15 The initial contact from the Safeguarding Midwifery Adviser was dealt with by a member of Children's Social Care Screening Team. The screening team formed part of the Haringey MASH⁶. The Social Worker dealing with the telephone contact advised that Mother and Child R should not be discharged until it had been established that it was safe to do so. Subsequently, when information had been gathered from Police and other agencies, the Social Worker recommended that Mother and baby could be discharged, that there were no safeguarding concerns and no further action was required. The assessment and outcome of the contact was discussed with a manager and authorised (from the records and with no further discussion) by a second manager.

7.16 When considering the possible reasons why a decision was reached by Haringey Children's Social Care MASH not to undertake a fuller assessment of the parents and any risks posed to the children at this time, it is important to note that in March 2013 Haringey Council was made subject to a judgement in the High Court, in what became known as the AB-CD case⁷. This judgement had a profound effect on the sharing of information within MASH teams throughout many local authorities. In that case the High Court had ruled that Haringey Council had acted unlawfully in obtaining information from agencies without parental consent, when there was no evidence that the child was at risk of significant harm. Although the circumstances relating to the referral from Hospital 1 concerning Child R did not fall into the same category of information sharing considered in the AB-CD case, the review has been informed that this judgement significantly diminished the confidence of those staff and managers working in the MASH in their decision making about thresholds and information sharing. This resulted in a significant reduction in the number of cases discussed at MASH decision making meetings. It also led to a lack of certainty amongst staff, and impacted on the engagement of agencies in the MASH. Thus, over time the working culture in the Haringey MASH moved from one characterised by a high level of multi-agency working to one which valued rapid triage of cases by social care on the basis of the referral information, supported by limited information gathering from other agencies.

7.17 A decision was made by the two screening managers that the referral from Hospital 1 was one which did not warrant a MASH episode, i.e. involving a full range of checks. This decision compromised the ability of the local safeguarding partners to research, interpret and determine their own agency's data and intelligence, which in turn was a significant missed opportunity to fully assess any

⁶ Every London local authority agreed in 2011 to form a MASH in the belief that this would provide a more effective and efficient means of making decisions about further assessment and service provision.

⁷ AB and CD v The London Borough of Haringey [2013] EWHC 416 (Admin)

risk that Mother may have posed to Child R and his sibling. Police officers were asked by the managers to undertake a review of intelligence systems to see what information was held and then share it without reporting it on the full MASH paperwork. The Police declined this request, on the grounds that they could only share information in circumstances where cases were being fully processed, and asked for a full MASH episode to be conducted.

7.18 The July 2014 record of the MASH information Gathering Form for the Child R referral does not identify a date for a MASH meeting and does not stipulate which professionals should provide information. This would have been standard procedure in Haringey at the time for collating information to be shared and for the referral to be discussed at the MASH meeting. However, it seems that in this case the screening team managers decided that it was sufficient for a social worker to contact the appropriate Police Officer in the Extradition Unit for information about the reasons for Mother being subject to a EAW, rather than allowing the Police to provide their own data and intelligence. It is unclear exactly how this situation was reached⁸, but as the Children's Social Care IMR author points out it could have been '*a combination of non-compliance, uncertainty about each MASH partner's role and responsibility, additional work pressures and a lack of clarity about MASH protocols.*' Additionally, the review has been informed that there was a high turnover of agency social work staff and managers in the MASH at that time.

7.19 In the event the social worker contacted the Extradition Unit herself, and no further checks were made by the police officers working in the MASH at that time. This was perhaps one of the most significant communications which occurred between the Police and Children's Social Care during the period under review. The screening team social worker contacted the Metropolitan Police Extradition Unit and spoke to the case officer. The social worker made a brief recording of the contact, however the Police Officer made no record. There are inconsistencies in what each professional recalls about this conversation and this is discussed in the Findings Section of the review. The recording of the social worker notes the year of Mother's conviction, the length of her sentence and that she had breached her licence. The recording does not include important information that Mother had been a central instigator of the violence resulting in the murder. It confirms that the mother was heavily pregnant and could not be extradited, and concludes that "*there is no suggestion that she would pose a risk to children*". The Police Extradition Officer has been interviewed about the conclusion reached by the social worker and has stringently denied that he would have made such a risk assessment of Mother.

7.20 The Social Worker concluded her recording, after speaking to the officer, by stating that "*the mother committed this crime as a younger, childless woman. She appears to have come to the UK and made a better life for herself by having children and a partner. The Act of murder appeared to be unintentional and the*

⁸ The two managers have left the employ of Haringey and cannot be contacted.

incident appears to have been borne out of stupidity rather than a cold blooded attack.” This professionally optimistic recording shaped the decision to take no further action at that time. The recording of this telephone conversation was, when compared to the detail of the EAW subsequently received from the Police Extradition Unit, overly optimistic, misleading and falsely reassuring.

7.21 This recording was, however, to be subsequently referred to as the reason for not progressing a child and family assessment. It was referred to again when the Team Managers decided in January 2015 that an assessment was required following receipt of the Merlin concerning the domestic violence incident at Christmas 2014. It is evident that this was a conversation that should have been taking place between the Officer in the Extradition Unit and the Police Public Protection Officer in the MASH. If this had happened, the Police Officer in the MASH would have been in a position to ask for a copy of the warrant and could have asked further questions about why bail had been granted, whether any assessment of risk had been undertaken and why no MERLIN notification had been completed.

7.22 The approach adopted by the Screening Team Manager also meant that no checks were initiated with (for example) Community Health, to ascertain whether health visiting services were being provided to Sibling 1, or with the family GP. In this case it would have established that the family had not registered with a GP in Haringey.

7.23 When the family came to the attention of Children’s Social Care again, in the form of the Merlin concerning the Police visit to the home address on 25 December 2014, the screening manager acted appropriately. She evaluated the referral, including a review of the information provided in July 2014 and taking this into account, she decided that the case should be subject to a children and family assessment. She also requested that the Extradition Unit send a copy of the EAW to a member of the Haringey MASH Police Protection Desk. The referral was then passed electronically to the first response team with a recommendation that the murder allegation should be explored again in order to clarify which police officer was monitoring mother in the community and consult with other professionals having contact with the family. No full MASH episode was initiated and it was assumed that the social worker undertaking the child and family assessment would gather information from other agencies as part of the assessment.

7.24 The action of the Screening Manager displayed an appropriate level of concern that any risks posed by the parents to the children should be further explored. Unfortunately, the information received from the National Crime Agency, Extradition Unit, detailing the circumstances of Mother’s murder conviction, although recognised as important, was not uploaded onto the electronic system, but sent by email. This, together with delay in allocating the case due to pressure of work following the Christmas holiday period, meant that when the case was allocated, crucial information had not been accessed or

assessed, leading the social worker to question her manager as to whether an assessment was appropriate. If a child and family assessment had been undertaken earlier, (i.e. at the time the copy of the EAW was received), it might have provided Children's Social Care with the opportunity to fully explore the parents' history, their parenting skills and the standard of care offered to Child R and Sibling 1, as well as exploring whether the parents' required additional agency support.

7.25 It is also recognised that there were possible missed opportunities during Mother and Child R's limited engagement with the Health Visitor, which may have revealed the injuries to Child R's left arm. It is known, as indicated at 5.7, that there was an occasion when Child R was seen by a Health Visitor in early November 2014, when there may have been fractures to his left arm. It is of note that Child R was not brought to the appointment with the Community Staff Nurse (who was part of the health visiting team) in early January 2015, when once again his left arm may have been injured. This missed appointment was followed up with Father by the Community Staff Nurse, however, when Father said the appointment letter had not been received, and once reassured that all was well, no further appointment was made. It was left to the parents to contact the health clinic for Child R to be weighed. It was a lost opportunity for Child R to be reviewed by a GP, not least because he was flagged as a '*child of concern*' at the surgery, due to Mother's possible impending extradition.

7.26 When considering the action taken by Police and the EDT to protect Sibling 1, following Child R's admission initially to Hospital 1 and then Hospital 3, it is apparent that a Strategy Meeting/Discussion should have been convened during that weekend, as events began to unfold. If this had occurred, information concerning the most likely cause of Child R's injuries could have been fully explored and the appropriateness of Sibling 1's placement with relatives and unsupervised contact with her parents could have been discussed in the light of Child R's injuries.

In view of the parents' limited spoken English were appropriate measures taken to ensure interpreting facilities were used?

7.27 Appropriate arrangements were made by all agencies involved with the parents to ensure that interpreting facilities were used. This is particularly evidenced when Mother gave birth to Sibling 1 at Hospital 4, and when her initial booking appointment was postponed at Hospital 2, when she was pregnant with Child R, until an interpreter could attend. Similarly, midwifery staff at Hospital 1 used interpreting services, as did the agency Health Visitor and the GP Surgeries Mother attended in Lambeth and Haringey. It is known that Father accompanied Mother to the GP Surgery in Haringey on occasions. However, this appears to have been in the main related to issues concerning 'fit to fly' letters and information about Sure Start Centre facilities. When Child R was initially admitted to the PICU at Hospital 3, Father interpreted for Mother; however, the Clinical Site Practitioners who assumed responsibility for Child Protection for out of hours

contacted the telephone interpreting service several times during the course of Child R's admission. At the time of Mother's arrest in January 2014 Police ensured that she had access to Language Line and an interpreter attended at her subsequent court appearances.

Did the family's immigration status have an impact on the child/ren or on the parents' capacity to meet the child/ren's needs?

7.28 Both parents were from the same European country, and although Father spoke English, the extent of Mother's knowledge of English was unclear to agencies. This must have impacted on her isolation, especially after the children were born. As a citizen from a country within the European Union, Father's immigration status was legal. Mother, however, was a fugitive and it can only be presumed that this impacted on her and Father, as parents. Until her arrest in January 2014, both Mother and Father would have experienced a degree of anxiety that Mother's unlawful status in the UK could be discovered at any time. This could have only added pressure on their relationship, and their capacity to meet their children's needs, especially after Child R was born. Mother became pregnant with Child R approximately six months after Sibling 1's birth. At her booking appointment at Hospital 2, Mother told the midwife that the pregnancy was unplanned. The arrival of another child, so soon after the birth of their daughter, would have presented both parents with additional demands. This could only have been exacerbated by their housing situation. The family occupied accommodation in the private rented sector, which consisted in the main of a single room in various multi-occupancy houses.

7.29 Details of the parents' financial situation are not known to the review. It was stated during Father's criminal trial that he worked as a painter in the construction industry, with his brother (Child R's paternal uncle). However, given that the couple had been evicted on two occasions in the past, for non-payment of rent, it is unknown as to whether Father's income was sufficient to meet the financial needs of the family. After their second eviction, the family was classified as homeless whilst living in Lambeth, which resulted in their move to Haringey. The accommodation in which Child R and Sibling 1 lived prior to Child R's death has been described by agencies who visited, as very small, but clean. It was also documented by the agency Health Visitor that it was damp and had cockroaches. The stress of living in such cramped conditions would be difficult enough for most families. However, the additional strain of Mother's impending return to prison, together with the uncertainty of not knowing whether she would be imprisoned in a mother and child unit, could only have increased anxiety levels.

7.30 It is known that the couple argued, as evidenced by the Police being called on Christmas Day 2014. In the course of Father's criminal trial, it emerged that the paternal uncle and his partner were also aware that the couple's relationship was strained. The difficulties the parents experienced in their relationship, as well as

the strain of Mother being subject to extradition proceedings may have also impacted on their capacity to meet the needs of the children.

7.31 In addition, both parents had criminal convictions, Father was a regular cannabis user, and had convictions for being drunk and disorderly. When all of the above elements are taken into consideration, it can be concluded that the parents faced significant pressures when attempting to meet the needs of their children.

Were there any issues in communication and information sharing within and between agencies?

7.32 The review has shown that there were communication and information sharing difficulties within and between agencies, as evidenced at the following instances:

- In February 2013 when Mother was required to leave her employer's address, whilst working as a nanny, Father arrived to collect her belongings. Police were called to prevent a breach of the peace. Mother was 6-7 months pregnant at the time with Sibling 1. Police recorded the incident as a breach of the peace, but no mention was made that Mother was pregnant, and a Merlin was not raised, even though the threshold was met for its completion.
- Mother's first appearance at Westminster Magistrates Court at the Extradition Hearing in January 2014, should have resulted in further inquiries being made with Children's Social Care, given that Mother had a young child and was pregnant. (It is not known whether probation services were in attendance at Court, as already explored above).
- Officers from the Extradition Unit completed a crime report relating to Mother's arrest in the extradition process. A Merlin report should have been created when they arrested her, as she was caring for Sibling 1, aged 8 months. Mother also advised Police that she was pregnant. On both occasions the threshold for a Merlin report was met. If a Merlin report had been completed, these concerns would have been shared with Children's Social Care, highlighting Mother's status as a convicted murderer, residing illegally in the UK, with her daughter and expecting another child. This would have instigated a risk assessment for Sibling 1 and the unborn child.
- In April 2014 Police were called to an address in South London where Mother, Father and Sibling 1 were being evicted for non-payment of rent. It was noted that Mother was pregnant; the family was given emergency housing. Lambeth Housing Department do not appear to have undertaken any assessment of risk posed to the children. Police recorded this dispute on the crime report relating to the extradition proceedings. However, no Merlin was created. If it had been, information would have been shared with Children's Social Care that the family was temporarily homeless due to debt. This could have instigated a risk assessment for Sibling 1 and the unborn child.

- As a result of this eviction, Mother was in breach of her electronic monitoring tag conditions. Serco notified Police of this breach and Mother was subsequently arrested and brought to Westminster Magistrates Court, and bailed with the same conditions. A Merlin report was not created, and therefore no subsequent Children's Social Care assessment took place.
- In July 2014, Midwifery staff contacted Police on the 101 telephone line on two occasions because of concerns that Mother was wearing a tag and may have been a convicted murderer. The calls were dealt with by call handlers and were given a classification code of a) suspicious circumstances, b) contact record and c) repeat caller⁹. Each code could have had a qualifying code of 'child at risk', however this did not happen and safeguarding concerns were not recognised. Instead, once each record had been created, and reviewed by the Duty Officer, it was closed.
- The interpretation of information discussed on the telephone between the Police Officer from the Extradition Unit and the Duty Social Worker on 22 July 2014 (following the contact from the Safeguarding Midwifery Advisor) meant that any risk presented to the children by Mother (or indeed Father) was not fully addressed. This was because the contact was not treated as a referral which required a full MASH investigation/assessment. If this had happened, the full context of Mother's offending and conviction would have been known and if a Section 17/Section 47 investigation had followed, the extent of risk posed to the children could have been appropriately assessed.
- The failure to upload the National Crime Agency's (NCA) Fugitive's Unit report (i.e. the full details of Mother's EAW) when it was received on 5 January 2015, onto Children's Social Care electronic recording system, meant that crucial information contained in this key document was never known or taken into account. This resulted in the case remaining unallocated until after notification was received of Child R's catastrophic brain injury. It is of significant concern to the review that the NCA Fugitive's Unit report had still not been uploaded onto the electronic system at the time the Children's Social Care IMR author was writing her report, and she was required to rely on a hard copy in order to do so.
- On 23 January 2015 Father called the LAS and Child R was found to be in cardiac arrest. It was not until three and a half hours after the call and Child R was in Hospital 1 that the LAS informed Children's Social Care of this event. The hospital did not contact the EDT until a further two hours later. By the time the call was made, the EDT had taken over responsibility for referrals to Children's Social Care. However, at this point decisions had already been

⁹ Calls to Police are audio recorded on a Computer Aided (CAD) Dispatch Record. Each CAD is given a classification code and where appropriate a qualifying code.

taken about arrangements for Sibling 1 to be looked after by the Paternal Uncle's partner. Child R, because of his life threatening condition, was being moved to Hospital 3. Children's Social Care/EDT had not been notified, consulted or involved in any preliminary discussions concerning Child R, Sibling 1, the parents or family members. Had this information been shared more promptly, it is possible that the day time service may have been involved in assessing arrangements for Sibling 1 earlier in the day and may have been able to inform the multi-agency planning and child protection enquiries from the start.

- Consideration that Child R's injuries were possibly the result of NAI was discussed very soon after his arrival at Hospital 1. When he arrived at Hospital 3, the medical record clearly indicates that NAI was considered from the beginning of the admission and in the initial meetings with parents. Safeguarding concerns were expressed by the Children's Acute Transport Service (CATS) who transferred Child R to Hospital 3. The CATS were accompanied by two uniformed Police Officers and an officer from the CAIT. Information provided by Hospital 3 in their statement to this review stated that contact was made with the Haringey EDT about Child R's admission. However, an addendum produced by the Children's Social Care IMR author concerning the involvement of the EDT indicates that although there was information available as early as 19:17 on Friday, 23 January, no discussions appear to have taken place regarding the need to convene a Child Protection Strategy Discussion/Meeting until Monday 26 January when EDT Social Worker 1/First Response Team Manager 3 in her substantive role as a First Response Team Manager contacted the CAIT Police to make these arrangements.
- The Tier 3 Manager, CSC Senior Manager 1 was kept informed of events throughout the weekend. He also alerted CSC Senior Manager 2 to the situation. However, she has told the review that initially she was not overly concerned about Child R for two reasons. Firstly, at that stage (during Friday evening and Saturday) she considered Child R to be an unwell child rather than an abused child. Secondly, she considered CSC Senior Manager 1 to be well placed to deal with any safeguarding concerns if they did arise as he was a suitably qualified and experienced third tier manager. It was not until Sunday, when Father had self-harmed at Hospital 3, that CSC Senior Manager 2 considered that there was possibly more to the original account than she had been given. Evidence has been provided to the review that Paediatric Registrar, Hospital 1 made a telephone call to the EDT Social Worker about his concerns for Child R on the evening of 23 January 2015, and followed this up with a written referral, at 22:14, stating that he "cannot rule out the possibility of NAI". The interagency referral form was sent to the First Response Team inbox, which was not accessed until Monday, 26 January. The need for a clear protocol on how written information is shared out of hours is an outcome of this review, and is discussed further in the

Findings Section. From discussions with the EDT social workers on duty over the period of that weekend, the Lead Reviewer was informed that the Tier 3 Manager was told that this was a case of suspected NAI. However, none of the detail of the discussions between CSC Senior Manager 1, CSC Senior Manager 2 and the EDT social workers were noted by either of these senior managers, nor was their advice to the EDT Social Workers recorded on MOSAIC, the electronic recording system. Information concerning the case was recorded by the EDT social workers on Saturday, 24 January as ‘for information – watching brief only’. This may explain why little action was undertaken by the EDT throughout Saturday, 24 January until Consultant 1 Hospital 3’s call on the afternoon of Sunday, 25 January 2015.

- It is evident that there were communication and information sharing difficulties between Police, the EDT and Hospital 3 over the weekend of Child R’s hospital admission. While the doctor at the Hospital 1 was clear that the most likely diagnosis was non-accidental injury and communicated this to the Police and CSC at the time, it appears that the staff at Hospital 3 felt unable to be so definite. It seems likely that this meant that CSC and the Police did not feel able to act in as timely a manner as appropriate. However, given the initial diagnosis, perhaps they should have been more assertive in their discussions with Hospital 3. It is also apparent that the background history of the relatives with whom Sibling 1 was initially placed was not known at the time, due to misleading information provided to Police by the family.
- It is difficult to understand, given the critical condition of Child R, that action was not taken earlier, on the part of all agencies involved over this weekend, to instigate a Strategy Discussion/Meeting, as set down in statutory Child Protection procedures.¹⁰ This is further discussed in the Findings section of this report.

Were appropriate risk assessments carried out by all agencies following referrals?

7.33 Apart from attempts to ascertain information concerning the reason for Mother being subject to electronic monitoring tagging by midwifery services, before she was discharged home with Child R, there is no evidence that any appropriate risk assessment was undertaken by agencies involved with the family.

7.34 Lambeth Housing accommodated the family in emergency hostel provision and subsequently found them private rented accommodation Haringey, however there was seemingly no risk assessment undertaken.

7.35 The Agency Health Visitor noted on her visit following Child R’s birth that the accommodation in which the family was living was damp and had cockroaches,

¹⁰ Working Together to Safeguard Children, 2013, (at that time); London Child Protection Procedures

but made no comment as to whether any risk was presented to the children living in these conditions.

7.36 The decision by the Extradition Court Judge to grant Mother bail was not based on a risk assessment of safeguarding concerns, but was seemingly influenced by the Human Rights Act, Mother's pregnancy and her need to care for Sibling 1. Appropriate restrictions were put in place when she was granted bail, to ensure that she remained in the UK, which enabled her to care for her children. However, the bail conditions were concerned with monitoring Mother and not with the safety of the children.

Were senior managers involved at points in the case where they should have been?

7.37 The decision taken by the Duty Social Worker in July 2014 to close the contact from the Safeguarding Midwifery Advisor with no further action was reviewed and endorsed by two Managers in the Screening Team, Children's Social Care.

7.38 The second referral to Children's Social Care, following receipt of the Merlin in January 2015 was reviewed by the Screening Team Manager, who made recommendations for appropriate action. This manager comprehensively reviewed the case, and decided that the apparent reassurance recorded on the electronic record in July 2014, about the circumstances of Mother's murder conviction and the information provided by the Merlin relating to a non-crime domestic incident, needed reviewing. Unfortunately, vital subsequent information was not entered onto MOSAIC, the Children's Social Care electronic recording system. This meant that priority was not given to the need to undertake a risk assessment, and the case remained unallocated for several weeks thereafter.

7.39 As discussed at 7.27, Senior Managers were involved during the weekend Child R was critically ill. However, apart from being kept informed of the situation, their involvement was not proactive or directive in managing what was an extremely serious situation concerning a baby who was critically ill as a result of non-accidental injury.

Were there any organisational difficulties being experienced within or between agencies?

7.40 No specific organisational difficulties between agencies have been identified during the course of this review.

7.41 There were however organisational challenges for Children's Social Care. Ofsted inspected Haringey Children's Social Care between May and June 2014 and made an overall judgement that the department 'required improvement'; however, the inspection found that no children were left at risk.

- 7.42 There were operational difficulties in the functioning of the MASH during the period under review, as is manifest in the decision not to initiate a full MASH episode when the referral was first received from Hospital 1 in July 2014.
- 7.43 Children's Social Care had been managing a number of organisational challenges during the period between July 2014 and January 2015. Many of these relate to the instability of the social work workforce including the reliance on agency staff and the high turnover of managers. Of note is that of the four Team Managers involved with the Child R case none were permanent or substantive and two no longer work in Haringey. The Interim Head of Service is also no longer working in Haringey. Only one of the two social workers is permanent. The agency First Response Team Social Worker 1 has now left the employment of Haringey.
- 7.44 The management of service demands, even with the cover arrangements that were in place, during the Christmas 2014 – New Year 2015 leave period, placed pressure on the service at what has been described as a particularly busy period. Although this was a challenging period, all staff commented positively to the review about the level of support that practitioners and managers were willing to offer to one another to help manage the service. Inevitably there were pressure points and this revealed itself in terms of the Team Manager's allocation of this case for assessment, given that the First Response Team Social Worker 1 had a caseload of twenty children including a number of other assessments, cases for presentation to Initial Child Protection Conferences and case closures.
- 7.45 The addendum report provided to the review concerning the involvement of the Haringey EDT during the period of Child R's admission to hospital in January 2015 shows that the EDT had sufficient capacity and expertise to deploy, during what can be described as a relatively quiet weekend, without any obvious competing demands. It is noted, however, that the EDT Social Worker informed Police that she did not have the resources to assist with Sibling 1's placement in the foster home.
- 7.46 The major organisational difficulty experienced at the time by Community Health, which was responsible for health visiting services, was the ability to sustain a fully established health visiting team at the Health Centre where Child R was registered. This resulted in the Locality Manager having considerable difficulty in allocating work appropriately due to the diminished team. This problem had been longstanding for this particular health centre, which covers one of the most deprived parts of the borough and the vast majority of health visitor caseloads have some form of safeguarding concern. This presented staff working at the health centre with a daily challenge to manage workload, access supervision appropriately and have the capacity to assess and act on emerging risks.

- 7.47 The GP practice reported no organisational difficulties, but like the health visiting service the practice was under pressure with a high number of child protection cases, given the demographics of the area the surgery covered.
- 7.48 The appropriate action taken by the Hospital 1 midwifery team indicates that there were no organisational difficulties, given that support was provided by the Safeguarding Team in a timely manner.
- 7.49 There is no indication from information provided in the Metropolitan Police IMR that there were any organisational difficulties during the period under review.

8 Findings/Lessons Learned

- 8.1 Like many hundreds of thousands of people, both parents entered the UK as citizens of the EU. The difference in this case was that Father did so legally, whilst Mother was a convicted murderer and a fugitive from justice in her country of origin. She was able to live in the UK undetected for almost 18 months, during which time she gave birth to one child and became pregnant with another. She was able to do so, it seems, in part due to the parents' ability to attend only the most rudimentary health appointments, despite both Father and Mother coming to the attention of Police on several occasions, to live in various multi-occupancy houses and not to claim housing or state benefits. Yet, even when Mother came to the attention of Police, the family remained unknown to Children's Social Care until she was in labour with Child R in July 2014.
- 8.2 The reasons for this were several, and have been extensively explored in the section of this report which addresses issues of communication and sharing of information within and between agencies, paragraph: 7.33.
- 8.3 It was not until Mother was in labour with Child R in July 2014 that the family came to the attention of Children's Social Care. Midwifery staff and Safeguarding professionals at Hospital 1 had sufficient concern to contact Police when different explanations were given for Mother wearing a tag. The response they received from the Police 101 Service and Serco/EMS was unacceptable and displayed a serious lack of awareness, on the part of these agencies, of the fundamental principles of safeguarding children and adults. The concerns of midwifery staff were serious enough to have warranted the call to be further investigated, instead of which it was closed. This was a missed opportunity.
- 8.4 The review has been informed that this case has significantly impacted on the workings of the Police Extradition Unit and has led to a review of procedures when parents are arrested. All officers in the Unit are now aware of their duty and responsibility to inform Children's Social Care of their involvement, by way of Merlin notification. (see recommendation 10.5)

- 8.5 Although the safeguarding midwives contacted Police 101, with hindsight this may not have been the most appropriate line of enquiry. Subsequently, they did contact Children's Social Care, via the Single Point of Access telephone number. This was followed up with an inter-agency written referral. Mother and baby were allowed to be discharged without an assessment being undertaken by Children's Social Care. This was a missed opportunity for agencies to come together to understand, consider and assess any potential risk posed to two small children by their parents. As the Children's Social Care IMR author points out, recording practice in relation to the agency's contact with the Police Extradition Unit was not clear enough and did not distinguish between what was actually said and any interpretation that was given to this information. The social work record of this exchange makes a number of assumptions and false reassurances about Mother's history of serious violence, her substance misuse, criminality and fugitive status. A copy of the EAW should have been requested at the time, so that the full detail of Mother's conviction and the reasons for her recall to prison could have been appropriately assessed. The decision making which took place was solely reliant on a telephone conversation between an extradition police officer, who was not experienced in dealing with child protection and a social worker who overoptimistically interpreted the information she was being given.
- 8.6 This case has illustrated the importance of a risk assessment to be undertaken in respect of adults who have convictions for murder or serious violence and are, or subsequently become, parents, to determine the nature and level of possible risk this may have on their parenting skills and their capacity to change. The undertaking of such risk assessments is pertinent in all such cases, whether or not the offender is a UK national. The need to maintain professional curiosity on the part of agencies concerning the past history of parents is a lesson learned from this review.
- 8.7 The view that Mother was a suitable carer, without any assessment being undertaken, was one which was adopted throughout by Children's Social Care during their involvement with this family, with the exception of the Team Manager who requested an assessment in January 2015.
- 8.8 Despite Mother's status as a fugitive from justice and a non UK national, with a murder conviction, there was no statutory intervention (apart from Mother's appearance at Extradition Hearings) until after Child R's catastrophic injury. Some elements of information about this family were known to all of the agencies involved in this review. What was missing, however, was a sharing of this information within the context of the MASH, which could have led to an informed risk assessment being undertaken. There appears to have been a misunderstanding on the part of the Safeguarding Midwifery Advisor and the Named Midwife that the initial contact for their concerns about Mother should have been made with the MASH, rather than with the Police via 101. This would seem to indicate that the protocol for MASH referrals had not been appropriately communicated.

8.9 The lack of documentation detailing the specifics of Mother's crime was crucial in determining the actions of Children's Social Care and other agencies. This review has exemplified the importance of detailed information sharing between and within agencies, and for information to be appropriately uploaded onto records. Similarly, the review identifies the need to have a clear protocol and procedure for working within a multi-agency environment such as a MASH.

8.10 There was also confusion as to the status of the referral which was made by the Safeguarding Midwifery Advisor to the Screening Team, as detailed in the Health Overview Report. Some health professionals recorded their belief that the concern raised by the midwifery team '*had been formally considered by the Haringey MASH and others feel it had not been considered within the MASH.*' Confusion persisted when the case was discussed at the Hospital 1 weekly multidisciplinary joint child protection meeting with Haringey Children's Social Care on 31 July 2014. At that meeting the Children's Social Care representative reported that the referral was with the Haringey MASH and allocated to a Social Worker for further screening. This prompted a decision by the meeting to remove the case from those requiring weekly discussion, on the basis that there was an understanding that the referral was being actioned by Children's Social Care. In fact, the referral was closed on 23 July, after enquiries had been completed by the Screening Team. A referral was made to the MASH, but more importantly, it had not prompted a full MASH episode.

8.11 The lack of clear process for initiating a full MASH episode, as well as a breakdown in communication between agencies working within the MASH at the time, led to a dysfunctional situation where there was an absence of coordinated working and professional practice. This resulted in a missed opportunity to fully explore the information which was known about the family, and to gather additional information to undertake a comprehensive assessment. The need for a functional, well managed MASH, in which staff and referring agencies have confidence, is a key finding of this review.

8.12 It is significant to note that since Child R's tragic death Haringey LSCB has put in place a strengthened MASH Strategic Board with a clear improvement action plan, an updated and agreed Information Sharing Agreement and a MASH Operational Group meeting regularly to develop the MASH Operational Protocol and effective practice. Concerns were raised at the Case Group discussion that there was still confusion as to agreed processes for dealing with referrals and interagency working. This matter has been brought to the attention of senior managers in Haringey Children's Social Care and the review has been told that this view is not one which is shared by the majority of staff working in the MASH.

8.13 The fact that Mother was a female convicted of the murder of an adult, when she was a teenager, played a significant part in the way in which she was viewed by Children's Social Care managers and social workers. This was confirmed by

some of the practitioners who attended the case group meetings which took place as part of the Serious Case Review process. Practitioners said that if the convicted murderer had been male, the case would have been viewed differently, just as it would have been if Mother had murdered a child. The fact that Mother had been convicted of murder (even if the full details were not known), and had two young children, should have alerted all agencies that a child and family assessment was a priority.¹¹ This was especially significant given the contradictory accounts given by the parents as to the reason for Mother being electronically tagged. It was immaterial that her victim was an adult. Her murder conviction was sufficient to warrant further investigation. Had an assessment been undertaken at that time, it would have provided an opportunity for Father to be assessed, as well as Mother. The need for practitioners to fully investigate and gather information concerning parents involved in serious crimes of violence is an important lesson learned from this review.

8.14 The pressure on both Children's Social Care and Health Visiting Services has been documented in this report. The demographic makeup of the area in which the family lived during Child R's short life is one of high deprivation. Both agencies were reliant on agency staff and both faced situations where staff held caseloads of high numbers of child protection cases. This placed particular demands on all practitioners, including the GP practice at which Child R was registered and the health clinic where he was taken to be checked and weighed. It is now known to be probable that Child R had suffered non-accidental injury to his left arm on the occasions he was seen by health practitioners from the end of September until early November 2014. These were missed opportunities to identify that he was being abused and/or not being protected by his parents.

8.15 It is acknowledged that the High Court Judgement concerning Sibling 1, which has been made available to this review, exonerated Mother of any involvement in the injuries or failure to protect Child R from harm and decided that Sibling 1 be returned to her care. The CYPS asked for court's permission to appeal the decision. The permission was refused however, the court made a Supervision Order for ten months. Mother's testimony that she believed the pain and discomfort Child R displayed when moving his left arm was due to his BCG vaccination was accepted by the Judge, who found that Father was responsible for these injuries. However, for the purposes of this Serious Case Review, it is essential to document the occasions when Child R was seen by professionals at a time when it would seem highly likely that he had suffered non accidental injury. The review accepts that it is often difficult to recognise fractures in young babies unless an X-ray or CT scan is undertaken. In this case Child R should have been weighed without his nappy at the health clinic, but unless he had displayed pain

¹¹ Had Mother been convicted of such a crime in the UK she would have been subject to monitoring under MAPPA (Multi-agency public protection arrangements.) Such arrangements are in place to ensure the successful management of violent and sexual offenders, and in this case Mother would have come to the notice of CSC once she became pregnant with Sibling 1. <https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2>

or discomfort, practitioners would not have been alerted that anything was untoward. Although Mother gave evidence at the Care Proceedings Hearing that she thought Child R's discomfort in his left arm was a result of his BCG vaccination, no note was made that this was the case by any health professional when he was weighed at the health clinic or when he saw the GP for his eight week check.

8.16 The absence of Police Merlin notifications concerning this family has been documented and commented on in this report. The reliance by Children's Social Care and the EDT on Police assessment of risk is another feature which raises concern. There were opportunities during the review period for Children's Social Care to undertake an appropriate assessment of the family, which were missed, and this is a finding of this review.

8.17 The lack of involvement by the EDT in assessing the suitability of Sibling 1 being placed with the paternal uncle's partner was a result of false reassurance (based on information provided by the aunt at the time) from Police Officers that the placement was acceptable and that Sibling 1 was safe. It is not suggested that Sibling 1 should have been removed from the uncle's address in the early hours of the morning. However, it is significant that the EDT made no assessment at any time during that weekend as to whether the accommodation met the needs of this child and whether the arrangement was suitably safe, given that the parents though most of the time in hospital were possibly spending some time (residing) at the same address.

8.18 The delay in removing Sibling 1 from the care of extended family members was compounded by Police not being told that non-accidental injury was a very real possibility until late on Sunday, 25 January by a Consultant Paediatric Neurologist. However, given medical staff at Hospital 1 had identified from the time of Child R's arrival at the Emergency Department that his injuries were likely to be non-accidental, a Strategy Meeting/Discussion should have been convened as a matter of urgency. Given that Children's Social Care is the lead statutory agency for safeguarding children, it was the responsibility of the EDT and senior managers to coordinate, with Police and medical colleagues, a strategic approach to managing this case. As stated in *Working Together to Safeguard Children, 2015*, it is the responsibility of the local authority to convene a Strategy Meeting/Discussion¹². However, any professional with sufficient concern can request one.

8.19 The review has been informed that pressure of work on the EDT during the weekend of Child R's emergency admission to hospital was not significant. It is, therefore of further concern that no social worker accompanied Sibling 1 to the foster home, when she was made subject to Police Power of Protection. It was

¹²https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf pages 36-37

inappropriate for Police Officers to have taken Sibling 1 to a foster home without a social worker in attendance.

8.20 It is apparent that there was a lack of effective working together between the EDT, Police and medical staff during the weekend of Child R's admission to hospital. Differing accounts have been provided by Police, the EDT and Hospital 3 as to what information was known and shared during this period. The need for appropriately detailed, contemporaneous recording, including plans, actions and desired outcomes, especially where safeguarding children is concerned, is a requirement of good professional practice. This Serious Case Review has highlighted the need for timely and coordinated intervention on the part of practitioners and managers from all agencies in situations where non accidental injury to children is suspected out of normal working hours.

8.21 The review has learnt from information shared at the Case Group discussion that EDT social workers frequently have to rely on using 101 to contact CAIT Police Officers out of hours. This is often time consuming and requests for Police to contact the EDT are not always responded to. The Lead Reviewer has asked the MPS Panel Member about this matter and has been informed that this is not the usual out of hours procedure for contacting MPS CAIT officers. There are designated telephone numbers for contacting CAIT Officers in such circumstances, which Haringey EDT should have available. However, given the concerns raised by EDT staff at the Case Group meeting, a recommendation for this situation to be reviewed and rectified has been included at 10.4.

Good Practice

8.22 There are several examples of good practice in this case, and these are detailed below.

8.23 Whilst it is recognised that it would have been more appropriate for contact to have been made with the MASH in the first instance, the safeguarding midwifery team at Hospital 1 are to be commended for their persistence in attempting to ascertain whether Mother presented any risk to children, patients and staff on the ward. The action of the Safeguarding Midwifery Advisor and the Named Midwife is an example of good practice.

8.24 The GP surgery in Haringey displayed awareness of the importance of safeguarding children by employing a Health Care Assistant to deal specifically with child protection concerns and to bring them to the attention of medical staff in the practice. The persistence of the GP team to ascertain information about Mother and the circumstances of her needing 'fitness to fly' documentation is an example of good practice.

8.25 The fact that doctors from Hospital 1 and Hospital 3 questioned whether arrangements for Sibling 1 were sufficient to safeguard her is an example of good practice.

8.26 The decision by the Screening Team Manager to request a copy of the EAW and to recommend that an assessment be initiated, following receipt of the Merlin in January 2015, is to be commended. It is an example of good practice and demonstrates professional curiosity.

9 Conclusions

9.1 As research findings into Serious Case Reviews¹³ have shown, children who die as the result of parental abuse are often not known or subject to intervention by statutory agencies. There was limited contact with agencies during Child R's short lifetime, and there was no direct contact between the family and Children's Social Care. Given that Father has been convicted of killing his baby son, it cannot be concluded that his death could have been prevented if a risk assessment had been undertaken at the time Mother presented in labour at Hospital 1, or if Merlin notifications had been completed on the occasions the family came to the notice of Police prior to Child R's birth. What can be said is that any risk posed by the parents to their children and their parenting capacity would have been subject to assessment, which may have resulted in the family being offered additional early intervention support, and/or the children being made subject to child protection procedures depending on the outcome of the assessment..

10 Recommendations for consideration by Haringey LSCB

10.1 Seek assurance that the Haringey MASH is functioning as an effective unit:

- which is led by an experienced manager;
- with appropriate levels of engagement from all partner agencies;
- where information is appropriately gathered, shared, assessed;
- where Merlin notifications are reviewed and evaluated;
- that such information is uploaded onto the agreed electronic recording system; and
- that staff are fully aware of their roles and responsibilities in relation to current law and guidance on consent and information sharing.

10.2 Ensure that the revised Haringey MASH protocol is circulated to all partner agencies, so that professionals are fully aware of and conversant with the purpose, function and process of the MASH.

10.3 Seek assurance that when Police are asked by health agencies or Children's Social Care to undertake a welfare check on a family:

¹³ A study of recommendations arising from serious case reviews 2009-2010, Brandon et al

- There is an understanding between the two agencies as to what constitutes a 'welfare check'; and
 - Police Officers are clear as to what is being expected of them when undertaking such checks.
- 10.4 Seek assurance that when clinicians consider that the possible or likely explanation for a child's presentation is that he/she has suffered non accidental injury:
- it is clearly stated to, and understood by partner agencies, in particular children's social care and the police;
 - there is a strategy discussion/meeting so that all information is shared and that plans are made with each party clear of their ongoing responsibilities with the focus on protecting not only the injured child, but also any other children in the family.
- 10.5 Ensure partner agencies are reminded of their responsibilities that when it is evident that a child is likely to have suffered/is at risk of significant harm, a Strategy Meeting/Discussion is convened as a matter of urgency, including where such an incident occurs out of hours.
- 10.6 Undertake a service review of the Out of Hours Service (EDT), to define its remit and responsibilities, including the role of senior managers, to provide reassurance to the Board that there is effective working together between partner agencies, and that the service is 'fit for purpose'.
- 10.7 That this Serious Case Review is brought to the attention of the Ministry of Justice and the Home Office so that:
- the judiciary is made aware of the importance of taking into consideration any safeguarding risks to the children of foreign nationals convicted of serious and violent offences, who are brought before the Extradition Court;
 - Police officers who are present at such court proceedings are reminded of their duty under section 11 of the Children Act 2004 to ensure that their functions '*are discharged having regard to the need to safeguard and promote the welfare of children.....*' by informing Children's Social Care of such cases;
- 10.8 For all Metropolitan Police Service portfolio leads to ensure Every Child Matters (ECM) Policy Training is refreshed¹⁴.

¹⁴ The Metropolitan Police Service has a responsibility to ensure that it is able to meet the needs of children and that all staff have the training, knowledge and skills to identify concerns that may impact on a child's well-being and safety. This will ensure that the children and young people living or visiting London are safe and able to enjoy and achieve in life.

APPENDIX 1

References

Working Together to Safeguard Children, 2013, (at that time); London Child Protection Procedures, 2015

Working Together to Safeguard Children, 2015

<https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-2>

A study of recommendations arising from serious case reviews 2009-2010, Brandon et al

APPENDIX 2

TERMS OF REFERENCE

- 10.9 The scope of the review is from 1st August 2012 to 26th January 2015 from probable conception of Child R's sibling to death of child R.
- 10.10 What did each agency know about the parents' history and at what stage?
- 10.11 What did each agency know about each of the children and at what stage?
- 10.12 Bearing in mind agencies' knowledge about the parents, were appropriate risks and needs assessment completed and acted on?
- 10.13 Once agencies were aware of the mother wearing a tag what enquires were made and actions taken and were these appropriate?
- 10.14 In view of the parents limited spoken English were appropriate measures taken to ensure interpreting facilities were used?
- 10.15 Did the family's immigration status have an impact on the child/ren or on the parents' capacity to meet the child/ren's needs?
- 10.16 Were there any issues in communication and information sharing within and between agencies?
- 10.17 Were appropriate risk assessments carried out by all agencies following referrals?
- 10.18 Were senior managers involved at points in the case where they should have been?
- 10.19 Were there any organisational difficulties being experienced within or between agencies?