Derbyshire
Safeguarding Children
Board

Serious Case Review ADS14

Polly*

Lead reviewer and independent author - Jenny Myers

[25/08/17]

* This report will be published in line with statutory guidance. In order to preserve the anonymity for the child in this family, the author has:
- used initials to represent people
- used a pseudonym for the subject child

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2. Glossary of abbreviations and terms used in the report.

Polly -Subject of the SCR	
M	Mother of Child
BF	Birth Father
SW1	Social Worker 1
SW2	Social Worker 2
B1	Boyfriend 1
B2	Boyfriend 2
MGM	Maternal Grandmother
MGF	Maternal Grandfather
PGM	Paternal Grandmother
HV1	Health Visitor 1
HV2	Health Visitor 2
Cafcass	Children and Family Courts Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Services
DTHFT	Derby Teaching Hospitals NHS Foundation Trust
DSCB	Derbyshire Safeguarding Children Board
MASH	Multi Agency Safeguarding Hub
MARAC	Multi Agency Risk Assessment Conference
ICPC	Initial Child Protection Conference
DCHSFT	Derbyshire Community Health Services NHS Foundation Trust
NAI	Non-Accidental Injury
ALTE	Apparent Life Threatening Event
AD	Assistant Director
LAC	Looked After Child
DCS	Derbyshire Children's Services
SCR	Serious Case Review
ED	Emergency Department
IMR	Independent Management Review
SSCB	Staffordshire Safeguarding Children's Board
BHFT	Burton Hospitals NHS Foundation Trust
CIN	Children in Need Plan
CPP	Child Protection Plan
MHT	Metropolitan Housing Trust Ltd
ToR	Terms of Reference
DCC Legal Services	Derbyshire County Council Legal Services
ICO	Interim Care Order
DHCFT	Derbyshire Healthcare NHS Foundation Trust

3. Introduction

3.1. This overview report summarises the findings of an independently led Serious Case Review (SCR) commissioned by the Chair of Derbyshire Safeguarding Children Board (DSCB). It concerns Polly, described by her family as a beautiful girl with an infectious smile, twinkling eyes and a bubbly personality, a gentle and loving little girl. Polly and her family are from a white British background.

3.2. This (SCR) was conducted in accordance with Government statutory guidance entitled '*Working Together'* [1]following Polly's death on the 1st May 2014.

3.3. Throughout Polly's short life, there was regular multi agency professional involvement. She was placed on a child protection plan (CPP) because of pre-birth concerns about possible neglect in July 2012, and remained on this plan until the commencement of care proceedings in May 2013 when she became the subject of an interim supervision order and then an interim care order. The outcome of these proceedings was a supervision order made in October 2013.

3.4. On May 1st 2014, the local Ambulance Service attended the family home and on arrival found the mother's boyfriend (B2) giving cardiac massage to Polly; she was reported by him to have 'gone floppy' and had stopped breathing. She was taken by ambulance to Queen's Hospital Burton where, after further attempts at resuscitation, she was pronounced dead. The mother (M) and B2 were subsequently arrested and later charged with her murder.

3.5. On the 11th April 2016, M was convicted of murder and child cruelty and her boyfriend (B2) of allowing the death of a child. As a consequence of the court convictions and new information that was given in evidence at the trial, DSCB asked the lead reviewers to complete the overview report taking account of this new information. M subsequently appealed against her conviction and sentence duration. Her conviction was upheld but her sentence was reduced.

3.6. This case has received significant media attention and quite rightly, there is a need to understand more about the quality and effectiveness of multi-agency practice with Polly and her family, leading up to her death. However, it must be remembered that SCR's, as stated in statutory guidance (Working Together 2015, HM) are primarily about learning and improvement, not blame.

3.7. This SCR identifies some key themes for learning and improvement through an appraisal, analysis of practice, in light of what was known at the time, and the subsequent information received following the criminal trial.

[1] Working together to safeguard children, HM Government 2015.

4. Scope of the Review

4.1. The review covers the period from **1st May 2012** until the death of Polly on **1st May 2014.** Other significant information that relates to the review outside of this timeframe is summarised.

4.2. Full terms of reference for the Review can be found in Appendix 1. They aim to assess through the report process what actions and improvements have been made since the SCR was commenced, whether any further practice improvements are necessary and the identification of missed opportunities to clearly recognise and evidence the physical and emotional abuse suffered by Polly, leading up to her death. Information about Polly and the significant injuries she had already suffered that became available following detailed post mortem examination by experts and the report of the consultant paediatrician prepared for the criminal trial have also been considered in this review.

5. Methodology

5.1. Two highly experienced independent reviewers were commissioned to undertake the serious case review; neither had had any previous involvement with DSCB or member agencies.

5.2. Jenny Myers MA AA CQSW was the lead reviewer and independent author of this Overview Report. She is an experienced and accredited SCR author with SCIE (Social Care Institute for Excellence) and has over 30 years' experience of working in the field of child protection across the statutory and voluntary sectors. She has had no previous involvement with the case.

5.3. Daphne Rose RGN RHV MA was the second reviewer, although was not involved in the drafting of the final report. Daphne is a named nurse for safeguarding and has extensive experience of SCR's, having chaired a number reviews and panels, undertaking Welsh Practice Reviews, and authoring numerous Health Individual Management Reports.

5.4. Glenys Johnston OBE, a highly experienced consultant, who had no previous involvement in the case, (although she had undertaken previous SCRs and a Domestic Homicide Review for DSCB and Derbyshire County Council), was appointed as the Independent Chair of the SCR Panel for the second phase of the review.

5.5. Lincolnshire LSCB legal advisor Toni Geraghty provided some external scrutiny of the process and quality assurance of the IMR reports and legal advice to the DSCB in relation to this report.

5.6. A multi-agency SCR Panel established by DSCB supported the review. There were representatives from:

Derbyshire Police
Staffordshire Police
East Midland's Ambulance Service
Derbyshire County Council Children's Services
Staffordshire County Council Children's Social Care
Barnardo's Leaving Care Service
Derbyshire County Council Multi Agency Team
Derbyshire NHS Clinical Commissioning Groups
Derbyshire Community Health Services NHS Foundation Trust

Derbyshire County Council Youth Offending Service
Derbyshire Healthcare Foundation Trust
Burton Hospitals NHS Foundation Trust
Metropolitan Housing Trust Ltd
Stafford and Stoke on Trent Partnership NHS Trust
Derby Teaching Hospital NHS Foundation Trust
Cafcass
Derbyshire County Council Legal Services

5.7. Sources of data. The author and panel members had access to a significant amount of written material both for the first and second phases of this review. This included papers and statements for the trial, conference reports and other reports from the Care Proceedings. After the trial, all key agencies were also asked to submit an independent management review report (IMR) against a template devised by the lead author. In addition, the lead reviewer/s interviewed social worker two (SW2) and the Assistant Director of Early Help and Safeguarding. Two separate meetings were also held, one with the health SCR panel members and one with Derbyshire Children's Services and Derbyshire County Council Legal Services. The recent 'Pathways to Harm, Pathways to Protection: a Triennial analysis of SCRs in England (DfE) 2011-2014' has also informed the thinking of the Overview report author.

5.8. Practitioner involvement. All agencies reviewed their records and provided timelines of significant events and a brief analysis of their involvement; these timelines were then merged to create an inter-agency chronology. This was carefully analysed by the reviewers and the SCR Panel to identify practice and organisational issues to be further explored with the practitioners who had worked with the family, at the practitioner event. This took place in November 2014, facilitated by the lead reviewers and was attended by 24 multi-agency practitioners who had been involved with Polly and her family. Significant information was gained about how it had felt to work with the family and what the professional mind-set and understanding of the situation was at the time. This is reflected in the analysis of practice section of the report.

5.9. Family involvement. Polly's mother (M), birth father (BF), paternal grandmother (PGM) and the maternal grandmother (MGM) were interviewed by the lead reviewers in order to gain their perspective on the effectiveness of the multi-agency support given to Polly and her family. The maternal grandfather (MGF) although invited, chose not to participate directly in the review. B2 was interviewed by the lead reviewer in the latter stages of the review.

6. Brief family background and synopsis of the case

Family Composition -The family is white British as are the significant others.

Immediate family	**Significant others**
Mother to Polly (M)	Boyfriend 1 (B1)
Birth Father to Polly (BF)	Boyfriend 2 (B2)
Maternal grandmother (MGM)	
Maternal grandfather (MGF)	
Paternal grandmother (PGM)	
Brother to M	

6.1. MGM described M's childhood as ‘fairly normal’, but rather dominated by the additional health needs of her father and brother. As a teenager, there were some concerns around her emotional health, and she was referred to CAMHS (Child and Adolescent Mental Health Services) though never took up the offer of support. Other emotional health issues developed which resulted in M being seen by the Crisis Team due to thoughts of ending her own life and self-harm. In June 2010, a discharge letter was sent to her GP and the consultant in CAMHS, stating that she had no evidence of mental illness but was noted to have a history of aggression against others and of self-harm. Further contact with the Crisis Team in June 2010 resulted in their analysis that M may have traits of borderline personality disorder.

6.2. M's parents’ marriage ended during M’s later teenage years and she remained living with her father and brother, though maintained close contact with her mother who moved away with a new partner.

6.3. In 2012 M became pregnant and at the time was living in the converted garage at her father’s house. When the midwife became aware of the pregnancy, she was concerned about M and her unborn baby (Polly) and referred her to the perinatal mental health services. They did not accept the referral, as she was not deemed suitable for services.

6.4. Due to agencies’ concerns in relation to M's history of substance misuse, emotional health issues and potential for violent behaviour towards others, it was agreed at a pre-birth initial child protection conference (ICPC) that the baby would be made subject to a (CPP) at birth.

6.5. By the time Polly was born in July 2012, M's relationship with Polly's father had ended. M was observed over a period of time by professionals in the core group to have attached well to her baby and her care was deemed to be good enough for agencies to begin to consider that the CPP could cease.

6.6. However, professional concern increased early in 2013, as M became involved with a violent partner (not BF) so Polly remained subject to a CPP. Following a reported incident of domestic violence, legal proceedings were initiated in May 2013 when Polly was 10 months old. At the commencement of the care proceedings there was a brief period when Polly and M went to stay with MGM, but this arrangement was unsuccessful and Polly came into local authority foster care'.

6.7. BF was party to the legal proceedings, but following some issues regarding paternity; a DNA test was ordered in June 2013, this confirmed he was the biological father.

6.8. Whilst Polly was in foster care M was seen to have complied with all the expectations of professionals to ensure her child was returned to her care. The outcome of the Care Proceedings in October 2013 was a supervision order. It was agreed by all professional parties, M and BF that the original risk posed had decreased enough to allow Polly to return to M's care, subject to supervision of them in the community.

6.9. In the final care plan the local authority recommended that BF had contact with Polly, once a week for three hours, and this was to be supervised by PGM or M. BF from then on, had regular contact with his child, which eventually included Polly staying overnight and at weekends.

6.10. In October 2013, M started a new relationship with B2 who quite quickly took on a role of caring for Polly and being involved in her everyday life. The extent of this relationship and his role was not shared by M with all professionals working with the family.

6.11. There were a number of medical incidents and minor injuries that involved Polly between January and April 2014, the most significant being alopecia (hair loss) and a suspected febrile convulsion in February 2014. M and Polly, who was now 18 months old, moved out of the supported living arrangements in February 2014 after an eviction notice for damage to the property and began living in a neighbouring county in a rented flat.

6.12. Domestic arguments between M and B2 led to police involvement and a growing sense of unease by professionals about once again the risks to the child and M of domestic violence. This led to a multi-agency risk assessment conference (MARAC) being held on 30th April 2014. The following day Polly died.

7. Concise chronology of significant events: May 2012 – May 2014

Month	Summary
2012	
May	M attended for antenatal care. Team around the Family (TAF) meeting held. Common Assessment Framework (CAF) in place. Referral then made to DCS after additional information was received around M's mental health and history and possible risk for the baby.
June	Information received re violent episode between M and a neighbour. Records note M had a history of anxiety, eating disorder and deliberate self-harm and was referred to CAMHS. Pre-birth Initial Child Protection Conference held. Police report a violent incident between M's 'to be' partner and a previous partner. M disclosed that she was a cannabis user.
July	Core Group meeting held. CPP in place. Polly born at 38 weeks gestation. Routine midwifery care and handover to health visiting services. Further police involvement with M's 'to be' partner.
August	Core Group meeting held. Polly progressing well within developmental milestones. Health Visitor contacts continue. Further Police involvement with M's 'to be' partner in relation to violence and end of his previous relationship. Contact between M and baby's birth father noted.
September	Review Child Protection Conference, Polly remained subject to CPP. Core Group meetings held. Polly developing well. Good maternal bond noted. Relationship between M and BF uncertain.
October	Core Group meeting held. M attends 'Incredible Babies' course. Polly continued to progress well and no concerns expressed re parenting. Concerns raised that M not always available for appointments with Health Visitor.
November	Polly continued to develop well within milestones and no concerns noted in relation to parenting. Interagency work continued.
December	Core Group meeting held. No concerns identified. Polly still progressing well.
2013	
January	Core Group meeting held. Further concerns identified that M not always available for home visits as appointed. Children's Centre involved. Polly continues to thrive. Evidence of appropriate communication between agencies.
February	Incident of domestic abuse at family home between M and B1 attended by the Police but M refused to make a statement. Review Child Protection Conference. Polly remains subject to a CPP though category of concerns is changed.
March	Further incidents of domestic abuse reported between M and B1, evidence this information was appropriately shared across agencies but M appeared not to understand the risks of this to Polly. Baby continued to develop within milestones and good interaction with M continued. Core Group meeting held.

April	A further episode of domestic abuse reported between M and B1. Polly continued to develop well. M again not always in for planned appointments and when seen is identified as being low in mood. Evidence of appropriate information sharing between agencies.
May	Care proceedings initiated and Polly made subject to an interim supervision order. M and baby spend some time with maternal grandmother.
June	Polly made subject to interim care order and placed with foster carers. M did, after her initial opposition, eventually recognise her inability to keep the perpetrator away and agreed she was not in a position to contest the interim care order. M to commence a support group in regard to domestic abuse. Polly continued to thrive.
July	Polly continued to thrive in foster care and developed in accordance with her expected milestones. The viability assessment of BF and MGF, completed during care proceedings, concluded that neither could offer an appropriate environment for Polly to live in on a permanent basis.
August	Review Child Protection Conference held. M engaged well with services. Looked After Children Review held, Polly remained in foster care.
September	Infant remained in foster care, plan of rehabilitation to M agreed by the Court.
October	Care Proceedings concluded. A 12-month supervision order was made to the local authority. Parental responsibility was given to BF and Polly returned to live with M. During the proceedings, all parties agreed that M had made considerable progress in her understanding of the impact of domestic abuse on children. She had attended the Next Steps course and she had finally ended her relationship with B1 (the perpetrator of domestic abuse). Core Group meeting held.
November	Supervision network meeting held, both birth parents present, BF noted to be having regular weekend staying contact at his home with Polly and that this was going well. These arrangements were by mutual agreement. Infant progressing well.
December	SW visit to BF's home. BF reported M does phone sometimes and 'complains' about her current partner, but no suggestion of violence. Polly was progressing well.
2014	
January	M reports a break in at her flat and that her door had been damaged in an argument with her partner (B2). M reports to be low in mood. Child Protection Medical undertaken on Polly due to hair loss (bald patch on head which was confirmed as alopecia). The supervision network meeting identified M has been given 28 days to leave her flat and that her partner was not allowed at the flats.
February	Polly was taken by M to the ED in Queen's Hospital Burton via ambulance following sudden collapse at home and supposedly witnessed fit. When ambulance crew attended they witnessed M's partner (B2) doing chest compressions. Ambulance crew assessed that the infant was showing signs of life but was very unsettled. The Ambulance crew's impression was that of febrile convulsion, Polly was admitted to the Paediatric ward for observation and urine sample, but discharged in the early hours of the following morning. At the end of the month, Staffordshire Children Social Care was informed the family were moving to private rented accommodation in their area. They were informed that Polly was subject to a supervision order.
March	At the beginning of the month, M reported she had separated from her partner. Later in the month, there was Police attendance at the property, following an anonymous call reporting a domestic incident. When the Police arrived, M denied any violence. The Police noted that Polly was at the address and

	appeared well. An initial assessment was undertaken. M did not register Polly with a GP despite advice to do so on a number of occasions. At the end of the month, M self-referred to the ED at Queen's Hospital Burton. Polly had sustained a laceration to her lower lip. History given that the infant had banged her mouth on the side of the bath. Following assessment, the doctor asked for the injury to be reviewed by a senior doctor and Polly was discharged home.
April	Further incidents of domestic abuse reported at the property, which resulted in a referral to the Multi Agency Safeguarding Hub, (MASH), and then onto the Staffordshire MARAC which was held on April 30th. All agreed for the case to be recorded as MARAC high risk due to the risk of domestic abuse for M and for Staffordshire First Response Team to contact Derbyshire Social Services, due to Polly being subject to a supervision order. There was additional concern by professionals that M may now be minimising the level of violence and as such could place her child at risk. A legal planning meeting had taken place on 10th April 2014 with the District Manager, Senior Manager and SW2 present. The discussion concluded that on balance there was sufficient information based on the domestic abuse incident to return to court to ask for an interim care order. SW2 was asked to have papers to the legal department the following week, for filing with the family court so a court date could be allocated. The papers, though drafted by SW2, were not sent to legal services.
May	Polly was taken to the Queen's Hospital Burton by ambulance as she was in cardiac arrest. History taken by nurse that Polly was found by M having blue lips, appeared rigid and was frothing at the mouth. It was documented that B2 initiated cardio pulmonary resuscitation (CPR) and mouth-to-mouth resuscitation. Resuscitation continued in hospital, as per Advanced Paediatric Life Support guidelines. No response to resuscitation. CPR stopped at hospital. Sudden unexpected death in infancy protocol implemented and samples taken.
Post May 2014	On post-mortem examination, Polly was found to have significant injuries, possibly non-accidental. Post-mortem was suspended as the case being investigated by the Major Crime Unit. M and her partner B2 were arrested in connection with the death of Polly and subsequently released on bail.

8. Views of M and BF of Polly and Extended Family

8.1. The lead reviewers are grateful for those members of the family (mother of the child, birth father, maternal and paternal grandmothers) who met with them. It has been a very difficult time for all of them, and there is no doubt that the loss of Polly to those who knew and loved her is immense. Where possible, any feedback from these family members relevant to the review has been incorporated into the text.

9. Views of the Professionals who worked with the Family

9.1. The lead reviewer is also grateful to those professionals who participated in the review; it was clear at both the practitioner event and in interviews, that the emotional impact on them has been significant. In order to learn and improve it is essential that SCRs take account of their views in order to explain why things made sense at the time. These views and explanations have been woven into the appraisal and explanations of practice.

10. Summary and analysis of professional involvement with Polly.

10.1. This section provides a summary of the professional involvement with Polly, establishing not just what happened but where possible to understand more about why. It focuses on three significant periods over the two years where key aspects of the terms of reference (ToR) are addressed, including how timely and effective the help given to Polly and her family was and where agency practice was below expected standards. Questions or themes drawn out are underlined. The analysis of practice is informed by the IMRs by the key agencies involved. Learning points for the review and key findings/recommendations are then highlighted in more detail in the next section.

May 2012-January 2013-what happened?

10.2. After M became pregnant, she appropriately went to see her GP and booked in with the midwife. Records indicate that she was no longer in a relationship with the father of the child. She reported she did not drink, but did smoke cannabis, though had not done so since her positive pregnancy test. M requested a referral to mental health services and the Specialist Substance Misuse Midwife, suggesting a willingness to engage with support services. The Consultant Perinatal Psychiatrist at the Mother and Baby Unit completed a paper assessment of M's referral (she was never seen) and concluded that there was no evidence of any mental health illness, although she did have some previous history of violence against her brother and self-harm. They considered that M might have a personality disorder. This assessment did not at the time trigger a safeguarding referral or any further discussion with the safeguarding team for DHCFT, though on the basis of M's history and concerns for the safety of the unborn child, it should have (as per DSCB procedures) and would now. The relevance of the hypothesised personality disorder was lost.

10.3. M did not attend the first appointment with the Specialist Substance Misuse Midwife at the antenatal clinic. No plan was made for any follow up or further discussion with her by them as this specialist service was then withdrawn and not offered to M due to resources. The community midwife later reported that at 20 weeks pregnant, M was using cannabis again.

10.4. The community midwife first met M when she was living in her father's garage. Although it had a bed and heating she rightly considered this not suitable and as a consequence made a safeguarding referral to DCS for an assessment of her housing situation. M subsequently moved back into supportive accommodation with a teenage parent service run by the Metropolitan Housing Trust. It is important to note that M had previously lived at this accommodation in 2010 but had been asked to leave by Notice of Seeking Possession due to anti-social behaviour, youths being given access and damage to the property. Her new occupancy agreement included a behaviour contract, which restricted who could visit her flat, stated that no overnight guests were allowed and included a support plan to help her manage her visitors. The nature of this accommodation changed in October 2012 when the support service to the residents was withdrawn due to changes in service provision. The implications of this are discussed later in the report.

10.5. The midwife having received a letter from the Consultant Perinatal Psychiatrist relating to concerns about the potential significant risks from M to her unborn child made a referral to DCS. The risks highlighted were based on M's previous history of self-harm, volatile behaviour and previous referrals to CAHMS. An initial pre-birth child protection conference (ICPC) was held on the 26th May 2012 and resulted in the unborn Polly being subject to a pre-birth CPP.

10.6. The birth was normal, and M returned home to her supported living accommodation, with the CPP in place and an enhanced health visiting service. She was also provided with strong support from MGM.

Analysis of practice

10.7. This was a period that featured some evidence of good multi-agency practice where vulnerability and risks to the unborn child were identified in the pre-birth assessment and child protection conference and were acted upon. After Polly was born, apart from monitoring of Polly's growth and development, the primary focus was on practical support for M's needs for alternative housing, college access and on her relationships, rather than on some of the fundamental risks that had been present pre-birth.

The quality of the pre-birth and post birth CPP and core group activities

10.8. There were two areas that were not explored sufficiently within the CPP: M's drug use and her mental health, especially the need for a thorough assessment to establish the implications of that on her ability and capacity to parent.

10.9. In the criminal trial, the consultant paediatrician felt that the failure to assess her for a diagnosis of a personality disorder[2] was a significant omission. The author understands that the reason it was not pursued was because the perinatal mental health services consultant psychiatrist felt that M did not have a mental illness. Their analysis was based on previous assessments of M over a two-year period. However this meant that concerns about M's past history were somewhat minimised by all agencies. The health professionals in the SCR panel reported that where a mental illness has been ruled out pre-birth, a reassessment by a psychologist or psychiatrist would not usually be undertaken without a specific trigger, or change to the individual's presentation. Though M's mental health was a factor taken into consideration within the pre-birth CPP, the relevance of it got lost within the core group activities once it was deemed it could not be labelled as a mental illness with an identified service to follow up. This is a learning point for the review and something that the DSCB may want to consider further.

10.10. M's own family history and pattern of behaviour were extremely pertinent. If professionals had better understood the implications, it could have led to consideration of a request for further psychological assessment as part of the CPP. In trying to understand this issue it is important to recognise that the original 'diagnosis' of a personality disorder by the consultant psychiatrist was never formally diagnosed but hypothesised. However, the potential risks were documented and shared.

10.11. By 20 weeks gestation it was noted by the community midwife that M was using cannabis again. There was a lost opportunity when there was no follow up by the Specialist Substance Misuse Midwife after M's first missed appointment, as discussed the service was withdrawn. If followed up it may have provided more understanding about her reliance on cannabis and other emotional health issues that might impact on her ability to parent safely. This is something, which again is never fully assessed either then, or at any stage, as it was not embedded in the CPP. M in her interview with the lead reviewers

[2] Research by Falkov highlights that parents with a personality disorder may demonstrate unstable relationships, impulsivity, hostility, violence and a lack of empathy and this impacts on their ability to parent. The symptoms described usually emerge in adolescence and persist into adulthood; they include emotional instability, feelings of anger and negativity, disturbed patterns of thinking, impulsive behaviour, self-harming and intense but unstable relationships with others, especially with partners. At times, sufferers may have periods of remission when they function well. Personality disorders are well known to be associated with genetic and family factors such as a history of abuse and neglect during childhood

described cannabis as helping her cope, (she had been a regular user prior to Polly's birth), but with what and how she managed without it, was not a feature of the later social work or health input with her and it should have been. The IMR author for Derby Teaching Hospitals NHS Foundation Trust (DTHFT) also acknowledges that at this time, there was significant disruption to the specialist service due to sickness and maternity leave and so no resource was available to undertake the work. In addition, safeguarding supervision in midwifery had not commenced and the pre-birth protocol in the DSCB procedures was not yet developed.

10.12. Once Polly was born in July 2012, there were both planned and unplanned visits by key agencies. A Core Group of professionals met regularly to review the CPP and the level of risk and outcomes of their involvement with Polly and M. SW1 built a positive relationship with M and her extended family who both reported in interviews to the lead reviewers that they understood why professionals were involved and why the child was subject to a pre-birth CPP. Having viewed the contents of the pre-birth plan, it is interesting to note that at this time it accurately reflected concerns about M's history and risk. This was later lost as the case progressed, the core group and updated CPP focused on practical support before moving in the next time phase to being purely about risk to the child from the impact of domestic abuse. The significance of M's history on her parenting capacity and cannabis as a coping mechanism was not fully recognised, understood or assessed properly by any of the key agencies, either at this time, or at any time after. Finding 1 makes some recommendations for action in relation to the importance of having accurate assessments of mental health and drug use as part of pre-birth planning.

10.13. After Polly's birth, whilst there were some concerns about M's lifestyle and relationships, there were no reported incidents or observations of violence against Polly, in fact apart from reference to three possible incidents of aggression as a teenager, M did not appear to have a long history of violence to others and had no criminal convictions for violence. This is important as it helps explain the professional view at the time: earlier anxieties around the risk of neglect, and her potential to be violent were not materialising and M was not seen as a potential perpetrator of physical harm to her child.

10.14. A specialist health visitor (HV1) for vulnerable women took over when Polly was four months old and reported good emotional warmth, attachment and M attending well to the basic emotional needs. Polly's weight increased from 2nd to the 9th centile, which was in line with expected growth and development.

Professional relationship and engagement with M and Polly.

10.15. All professional records continue to note on numerous occasions the strong and loving bond between M and her child. In these early stages of Polly's life professionals felt their work was child focused. Both health and social work records frequently refer to having seen Polly when they visited. At no time were any concerning observations made about the interaction between them. In fact, the opposite is noted. Any anxiety related more to the number of visitors in the flat and the difficulty in engaging M in open conversations as there was always other people there. Although SW1 did manage to see M and Polly alone at times, the Health Visitor (HV1) did not see the child alone with M until October 2012, three months after the child was born. Seeing a young mother alone with her child is clearly an important part of undertaking a good professional assessment. This pattern continued as health visitor records showed that as time progressed out of 21 visits she was only able to see M and Polly alone on five occasions. Although she always obtained consent to discuss personal issues, it is questionable how effective this could be with others present. The author considers that it should be expected practice for social workers and health professionals, especially where a child is on a CPP with a parental history of domestic abuse, emotional health concerns and drug use, to see the mother/father/carer

alone with their child in order that there is opportunity for effective routine inquiry into relationships and other more personal matters. If this becomes an issue then supervision should be utilised to consider strategies for overcoming any difficulties. See Finding 2.

10.16. M was asked by the lead reviewers what advice she would give to professionals. She suggested that it was important for professionals to make sure they saw her alone and took her out of her flat when speaking to her to allow her to actually say how she felt. She referred to how hard it was to be on your own in that accommodation as other tenants were frequently in and out of each other's flats. In a recent article published by Sage (2016), Harry Ferguson[3] writes about the social work role in home visiting and the complexity of the experience. The preparation and need for social workers and, I would argue, other professionals, to really prepare and understand what they want to achieve when supporting a child on a CPP is crucial to a child's welfare; yet it would appear that supervisors and educators, spend little time preparing or supporting professionals to be skilled in the area. This is explored more in Finding 1.

10.17. Practitioners did report at the practitioner event their frustration at M's inconsistent engagement with them and tendency to avoid access visits or respond to messages. This was never seen as anything other than typical behaviour of other young parents in the neighbourhood as they stated, 'she did not stand out'. A key learning point from this is that non-engagement should be recognised, not as frustrating but as carrying the potential to harm the child and central to a child's welfare. It's a parent's choice not a child's choice, to be out, to be difficult to pin down, to not be seen alone, something recognised in the DfE Triennial analysis of SCRs (May 2016)[4].

10.18. Social workers and health visitors continued to be persistent in trying to see Polly and M, developmental reviews recorded that milestones were being reached and good attachment continued. There was no evidence recorded during the period after Polly's birth there was any substantial evidence of use of drugs including cannabis, but as mentioned previously, the opportunity to explore with M, her previous reliance on it, and how she was coping without it, does not seem to have featured as part of the health or social work records, and should have formed part of their continuing plan around the child. Reder and Duncan (1999)[5] promote the principles of a good assessment that emphasises how an individual's history helps describe who they are.

10.19. The Assistant Director for DCS reported to the lead reviewer that at this time there was no operating model for undertaking any parenting assessment other than the Assessment Framework triangle[6], and the core assessment that took place reflects this. More recently as the single assessment, (rather than core assessment), process has become embedded, DCS have adopted a range of tools for assessing families that reflect a systemic, person-centred approach underpinned by an evidenced-based theoretical framework and social workers have been trained to use them.

Professional engagement and relationship with Birth Father

10.20. During this period, the birth father (BF) had spasmodic contact with his daughter and the professional view of him was that he was a potential threat to M and his daughter's

3 H.Ferguson (2016) Making home visits; creativity and the embodied practices of home visiting in social work and child protection.
[4] Sidebottom P, Brandon M & Co (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case review 2011 to 2014 *DfE*
[5] Reder, P. and Duncan, S. (1999) Lost Innocents: A Follow-up Study of Fatal Child Abuse. London: Routledge

[6] Framework for the assessment of children in need and their families (2000) DH

stability. BF had a concerning history and at this time the concerns were justified. BF admitted in interview with the lead reviewer that he had a number of difficulties and took cannabis to manage his health issues. He had been banned from visiting the supported accommodation and warned by the police because of abusive texts to M. More analysis of BF's involvement, the continuing professional static view of him and the impact this had on the case is reported on in the later periods.

The role of Housing in the Core Group

10.21. Metropolitan Housing Trust (MHT) initially provided regular support to and monitoring of, M and Polly whilst they lived in the supported accommodation. However, they also issued first stage warnings for breach of M's occupancy agreement during this time. It is not clear if the implications of this were shared with other professionals or seen as relevant, though it clearly was. Metropolitan Housing Trust contract with DCC ceased at the end of October 2012. It thus changed from a supported accommodation service to in effect a 'housing management service'. The subtlety of these changes did not appear to be widely understood by the professionals involved in the case. The consequence was that oversight of the service and support planning ended, as did attendance at professional meetings, including the Core Group. The onsite support to Polly, M and the other residents was therefore significantly reduced from 37 hours to 2 hours per qualifying resident (a total of 16 hours). Metropolitan Housing Trust has identified a number of learning points as a consequence of this Review.

Summary points

10.22. The professional view, during the latter period of support and involvement was that M and Polly were doing well, much better than expected, and despite their frustrations at getting access and her inconsistent engagement, the original concerns about risk and vulnerability of the baby to neglect and domestic abuse had lessoned. In terms of parenting capacity, M was regarded as being well able to meet the developmental needs of her baby and there were discussions about actually removing Polly from the CPP. Anxieties that remained were in relation to M's association with risky males and her alleged cannabis use, though as stated it was not clear apart from observation how much scrutiny or challenge around this actually featured in interaction with M herself.

10.23. The danger of cultural normalisation and professional desensitisation (Pathways to Harm, Pathways to Protection: Triennial Analysis of SCRs in England (DfE) 2011-2014)[7] can leave vulnerable children without a full assessment of their needs. At the end of this period, it could be argued that some professionals saw the mother's behaviour and attitude as normal for other young parents in similar circumstances, with excuses for non-engagement being accepted at face value. Therefore, concerns about failed visits or not seeing the child alone were not escalated to supervisors or discussed as an issue within the Core Group. The need for professionals to maintain professional authority and to see every case as unique, and from a child's point of view, not solely the parent's experience is crucial. This is explored in Finding 2.

February 2013 - October 2013-what happened?

Polly was on a CPP; she was 6 months old.

[7] Sidebottom P, Brandon M & Co (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case review 2011 to 2014 *DfE*

10.24. This period featured growing concerns about M's association with unsuitable people and the increased risk she was exposing Polly to. She became more evasive and professionals found her harder to engage and visit.

10.25. In early February 2013, the Police and Derbyshire Children Services received reports of an incident of domestic abuse between M and B1, her boyfriend of the last five months. A child protection review conference took place and Polly remained on a CPP though the category changes from neglect to risk of emotional harm and physical abuse. Safeguarding checks highlighted that B1 had a history of violence and M was asked by SW1 to sign a written agreement that she would allow no contact between B1 and Polly, and no entry of him to her flat. M initially refused to sign this agreement and continued to associate with B1. M's emotional health appeared to deteriorate. She continued to associate with B1 and refused the offer of a refuge. Further reports of domestic abuse and damage to property occur; professionals found it harder to gain access to the flat as M refused them entry and Police Safe and Well Checks were carried out on several occasions which note that B1 is present. This was then shared with DCS. The increasing withdrawal by M from the professionals trying to support her, culminated in an assault by B1 on M in May 2013.

10.26. Derbyshire County Council informed M of their intention to issue care proceedings. An initial agreement is made in the court that M and Polly move in with MGM and Polly was made the subject of an eight-week interim supervision order. There was an expectation that if the arrangement broke down then MGM should inform the local authority immediately. The placement broke down in a matter of days and M returned to the local area and was seen once more associating with B1. An interim care order was made on the 5th June, as M was unable to keep her daughter safe. This was not opposed and Polly was appropriately placed with foster carers.

10.27. BF applied and was awarded parental responsibility after a DNA test proved he was the birth father. Viability assessments were carried out over the summer on both the BF and the MGF, but concluded that neither was viable as an alternative carer for Polly. M was required to undertake a programme of support to ensure she fully appreciated how she was a victim of domestic abuse and what steps she needed to take to ensure she was able to protect herself and her daughter in the future.

10.28. During the care proceedings, all agencies involved, including the Child's Guardian from Cafcass, and SW2 agreed that M had made significant progress and at the final hearing on 2nd October 2013, that Polly should be returned to her care under a 12-month supervision order. A residence order was also made to M and parental responsibility given to BF.

10.29. Not long after the conclusion of the Care Proceedings in October 2013, M began a relationship with B2.

Analysis of practice

Over emphasis on emotional warmth and attachment without a focus on the daily lived experiences of the child

10.30. Whilst measures were taken once risks increased to ensure that Polly was kept safe, it is the author's view that there continued to be a pervading sense of optimism by professionals that despite everything, M was parenting well, even if she was not engaging with them as well as she had previously. There was continued and possible over-emphasis given to the emotional warmth and attachment between M and Polly, without acknowledging what the daily-lived experience was for the child and how frightening it

must have been to live in the flat at times during this period. Seeing the mother, not the child as the primary client, was evidenced through discussions with the practitioners who reflected that the emphasis was weighted towards the needs of M, who was seen as a victim of domestic and sexual violence and thus professional support focused on the need for her to be kept safe and disassociate from her violent partner. These are not new messages and are repeatedly flagged in SCRs. There were increased attempts by professionals to ensure they saw M and Polly and regular visits to her flat, announced and unannounced, took place and included a Safe and Well check from the Police when they could not get access, but who on gaining access found Polly to be safe.

The use of written agreements

10.31. The use of written agreements is still common social work practice and is used in a number of ways. Most commonly in the lead up to issuing possible court proceedings a written agreement can highlight to parents the seriousness of a situation if circumstances do not change and outline any expectations the social worker may have of their behaviour in order to avoid such proceedings. They can also be used also as part of wider social work practice with parents/carers to set out what is expected of them, sometimes as part of a CiN plan However, in the author's view, written agreements and requiring individuals to sign them needs to be used with caution. They may be effective if the adult/s are central to their development, feel able to comply with realistic expectations and are clear what the consequences are if they are not adhered to. Good practice would suggest that written agreements are a statement of the local authority's concerns and advice to a parent, that they are not a contract and therefore there is no requirement for parents to sign their agreement. Asking M to sign a written agreement to cease contact with B1 was not helpful and placed an unrealistic expectation on her. This was later validated when M, in talking to the lead reviewers, acknowledged that when asked again to sign a written agreement not to see B2, she would not sign it as she had no way of enabling it to be adhered to based on her past experience. This issue is expanded on further in the next time period.

Involving abusive partners in assessment and planning

10.32. Throughout this period, when M was involved with B1, there was no attempt by professionals to engage him in any work, leaving the responsibility for protection solely in the hands of M. This is something that has been recognised in other SCRs and the recent Triennial Analysis (2016)[8] suggests that a key learning point is that professionals should not rely on victims of domestic abuse to protect their children. There needs to be robust challenge to abusive partners, something that requires a high level of professional skill and support.

Effective use of Care Proceedings under the Children Act 1989.

10.33. The SCR author has examined records to identify if there was any significant delay in taking any legal action to protect Polly once concerns began to escalate. DCS requested that M end her relationship with B1 in February and sign a written agreement, but M refused. At the child protection review meeting on 27th February 2013, because of the growing professional concerns about Polly's safety, the category of abuse for the CPP changed from neglect to risk of emotional harm and physical abuse. This was good

[8] Sidebottom P, Brandon M & Co (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case review 2011 to 2014 *DfE*

practice and appropriately recognised that Polly may be at risk. From the records, it is clear that professionals in the Core group concluded that Polly was not being neglected, even through this difficult period, as she was reaching developmental milestones, had good attachment to her mother and was well cared for.

10.34. Polly continued to be closely monitored through the revised CPP and Core Group meetings. This was initially adequate enough to continue to keep her safe at home. However, as the number of violent incidents and damage to property increased, the professional group became more concerned. Between February and April 2013 this included damage to three internal doors, doors being kicked in and damaged by a hammer, a broken mirror, blood spattering found on neighbour's doors, and anonymous referrals to the Police about banging noises in the flat. The Police attended a number of times. DCS sought legal advice on the 30th April 2013, whereupon they were advised that they could apply for an ICO.

10.35. Whilst care proceedings could have been initiated a little sooner, it is the SCR author's view that there was not a significant delay before appropriate legal action was taken.

10.36. The local authority threshold document filed at the outset of proceedings accurately summarises the history of concerns regarding M and her mental health, anger management, history of self-harm and her abusive relationship with B1. However, the application was issued on the basis of M's relationship with B1 and the risks that this posed to Polly and M's lack of cooperation with DCS. The legal threshold document asserts that there are grounds to believe that Polly is at risk of physical and emotional harm but this was not ever on the grounds of risk from M. During this time, it was never considered that M could pose a violent risk to the child, as there was no evidence to support that view. Examples of physical aggression or personality issues noted in reports from her adolescence were deemed historical in nature and, as such, not appropriate to rely upon, though these were never actually explored with her in any depth.

10.37. A more experienced male social worker (SW2) was allocated to the case to oversee the care proceedings. In an interview by the lead reviewers with M, she reflected that the change of social worker was a significant loss to her as she had a strong relationship with her female social worker. Although she did also acknowledge that SW2 had tried exceptionally hard to support her. A learning point that may be worth exploring more by DCS is how much the gender of the social worker, or impact of a change of social worker is taken into account in supervision when working with vulnerable young mothers who find building trusting relationships very hard.

10.38. At the initial hearing on 16th May 2013, the local authority was clear that the reason for proceedings centred primarily on M's abusive relationship with B1, and that the overall positive perception was that she was a capable parent with strong attachment to her child.

10.39. At the conclusion of the proceedings, the BF stated he did not want a contact order making and that he was happy for to work together with M to negotiate the issue of contact without the need for a defined order. All parties, including Polly's Guardian (Cafcass Officer), felt that the issue of contact could be managed in this way between the parents.

The lack of a comprehensive parenting assessment

10.40. In readiness for the third court hearing on 19th June 2013, a good deal of discussion took place regarding the appropriate assessments to be completed. At the Advocates meeting SW2 initially wanted an opportunity to assess M further and gain more information about her parenting skills and capacity. However, as he did not evidence any reasons for seeking these assessments in his court statement, both Polly's Guardian

(Cafcass Officer) and M's solicitor were opposed to this as they felt there were no grounds to justify it as part of the proceedings.

10.41. It is important not to view the case with hindsight here and place too much emphasis on the lack of parenting assessment at this time and what difference it might have made. In practice, it means observing a parent in an agreed setting outside the home, for a limited period to check if basic parenting skills exist. It would also have provided information in relation to the child's routine, behaviour management, keeping a child safe, supervision and general parenting ability and skills. The initial statement of SW2 used in evidence to the proceedings states during a Core Group held on the 26th March 2013, that Polly was making good progress under the CPP and that M's parenting was of a good standard. As that was only two months prior to the issuing of proceedings, and there had been no other information that suggested deterioration in that level of basic parenting by June 2013, then it may have been difficult to argue that a parenting assessment was required, although it would have provided the additional information detailed above. Any concerns raised by the foster carer with the HV1, and as a result of their observations of Polly whilst in her care, would not have influenced the decision, as they were collated later in August, some two months after the decision not to undertake a parenting assessment. The omission was that this information should have formed part of the CIN plan once Polly was returned home to M at the conclusion of the care proceedings.

10.42. An assessment schedule was filed with the court and parties setting out the planned social work assessment of M's ability to meet the needs of her daughter. The plan included discussing her understanding of the issues and concerns of the local authority regarding her daughter's welfare, family and social relationships and the impact of domestic abuse. None of the Parties raised any objection to the assessment plan. The resulting risk assessment prepared by SW2 dated 30th August 2013 however, focused predominantly on the issue of domestic abuse. SW2 was clear in his report that he felt that M had made progress in her understanding of abusive relationships and vulnerability and risk through participating in the Next Steps Freedom Programme. This is a course for women who want to learn more about the reality of domestic violence and abuse, and SW2 considered M had a greater understanding of her own behaviour as a consequence of her participation in the Course.

10.43. The Solicitor for Polly, the Guardian (Cafcass Officer) and the court did not raise any issues about the quality of the social work assessment within these proceedings. The report of the children's Guardian, filed towards the conclusion of the proceedings dated 23rd September 2013, stated she had considered the assessments and evidence of the local authority. The local authority's plan to rehabilitate to the care of M appeared, in view of the evidence before the court, to be appropriate and Polly's Guardian (Cafcass Officer) supported the local authority's care plan.

The effectiveness of the supervision order and child in need plan

10.44. The importance of all professionals understanding their role in the multi-agency plan around Polly once she returned home was an essential part of keeping her safe, and yet it appeared that there was significant confusion about the implications of the supervision order and their role in monitoring Polly. This became very clear at the practitioner event, and the consequences are discussed more in Finding 3.

10.45. Although there was a children in Need Plan (CIN), it did not take into account the changes that had taken place whist Polly was in foster care, the emotional health of M, nor carry through on the work of Next Steps with M. Nor was it adequately updated to reflect the change in circumstances as risk to Polly increased once the domestic violence between M and B2 increased. The notes in the report of the consultant paediatrician to

the criminal trial indicate that in foster care there were examples of the impact of M's parenting capacity upon Polly. She noted that her development was unaffected by removal into foster care, which for a child where there had been such strong attachment noted with her mother, you would have expected to see some distress. Polly had rapidly met her milestones, put on weight and slept better. It was noted in health records that on 18th July 2013, Polly had not been clingy, as contact with M had been cancelled for a week. Later it is recorded that the foster carer expressed concerns to the HV1 that M was not feeding Polly during what were now extended contact sessions. In themselves, they were small clues that M may need additional support to care for Polly in order to parent her properly. In particular, consideration of the Polly's weight gain in foster care, compared to previous and subsequent gain should have been included.

10.46. M confirmed in interview with the lead reviewers that she had undergone the Next Steps programme, but she did report that although she had undertaken the course, she had only done it on a one to one basis with the tutor as she found the group process overwhelming, *"I find groups difficult*". This is significant as it relates to her problem in managing certain social situations and the impact it had on her emotional health. This was not recognised at the time by professionals as having any relevance to her ability to parent. As M explained, it meant that going to local mother and toddler groups or anything that helped with isolation and benefitted a growing child, was not easy for her to access. There was in fact an expectation in the CIN plan that M would go to a toddler group. Clues to M's emotional health was not explored sufficiently enough by the professional team.

10.47. The second issue that was not appreciated was the impact on M's confidence and ability to parent a child who had changed significantly since spending three months in foster care. Polly had changed from a pre-mobile baby into a toddler who had begun to reach significant developmental milestones and was now walking and talking. In interview for this review M reported that she felt, "*she was not the same child, ...she had changed that much ...it was like having a different child".*

10.48. Once Polly was returned to M's care, HV1 did pick up some of the struggles M was having with her daughter to eat and to manage her unsettled sleeping. However, none of the above information was relayed or communicated in supervision or noted in the network review meetings as being concerning, in fact the review minutes of November 2013 note that there were no concerns by HV1 about the home environment or the toddler's growth and development. The comments by the Health Visitor have been extrapolated as part of the DCHFST IMR buried within extremely detailed reports of M's problems and issues suggesting that focus on Polly and what her behaviours were indicating, was lost. There is no obvious explanation to understand more about why, but it does highlight the lack of clarity that professionals had about the purpose of the supervision order, the CIN plan and their role in it. This is explored more in Finding 3.

10.49. M began a relationship with B2, who was known to Barnardo's as a care leaver. SW2 spoke with a Barnardo's leaving care worker on 25th February 2014, who confirmed they did not have concerns regarding B2's conduct with children. SW2's manager also read B2's records for information, which led SW2 to conclude without having the full picture, that he did not pose an immediate risk. It is of concern that it appears B2 was never spoken to directly or formally assessed, something that in interview with the lead reviewers SW2 recognised as an error. If he had undertaken a more robust check, it would have revealed a significant history of self-harm and previous incidents of domestic abuse with a previous partner. Research demonstrates that information about men in families is often taken from mothers and there is a lack of respectful curiosity about men in families. This is more concerning when male partners change with a level of frequency (Hidden Men: Lessons from Serious Case Reviews NSPCC 2015). See Finding 3.

10.50. In light of M's history, the CIN plan should have clearly identified what would happen if new partners emerged, what assessments should take place and what the expectations of M were in terms of her parenting, and should have been outcome focused. Having reviewed the CIN plan, it is the lead reviewer's view that there was a continuing naivety by the professionals that M had got over her violent relationships, understood the consequences and that she was unlikely to resume other similar relationships. There was no evidence other than her compliance with a domestic abuse course (Freedom Programme) that this was true.

November 2013 - May 2014-what happened?

Polly was 16 months old. She was mobile and like many toddlers of that age was becoming a little more challenging to parent. She was seeing her BF and PGM regularly. B2 was also taking on a parenting role in Polly's life.

10.51. M's relationship with B2 was volatile, with apparent frequent 'fallings out'. When housing association staff visited the flat in November, they stated there was evidence of the smell of cannabis. They saw Polly on this occasion and she was in her mother's arms and crying which M said was due to having fallen off the bed. The MHT staff reported their concerns to SW2 who asked HV1 to visit and check on Polly. HV1 subsequently went to the flat and noted in her records that it was warm and clean, there were minimal but enough toys, and also that B2 was present at the visit. This was only a month after Polly returned from foster care.

10.52. Polly was having regular contact with BF and PGM. On one occasion, BF reported that he had to keep her, as when he tried to return her home M was not there. BF confirmed to the lead author that this was not unusual. In November 2013, when PGM was bathing Polly, she noticed bruising to her buttocks. BF took photos of the bruising and stated to the lead reviewers that he advised SW2 he had taken photographs on this occasion and again when she had bruises on her face (M said these were caused by Polly sleeping with her face against the cot, though this was not accepted by SW2).

10.53. In December 2013, M admitted to damage to the door of her accommodation and this was linked to an argument involving B2. This incident along with other altercations with residents resulted in M receiving an eviction order in January 2014 and B2 being banned from the property.

10.54. At a multi-agency meeting with M and Polly at the beginning of January 2014, a bald patch was noted on Polly's scalp, as well as some bruises on her lip and chin, and a blister on her finger. A child protection medical was arranged by the service manager who chaired the meeting, for the same day at the Royal Derby Hospital, where she was seen by a paediatric consultant and registrar. The hair loss was not considered to be due to an injury but to be alopecia, and the bruising to the lip and chin was consistent with M's explanation that her daughter had tripped and was accidental in nature. The blister on her finger was likely to have been accidental, though non-accidental injury was not excluded. A follow-up appointment was made for the alopecia at the dermatology clinic.

10.55. At the beginning of February 2014, a 999 call for an ambulance was made by B2 concerning Polly (now 18 months old), due to a sudden collapse and witnessed fitting (M had been out shopping at the time). The paramedics recorded Polly as having had a collapse and fitting after a high-pitched scream. Polly was described by B2 as 'floppy' and 'blue' (cyanosed). When the ambulance arrived, B2 was in the hallway performing chest compressions on Polly, who appeared to recover, began breathing and then vomited. Polly was taken by ambulance to Queen's Hospital Burton. She was crying in the ambulance and consoled by M. The paramedics recorded Polly's heart rate and temperature, which was 35.3C. On admission to ED, she was described as looking

miserable and being floppy and lifeless. It was noted by ED staff that Polly had a red rash on her chest and a congested sore throat. It was therefore thought the episode might be an indication of a febrile convulsion as a result of a viral infection. Polly was seen at the hospital by a registrar and foundation year two doctor and admitted overnight for observation and urine tests, as it was noted that she may have received rib fractures from the chest compressions.

10.56. M and Polly moved to a flat in Staffordshire towards the end of February 2014. Staffordshire Children's Social Care was informed of the move into the area; however, DCS remained responsible for the management of the case. It is recorded by SW2 that the accommodation was of a good size and standard. At this point M advised she was no longer in a relationship with B2 saying the relationship, "wasn't working".

10.57. In March, Staffordshire Police attended the home address due to an anonymous call regarding a domestic dispute. Further investigations show the call was made by M herself.

10.58. At the end of March, Polly was taken by M to Queen's Hospital Burton with a laceration to her mouth, which M said she had received by falling in the bath. This explanation was accepted.

10.59. In early April, M had still not managed to register her daughter with a local GP; she had tried, but was told by the GP practice that they could not process the application that day and to return another day.

10.60. M stated again to SW2, that she was no longer in a relationship with B2. However, the following day the Police were called to the home following two 999 calls in relation to B2 being at the address. It was alleged B2 had made threats to kill M and burn the flat down. M withdrew the complaint against him the following day. This led to discussions with the MASH for a MARAC on the basis that M was not taking the threats as seriously as she should and questions were asked about her ability to safeguard Polly.

10.61. Polly was seen by HV2 at this time and noted to be happy and sociable, but appeared to be slight for her age.

10.62. The MARAC took place on 30th April where there was a lengthy discussion following an in-depth sharing of historical information of social care involvement. The primary concern was in line with discussions from the earlier MASH meeting, that M may be continuing to play down the risks she could be placing herself and Polly under. The recommendation was for further assessments to be undertaken. It should be noted that there was no information shared at the MARAC that M herself may be posing a risk to Polly.

10.63. The following day, M made a 999 call. Paramedics promptly attended the home address and took Polly to Queen's Hospital in Burton, where Polly was pronounced dead at 17.00 hours.

Analysis of practice

There was a continuation of multi-agency activity during this period; however, it was in the context of Polly being on a supervision order and a CIN plan rather than a CPP. There was an increase in the number of medical interventions and reported minor injuries to Polly.

Professionals' relationship with Birth Father

10.64. BF's relationship with professionals could at best be described as superficial. His main contact was with DCS, which he described as a negative experience. As noted earlier in

this report, there had been a previous assessment of him just after the birth of Polly that suggested he could pose a risk to the mother and child's stability. However, this initial negative assessment was never revisited by social care after he gained parental responsibility, but continued to influence the professionals' view of him.

10.65. Once BF gained parental responsibility, contact was arranged informally between him and M as specified in the terms of the supervision order, initially supervised by PGM and for not more than three hours a week. This contact increased significantly as M's situation at home deteriorated and by December 2013 BF was having more regular contact, including overnight care of his daughter. No concerns were raised about his interactions or his care of her. It was obvious from BF that he delighted in Polly and he felt that she had had a very positive impact on his life. BF told the lead reviewers that he felt marginalised in his dealings with other services as they rarely involved or consulted with him, though he did attend a couple of review meetings. BF said that the only time he felt included and listened to was during the care proceedings when he felt that the for the first time a formal process and structure gave him a voice.

10.66. It became clear during the review that SW2 was not initially aware of the increased reliance M was putting on BF to look after Polly. Once he was, he suggested that BF undertook a parenting assessment. This was relayed via a telephone call and, in fact, caused a lot of anger and distress to BF, who felt that he was doing very well and that any assessment of him may once again decide he was unsuitable. The original viability assessment of him had not been positive so his anxiety was somewhat justified. The relationship between BF and SW2 broke down. In trying to explain why BF had not reported more directly the concerns about how his daughter was being cared for by M and the risk he felt she was under, he explained that as contact was informally arranged between them if he made any allegations against M she could just stop contact. BF reported to the lead reviewers that he also was very anxious that he might then be accused if there were any bruises. In fact, he later reported to the DCS Assistant Director during this review that the blister on her finger was because of Polly touching a hot dish when in his care.

10.67. There is a learning point here around the unintended consequences of estranged young parents arranging their own contact arrangements: it makes it very difficult for either of them to raise safeguarding or other concerns, as any untoward communication between them may put their own contact arrangements at risk. BF gave the lead reviewer a number of examples where he had concerns about M but did not want to upset her and risk a change to contact. He had no trust in the SW2 to take anything he said seriously. He felt his one attempt to raise the alarm, after he saw bruises on Polly and took photographs on his phone, had not been taken seriously or acted upon. The accuracy of this is disputed following rigorous investigation on behalf of the local authority to clarify if the photographs had been shared with SW2, both following the criminal trial and again as part of this review. No evidence was found in the records that BF had actually shared the photographs of Polly with the local authority, though he clearly had them in his possession. Further discussion about how contact was arranged is referred to in the previous section.

10.68. The IMR author for DCS commented that some of what influenced BF's view of DCS was a significant history of his own involvement with them. She suggests that whilst there is little that can be done to counteract that, there are learning points for Children's Social Services about how managers support workers in dealing with aggression and challenging behaviour which can influence future interactions and decisions and the impact this might have on the child. They also need to ensure that separated fathers are involved in planning processes and that assessments are revisited in light of new

information. One of the key findings (Finding 4) of the review is around the quality of professionals' relationships and assessments of male carers/partners.

Health Visitor service to fathers/partners

10.69. BF and B2 were both clearly involved on a regular basis in the care of Polly during this time. However, the health visiting service did not engage with either of them on any level. The CIN plan did not specify that the health visitor should ensure that the BF was supported with his newly acquired parental responsibilities and this was a missed opportunity to develop his confidence in the support services and develop his parenting skills. Although health visiting should be a family service, in reality the service is still primarily delivered through the mother or when required, with foster carers. BF could have benefited from health visitor interventions in his own right and could have been offered this through a well thought-out care plan. The feedback from practitioners and the IMR authors was that they considered his involvement as minimal, thinking he only had supervised contact with Polly once a week.

10.70. A recent evaluation, conducted by the Institute of Health & Society at the University of Worcester of father-inclusiveness training for health visitors and community practitioners found significant improvements in knowledge and attitudes, and sustainable changes in practice, among course participants[9].

10.71. This review has identified that health visitor contact with fathers was not DCHSFT policy at the time Polly was born. However, since this case there has been a change to policy in Derbyshire and health visitors are now registering father's details on the electronic records and assessing their role in caring for their child. Health visitors are now expected to involve fathers, whether or not they are living with the child. It is the authors' view that relevant Health Trusts should consider, '*father inclusiveness training'* for health visitors.

Eviction and house move

10.72. The escalating concerns regarding M's negative behaviours and relationship with other residents in housing association premises at the end of 2013 resulted in her being served with an eviction notice and as a consequence, she moved with Polly to Staffordshire in January 2014. BF told the lead reviewer that at this time he had significant concerns about M's behaviour, she had left Polly with him for over a week, and he had evidence that she was drinking (he described pouring a bottle of spirits down the sink at the flat to stop her drinking it, after finding her drunk). None of this he felt able to share with SW2.

10.73. The move was a significant change in Polly and her mother's circumstances. M was resourceful in finding accommodation, which was of a good standard, and the move appears to have been considered as positive by all agencies involved, as well as her extended family.

10.74. The seriousness of the events that led to the eviction was not considered at the time to be having an impact on M's ability to parent. The reality of what life had been like for Polly in the last few weeks at the flat did not appear to have been a key focus. The CIN plan was still reflecting the concerns regarding domestic abuse and professionals continued to

[9] Evaluation of a Training Programme and Toolkit to Assist Health Visitors and Community Practitioners to Engage with Fathers as Part of the Healthy Child Initiative:

view this as the priority. However, from the agency records it would appear this was also the time when M became more unpredictable when she engaged with professionals, and would often 'not be in' for scheduled appointments with the Health Visitor albeit there were times when professionals believed she was actually at home. M would often say she would do things and then not follow them through. This included assuring professionals that she would sever her relationship with B2. She disclosed to the lead reviewers that B2 was often hiding in the bedroom when professionals called at the flat. The fact that he was in the flat when professionals called often by appointment may suggest an element of exerting his power and control over her, as she would have been unable to disclose any concerns she might have had knowing he was listening, or alternatively her collusion in trying to avoid professionals knowing he was present, but not wanting to admit it. There were, however, other things she said she would do which she didn't follow though and this included attending the children's centre, allowing professionals to support her by keeping key appointments and, importantly, registering with a local GP. Again in interview with the lead reviewers, M talked about how hard it was for her to go to groups and her lack of confidence in doing so, especially where other mothers seemed older and more able than she was. She also described to the lead reviewers what she now feels was an abusive and controlling relationship, where she was never alone, something the MGM also feels had a significant impact on her emotional health at the time.

10.75. Despite the move to a new area, continuity in the provision of social care was maintained by DCS, which was positive. Staffordshire Social Care was informed of the move and the legal status of Polly, but this was only done verbally and not followed up in writing, which it should have been. Although this omission did not directly impact on the case, it could have. This meant that as issues started to escalate, there was only limited information held by Staffordshire about Polly and her family circumstances. This practice issue has been addressed by DCS.

Evidence of effective parenting

10.76. There are frequent references in professional records, especially in the health visitor records, describing the positive interactions between mother and Polly that suggest there was no concern about M's parenting. Certainly there is evidence given by both family members and professionals of them enjoying fun times, (the reviewers were able to see a short video clip on BF's phone of M and Polly dancing together) and at the practitioner events other professionals gave examples of the bond between them. However, there is little description in relation to effective parenting. This apparent positive assessment of mother was made despite M herself identifying, as mentioned previously, that she had found it difficult when her daughter returned to her care from foster care saying "she left a baby and came home a toddler".

10.77. There are observations about Polly eating lunches of convenience snacks such as crisps, yet it is unclear what advice was given around healthy meals. Whilst the CIN plan stated that was an expectation of growth and development, weight was not specified as a concern to be monitored, the focus was still around risk of domestic abuse, so the understanding from HV1's view was that as weight had not been identified as an issue with her she would only weigh Polly every three months. As mentioned previously, the importance of the weight gain in foster care and feedback to the HV by the foster mother had not been embedded in the CIN plan. This is picked up more in the section on faltering growth. At this time, the level of contact the health visitor was having with M and her daughter was set out in the CIN plan as monthly. The primary role was to monitor growth and development.

10.78. M was frequently not at home for arranged visits with the health visitor, who made many attempts to visit her. There were three 'no access visits' in December 2013 alone. In

adherence with policy, the health visitor wrote to M after these three failed attempts, and initiated the escalation policy and informed SW2. The social worker advised that he had seen the family along with the family support worker. This on-going contact with social care gave the health visitor some reassurance the family was being seen regularly. However, there is a learning point here for health visitors working with families like this: as the health visitor role is very different to that of social care, the health visitor should have gained access to address the health and development of Polly as part of the agreed CIN plan. There is some learning also about whether it is acceptable for a child on a supervision order to only receive health visiting at the level of a child on the *Healthy Child Programme* (the Government's early intervention and prevention programme) or whether it should be that children on a statutory order need a more regular and robust visiting schedule and a clear weighing pattern. The DCHSFT Health Visitor (HV1) had identified that the visiting pattern should be at least 3 monthly, whilst subject to a CIN plan (supervision order). This is an enhanced level of health visitor service, which includes the Healthy Child Programme and, as such, is more than the level of a child who is universal and requires only the Healthy Child Programme contacts.

The importance of outcome focused plans

10.79. This was an issue, which was particularly evident in the review of the M's behaviour after the care proceedings. M often said she would do things such as break from B2, attend the children's centre, allow workers to support her in keeping key appointments and registering with a GP, but this was rarely followed through and excuses would be made as to why this had not happened, or M would say it had happened, which subsequently was found not to be the case. She would however, occasionally follow through on things, such as taking Polly for a follow up hospital visit for the alopecia. If there had been a very clear outcome focused plan, with timescales for the completion of tasks, and effective monitoring, it would have become evident that M was not following through on key actions or commitments. The work around outcome-focused plans is therefore very applicable to addressing the issue of disguised compliance where there is a disconnect between what a person says they will do and what they actually do. The need for more authoritative practice is explored in Finding 2.

Escalation of medical concerns/interventions

10.80. The lead reviewer has analysed the multi-agency timeline that detailed the chronology of medical concerns and the appraisal of the medical responses contained in the Health and DCS IMRs during this latter timeframe. It is important to note that between April 2012 and May 2013, while Polly was subject to a CPP, and there were concerns about her mother's lifestyle and relationships there were no reported injuries to the child.

10.81. Between November 2013 and April 2014, when Polly was on a supervision order, there were five separate occasions when injuries were noted by the SW2 and shared with health professionals. Of these, a small bruise, scratch mark and bruise on the bridge of the nose and knee were injuries not unreasonably felt to be consistent with the minor bruises seen in many mobile toddlers, and therefore not requiring a child protection medical, though the small bruise should have initiated a conversation from SW2 to the HV1, which it did not as the manager of the social worker knew that HV1 had visited Polly and her mum the night before and had no concerns.

10.82. The other concern was in relation to a rash viewed as a consequence of teething and dribbling. In themselves, these were not viewed as suspicious, nor should they have been. It is important not to use hindsight here, as at the time they did not have the significance they have now when looking back at Polly's history. However, the overall number should perhaps have been viewed as an indicator that more questions about the supervision of

Polly should be asked. BF, as mentioned previously, told the lead reviewers that he did have significant information, including photos of bruises to Polly on his mobile phone, which if had been known by the professional group would have alerted them to the deterioration in the care and supervision of Polly.

10.83. There were three more concerning medical presentations. In January 2014 a bald patch was noted on the back of Polly's head, a mark under the chin (which BF said occurred at his house when she fell on the carpet), a small mark on the upper lip and a small blister mark on her little finger. These injuries were subject to a child protection medical that the service manager instigated that day. It was the bald patch in particular that caused the Service Manager to be concerned as she felt that neither M or BF could provide an explanation and it could not have come "out of the blue". SW2 spoke to the doctor at the hospital alone, prior to the child protection medical and in his view gave him the background to the case, including information on the previous CPP and the care proceedings. However, the consultant paediatrician reported to the IMR author that he was not informed of the significance of the child protection history including Polly's period as a looked after child (LAC), or M's previous history. This is disputed by SW2, who felt he had given a full history. The information that was clearly received was that the injuries were deemed to have happened when in BF's care over the weekend and that DCS were involved due to previous domestic violence issues with a previous partner.

10.84. There were three areas of note from the medical. The first was that the area of alopecia areata [10]did not show any trauma to the back of the head, which could have caused hair loss and the hair was already growing back, though Polly was referred for dermatology for a second opinion and photos were taken of all the marks and hair loss. Polly was brought to an appointment on the 16th April 2014 to review the alopecia. There was evidence of hair regrowth and no further actions were considered necessary, and Polly was discharged from this service.

10.85. The second injury was an abrasion on Polly's chin which was consistent with the explanation of tripping and likely to be accidental, and the third a healing abrasion on the middle finger. This lesion was initially described as a blister that appeared spontaneously. It subsequently de-roofed and was crusted over. There was no explanation offered by M for this injury and BF was not asked, though he has recently explained how the injury happened accidently. The medical report from the consultant paediatrician noted that non-accidental causes for this lesion could not be ruled out, but the child may have done it herself. The SW2 therefore concluded that the child protection medical had examined thoroughly all Polly's injuries and there was no evidence of any non-accidental injury (NAI). This was then communicated by SW2 to the multi-agency team.

10.86. On March 23rd 2014, M took Polly to the Queen's Hospital in Burton with a lacerated lip. This was thought initially to be serious enough to require a transfer to Birmingham Children's Hospital as they had more expertise in the area of mouth injuries, though was not required once the case was reviewed by a senior doctor at Queen's. There was no indication in the presentation to make the ED staff suspicious that the injury had been inflicted. The Hospital had no prior information on Polly's child protection history or legal status so the injury was taken at face value and not considered to be suspicious. Mouth injuries of this sort are not uncommon accidental injuries in mobile toddlers, although there

[10] This is a condition thought to be caused by the immune system in an individual's body reacting to their own hair, causing bald patches. The trigger is unknown, but may include infection, viruses, some medications, and there may be a tenuous link to stress. There is no specific treatment and the hair regrows spontaneously.

is also some research evidence that they may also be caused by inflicted or non-accidental injury. As a minimum, it was another indication of poor parental supervision.

10.87. SW2 was not aware of the injury until he saw Polly and M in early April and noticed the marks. As Polly had already attended the emergency department at hospital, the social worker took no further action. Authoritative practice would suggest that it may have been pertinent for SW2 to be more inquisitive about the cause of the injury, maybe asked to see where it had happened, in trying to understand why, two weeks had passed, and at the time he was not viewing it as suspicious.

10.88. These attendances from January onwards should have identified an escalation of concern for Polly. There were several opportunities when her minor injuries and care should have been considered in the context of neglectful/inadequate parenting in relation to child safety. Risks are not static and must be reassessed as circumstances change. The fact that they were not, when the child was subject to a supervision order, suggest the multi-agency team were still focussing primarily on the needs of the mother, her housing situation and risk of domestic abuse. The practitioner event confirmed this analysis.

10.89. For SW2 this would have been seen in the context of the child continuing to present as a happy toddler who had a good relationship with her mother. From these marks and injuries there was insufficient evidence at the time to suggest that the social worker could have predicted in any way that the M would murder her daughter in a violent assault of the nature that is now found to be the case. However, they were indicative of a growing picture of a mother who may have been struggling with an active toddler, and that should have called for a review of the support being offered.

Not a febrile convulsion

10.90. When Polly was found in a collapsed state by B2 in February 2014, her temperature was recorded to be 35.2 C (which is below normal), yet both the ambulance crew and the hospital staff record this as being a possible febrile convulsion[11] despite there being no evidence of a high temperature (during the trial this event was identified as 'life threatening'). Because the ED (emergency department) attendance was reported as a febrile convulsion and this continued to be the medical view, the potential for a differential diagnosis was never challenged. Staff may have presumed that it was a febrile convulsion, as these are more common in small children, and as mentioned earlier, there was indication of a viral infection that could have caused fitting.

10.91. The consultant paediatrician who reviewed practice for the criminal court case concluded that the febrile convulsion was in fact an apparent life-threatening event (ALTE) [12]. She reflected that had this been part of a considered diagnosis, then it would have triggered non-accidental injury being considered in the examination of Polly, further

[11] A febrile convulsion can be described as seizure (or fit) that can happen in a young child (usually aged between 6 months and 5 years) who develops a temperature. Febrile convulsions are common, affecting about 1 in 20 children and do not usually cause long-term problems or require any specific treatment.

[12] An ALTE is a clinical presentation that may have a number of different causes, for example cardiac, seizures, infection and, importantly, non-accidental injury. Events are characterised by apnoea (stopping breathing), colour change, change in muscle tone (usually diminished), and / or choking or gagging, with no cause apparent on history taking or examination. In some cases, the observer fears that the infant has died. A number of authors/ guidelines consider the definition to apply to infants under 1 year of age and for those over 45 weeks of age to be at low risk.

medical examinations/scans and a paediatric senior registrar would have reviewed the case and undertaken discharge. The Partners-in-Paediatric Guidelines (local regional guidelines) recommend for ALTE, a 24-hour period of in-patient observation and investigation. In addition, for severe events (those receiving some form of CPR), senior review by a consultant is advised.

10.92. In trying to understand why the medical diagnosis was in contrast with the Consultant Paediatrician's view expressed in the criminal court case, the external medical report for BHFT concluded that ALTE's are less common in children of Polly's age. They suggest that the junior doctor on call might not have been familiar with the signs of an ALTE, or the regional guidelines on what to do if you suspect one, as mentioned above. Febrile convulsions in small children are quite common and Polly had some signs of infection and, therefore, with no other concerns, wider information on Polly's background, or unusual behaviour from B2 and M, (who appeared appropriately concerned), the medical view was formed. The presentation of Polly at the time did not therefore appear to warrant further investigations.

10.93. An additional concern was that the medical assessment in ED indicated that there may a possibility of rib fractures caused by B2 undertaking chest compressions on Polly (the ambulance crew had witnessed this). When asking why as part of this review this was not explored further, the medical view was that it was highly unlikely that a toddler of this age would have received fractures through chest compressions. Polly had recovered well, showed no signs of any trauma, or breathing difficulties, (which she would have had if fractures existed). However, the rationale for not doing so should have been documented on her notes by medical staff at the hospital.

10.94. No detail was given of other services being provided at the time or whether Children's Social Care knew of Polly. This may be because this was not asked for or asked for but not filled in, or because M and B2 denied any such involvement. After a few hours observation on the ward, Polly was discharged home in the middle of the night after some parental pressure. Discharge from hospital of a small child, in the middle of the night is not common practice in Children Assessment Units / Urgent Care Centre, though does occasionally happen if felt to be in the child's best interests.

10.95. A discharge letter was completed and addressed to the GP in Derbyshire. The planned follow-up appointment was noted to be requested for two weeks' time, but in fact was not given until 21st May 2014, by which time Polly had died.

10.96. A review of the records by the author of the Burton Hospitals NHS Foundation Trust IMR showed there were no recordings on the record sheet in relation to safeguarding issues; these sections on the pro-forma were empty. This would suggest that despite safeguarding issues being part of the record sheet and, therefore, should be part of any differential diagnosis, safeguarding issues were not considered. The hospital was not proactive in ascertaining if Polly was known to any statutory services. When children attend ED or are admitted to hospital, information as to whether they are known to Children's Social Care or have a social worker should form part of the documentation. A number of recommendations for change have resulted as part of the internal review for BHFT and for other health partners - see Finding 5.

10.97. The admission of Polly to hospital in February 2014, following the supposed 'febrile convulsion', was never reported to SW2. Once SW2 found out from MGM that Polly had been admitted to hospital, SW2 was proactive in making phone calls to the hospital and spoke to several doctors to try to establish exactly what the cause of the fit had been. The records on the file of SW2 show he asked specifically about any link between the hair loss

and the convulsion, but the doctor he spoke to could see no connection. There was no suggestion whatsoever that at the time this might be an NAI.

Was there evidence of faltering weight?

10.98. There is some discrepancy between the view of the health professionals on the SCR panel and that concluded by the consultant paediatrician who presented at the criminal trial that Polly had lost significant weight in the last few months of her life. This matters as it suggests that professionals were not monitoring Polly's weight and growth sufficiently. As part of the review, the author asked the Designated Doctor on the SCR panel to review all the weight and growth records and plot an accurate growth chart.

10.99. When Polly was born, her weight was between just below the 9th centile[13]. She grew along the 2nd centile for the first four to five months. Her weight then increased slowly across centiles to around 9th centile when she was about 11 months. During these early months, her growth was consistent with her birth centiles and therefore did not give any cause for concern and certainly not for escalation. At 11 months, when in foster care, her weight and height increased rapidly to the 25th centile. This should have alerted health professionals for the need to monitor Polly's weight more regularly once she returned home. Expected practice would be that any child returning from foster care to a parent should have their baseline measurements taken at that time. This did not happen. It is not clear why the HV1 did not and it can only be presumed that this was as oversight. The CIN plan did expect growth and development to be part of the health visitor role.

10.100. In November 2013, M identified that her child was a 'fussy eater' and arrangements were made to weigh her at the next visit. This was three months after her return from foster care; the growth measurement in November 2013 is not documented, due to the passage of time the reason for this cannot be recalled by the health visitor. When Polly was seen in January 2014, she was not weighed as it was at the CIN review meeting and it was not felt appropriate to weigh her in the social care offices. It could however, be argued it would have been valuable information for those present at the meeting to have had an up to date measurement for their own records at that time. An appointment was arranged for two days later, but again, there is no documentation of this in the health visitor records. Polly was weighed at the child protection medical in January, but this growth measurement was not received by the health visiting service. At this time, it is important to recall that Polly was not on a CPP for neglect, she was on a supervision order and viewed as a Child in Need.

10.101. Polly was weighed one more time, one week before she died, when her weight was again on the 9th centile. Polly was very fractious about being weighed so was weighed in vest and pants, the health visitor described her as slim, but M is very petite and BF is also slim. Queen's Hospital Burton have substantiated as part of the SCR process that they did not weigh Polly when they saw her in February 2014. What is clear is that Polly's weight and growth were not regularly monitored, despite it being part of the CIN plan.

[13] A centile chart shows the pattern of growth that healthy children usually follow. The curved lines on the charts are called centile lines. These show the average weight and height gain for babies at different ages. If a child's weight is on the 25th centile, this means that if you lined up 100 children of the same age in order from the lightest to the heaviest, the child would be number 25 and 75 children would be taller. It's normal for a child's weight or height to be anywhere within the top and bottom centile lines on the charts.

Polly grew at a sub-optimal rate; she had the potential to put more weight on, as had been demonstrated when in foster care, but she was not recorded to be actually losing weight.

10.102. Following this case and other reviews, health-visiting policy on weighing children has now changed where neglect is an issue, but it has to be seen as such. Health visitors are also expected to seek safeguarding advice on how often a child's weight should be reviewed. It is treated as a much higher risk with a number of cases having a CPP alongside the supervision order and clarity regarding visiting families.

Delay in seeking legal advice

10.103. From January 2014, professional concern began to rise, and there were a number of incidents that suggested that whilst there was no evidence of non-accidental injury to Polly, there was evidence that in addition to increased concerns about domestic violence between M and B2, her supervision and care might also be deteriorating.

10.104. There were two occasions when DCS were given legal advice to progress a PLO process or commence care proceedings, once in January (PLO) and once in April 2014 (care proceedings). In January 2014, this was via email to SW2, when the concerns centred on M and B2 and the reported physical and verbal conflict within their relationship. Reference was also made to the recent child protection medical where a diagnosis of alopecia was given, and other minor cuts and bruises. Appropriate legal advice was given that suggested that the SW2 should send M a Public Law Outline (PLO) letter and call a PLO meeting to inform M that DCS were considering re-issuing care proceedings to pursue a plan of long term care for Polly. If a PLO is triggered this entitles M to obtain free legal advice. Clear advice was also given to SW2, to require M to end her relationship with B2, swab test her for drug and alcohol abuse, and for M to commence some more sessions with the original key worker from the Next Steps programme. SW2 was also advised to draw up a very clear contract of expectations/ PLO agreement to make it clear what M needed to do to avoid proceedings, and what the consequences of non-compliance would be. A suggestion was also made to call a network meeting of all professionals involved with the case to gather and record any additional concerns; this could then be used, as evidence should the case return to court.

10.105. In the lead reviewer's view, this was good advice and appropriately referred back to the original concerns that took account of M's previous history. The lead reviewer has tried hard to ascertain why this comprehensive plan of advice was not taken up. From the perspective of the social worker, each time he felt worried about Polly, medical opinion, was that there was no NAI, the HV1 continued to see her as thriving, and reaching her developmental milestones, and M continued to convince SW2 that she was not seeing B2 or that their relationship was not violent. At one point, the SW2 and his manager had viewed CCTV footage from the supported living accommodation of B2 and M that supported this view, and did not evidence that there was violence between them. In essence, following receipt of the legal advice SW2 made more enquiries about the original facts and was persuaded that the concerns were not as significant as originally presented to the legal advisor. However, there was a naivety in the assessment of the situation, too heavy reliance on medical opinion as to the presence or absence of physical abuse, and a lack of authoritative action or direction by management to take up the legal advice. In simple terms, it was felt that it was still in Polly's best interest to be at home with her mother, and that M was not herself posing a risk.

10.106. The concerns did not go away. In fact, they increased. There was a legal meeting held on the 10th April 2014, where it was agreed there was now sufficient evidence (following the alleged burning of the cot by B2) to issue urgent Care Proceedings, and ask for an ICO, but that the papers would have to be submitted within seven days to capitalise on

the immediacy of the alleged latest domestic abuse incident. SW2 visited M to obtain details of the incident, but she withdrew her allegations. As there was no physical evidence or witness testimony to say otherwise, along with the fact that other information such as non-attendance at certain appointments also turned out to be inaccurate, SW2 felt the evidence to justify an immediate return to court dissipated, hence the team manager did not send the papers to legal services within seven days, although the SW2's Manager did email legal services to indicate that he still intended to do so.

10.107. There was therefore a delay in taking legal action, and the authors view is that this was a missed opportunity by DCS. There was concrete evidence of drug use by M on 16th April 2014 and 25th April 2014(the first observation since M was 20 weeks pregnant). M had refused a drug test, and if it this had been investigated more thoroughly could have provided grounds if not for care proceedings, for further inquiry and consideration of putting Polly back on a CPP.

10.108. SW2 was advised by the Legal Services Department as part of the legal meeting on the 10th April, three weeks before Polly's death, to ask M to sign a written agreement saying she would not allow B2 to come into contact with Polly, but M refused to do this. In this instance, the childcare solicitor asked for a written agreement to be signed as a way of indicating to M clearly what was required of her, on the basis that urgent legal proceedings were going to be issued for an ICO with a view to the removal of Polly into care. The written agreement would have provided evidence to the court that M had been formally asked and understood that she needed to cease contact between B2 and Polly.

10.109. For M, there was confusion about why she was being asked to sign a written agreement for legal purposes. When it was part of the on-going work between her and the SW2 to manage risk. The role of written agreements, as discussed in the appraisal of practice, appears to be common and, yet, it is known that women who are in situations where domestic abuse is a risk will find it very hard to comply with such an agreement. If they are used, social workers need to be clear with families as to their purpose, and consequences of non-compliance.

The multi-agency risk assessment conference (MARAC)

10.110. The domestic abuse incident of 4th April 2014 between B2 and M was referred to Staffordshire's MASH by the police. Due to the level of concern being 'high' and a belief that the threats may be carried out, they passed details onto the Staffordshire MARAC, which took place three weeks later on the 30th April. The Chair of the Staffordshire MARAC informed the SCR panel that the discussion that took place was based on three known episodes of domestic abuse, Polly being the focus of the risk assessment. SW2 attended and there was a lengthy discussion as the MARAC panel felt that there was danger of a minimization of the seriousness of the abuse by the victim (M). Their concern was increased due to her isolation with no real local family support. They were also not convinced that M had the capacity to safeguard either herself or Polly from potential physical or emotional harm, and that there was potential risk from the perpetrator. As a consequence of this meeting some practical, though non-urgent actions were allocated, but tragically, Polly died before any of these actions could be undertaken.

10.111. Barnardo's in Derbyshire were supporting B2 through their 'Leaving Care Services', commissioned by Derbyshire County Council. Barnardo's were not aware that B2 had moved areas from Derbyshire to Staffordshire. Furthermore, as a service supporting this young man in aftercare they did not consider he posed a risk to others, and felt they had a positive relationship with him. They had a very different profile of him that did not include safeguarding concerns and it was identified at the learning event that they were unaware

of the escalating domestic abuse incidents, which resulted in the MARAC referral in Staffordshire, and were not invited to attend the MARAC itself. This should have been the responsibility of SW2, who did attend the Staffordshire MARAC meeting.

10.112. One observation from the learning event was that professionals did not appear to be clear whether B2 was in a relationship with M and was caring regularly for Polly, or whether he was just a friend. Either way he was significant in Polly's life. M had denied on a number of occasions that she was in a relationship with him and yet he seemed to be present at times of key incidents. Overall, this highlights the need for those professionals who have most contact with the child to be clear who and what men are having regular contact and care of a potentially very vulnerable child, and to be more willing to obtain this information from parents, and to ensure that information, once known, is shared though MARAC processes and with other relevant professionals. See Finding 4.

10.113. It has been identified that both DCS & Derby City's Children Services are signatories to the MARAC Information Sharing Agreement (ISA) at strategic director level. This means of all the directorates responsible for the 'care of children' including leaving care teams, the local authority holds responsibility and therefore should be represented at the Derbyshire MARAC meetings. This should result in information being updated onto the appropriate data systems. In order to provide accurate relevant information to share at MARAC meetings, any research conducted via the MARAC representation should include an update from any known workers including for example, a leaving care worker. Any actions from the MARAC identified for those workers in the safety plan will be their responsibility.

11. Additional learning points from the wider appraisal and analysis of practice that address the additional terms of reference of the review.

Parental drug use

11.1. The initial referral to DCS prior to Polly's birth made reference to mother's use of cannabis and this was explored in the pre-birth conference. M stated that she had stopped using cannabis as soon as she became pregnant, though she later admitted to the midwife some use at 20 weeks pregnant. The suggestion of possible cannabis use remained a feature of the case but it never became a focus. There was a sense, and this was reflected in SW2's court statement, that mother was young and mixed with people who were or might be users of cannabis.

11.2. On two separate occasions, M was asked to take a drugs test as concern had been raised that she might be using it. There was however, little direct evidence obtained by the SW2 that M was taking cannabis or what affect this might be having on her parenting until April 2014 when visits by SW2, the community care worker and the Fire Service raised concerns that she was directly under the influence of some substance. There were no immediate consequences for M of refusing to take the drugs test. Legal advice had been sought by SW2 in January 2014, when he was advised to get swabs and have a Public Law Outline meeting with M and her lawyer to inform her that DCS were considering issuing Care Proceedings. None of this happened and was, in the author's view, an error.

11.3. As mentioned before, there should have been more inquisitive action to ascertain the level of drugs use in the household. BF certainly had this information. As B2 was never seen as a substitute carer for Polly there was no assessment of his drug use or whether,

once he became a regular feature in M and Polly's life, there had been a significant increase in the use of cannabis by either adult. It is not therefore possible to ascertain what impact this might have had on M's capacity to parent, her emotional health or mood as it was never evaluated or properly assessed.

11.4. There are two areas for learning in relation to this issue. Firstly, that it is important for views about what might be "normal" behaviour around cannabis use for groups or communities to be challenged through good supervision and critical analysis. Secondly, that there is a need to ensure that the use of drugs testing within a child's plan is specific and that the adults are clear as to the consequences of either a refusal of a drugs test or a positive drugs test. There was an anomaly in social work practice in DCS in that social workers were expected to undertake drug swab testing. Skilled and experienced drug workers originally supported this practice, but as funding ran out social workers that received the training carried it on and it became custom and practice. However, it has become clear that the practice is too often employed without clarity on what it is trying to achieve and doing drugs tests in an ad hoc way is not appropriate for children's social workers. As a result of this SCR, the practice is being reviewed by the AD for DCS and some clear guidance written for social workers.

Housing of young vulnerable adults

11.5. When pregnant in March 2012, M moved to live in supported accommodation for up to eight vulnerable young women; a full time support worker was on site. M had previously had a tenancy at the same scheme but been evicted. The funding for this service ended in September 2012, M, and Polly, when she was born, continued to live there until February 2014. The only replacement support offered was a limited housing management and two hours per qualifying resident weekly floating support by another agency. The role of the support worker in 2012 had been very positive, as she was involved in multi-agency arrangements for support and safeguarding/protection. Her daily presence also meant that she was able to offer some supervision of the family, when direct engagement was a challenge. It transpired from the learning event that knowledge of this change in circumstances was not widely known or understood amongst professionals who attended the premises. Therefore, professionals may have assumed that there was at least some support at close-hand to M and Polly, but, in fact, this was not the case.

11.6. When full-time support ended in September 2012 a risk assessment by all agencies would have been expected and to have reasonably identified the likely impact of the withdrawal of full-time residential support. As a result, this may have relocated such a vulnerable family to another supported housing scheme. No such risk or impact assessment seems to have been considered, as discussed previously. Although it was not specifically designed to accommodate children after support funding was withdrawn, two of the residents did have young children. There was considerable concern from the professional group about the suitability of a young mother being in this accommodation, which became known locally as a place where drugs and alcohol were used and young men hung around, often causing nuisance or criminal damage. Furthermore, there were violent incidents at the property, resulting in requests for police attendance, some of which involved M and, therefore, Polly was exposed to these incidents. Finding 6 makes some additional recommendations around the need for appropriate assessments to be undertaken when considering provision of housing for vulnerable families.

11.7. The revised ToR asked the review to consider the extent to which the wider community were sufficiently aware of and engaged in the child protection process, and how any

information was obtained and utilised. The main issue is that whilst some associates of M, including another resident at the supported accommodation and B2, had observed worrying behaviour by M to Polly, they did not report it. The reasons behind this are not easy to address, there is a lack of confidence or trust in statutory services and a perception that 'to snitch' on a friend or partner would be considered wrong. The intensity of these young relationships cannot be underestimated and prioritising child protection above their own needs, when they themselves have their own vulnerabilities, may just not be possible.

Cross border moves and notifications

11.8. The professional view of the move to Staffordshire, albeit a short distance away, was that it was a positive step, 'a fresh start' for M and Polly. The growing tensions and violent incidents in the previous supported accommodation had resulted in an eviction notice. Whilst some of the incidents had been between M and other residents, the majority, which triggered the eviction, had occurred between M and her current partner, B2, so there was also a significant element of the existing conflict travelling with the family to their new home. HV1 and SW2 worked hard to support the move and both felt that things were initially better once the family had moved out of the flats. There were, however, some issues with the way Staffordshire Children's Social Care and health services were made aware of the family's move into the area. The social worker had made a telephone call to alert Staffordshire Social Care that the family were now living in their area, but did not follow it up with any written information. Although this did not actually impact on the case, on reflection SW2 thinks he should have done this as confirming verbal updates in writing should be expected practice. Although the case was not going to be formally transferred, it was important that Staffordshire had relevant information of the family history so that any emergency calls or incidents, or requests for service could be appropriately responded to.

11.9. The notifications system has now been reinforced and business support ensures that the receiving local authority is notified in writing that a child that is subject to a supervision order or Care order has moved to their area. A system is well embedded for informing other local authorities when a child that is the subject of a CPP moves into their area and a transfer-in conferences takes place. Whilst other local authorities are informed when children who have been receiving services under a CIN plan move into their area, this is sometimes done by telephone and sometimes in writing. A consistent approach is recommended whereby local authorities are informed in writing.

11.10. When the family moved to Staffordshire, M was advised by SW2 to register with a local GP. She did not follow this recommendation through, though it appears she did try to register at one point. Health visitors were at this time attached to GP practices and, as such, the primary source of information on patients/children who transfer into the area is dependent on them registering with a GP, unless there are safeguarding concerns and a child is the subject of a CPP. In such cases, there should be direct contact between the Health Visitors with an expectation there will be formal contact for a full and proper handover of information. Polly was not on a CPP, but was subject to a legal order and she and her mother had previously been living in accommodation where visits from agencies were frequent. Therefore, it was important for services in the area to engage with M and Polly as soon as possible. If a family fail to register then this should be seen in the context of a wider risk assessment about their children and alert professionals to the possibility of wider concerns. The electronic registration in child health-Staffordshire indicates that M had moved into the area some six weeks prior to them receiving the records. There was no handover provided to HV2 in Staffordshire at the point the family had moved into the area.

12. Summary

12.1. This review has, through the practitioner event and via other documentation and interviews, identified a number of practice and organisational issues, which need to be considered by the DSCB, SSCB, and individual agencies, in order to ensure that there is learning and improvement. The findings and recommendations in this report build on the work undertaken for this review prior to the criminal trial and expand on them in light of new evidence obtained post-trial and the wider ToR.

12.2. It should be noted that there was evidence of initial appropriate multi-agency practice by a group of committed workers who mostly communicated and worked well together on the CPP, regularly attended Core Group meetings and saw M and Polly often and remained consistent throughout the case. They were also adequately supervised and well trained. This is not a case characterised by a repeated lack of adherence to procedures. However, the multi-agency practice became less organised once the supervision order was made and this is significant.

12.3. Adequate health visiting practice is evident in the DCHSFT records for Polly and her mother both in the antenatal period and post-natal period right up to the transfer out of records to Staffordshire in March 2014. Polly was fully immunised, and her development was assessed using an evidence-based tool (ASQ Questionnaire). There is, however, some learning and improvement needed around weighing frequency and record keeping. There must be clarity within CIN plans around how often a child should be weighed and measured. Health visiting must record for every visit, whether planned or unannounced, and identify whether or not it resulted in access to the child. Records should be made within 24 hours of the contact and regular record keeping audits should be undertaken.

12.4. A number of professionals described M as hard to engage; she was often unavailable for scheduled appointments and it was difficult to determine what was happening in her life and with whom she was associating. Workers were persistent in their communication with her and when they felt concerned, reported appropriately to the police for a Safe and Well check.

12.5. Despite the concerns professionals had for the mother and her child, all agencies commented on the positive and warm relationship between them, which was evidenced through the child meeting developmental milestones, general attachment and her compliance with completing a domestic abuse programme, which were considered as beneficial to both her and her child. The concerns that were raised tended to focus on mother's relationships with other young people, her vulnerability to domestic abuse and her propensity for involvement in violent outbursts, threats or damage to property. The author considers that some of these concerns should have resulted in a more rigorous analysis and assessment of risks that M herself posed to Polly.

12.6. It is clear there has been a huge emotional impact on those professionals who worked with M and Polly. As they noted in the learning event, this was a young mother who they felt had bonded surprisingly well with her child and did care very much for her. It was also noted that although she was at times difficult to engage, her behaviour was not different to many of the young mothers they work with, in that *'she did not stand out'*. This makes it hard to draw conclusions about how in the future such a tragedy can be prevented. However, there are some specific practice improvements that can be made.

12.7. It is also important to hear the voice of M, who now faces a significant period in prison so the review can consider if she has information to share that could be useful to agencies working with other families in similar circumstances. Whilst she has a long time to consider what it was that caused her to inflict such cruelty on a child she clearly loved and

was attached to, she has reflected on some of the things that would help another young and vulnerable mother to prevent them ending up in a situation such as hers. Her advice to other young mums is:

"Make sure you work with professional people and social services, don't just think they want to take your child away, they are actually just trying to help you, it's just you might not see it at the time."

"If your men don't treat you with respect get away, look at your child, they need you more than anyone else."

For professionals, M reflected that if they are working with other young women:

"Make sure you see them alone, not with their partner all the time, it's not possible when in an abusive relationship to speak freely, ask the right questions, be really open about what your concerns are about, don't use written agreements to keep us away from abusive partners, as we can't control other people's actions."

13. Key findings and recommendations

13.1. The Findings relate to issues that will, if addressed, impact on improvements in current professional practice. In addition, there are a small number of specific recommendations.

Finding 1	The Child Protection Plan did not consider whether M should be subject to more detailed assessment to fully explore the implications of her mental health needs and drug use on her capacity to parent.
Finding 2	There was not enough evidence of authoritative professional practice that saw Polly as the primary client and this resulted in a fixed view that attachment and parenting continued to be good enough, as risks increased.
Finding 3	There is lack of understanding by professionals about their role and responsibility when a child is subject to a supervision order that can result in a lesser degree of protection than when a child is the subject of a Child Protection Plan.
Finding 4	There was little recognition of the role the boyfriend (B2) and father (BF) were playing in the Polly's life. This resulted in a lack of professional assessment of both the benefits and risks they posed both to the mother (M) and Polly.
Finding 5	ED and paediatric staff did not sufficiently consider whether child abuse or neglect was a possibility when Polly presented with medical issues during the last few months of her life.
Finding 6	There was insufficient consideration of the importance of the provision of suitable housing for M and the impact of it on Polly.

Finding 1: The Child Protection Plan did not consider whether M should be subject to more detailed assessment to fully explore the implications of her mental health needs and drug use on her capacity to parent.

13.2. CPP's are the key to ensuring that all aspects of risk to the child are addressed. In Polly's case this was especially important after her birth. Their purpose is clearly specified in Working Together (HM 2015): a plan should include specific, achievable, child-focused outcomes intended to safeguard and promote the child's welfare and include realistic strategies and specific actions to bring about changes necessary to achieve the planned

outcomes. The core group are responsible for delivering the plan alongside full engagement and participation of the parent.

13.3. The danger is that whilst initial assessments pre-birth may appropriately identify the risks, once a child is born, the everyday needs of the adults become the primary focus of the work in the core group. For Polly, the importance of establishing facts about her mother's psychological functioning was not embedded in the CPP and the relevance of past history, especially if a parent functions better than expected, as in M's case, is lost.

13.4. In a summary of learning from SCRs, the NSPCC has collated and analysed evidence about risk factors and learning associated with parental mental health problems[14]. They explored the findings of a study of 33 serious case reviews in England from 2009-2011 (Brandon et al) [15] of which over half found parental mental health to be a factor in the death or serious injury of the child. The study confirms that professionals sometimes lack awareness of the extent parental mental health impacts on parenting capacity, which may result in a failure to identify potential safeguarding issues.

13.5. There are a number of relevant areas from the study that are very pertinent to this case review. Prior to Polly's birth, it was clear that whilst M was not diagnosed with a mental illness the consultant psychiatrist that reviewed her referral felt she displayed many symptoms of having a borderline personality disorder. In fact as recorded, she viewed M as potentially posing a significant risk to an unborn child.

13.6. A series of stress factors existed for M at certain times, such as domestic abuse, a dependence on drugs and alcohol, alongside changes in circumstances, and her daughter's behaviour, all of which can exacerbate underlying mental health problems, which may increase risk to the child. In examining this case, the author believes that all of the above probably did affect how M coped with her daughter. For M, this was particularly evident after Polly came back from foster care in October 2013. As mentioned earlier in the report M described Polly as being a different child, having changed in the three months she was in care from a baby to a toddler. The impact of her eviction in January 2014, house move, isolation and very latterly emergence of a reliance on cannabis, were clues that she was indeed under a lot of stress. The learning for this review is that professionals never really explored if M did have a significant psychological disorder that would increase the risk to Polly, or her capacity to parent as stress factors increased.

Recommendation 1: The impact of hypothesised personality disorder, or other parental mental health issues, should always be assessed as part of a Child Protection Plan, any drug use and past history should be taken into account when assessing future risks. Further appropriate assessments should be considered where a parent's mental health presentation is identified during assessments by other professionals as being of significant concern or having the potential to have significant impact on the care of the child.

Finding 2: There was not enough evidence of authoritative professional practice that saw Polly as the primary client and this resulted in a fixed view that attachment and parenting continued to be good enough as risks increased.

[14] NSPCC (2016) Lessons from SCRs, C&YPN (25th oct-7th Nov 2016)
[15] M, Brandon et al (DfE 2011) A study of recommendations arising from SCRs 2009-2010.

13.7. A significant number of SCR's have over the years found that professionals had an undue sense of optimism about a case, missed the signs of disguised compliance and focused too much on the parent or carer at the expense of the child. There is a risk that whilst collectively working very hard to support a family, challenging and unacceptable behaviour is not always addressed in a meaningful way which highlights what the consequences will be. The author would argue that whilst there was not endemic poor practice in this case there was a lack of authoritative practice as evidenced in the appraisal section of this report. Some of this was caused by the professional view that M was difficult to engage with. In exploring in more depth with the practitioners as to why this was, and what strategies were used to address it with her, it became clear that it is a feature for professionals working with not just this case, but others, and that this leaves some of them feeling immense frustration. Authoritative practice is also about being clear about what a home visit entails, the complexity of managing the often unpredictable environment and how to make it meaningful in carrying out assessment tasks. It is, as Harry Ferguson (2016) discusses in his article in Qualitative Social Work, the place where most social work practice goes on, but is largely ignored in terms of research and social work literature.

13.8. Any non-engagement with service users should be recognised not just as a frustration as reported by professionals in this case, but as central to a child's welfare and carrying the potential to harm a child as it also prevents an assessment of their needs. Non-engagement is reported to be a feature of a significant number of previous case reviews (DfE Triennial Analysis 2016[16]). It was hard to determine how much M manipulated the professional group to do just enough to stop any significant action being taken. This was the view of the judge at the trial as in her judgment she described M as a ' *devious, manipulative and selfish young woman who would stop at nothing to get her own way.*' She also recognised that to all outward appearances M appeared to be a loving and caring mother. What was not understood was M's motivation, it could also have been that she was being coerced and frightened by B2, either way she was actively trying to ensure professionals didn't find out about some things i.e. that her partner was hiding in the bedroom.

13.9. The lead reviewer felt that the professionals had an overly optimistic view of her ability to change, as well as significant empathy for her as a victim and a liking for her. This was also compounded by the fact that she had appeared to do significantly better than expected in the early care of Polly and demonstrated good attachment, as recognised by the judge at the criminal trial. When concerns about a violent ex-partner resulted in Care Proceedings being initiated, and Polly coming into care under an ICO and being in foster care for several months, she did comply with all that was required for the child to come home. It seemed when she was under pressure she did do just enough to assure professionals of her compliance, though they often struggled to see her and Polly alone. In analysing this further, the practitioner group was asked more about their understanding of M's capacity to change and whether it was clear to both them and her, what was required. There was a sense that the CPP and, latterly, the work following the making of the supervision order did not adequately outline what a good outcome for Polly would look like. The author understands that there are to be audits of CPP's by the DSCB, to seek confirmation that plans are outcome-focussed.

13.10. The practitioners had differing views about whether M or Polly was the primary focus of their service. This is concerning as the confusion contributed to them at times losing sight

[16] Sidebottom P, Brandon M & Co (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case review 2011 to 2014 *DfE*

of what life was really like from the child's point of view, especially when there had been violent arguments and significant damage in the flat where they lived. The needs of M, like in so many other cases, tended at times to dominate the professional attention. Whilst there is good evidence that professionals saw and observed Polly regularly, their primary focus appeared to be on Polly's physical well-being at the time and the relationship and attachment with the mother, rather than the quality of Polly's overall wellbeing within the context of the physical environment and the M's emotional capacity to keep Polly safe. It must be emphasised that where there are concerns and the welfare of a child is involved 'it is the child who is the client' in that the child's welfare is paramount. The views of the foster parent whilst the child was in her care, and who had observed concerns regarding feeding were not heard or did not have an impact. Having a foster carer log might assist in informing any child care plans once a child is discharged from care and ensure that important information is not lost.

13.11. On reflection, the professionals at the practitioner event could see from the timeline shared at the event, how the potential risks to Polly were growing. Once the family moved areas, the optimistic view that all would be much better prevailed and this was reinforced by the perceived continued good attachment between mother and child and material things, such as how the house looked, alongside the continued belief that any risk to Polly was from the volatile relationships of her mother, rather than the risk her mother actually posed. However, there were at least two occasions in April 2014 when M was felt to be under the influence of drugs and action could have been taken, be it via legal proceedings or via child protection procedures.

13.12. The impact of domestic abuse and potential harm to Polly was rightly recognised by the professional group and, at one point, resulted in protective action being taken and Care Proceedings being issued and Polly going into care (as discussed previously). However, it is the lead reviewer's belief that the continued focus on the single issue of domestic violence after the Care Proceedings, detracted from any further re-assessment of M's parenting capacity, emotional health and wider risk.

13.13. Despite M attending the Freedom Programme in the summer of 2013, violent incidents and criminal damage continued to be a feature of the case after Polly returned home in October. M started a new relationship almost immediately with B2 and it was volatile from the outset, and drug use once again became a feature. There were five Police call-outs and reported incidents in the three months leading up to the death of Polly, alongside five occasions when injuries to Polly were noted and investigated by DCS and two hospital presentations. It is not clear whether there was a level of disguised compliance by M with services, or of more concern, that professionals had just not considered enough whether she had the emotional ability to change patterns of behaviour due to self-esteem, personality, previous history, or even recognise when someone posed a danger to her child. As previous SCRs highlight, it is this combination of multiple risks that puts a child at risk of serious harm, and this was missed.

13.14. MARAC processes were instigated due to an increase in the domestic abuse concerns, which challenged the optimism that the move to Staffordshire had resulted in positive change. The element of regular observation and oversight of Polly provided by the housing scheme staff and other residents had been lost, and M and Polly were actually more isolated once they moved. However, none of the original risk factors had actually disappeared. In fact, they had started to reappear.

13.15. All professionals need to be mindful of the possibility of and the need to understand cognitive bias, particularly in regards to confirmation bias; to be aware of the risk of only accepting views which accord with their own personal view and so confirm their own interpretation of any situation, in this case, that things were noted to be better as the family

were no longer living in what was viewed as risky and inadequate accommodation. The issue is whether this in any way distracted professionals from the focus on the child as the primary client. Reflective supervision processes and training must address the danger of professionals being drawn into too familiar or empathetic relationships with services users and a failure to maintain authoritative, inquisitive, challenging child focused practice from a supportive base rather than undue optimism (Triennial Analysis 2016[17]).

13.16. Research in Practice published a series of briefings about engaging with resistant, challenging and complex families. They stress the importance of relationship-based practice (RBP) that is best summarised as, 'Empathy and relationship skills balanced with an 'eyes-wide-open', boundaried and authoritative approach'[18] (Fauth *et al*, 2010). This was something that was at times missing from the work with Polly and her mother.

Recommendation 2: Agencies must review their professional supervision/training/models of practice to ensure that they adequately address the need for authoritative/relationship-based practice and challenge the use of the term non-engagement.

Finding 3: There was a lack of understanding by some professionals about their role and responsibility when Polly was subject to a supervision order that resulted in a lesser degree of protection than when she was subject of a Child Protection Plan.

13.17. One of the other most significant practice issues that the review has identified was the impact that the supervision order seemed to have on some of the professionals involved. The statutory order was made as a result of care proceedings where the risk identified related to mother's association with a violent ex-partner, and the perceived risk that he posed to the child had decreased. The professional view at the time was that M had complied with all that was required of her, was demonstrating a good level of contact and attachment to her child and had ended contact with her violent ex-partner. All professionals felt that the decision to place the child back home and be considered as a child in need was the right one.

13.18. In law, while a supervision order is in force, it shall be the duty of the supervisor to (a) *assist, advise and befriend the supervised child*; (b) *to take such steps that are reasonably necessary to give effect to the order*; (c) *where the order is not wholly compiled with; or the supervisor considers that the order may no longer be necessary, to consider whether or not to apply to court for its variation or discharge.*

13.19. From the making of the supervision order to Polly's death, there continued to be regular professional involvement with the family. SW2 made regular home visits, some of which were unannounced, held network and supervision review plan meetings and oversaw a child protection medical. Health colleagues had their own visiting regime. However, professionals reflected at the learning event that they were actually not as clear of their role in relation to the supervision order, as they were when a CPP was in place, feeling that it was somehow a lesser process. They had not understood the relevance of the statutory order. In trying to understand why this was the case, it became clear that they

[17] Sidebottom P, Brandon M & Co (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case review 2011 to 2014 *DfE*
[18] Fauth, R., Jelicic, H., Hart, D., Burton S., and Shemmings, D. with Bergeron, C., White, K. and Morris, M. (2010) Effective Practice to Protect Children Living in 'Highly Resistant' Families. London: Centre for Excellence and Outcomes in Children and Young People's Services.

did not have enough legal knowledge or understanding of the implications of the order, had never received a copy of the supervision order from the social worker, or had sight of the plan, which was included within the terms of the order and outlined the work they collectively should be undertaking. This was different from when Polly was on a CPP and they were part of a Core Group. It would seem that the process, once a supervision order was made, became less robust. It was identified that DCS does not routinely share the copy of the orders with other professionals, however it would be expected that a social worker does ensure the details contained in the order, if not shared, are transferred clearly to the CIN plan that the multi-agency team support.

13.20. In this case, SW2 did hold regular network meetings, and the first CIN plan did outline tasks and expectations, but the terms of the supervision order, which the lead reviewer has examined, were not transferred adequately enough into Polly's CIN plan. Professionals were not clear about what outcomes they were seeking other than general support. In the latter phases of Polly's life, their work focused mainly on the need to support M to move out of the scheme accommodation where they lived, and monitoring of Polly's health and development. There should have been clearer management oversight of the case by health and social worker supervisors. Managers should review CIN plans with their staff to ensure they adequately address risks and vulnerabilities. The CIN plan for Polly needed to ensure that not only the professionals, but also her parents were clear about expectations whilst their child was subject to the supervision order and what the consequences of non-compliance would be. The plan should be shared and kept updated and reflect changing circumstances and risks.

13.21. An additional issue that also needs to be emphasised is to ensure that professionals are clear that if concerns about the safety or potential harm to the child begin to escalate then a supervision order does not prevent a parallel process of child protection taking place. Professionals should consider holding a strategy meeting to determine whether a Section 47 enquiry should be completed, which may lead to an ICPC. There seemed to be an assumption made by professionals that the main option open to them in light of their increasing concerns was to go back to court.

13.22. The lead reviewer has noted that Derbyshire Child Protection procedures, which were updated in February 2014 and regularly thereafter, say consideration should be given to a CPP when a supervision order is granted and that this should run in parallel to any order. However, they feel this should be strengthened. The author is advised that the DCS policy now states that a CPP should be considered appropriate for a minimum of 6 months where a child is returning to carers in whose care the significant harm originally occurred. The plan should be specific and purposeful in its aim to reduce risk and build on strengths to support the child in their care arrangements, it is expected that children subject to a SO are visited at a minimum of every 4 weeks.

13.23. This finding has wider significance for the child protection system and the author questions the value of supervision orders in current practice. They are frequently obtained for children where there has been previous child protection concerns, resulting in care proceedings, and used as a tool to test out rehabilitation. If there is on-going risk then it might be more appropriate for children's services to consider if a care order with placement to parent/s would be a more suitable option. Alternatively, supervision orders should as a minimum have a CPP, rather than a CIN plan, alongside it. A number of other LSCBs have recently published SCRs where children have been seriously harmed where a supervision order has been used to monitor the child. (See Sophie-Hertfordshire LSCB 2016)

Recommendation 3: Any child who is **returning** to a carer where there have been safeguarding concerns should have a Child Protection Plan rather than Child in Need Plan, running parallel to the supervision order for at least the first six months.

Recommendation 4: Derbyshire Safeguarding Children Board should undertake a multi-agency audit of children subject to a supervision order, to assure themselves that there is good evidence that care plans made post supervision orders are robust and outcome focused.

Finding 4: **There was little recognition of the role the boyfriend (B2) and father (BF) were playing in Polly's life. This resulted in a lack of professional assessment of both the benefits and risks they posed both to the mother (M) and Polly.**

13.24. Throughout DCS's involvement with M, she had a number of male friends or partners. Whilst some of these relationships appeared transitory, there was too much reliance on M to self-report on them. The NSPCC's document "Hidden Men" (2015)19 highlights the very important role men have in children's lives and influence on the children they care for. Despite this, they can be ignored by professionals who sometimes focus almost exclusively on the quality of care the children receive from their mothers. The report also comments on the extent that professionals can rely too much on mothers to tell them about men involved in their children's lives: "If mothers are putting their own needs first, they may not be honest about the risk these men pose to their children.

13.25. As discussed, there was also a lack of professional curiosity about the role B2 was playing in the child's life, or discussion with M on her own as to the nature of their relationship, which continued to be volatile. Explanations that she was no longer in a relationship with him were accepted, and her previous history not properly taken into account.

13.26. It was clear that B2 was a feature in Polly's life from as early as October 2013 right up to her death in May 2014, despite the fact that M kept saying that the relationship had ended. SW2 did make some enquiries, asking him for his address and occupation, and there was a review of his old social care records from his time in care. However, there is no record of either any Police checks on B2 being made by a social worker, nor any exploration of his background with his aftercare worker in Barnardo's who was proactively engaged in discussions about B2 and his relationship with M and the child. No formal assessment was undertaken on B2 and this is a clear omission. Regular liaison with the aftercare worker and a police check would have revealed additional information about B2's volatile relationship with his ex-partner. B2 said in interview with the lead reviewer that the social worker never talked to him about either his own background, nor asked him about the nature of his relationship with Polly and M. He knew that some checks on his background had been done by SW2, but said they never asked his permission to undertake them. If they had, he said he would have complied. As a consequence of this review, the training department within Children's Services has been asked to devise a training package based on the NSPCC document "Hidden Men" for delivery during 2017. This will highlight the need to ensure that fathers and partners are included in assessment and planning and address some of the underlying reasons and cultural barriers which can lead to their exclusion from the process.

[19] NSPCC (2015) Hidden Men: Learning from Serious Case Reviews

13.27. A feature of this case review was the way professionals worked with BF and ensured that he continued to have his views heard in the work they were undertaking with Polly. An initial viability assessment of him by DCS had concluded that the state of the house he lived in, and his use of cannabis, which he admitted using to help control the symptoms of his attention deficit hyperactivity disorder (ADHD), meant that he was not viewed as a suitable permanent carer, although it was acknowledged the state of the house improved.

13.28. This decision was revisited in January and February 2014, once he had continued to have increased contact, including overnight and week-long stay. However, this was not followed through to a new assessment. Initially he had not been able to play much of a role in the life of the child as his ex-partner (M) questioned whether he was the birth father. However, once he was proved through DNA testing to be the father he gained parental responsibility and contact, which was initially three hours a week to be arranged between him and M. The Social Worker visited him to check progress, had some telephone contact with him and invited him to attend the network meetings, which he did.

13.29. As the contact increased, it was felt by DCS that BF ought to undergo a parenting assessment, but the way this was explained was not helpful and the relationship between BF and SW2 deteriorated. Contact between them came to an end, and it was acknowledged by SW2 in interview with the lead reviewer that greater effort should have been made to pursue this, and for BF to be re-engaged.

13.30. In the meeting with the lead reviewers, BF explained his situation at the time and that he felt that he had not been listened to or consulted by SW2 or health professionals, especially when he was voicing concerns about the care and safety of his child by M, at the time of the child's hospital appointments for hair loss and following the admission for a suspected febrile convulsion.

13.31. This finding is a common feature of many cases where there are young, vulnerable fathers. There was no evidence that BF posed a risk to Polly and, in fact, he was actually providing some good protective care and financial support, but it would seem that his parental role was not seen as that significant. DCHSFT reflected that they sought no contact with him at all. A review of the role of Health Visitors' roles in 2007 suggested that Health Visitors often make assumptions about young fathers and can be ill-equipped to give them support (DOH 'Facing the Future: a review of the role of Health Visitors 2007).

13.32. It was apparent that the professionals were not clear as to the role BF was playing, or how much contact he had in the weeks before Polly's untimely death. He advised the reviewers that one issue that did not help from his perspective was the consequences of the agreement in the care proceedings not to have a defined contact order. He felt that if he challenged the quality of M's care of the child she would stop arranging or allowing contact, and, in fact, there were times when this was the case. However, as previously stated, this arrangement was the direct wish of both the BF and M. It has also been clarified that father was legally represented in the proceedings and he put forward his case for care and contact, but was assessed as not being able to offer a permanent home to Polly due to his personal circumstances. However, it was agreed that, with support, he could have weekly supervised contact with his daughter for up to three hours. Contact arrangements and any issues resulting in them should have been specified in the CIN plan, regularly reviewed, and a package of support offered to BF to help him take on his new parenting role and assess any other risks.

Recommendation 5: Where there are safeguarding concerns for children, fathers/male partners must be adequately consulted, supported and assessed in the care of children, even if they are not the primary carer.

Finding 5: ED and paediatric staff did not sufficiently consider whether child abuse or neglect was a possibility when Polly presented with medical issues during the last few months of her life.

13.33. Professionals in paediatric and accident and emergency teams have a vital role to play in the identification of some of the most hidden but severe forms of child abuse and neglect. Medical staff, especially those who are less experienced, must be mindful of the potential for abuse to have taken place and not be so focused on medical diagnosis that other explanations are not sought. Recognising signs of abuse is difficult and even with inquisitive and wider questioning easy to miss, sometimes with fatal consequences. However, the taking of a detailed history and consideration of social circumstances when reaching a conclusion about the cause of a medical presentation is crucial. The NSPCC (2016)[20] highlight the importance of a focus on improving practice within the health sector in this area following recent lessons from other SCRs that are very pertinent to this case.

13.34. As discussed in depth in the appraisal of practice, in the months before her death, Polly had a growing number of minor injuries and medical concerns. She been admitted to hospital following a suspected febrile convulsion, had developed alopecia areata, and had had a cut lip (mother's explanation for this had been accepted).

13.35. The health IMRs and lead reviewer considered whether there had been adequate professional curiosity by medical staff at the hospital to look at alternative explanations for the suspected febrile convulsion and cut lip and conclude that there was not. It is important that when a diagnosis is not certain that safeguarding issues are fully considered by conversations with the social worker and health visitor as part of any differential diagnosis and seen chronologically. The injuries themselves may be minor, but they should be seen in the context of any change, additional stresses that may be impacting on the parent and reviewed as part of any CIN plan. It is also vital that there should be liaison with health, and social care about any follow up appointments, and to consider the impact of parental avoidance when a follow up appointment is missed, in this case the follow up to the supposed febrile convulsion episode.

13.36. In 2014, an alert system (which would flag any safeguarding concerns on a child to medical staff) was only available to medical staff in ED in Queen's Hospital Burton if the local authority children services had previously shared the information. Staffordshire Children's Social Care and BHFT did have a process for sharing information on children in their area who are known to be at risk, but it did not include Polly as she was still seen as a Derbyshire child and no such cross-border agreement to do so existed. More recently, BHFT has implemented a more robust system in place that highlights every child who has an alert using a red flag to prompt further narrative and enquiry. However, the information sharing with Derbyshire is reported by them to still be inconsistent.

13.37. It is hoped that the CP-IS project (Child Protection Information Sharing) in the NHS will deliver a higher level of protection to children who visit NHS unscheduled care settings. The project began in 2014 and by 2016 the aim was for 30% of sites being live, 50% in 2017 and 80% in 2018 (Health and Social Care Information Centre (HSCIS). Before this project is 'live' across England, unscheduled care settings must be

[20] NSPCC (2016) Lessons from serious case reviews paediatrics and A&E care (CYPN 27th Sept-10Oct 2016)

more proactive in ascertaining whether there are safeguarding concerns and these should be part of the differential diagnosis and care plan that includes not just children that are on a CPP but also a supervision order, something which at present the CP-IS system is not set up to consider. Derbyshire and Staffordshire NHS Trusts have signed up to the CP-IS project and have confirmed they are on target for implementation in January 2018.

13.38. The non-medical practitioners at the learning event felt that whilst there was a level of pertinent challenge by themselves in examining the details of the hair loss in more depth there had, on reflection, been an inadequate level of curiosity by the whole multi-agency team about what might be contributing to Polly's hair loss. Although there was no medical evidence given to them at the time that the hair loss was caused by anything suspicious, it should have prompted further enquiry about how Polly was experiencing her daily life and any stress she was under. The previous GP was also unaware of some of these issues, as this was around the time the child was not registered with a local GP.

13.39. There was liaison between the paediatric consultant who undertook the child protection medical and SW2, when Polly was not taken to two follow-up appointments with the dermatologist for the alopecia; however, this was not viewed in the context of potential signs of parental neglect. As mentioned previously in this report, the significance of missed appointments should not be ignored.

Recommendation 6: ED and paediatric staff must ensure that they always consider abuse or neglect within their differential diagnosis [21] when considering the reasons for a child's presentation. Where this remains a possibility, this should be recorded and appropriately risk-assessed, considering all available information. This is particularly important for young children who present with a seizure, febrile convulsion or ALTE. Consideration should also be given to obtaining an examination of the child's eyes by a paediatric ophthalmologist. This may provide additional clues to the cause of the event, including retinal haemorrhages in the case of shaking.

Recommendation 7: Both Derbyshire and Staffordshire Social Care and Healthcare Partners should ensure that Child Protection – Information Sharing (CP-IS) is implemented.

Recommendation 8: Missed medical appointments for children on a child protection or children in need plan should no longer be recorded as DNA (did not attend) but always seen in the context of '*was not brought*', to ensure that parental neglect is considered as a factor. A risk assessment should be considered and appropriate action taken as a result of this classification.

Finding 6: There was insufficient consideration of the importance of the provision of suitable housing for M and the impact of it on Polly.

13.40. This review has highlighted the need for robust assessments to be undertaken when considering the provision of housing for vulnerable young mothers. During the review, it was identified that the accommodation M lived in from 2012 was not suitable once Polly was born. This was especially so once the provision of the support worker had been withdrawn, which resulted in increasing concerns over the security of the building, and included damage to the property and the volatile behaviour of M and other residents There

[21] The process of differentiating between two or more conditions which share similar signs or symptoms.

was a lack of assessments in relation to the safety and welfare of Polly during this time and none of the issues in relation to why M was eventually evicted were addressed before M and Polly were rehoused. There was an over optimistic view that the rehousing of M and Polly would solve long-standing problems.

Recommendation 9: DSCB Partner Agencies should consider how more robust assessments are undertaken when vulnerable parents with children, where there are safeguarding concerns, are housed. These assessments should consider the risks associated with housing being offered and its suitability in relation to the age of child/ren.

14. Conclusion

14.1. This SCR has sought to address the effectiveness of professional practice, including decision-making, assessment and information sharing over the two-year period of the review as specified in the ToR. It has also sought to identify wider learning points for the safeguarding system.

14.2. The death of any child is a tragedy, however, when the death is considered to be due to abuse or neglect there is a temptation to try and ascertain if the death was predictable or preventable. As Eileen Munro said following her review into the child protection system[22], "*it is important to be aware how much hindsight distorts our judgement about the predictability of an adverse outcome*" Once we know what the outcome was we look backwards and want to explore why signs that seem obvious now were missed. The Triennial Analysis (DfE 2016[23]) urges us to move away from this approach, "*children can be harmed within the contexts of risk and vulnerability. There may be opportunities for prevention and protection, even without being able to accurately predict when children will be harmed and in what manner".* The important point is that we need instead to acknowledge room for improvement in the local safeguarding systems as expressed through the learning points and findings in this report.

14.3. It was appropriate that Polly was made the subject of a CPP at the time of her birth. However, 10 months later, the concerns by professionals were too focused on the needs of her mother, and the risk she was deemed to be at as a victim of domestic abuse. The failure not only to continue to consider wider past history, including a thorough exploration of early childhood, but also to re-evaluate their assessment of M's parenting as being good enough as Polly grew older continued to ensure that an unduly positive picture of M's capacity to parent safely went unchallenged, and the daily lived experience of life for Polly was somewhat lost.

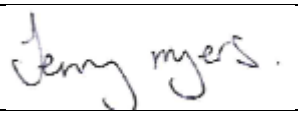
14.4. In addition, the supervision order may have deflected professionals' focus away from the original safeguarding concerns, which were present before birth. There was a lack of an outcome-focused CIN plan. That said, the evidence available to professionals at the time (there had been no medical diagnosis of NAI), led them to believe that the attachment and parenting of Polly by M was more than adequate and though she still had volatile relationships with friends and partners, it did not suggest that she posed a direct risk of physical harm to Polly, although in the latter weeks of the child's life she clearly did. Recent SCRs indicate that only 4% of non-accidental deaths of children are perpetrated by birth mothers, so whilst elements of risk and failure to protect or neglect are common, understanding the complexity and indicators in order to predict that a mother, especially

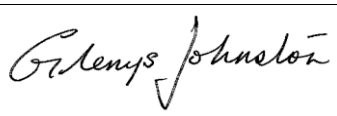
[22] The Munro Review of Child Protection, Final Report; a child centered system 2011 (DfE)
[23] Sidebottom P, Brandon M & Co (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case review 2011 to 2014 *DfE*

one who demonstrated strong attachment, may kill her child is extremely difficult. From the facts and evidence in this case, such an act by M could not have been predicted. The birth father himself admitted to the review author that whilst he had many concerns about his ex-partner's behaviour, the people she associated with and her reliance on alcohol, at no time did he anticipate that she would fatally harm their daughter.

14.5. It must be acknowledged that whilst some risk elements were recognised, in the months leading up to the Polly's death it would appear the violence between M and her then partner was escalating, yet being minimised by her. Professionals made much of the positive relationship observed between M and her child and this appeared to lead, at times, to a prevailing sense of optimism and a lack of professional curiosity about the current partner, violent incidents, drug use and his care history and background. Professionals should have been more inquisitive about the impact of M's new partner and her other relationships on the safety and health and welfare of Polly. There was also a missed opportunity to go back to court or invoke child protection procedures between February 2014 and April 2014.

14.6. Tragically, as professional concern was once more escalating and steps were being taken to return the matter back to court, Polly died before any further protective action could be taken.

Lead Author		
Print Name	Jenny Myers	Jenny Myers MM AA CQSW
Date	25th August 2017	25th August 2017

Independent Chair of the SCR Panel for ADS14		
Print Name	Glenys Johnston	Glenys Johnston OBE
Date	25th August 2017	25th August 2017

Appendix 1

TERMS OF REFERENCE: SERIOUS CASE REVIEW ADS14

Statutory basis of the Serious Case Review

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances.

Regulation 5(1)(e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and
(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Timeframe for the review

The SCR will cover the time period of 1 May 2012 to 1st May 2014.

Terms of reference.

1. Determine whether decisions and actions in the case comply with the policy and procedures of named services and the LSCB.
2. Examine inter-agency working and service provision, including quality of assessments, for the child and the parenting capacity of the mother/ mother's partner.
3. Determine the extent to which decisions and actions were child focussed.
4. Examine the involvement of the child's birth father, grandparents and other significant family members in the life of the child, and family support provided to the subject family.
5. Examine the effectiveness of services and information sharing between children in care/leaving care services involved with the mother's partner and the impact of these on the subject
6. Examine the effectiveness of information sharing/ working relationships between cross border agencies, particularly Derbyshire and Staffordshire areas.
7. Seek contributions to the review from appropriate family members and keep them informed of key aspects and progress.
8. Hold a learning event for practitioners and identify required resources.
9. Establish any learning from the case about the way in which local professionals and agencies work together to safeguard children.
10. Identify any actions required by the LSCB to promote learning to support and improve systems and practice.
11. To determine whether, and if so, what changes in practice are necessary to prevent any such missed opportunities in the future.

12. To determine if opportunities were missed to identify and evidence the physical and emotional abuse suffered by ADS14 and intervene appropriately in her care to prevent her death.
13. Identify the information, which was available to professionals regarding ADS14's physical and emotional presentation during her life and to consider how effectively this information was evaluated and used.
14. Identify the information which only became available post- mortem and to consider whether this information could have been available during ADS14's life and whether mechanisms are in place to achieve this
15. Identify the information, if any, which was or should have been available to professionals working with M and B2 which would have enabled them to predict M and B2's behaviour towards ADS14. To consider whether this information was used effectively and whether any incorrect assumptions prevented effective protective practice.
16. Determine the extent to which decisions and actions were child focused, rather than focused on either M or B2.
17. To consider the information which was known about M during her pregnancy and whether this was effectively acted upon prior to ADS14's birth.
18. Examine whether effective use was made of care proceedings under the Children Act 1989. This should include consideration as to the evidence, which was presented to the Court; in particular, the available evidence in relation to the attachment between M and ADS14 and M's psychological functioning. Evaluate the effectiveness of the implementation of the supervision order, which had been made in respect of ADS14.
19. Consider whether M and B2's drug misuse was effectively evaluated and whether the impact of this on their ability to care for ADS14 was understood.
20. Consider the extent to which the wider community (including associates, friends and neighbours) were sufficiently aware of and engaged in the child protection process. Consider how information from the community was obtained and utilised.
21. To consider whether any factors relating to gender, culture, ethnicity, or disability were effectively identified and appropriately informed decision-making.
22. To consider the appropriateness and receipt of professional training.
23. To consider any organisational issue (including the level of experience of workers) which may have affected practice.