Derbyshire
Safeguarding Children
Board

Serious Case Review ADS14

Polly*

Executive summary

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[25/08/17]

*The full report will be published in line with statutory guidance. This is an executive summary of the published report. 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

1. Table of Contents

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 executive report summarises the findings of an independently led Serious Case Review (SCR) commissioned by the Chair of Derbyshire Safeguarding Children Board (DSCB) following Polly's death in 2014.

3.2. 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.

3.3. 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.

3.4. 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.

3.5. 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.

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.**

4.2. Two highly experienced independent reviewers led the review. A multi-agency SCR Panel established by DSCB and was chaired independently. 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

4.3. The SCR lead reviewer and author took account of the experiences of both practitioners and those in Polly's family who wished to contribute. Their views have informed the learning and analysis.

5. 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	

5.1. Polly lived for most of her life with her Mother (M) in supported accommodation and then latterly in privately rented accommodation. She was a lively and loving toddler.

5.2. 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.

5.3. 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.

5.4. 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.

5.5. 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.

5.6. 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.

5.7. 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 her mother went to stay with MGM, but this arrangement was unsuccessful and Polly came into local authority foster care'.

5.8. 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.

5.9. 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 Oct 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.

5.10. 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.

5.11. In Oct 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.

5.12. 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.

5.13. 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 Polly 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.

6. Summary

6.1. There was evidence of initial appropriate multi-agency practice by a group of committed workers who mostly communicated and worked well together, 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. Polly came into contact with a variety of child protection professionals, both within social care and health settings, including an admission to the Emergency Department in February 2014 with a suspected febrile convulsion.

6.2. 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. 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. What is clear from the review is that Polly's weight and growth were not regularly monitored, despite it being part of the CIN plan. 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.

6.3. 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.

6.4. 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. There were occasions when DCS were given legal advice to move to move into the Public Law Outline process (January 2014) and thereafter to initiate care proceedings (April 2014), once in January and once in April 2014. Whilst this does not mean Polly would automatically have been removed from her M's care it does mean the opportunities to place the case back before the court were lost.

7. Key findings and recommendations

7.1. The fully published SCR provides a detailed summary of the professional involvement with Polly. The key findings, recommendations and learning points are summarised below.

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.

7.2. CPPs 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.

7.3. 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 and how that might impact on her parenting capacity and ability to keep her daughter safe, was not embedded in the CPP and the relevance of her past history was lost.

7.4. 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 Oct 2013 when she described her daughter as seeming like 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 Jan 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.

7.5. 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. 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.

7.6. 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. 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.

7.7. 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'[1] (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.

7.8. 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.

[1] 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.

7.9. From the making of the supervision order to Polly's death there continued to be regular professional involvement with the family. 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. In trying to understand why this was the case, it became clear that they 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 and which should have been transferred to the CIN plan.

7.10. 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. It should also have had good management oversight.

7.11. 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. 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.

7.12. 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.

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.**

7.13. 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)[2] highlights the very important role men have in children's lives and influence on the children they care

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

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.

7.14. There was also a lack of professional curiosity about the role B2 was playing in Polly'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.

7.15. A feature of this case review was the way professionals worked with BF. An initial viability assessment of him by DCS had concluded that he was not viewed as a suitable permanent carer. This effectively influenced the amount of contact professionals had with him and PGM. As his contact increased with Polly it was felt by Children's Social Care that he ought to undergo a parenting assessment, but the way this was explained was not helpful and the relationship between BF and SW2 deteriorated and contact. between them came to an end.

7.16. In the meeting with the lead reviewers BF explained his situation at the time and 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. 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 help him take on his new parenting role and assess any other risks.

7.17. 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 by any of the agencies involved.

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.

7.18. 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.

7.19. 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). 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 [3]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.

7.20. 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). [4] 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.

7.21. 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.

7.22. 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. Before this project is 'live' across England, unscheduled care settings must be 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. Both Derbyshire and Staffordshire NHS Trusts have signed up to the CP-IS project.

7.23. 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.

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[3] 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.

[4] 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.

Recommendation 6- ED and paediatric staff must ensure that they always consider abuse or neglect within their differential diagnosis [5]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 assessments 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.

7.24. 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.

7.25. Metropolitan Housing Trust went through significant changes to their contract with Derbyshire County Council at the end of October 2012 resulting in a reduction in support to their vulnerable residents including that to M and Polly. These changes did not appear to be widely understood by the professionals involved in the case. The consequence was that the input regarding Polly and M's housing situation was not available to practitioners.

7.26. 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 service provided was reduced, 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 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.

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

8. Additional Learning points from the wider appraisal and analysis of practice

Parental drug use

8.1. 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, even after M refused to take drug test in January 2014 and after two separate observations in mid and late April 2014 by professionals that she was under the influence of some substance. 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.

8.2. 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 for social workers written.

Housing of young vulnerable adults

8.3. 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. 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.

8.4. 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. 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.

Cross border moves and notifications

8.5. 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. 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.

8.6. 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.

8.7. 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

The use of written agreements

8.8. 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. However in the authors 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.

9. Conclusion

9.1. 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. It has also sought to identify wider learning points for the safeguarding system.

9.2. 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[6], "*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 review (DfE 2016) 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.

9.3. 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.

9.4. 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 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.

[6] The Munro Review of Child Protection, Final Report; a child centered system 2011 (DfE)

9.5. 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.

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

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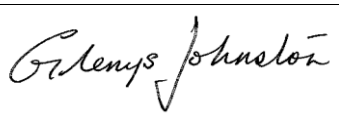
Independent Chair of the SCR Panel for ADS14	
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