city & hackney safeguarding children board

CITY OF LONDON & HACKNEY SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CHILD N & O

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Contents

1 INTRODUCTION

1.1 EVENT TRIGGERING THIS SERIOUS CASE REVIEW & KNOWN BACKGROUND

1.1.1 On 18.03.17 child N (a 16 month old male) was assaulted by his father. His female twin (child O) sustained serious injuries in the same incident. Child N was brought to Royal London Hospital in full cardiac arrest by the Helicopter Emergency Medical Services (HEMS) and pronounced dead. His twin was transported to the same hospital then via the Children's Acute Transport Service (CATS) to Kings College Hospital for further treatment. Father subsequently pleaded not guilty to murder, admitted manslaughter on the grounds of diminished responsibility and in October 2017 was sentenced to indefinite detention.

1.1.2 The family had limited involvement with universal services in Haringey and had only lived in Hackney for about a fortnight before the children were assaulted.

1.1.3 Father, who originates from Bangladesh had first arrived in the UK (possibly via Romania) on a student visa on 22.01.10. He was served papers on 03.10.14 in respect of him being an 'over-stayer' and in consequence, had no recourse to public funds (NRPF)[1]. He initiated an appeal on 12.01.17 which remains outstanding. The twins' mother, who is of Romanian origin, has a right to reside in the UK.

1.1.4 Mother and the children (and latterly father) were registered with a GP in Haringey. Father was not (so far as is known) in receipt of any other public services and he had no criminal record in the UK.

CONSIDERATION OF A SERIOUS CASE REVIEW

1.1.5 The independent chairperson of the City & Hackney Safeguarding Children Board (CHSCB) made an immediate decision on 20.03.17 that the required criteria for completing a serious case review (SCR) (reproduced in paragraph 1.2.1) were satisfied for both children.

1.1.6 The Department for Education (DfE), regulatory body Ofsted and the 'National Panel of Independent Experts' (NPIE)[2] were informed of the above decision and this review was undertaken between April and October 2017 in accordance with the terms of reference (reproduced in section 4).

1.1.7 Following approval by the CHSCB, a copy of this report is being sent to the NPIE and to the DfE.

[1] No recourse to public funds (NRPF) is a condition imposed on someone due to her/his immigration status. S.115 Immigration and Asylum Act 1999 indicates that a 'person has no recourse to public funds' if s/he is subject to 'immigration control' e.g. a visa 'over stayer' such as child N&O's father

[2] The NPIE was established by central government in 2013 in order to advise LSCBs on the initiation and publication of SCRs.

1.2 PURPOSE, SCOPE & PROCESS OF THE REVIEW

1.2.1 Regulation 5 of the Local Safeguarding Children Board Regulations (LSCB) 2006 requires LSCBs to undertake reviews of 'serious cases' in accordance with the statutory guidance in *Working Together to Safeguard Children* HM Government 2015. A 'serious case' is one in which abuse or neglect is known or suspected and either the child has died *or* has been seriously harmed and there is cause for concern as to the way in which the local authority, LSCB partners or other relevant persons have worked together to safeguard the child.

1.2.2 Its purpose is to identify required improvements in service design, policy or practice amongst local, or if relevant, national services. A SCR is *not* concerned with attribution of culpability (a matter for a criminal court), nor (when that is relevant), the cause of death (the role of a Coroner).

1.2.3 The period of review was agreed as being from the birth of the twins (November 2015) to the date of their assault. It also considered issues of relevance emerging from the dates of the parents' respective arrivals in the UK and the post-incident responses by local agencies.

1.2.4 An independent report was commissioned from www.caeuk.org so that on the basis of material supplied (a merged chronology of agencies' contacts and self-critical individual management reviews), the lead reviewer would:

- Collate and evaluate it
- Conduct consultation / learning events with relevant professionals and
- Develop for consideration by the SCR review team a narrative of agencies' involvement and an evaluation of its quality, conclusions and recommendations for action by the CHSCB, member agencies and (if relevant) other local or national agencies

1.2.5 A consultation event with relevant professionals was planned for a point when the sequence of events and issues arising from them were sufficiently clear. The aims of such involvement were to ensure the accuracy of information within the report, to justify or amend provisional conclusions and to encourage acceptance and application of the learning that was emerging.

1.2.6 The SCR review team was comprised of representatives from:

- The City & Hackney Safeguarding Children Board (CHSCB)
- The City & Hackney Clinical Commissioning Group (CCG)
- Hackney Children's Social Care
- The Metropolitan Police Service (MPS)

AGENCIES' CONTRIBUTIONS

1.2.7 The following agencies supplied information to the SCR:

- Haringey CCG (GP Services for mother and children)
- Whittington Health NHS Trust (midwifery & health visiting services)
- Hackney Children's Social Care (First Access & Screening Team)
- London Ambulance Service (LAS) NHS Trust (responding to the incident)
- Metropolitan Police Service (MPS) (responding to the incident)

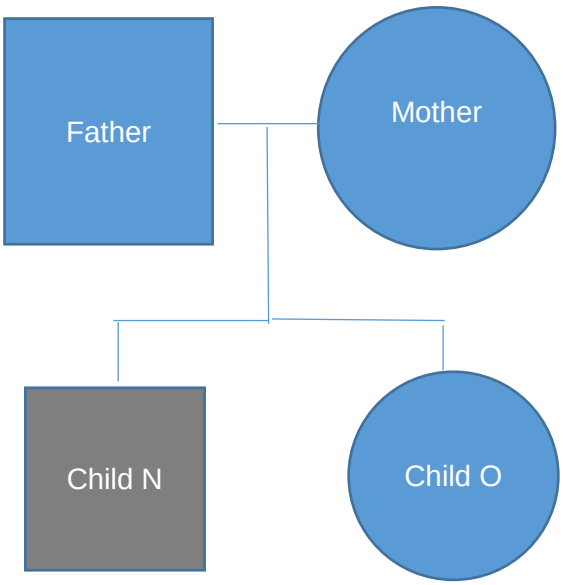
FAMILY INVOLVEMENT

1.2.8 The parents were informed that a review was being completed though the need to avoid undermining the criminal investigation necessitated postponement of their involvement.

TIMETABLE FOR COMPLETION OF SERIOUS CASE REVIEW

Event	Target date
Decision to initiate serious case review & formal notifications	20.03.17.
Initial scoping meeting	11.04.17
SCR review team meeting 1: planning the review process	05.05.17
SCR review team meeting 2: consideration of individual management reviews & a 'preliminary' overview	18.09.17
Submission of 'draft 1'overview	29.09.17
Meeting with mother of child N & child O	30.10.17
Staff learning event	31.10.17
Submission of final 'draft 2'overview	31.10.17
Quality assurance with SCB Professional Adviser	13.03.18 & 10.04.18

STRUCTURE OF CHILDREN'S FAMILY



2 SIGNIFICANT EVENTS

2.1 USE OF UNIVERSAL SERVICES PRIOR TO REVIEW PERIOD

CONSULTATIONS WITH GP PRACTICE

2.1.1 Mother is known to have been registered with a GP Practice and on occasions consulted doctors there for routine reasons unrelated to this SCR. Father was not at this time registered with any GP.

ANTE-NATAL CARE

2.1.2 In late April 2015 a GP referral for ante-natal care was made to Whittington Hospital Maternity Service. The referral contained no grounds for concern about mother or her unborn child/ren. At her initial appointment the estimated date of delivery (EDD) was the end of December.

2.1.3 Mother reported having a supportive partner and although asked, made no reference to past or current domestic abuse. She reported no history of mental health conditions in either parent. Mother's ethnicity was recorded as a Romanian Christian and father's as a Bangladeshi Muslim.

2.1.4 The pregnancy was initially evaluated as 'low risk' though subsequently raised to 'high' when a scan was completed 18 weeks into the gestation and a revised EDD calculated. In July 2015, anti-natal care was appropriately transferred to a specialist 'Twin Clinic' and routine medical needs of mother addressed. Mother engaged well with ante-natal care, attending 12 appointments in total. Records do not indicate whether father was present on any of those occasions.

BIRTH & IMMEDIATE MIDWIFERY SUPPORT.

2.1.5 It is known that father was present at the birth of the twins (which for medical reasons had been induced). The GP Practice received a routine confirmation of the event.

Comment: Ante-natal and labour-related documents should capture the presence of a partner.

2.1.6 The day after the discharge of mother and babies (day 6 post-birth), when they were accompanied by father, the midwife completed a home visit. The babies were overdressed and advice was offered. Mother described her partner as 'supportive', although records do not make it clear if he was present.

2.1.7 A further visit was made at day 11 when both babies were seen to be thriving. Routine advice was offered and a formal handover from the midwife to the Health Visiting Service was completed.

2.2 REVIEW PERIOD

NEW BIRTH VISIT & PLANNED FOLLOW-UP

2.2.1 At the new birth visit completed by a 'bank' health visitor HV1 both parents, babies and the maternal grandmother were present. Reportedly because he was working 'nights', father was asleep throughout the visit. The accommodation (a studio flat) was described as spacious and well organised. The kitchen and bathroom facilities which were shared were clean and well maintained. It was reported that the family was due to move to larger accommodation.

2.2.2 No interpreter was used for the visit and in HV1's view, mother's command of English was 'reasonable'. No family history of mental health difficulties or substance misuse was identified. Discussion of the possibility of domestic abuse was prevented by the presence of father and the maternal grandmother (who was reportedly going to remain for two or three months).

2.2.3 Mother said that both she and her partner had come from Romania and was advised to encourage her partner to register with a GP.

2.2.4 At a GP / health visitor liaison meeting a couple of weeks later (attended by a different health visitor HV2), the birth of the twins and a consequent need for additional support was noted. Father's need for a GP was not discussed.

Comment: such liaison is good practice; the proposed 'enhanced' level of health visiting did not imply any specific grounds for concern.

2.2.5 Because the twins weighed less 2.5Kg, a follow-up visit was agreed and completed in late November 2015. The twins were gaining weight. Both parents were present and HV1 informed them of local sources of support such as Home Start and Children's Centre Outreach. Grandmother was reported to be due to return to Romania in March 2016. The issue of father's lack of a GP was not discussed.

Comment: it seems that HV1's stated intention of further contact in January 2016 (whether at home or in clinic is uncertain) was not followed through; there is no record to confirm that HV1 sent the family any details of local sources of support.

2.2.6 In early December 2015 father *did* register with a GP and confirmed his ethnicity viz: his mother was Romanian and father from Bangladesh.

2.2.7 At a post-natal check-up completed just before Christmas 2015 mother was accompanied by her partner. About 2 weeks later the twins' routine 8 week check revealed no concerns and included a reference to the support being offered by their maternal grandmother. The children were given their first immunisations on this occasion. Mother's anxiety which was observed by a now retired nurse, was assumed to reflect only the additional demands of twins, remained unexplored and resulted in no additional action.

REFERRAL TO PAEDIATRIC CLINIC

2.2.8 Prompted by a minor skin anomaly detected by HV1 at the time of her visit at the end of November 2015 (though not at birth or the initial baby check), the GP referred child N to a paediatric clinic. At a further presentation by both parents of child N in January 2016 it was noted that the family had not received an offer of a hospital appointment. A re-referral was initiated and child N subsequently examined a week later by a paediatrician. S/he in turn referred child N to a dermatologist. Records do not specify whether both parents were in attendance on these occasions.

2.2.9 When treatment of child N began a few days later both parents were present and shown how to administer the prescribed medication. There were two further appointments associated with child N's condition in early February 2016. Treatment administered by parents continued for some months and proved effective.

2.2.10 The second immunisations of both children had been administered on in early February 2016 but the children were not presented for their third 4 weeks later. The children eventually received them in November 2016 when this anomaly was recognised.

GP CONSULTATIONS

2.2.11 Child O and child N were presented to the GP Practice by both parents in late February 2016. No concerns about the care of the children or the parents' behaviour were noted.

2.2.12 In April 2016 mother consulted her GP over a minor medical matter. This was the last occasion on which she was seen in her own right before the assault on the children a year later.

Comment: though father had almost always been present at the twins' various health appointments, he was not present on this occasion.

2.2.13 By August 2016 parentally-administered treatment of child N was successful enough to enable discharge from the dermatology clinic.

1 YEAR DEVELOPMENTAL REVIEW

2.2.14 The family was not followed up in January 2016 as intended by HV1 and the next contact with the Health Visiting Service was in December that year when the standard 1 year developmental review was completed by a community paediatric nurse. A 14 month '*Ages and Stages*' questionnaire was completed with mother. Both children were noted to be progressing well and to have a loving and secure relationship with their mother. Mother was regarded as engaging positively with health advice offered. Records do not confirm the presence or absence of father.

2.2.15 The case was at this point allocated for universal health visiting service and the next routine contact would have been a 2 year developmental review.

2.2.16 Though records do not confirm which parent presented them, both children were seen by a GP in late December 2016 and reassurance offered about a minor childhood condition. No further contact with health agencies took place until the developments in March 2017 described below.

2.2.17 It is understood that the family moved on 01.03.17 from address 1 in Haringey to address 2 in Hackney.

AN ALERT FROM FATHER'S WORKPLACE

2.2.18 On 13.03.17 the same bank health visitor (HV1) who had completed the initial birth visit received a call from the manager of the hotel at which father was understood to be an employee. The manager reported concerns about how much time father was taking off work. She also referred to father's claim that he needed to be at home so as to keep the children safe. Father was thought to be present during this conversation.

2.2.19 HV1 agreed that the manager would encourage father to contact Children's Social Care and if he did not, then the manager undertook to do so. HV1 confirmed the family's new address in Hackney and offered advice about the nearest Health Centre. The health visitor planned to complete a transfer summary and meanwhile provided a verbal handover to the Health Visiting Team at the relevant Health Centre.

Comment: in response to an unusual situation, HV1's responses were sensible and proportionate to the known facts.

FATHER'S CALL TO HACKNEY CHILDREN'S SOCIAL CARE & FOLLOW-UP

First Access & Screening Team (FAST)

2.2.20 On Monday 13.03.17 father made a phone call to Hackney Children's Social Care First Access & Screening Team (FAST)[3]. He confirmed the family's move on 01.03.17, which he said had been prompted by his partner having an affair with one of the male residents in the shared Haringey house. He reported mother had been having sexual intercourse with this individual with the twins present in the bed. Father claimed to have a recording of such behaviours on his mobile phone.

[3] FAST (comprising co-located Police, Health, National Probation and Children's Social Care staff) was established in October 2015 and screens all incoming referrals to establish whether they meet the threshold for 'statutory social work intervention', 'early help support', 'advice and guidance' or just information.

2.2.21 Father made generalised comments about mother shouting and slapping the children though offered no dates or times. He thought she was not 'normal'. He said that he had raised these issues with his partner since January 2017 but matters remain unchanged. Father also reported (inaccurately) that the children were not registered with a GP though (correctly) that they had received their standard immunisations.

Initial response

2.2.22 The social worker to whom the referral was passed noted her concern about father's reported response to his partner's behaviour and recommended further checks as follows:

- '*Is the mother in a sexual relationship with another male and who is he?; does she understand the risks if she is having sex with the children present?; does the mother find the children's behaviour challenging and does she need support to manage them: - establish the nature of her relationship with the children's father and screen for any concerns around domestic violence'*

2.2.23 The record indicates a need to check whether a health visitor had recently seen the children, whether they were registered with a GP and ascertain whether there were any concerns about the family whilst in Haringey. A visit by 'Early Help' was recommended if efforts to contact the mother were unsuccessful. The case was held in FAST for completion of initial checks and a discussion with mother.

Comment: the response to the referral was thoughtful, and appropriately drew on management advice; records do not indicate whether the father's affect or speech patterns were noteworthy.

First follow-up

2.2.24 Phone contact was established with mother on Wednesday 15.03.17. Via an interpreter, a shocked mother responded to the allegations made by her partner and said that they were ridiculous. She described a relationship of some five years duration which, although not perfect, was 'OK'. Mother described differences of view about women's roles rooted in their differing religious allegiances. She spoke of her partner's suspicious and restrictive conduct as 'stressing her out' e.g. calling her a slut and thought her mother's imminent arrival would help.

Comment: apparent cultural sensitivity / relativism should never diminish the unacceptability of domestic abuse.

2.2.25 Mother reported that she had persuaded her partner to attend the GP the next day (16.03.17) to seek advice on what she perceived to be his cannabis-induced distorted thinking and occasional hallucinations. Mother expressed confidence that father would not hit her or the children (though acknowledged her siblings' concern that he might).

2.2.26 Mother explicitly denied ever hitting her children and reported that her partner had not raised his concerns with her. She referred to him initially using cannabis at a time when (feeling unwell in the early stages of pregnancy), she had returned to spend time with her mother.

2.2.27 The social worker confirmed with mother that she knew what to do if she felt unsafe, discussed a referral to the 'Domestic Abuse Intervention Service' DAIS (to which mother agreed) and undertook to liaise with the Health Visiting Service. Arrangements were subsequently made for a 'transfer-in visit' by the local Health Visiting Service who were briefed about the referral, concerns about domestic violence and the current absence of a local GP.

Second follow-up & acknowledgement of domestic abuse

2.2.28 On Friday 17.03.17 the social worker learned in a phone conversation with father that he had not, as planned, attended the GP Practice. He repeated his allegations, admitted current use of cannabis and referred to the use of cocaine some five years previously. The social worker described this conversation as being frustrating because father kept repeating his sense of helplessness without being able to elaborate.

Comment: responses continued to be cautious and proportionate.

2.2.29 The social worker contacted St Anne's Hospital in Haringey and was advised on how to seek confirmation of any prior contact by the father of child N and O with its Mental Health Service. Liaison with the Police Public Protection Unit revealed *only* a one-off contact with father some five years earlier at an address believed to be a brothel. On the same day, the social worker had a second phone conversation with mother (a different interpreter assisted). She laughed at the suggestion her partner had recorded her infidelity and spoke of waiting seven years to have children and that she would do nothing to harm them.

2.2.30 Mother spoke of her partner's growing jealousy over the past two months, 'often' coming home during the day to check up on her (e.g. checking the cupboards, fridge and pantry apparently looking for men). She revealed that her partner had tied them together in bed with shoelaces so that he would know if she got out. She also disclosed that two weeks previously, father had slapped her in the face. She had not informed the Police and had accepted his apology. She described her partner's stated wish to be helped, a reluctance to consult a doctor and his acute fear she will leave him. She said he was not in touch with any mental health services.

Comment: the term 'jealousy' was recorded but the conduct attributed to father sounds more controlling and paranoiac than the jealousy a father might feel if a baby is consuming a disproportionate quantity of a mother's time; it should be noted that the social worker at this point had no knowledge of father's previous conversations with, or any concerns expressed by, his employer.

2.2.31 The FAST social worker later again consulted her 'screening and referral manager'. It was agreed that she should explore with mother her partner's mental health and check with Mental Health Services in Haringey. The social worker was also tasked with undertaking a further discussion with mother about safety planning.

Referral on to Domestic Abuse Intervention Service

2.2.32 Mother assured the social worker that she had no concerns about her personal safety. She reported that her brother was aware of the situation and held a key to the property. She was also confident that her partner would do nothing to harm the children whom, she said 'he loved more than her'. Mother reported that her partner's brother and mother had referred to previous depressive moments and fits of anger.

2.2.33 The twins' maternal grandmother was due to arrive on Sunday of that weekend and mother said that they would work on persuading father to consult a doctor. Following Friday's conversation, the social worker again consulted the screening and referral manager and initiated a late afternoon referral to DAIS.

Comment: the responses were all justified and timely; nothing suggested the level of immediate risk that events next day demonstrated.

TRIGGER INCIDENT

2.2.34 At 23.12hrs on Saturday 18.03.17 a member of the public made a 999 call and alerted Police to an incident at address 2. A female could be heard screaming. The caller also requested an ambulance for a 'sick baby'. Two further calls were made by the same person and another caller rang to report that '*someone is trying to kill their own children' – the wife is screaming*'. That caller indicated that the victims were twins and that they had been punched.

2.2.35 Officers arrived at 23.22hrs and within a minute placed an urgent call to London Ambulance Service (LAS). Two minutes later they requested helicopter transport and confirmed that there were two children with bleeding head injuries. At 23.24hrs the LAS declared the incident 'critical'.

2.2.36 The children were transported to hospital as summarised in section 1 of this report. At 23.53hrs father called Police to offer his location and said that he had killed both children. Officers attended the location provided and completed an unsuccessful area search. Father was later detained.

2.2.37 LAS informed Hackney's Emergency Duty Team of the events at 04.30hrs on 19.03.17 and on Monday 20.03.17 the case was allocated to the Service's consultant social worker. On the same day Haringey's Safeguarding Children Adviser (SCA) liaised with Hackney Safeguarding Children Team (Health) and received confirmation that the latter's Children's Social Care had accepted a referral the previous week.

3 POST INCIDENT RESPONSE

3.1 INTRODUCTION

3.1.1 In an attempt to identify all possible learning, the CHSCB has sought to understand responses that followed immediately after the assaults on the twins. The 'rapid response meeting'[4] convened after the incident was informed that:

- A St. John's Ambulance[5] rather than a London Ambulance Service (LAS) vehicle has been dispatched to the incident
- A 'year 1' paramedic student made up half the crew
- The Royal London Hospital, to which the vehicle with child O was directed was only informed of an 'unwell' toddler, ahead of the vehicle's arrival

3.1.2 Initial and supplementary reports supplied by the LAS were triangulated with those of the MPS and indicate the following detailed time-line:

- 23.12hrs – member of public (caller 1) made a 999 call and sought ambulance attendance at the home address for a 'sick baby' and Police attendance with respect to a screaming female. Caller 1 made two further calls repeating that request
- 23.15hrs – call received at the LAS Emergency Operations Centre (EOC) from attending police officers relaying what they had been told i.e. the need for an ambulance to attend a 'sick baby'
- 23.19hrs – A 'caller 2' phoned 999 to report that '*someone is trying to kill their own children; the wife is screaming*'; this caller specified that the children were twins
- 23.22hrs – police officers arrived on scene
- 23.23 – police officers sought urgent LAS attendance
- 23.24 the police officers sought Helicopter Emergency Medical Services (HEMS) and advised that there were two children with bleeding head injuries
- 23.24hrs The LAS EOC declared this to be a 'critical incident'
- 23.25hrs – A Fast Response Unit (FRU) of a paramedic and a student operating together constituting a 'Joint Response Unit' JRU[6] 'self-dispatched'
- 23.30hrs - on the arrival of the above JRU, the crew were directed by police officers to the two patients and consequently alerted the EOC to this being a 'high priority' and confirming the need for the dispatch of a 'duty officer' and the HEMS

[4] A 'rapid response meeting' is held after the death of any child in a local authority area.
[5] The LAS currently contracts a small number of private ambulance providers to assist at times of peak demand. 'St. Johns Ambulance' was on duty as a paid contractor working alongside the Joint (with Police) Response Unit

3.1.3 The LAS report acknowledges that a further (untimed in its submitted report) message had been received *after* the 23.15hrs alert by Police and indicated that '2 babies were bleeding from the head and that a male had attacked his family'. This *may* refer to the Police report of 23.24hrs from which time it was clear that the LAS had been informed of the presence of *2* injured infants. By 23.30hrs (18 minutes after the first call by a member of the public) LAS staff had been able to see the actual situation for themselves. Wholly understandably, the bereaved mother has described those minutes as feeling like hours and still struggles to come to terms with the fact that her son's injuries were too serious to survive.

3.1.4 In consequence of the initial 999 call referring only to a sick baby and screaming female, there was a delay before accurately briefed and sufficiently skilled paramedical staff were on scene and able to help. Following application of extensive efforts to address the urgent medical needs of the children, the advance briefing offered by the JRU crew conveying child O to the Royal London Hospital was incomplete.

3.1.5 No evidence has been located to indicate that the above response made a material difference to the less severely injured surviving child (child O). The LAS has confirmed that its post-event de-briefing addressed the personal learning needs of the crew who responded as best they could in a rare and especially traumatic situation.

3.1.6 CHSCB is satisfied that the responses do not suggest any *systemic* weakness in the ability of the LAS to respond to such critical incidents.

4 ANALYSIS / RESPONSE TO TERMS OF REFERENCE / LEARNING

4.1 INTRODUCTION

4.1.1 The ten elements of the agreed terms of reference have been reproduced below and the performance of each relevant agency evaluated. The broader learning that emerges is outlined in section 5.

Were practitioners aware of and sensitive to the needs of the child in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?

4.1.2 The services provided by midwives and doctors prior to the birth of the twins appear to have fully satisfied respective professional standards. No cause for concern (other than the fact of mother expecting twins) was discerned.

4.1.3 After the twins were born, the responses of the midwife and subsequently the health visitor were timely and reasonably thorough. Father's presence at the health visitor's initial and follow up visits served to deny mother the opportunity for sharing any account or fear, of domestic abuse. The inability to address this issue should have been recorded by the health visitor. Furthermore, seeking and recording a response to the possibility of mental health difficulties or substance misuse was overlooked.

4.1.4 Mother had been asked about domestic abuse on three occasions during her ante-natal period though not at the point of discharge to health visitor care (current midwifery practice is reported to be that the issue is raised in accordance with NICE guidelines, at every maternity visit and the result recorded). HV1 should have captured her inability to address the issue in her records so that the need to raise it could be recognised and addressed at a future contact.

4.1.5 Nothing untoward had emerged from the family's contact with local agencies until some two weeks before the incident. The health visitor's response to the unusual and difficult call from father's manager was a well-informed and proportionate one (though she could have agreed to pass on the concerns if neither the father nor manager did so).

4.1.6 The responses of Children's Social Care staff in the week immediately preceding the death of child N were (in relation to the apparent urgency) prompt and logical. They recognised the possibility of father's mental health and/or domestic abuse being a feature of the reported situation.

4.1.7 No formal assessment had begun and as such, the understanding of the children's needs was based solely upon parental accounts and network checks.

4.1.8 Mother's confidence in her partner's love of his children, reinforced by the imminent arrival of her mother served to indicate that there was little or no imminent risk of significant harm to the children. The social worker's conversations with mother usefully served to increase her appreciation that she was experiencing some form of domestic abuse.

When, and in what way, were the child's experiences ascertained and taken account of when making decisions about the provision of services? Was this information recorded?

4.1.9 The records maintained by the health visitor confirm that she justifiably believed that mother was receptive to health-related advice. Observations of a consistently positive relationship between mother and her babies were captured. To the more limited extent that father was seen with the children, their degree of attachment or affection toward their father is less apparent.

4.1.10 The community paediatric nurse who completed the year 1 development check made good use of developmental instruments and recorded her observations of how the twins played and interacted.

4.1.11 Events overtook the responses being set in place by staff from Hackney Children's Social Care, although the records maintained by the social worker make it clear that she was alert to the emotional impact on the twins arising from the levels of domestic abuse emerging from the initial accounts.

What were the key relevant points / opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way? Did you agency liaise / engage appropriately with other agencies?

4.1.12 The limited number of key points for assessment and decision–making were at:

- Ante-natal presentations of mother
- The birth of children N and O
- Peri-natal contact by midwife and health visitor
- Consultations with GP Practice in respect of mother or her babies
- Hackney Children's Social Care response to father's referral of 13.03.17

4.1.13 During the first four opportunities set out above, any additional level of need quite understandably reflected the fact of there being twins, rather than any perceived inability or deficit with respect to parenting.

4.1.14 The response by the FAST to father's referral recognised the need and specified what should be assessed. The killing of child N occurred before that planned assessment commenced.

4.1.15 Inter-agency liaison was also unremarkable. When the health visitor was alerted by father to his perceptions of the twins' mother, she made an immediate oral link with the local Health Visiting Service provider. The assessment being planned by Children's Social Care quite properly anticipated liaison with health visitors and GP.

4.1.16 The only recurring sub-optimal practice (amongst health practitioners) was the failure to capture the presence or otherwise of the children's father or to explore his influence and impact on the children. Father's failure to register with a GP was an entirely lawful choice and did not of itself, offer justification for action by any in the professional network, although HV1 could usefully have pursued the issue at her follow up meetings and formal liaison with the GP liaison.

Did actions accord with assessments and decisions made? Were appropriate services offered / provided, or relevant enquiries made, in the light of assessments and was the family signposted to appropriate support?

4.1.17 All recorded actions by health professionals and Social Care staff accorded with the needs perceived at the time. The FAST worker was contemplating the involvement of 'Early Help'.

Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?

4.1.18 The above issue was of no relevance in this case. All communication and information sharing prior to the incident, was undertaken during office hours and without difficulty.

Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?

4.1.19 There were differences of opinion with respect to the question of how good mother's command of English might be. Midwives, doctors and the health visitor regarded it as sufficient for their respective purposes. The FAST staff determined it to be necessary to communicate via an interpreter.

4.1.20 The above difference does not imply any insensitivity on the part of those whose judgements had been that mother's understanding was sufficient. The approach taken by FAST was a cautious one, in the knowledge that an in-depth assessment was to be completed and likely to explore sensitive issues.

4.1.21 The potential implications for parents from such significantly differing cultures remained unexplored by the health professionals with whom mother (and to a much less extent father) had contact.

Were senior managers or other organisations and professionals involved at points in the case where they should have been?

4.1.22 The liaison between midwives, health visitors, hospital staff and GPs appears to have worked well. In formulating a response to the contact by father the FAST worker appropriately sought and obtained management direction.

Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?

4.1.23 Other than the issues identified in respect of poor recording, nothing has been seen that implies any significant departure from the professional expectations or procedural requirements of involved professionals.

4.1.24 The Children's Social Care IMR identified some minor delays in an otherwise effective response to the presenting circumstances and the recommendations in section 5 reflect the organisational responses now required.

Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case? & was there sufficient management accountability for decision-making?

4.1.25 Because the family had moved out of Haringey without notifying the Health Visiting Service in that borough, a local Hackney health visitor had not been allocated until the responses of the FAST social worker triggered the allocation process.

4.1.26 None of the involved agencies has identified any staffing or resource-related issue that impacted upon the services provided and nor has any evidence been found to suggest any lack of management accountability.

5 CONCLUSIONS & RECOMMENDATIONS

5.1 CONCLUSIONS

5.1.1 Few if any events or observations that might hint at what was to come emerge from the period prior to or after the births of the twins. Until father's call to the health visitor in early March 2017 nothing distinguished this couple from the many thousands of others in comparable circumstances.

5.1.2 Although there exists no grounds for supposing that even optimal responses would have made a decisive difference to the tragic event of March 2017, the case does reinforce the importance of:

- Identified or unidentified fathers in terms of potential value or risk
- Routine enquiries with respect to the possibility of domestic abuse
- The relevance of cultural / linguistic barriers to mutual understanding

5.1.3 The evidence from the records evaluated is that intra and inter-agency communication (whilst limited in quantity) was clear.

5.1.4 The additional pressure that twins impose on any relevant parent was recognised by health professionals and responded to appropriately. Whilst questions were beginning to form in the minds of health visitor and social workers about the mental health needs of father and mother, no differences with respect to risk is evident.

5.1.5 No agency or individual was able to (nor could be reasonably expected to) anticipate or prevent the actions taken by father within so few days of him raising his concerns about his partner.

5.2 RECOMMENDATIONS

CITY & HACKNEY SAFEGUARDING CHILDREN BOARD

5.2.1 In its commissioning or delivery of training, the CHSCB should promote the learning from this SCR, with a specific focus on ensuring that issues relating to faith or culture do not dilute the safeguarding response for children or adults exposed to domestic abuse.

WHITTINGTON HEALTH NHS TRUST

5.2.2 The Trust should:

- Audit the use of interpreters at new birth / new contacts
- Audit the extent to which the health history of involved fathers (mental health, substance misuse, other factors impacting upon parenting) is being captured

CHILDREN'S SOCIAL CARE

5.2.3 An oversight mechanism is required in FAST so as to ensure timely completion of tasks and transfer of case for assessment.

5.2.4 Staff should be reminded that DAIS is able to contact those experiencing domestic abuse on the day of referral if requested to do so by phone.

HARINGEY CLINICAL COMMISSIONING GROUP (CCG)

5.2.5 Haringey CCG should by means of its IRIS[7] training, dissemination of NICE guidance and development of a 'post-natal exanimation template respectively, encourage:

- Practice nurses to act on any concerns and escalate them appropriately
- Practitioners to ask depression-related screening questions at 6-8 week post-natal consultations
- GPs to see mothers alone at 6-8 week post-natal consultations

[7] IRIS – (Identification and Referral to Improve Safety) is a general practice-based domestic violence and abuse training support and referral programme that has been evaluated in a randomised controlled trial. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. It is aimed at women who are experiencing domestic violence / abuse from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators.

6 GLOSSARY: ABBREVIATIONS / PROFESSIONAL ROLES

Agency / Abbreviation	Meaning
A&E	Accident and Emergency Department
EDD	Estimated date of delivery
DAIS	Domestic Abuse Intervention Service
EMIS	EMIS Health, formerly known as Egton Medical Information Systems supplies electronic patient record systems and software used in primary care in England
FRT	First Response Team
IRIS	IRIS – Identification and Referral to Improve Safety
LSCB	Local Safeguarding Children Board
MPS	Metropolitan Police Service
NICE	National Institute for Health & Care Excellence
NPIE	National Panel of Independent Experts
SCR	Serious Case Review
Hackney Children's Social Care	
SW1	
SW2	
GP Service	
GP1	
GP2	
Hospital Trust	
Health Visiting Service	
HV1	
HV2	
Medical Services	
Addresses	
Address 1	Haringey
Address 2	Hackney