Serious Case Review

Case 11

Alex
(Assigned Pseudonym)

Overview Report
(FINAL May 2020)

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GLOSSARY

A child who has been in the care of their local authority for more than 24 hours is known as a looked after child. Looked after children are also often referred to as children in care, a term which many children and young people prefer.

The Looked After Children's system includes terminology and acronyms that may not be understood. A Glossary is therefore provided.

Birth parents Biological parents, sometimes referred to as 'natural parents'.

Care by family and friends Care provided by friends and relatives for a looked-after child or young person. Previously referred to as 'kinship care'. Government guidance also uses the term **'connected care'**.

Care plan A document that sets out the actions to be taken to meet the child's needs and records the person responsible for taking each identified action. The local authority is responsible for ensuring that it is regularly reviewed and that the identified actions happen.

The local authority that looks after the child must arrange for them to have a **health assessment** as required by The Care Planning, Placement and Case Review (England) Regulations 2010. The initial health assessment must be done by a registered medical practitioner. Review health assessments may be carried out by a registered nurse or registered midwife and must be undertaken every six months where a child is under five.

Independent reviewing officer (IRO) The person who makes sure that the health and welfare of looked-after children and young people are prioritised, that they have completed and accurate care plans in place (which are regularly reviewed and updated), that any physical, emotional health or wellbeing needs or assessments identified by their care plans are met or completed, and that their views and wishes, and those of their families, are heard.

A looked-after child review is a regular meeting that brings together those people who are closely concerned with the care of the child. It is an opportunity to:

- review the child's care plan
- discuss the child's progress
- make plans for the future.

A **parallel plan**, also referred to as a twin track plan, is a term used when a contingency plan for a looked after child is being explored at the same time as the primary plan for the child. As part of permanence planning for looked after children, parallel plans must be drawn up to ensure that alternative plans have been explored and are available without delay if the preferred permanent outcome proves unachievable.

The **supervising social worker** provides both **supervision** and support, and acts as the conduit between the **fostering** household and the **fostering** service and is separate from the role of the foster child's **social worker**.

1. Introduction and Circumstances Leading to the Review

1.1. Alex was 11 months old and living with connected carers in Area B subject to a Full Care Order placed by Area A. Alex was taken to Area B Hospital by ambulance and admitted with cardiac and respiratory failure from suspected non accidental injuries.

1.2. Medical Investigations found that Alex had a bleed to the right side of the brain, which was causing pressure, a bleed within an adrenal gland, an old rib fracture, and evidence of a past bleed in the lungs, which could have been injury or past infection. Added to this Alex also had extensive bruising reaching from forehead, body, arms, legs and sole of a foot.

1.3. These diagnoses resulted in significant disabilities for Alex leading to a requirement for care in a Children's Hospice.

2. Methodology and Scope

2.1. The request for a Serious Case Review was agreed by the Independent Chair of Walsall Safeguarding Children Board (under previous arrangements) following a Rapid Review meeting on 11/02/2019.

2.2. Full Terms of Reference, rationale for the scope and methodology of the review etc. for this SCR can be found in Appendix 1.

2.3. This review takes into account interagency involvement covering the six months prior to the date that Alex presented at hospital. This period covers just prior to placement with the connected carers until the date that Alex became critically ill at home. Key background information will also form part of the review that will inform the more contemporary elements for analysis and learning.

2.4. For the purposes of this review, Area A is the placing authority where Alex's birth family live, and Area B is the area where Alex went to live with the connected carers.

2.5. In order to differentiate between the different carers for Alex and parental relationships the following coding system will be used.

Family member:	To be called:
Birth Mother	Mother
Birth Father	Father
Foster Carer Mother	FCM
Foster Carer Father	FCF
Connected Carer Mother	CCM
Connected Carer Father	CCF
Older Children of Connected Carers	Child 1, 2, 3 etc (Oldest =1)

3. Family Engagement

3.1. A key part of undertaking a SCR is to gather the views of the family regarding the services they received from agencies and share findings of the review with them prior to publication. Due to the nature of the family circumstances and the scope of the review, the independent reviewer met with the connected carers prior to the first professionals' workshop. Their views have been incorporated as appropriate throughout this report. Arrangements will be made to feed back the learning to Alex's birth mother and father as well as the connected carers on conclusion of the review.

4. Background Prior to Scoping Period

4.1. Alex was the eighth born child to parents who have significant previous involvement with children's social care. When Mother was pregnant with Alex, pre-birth planning commenced, Alex was placed into local authority foster care immediately following birth. An extended family member of Alex's mother was identified as a possible connected carer for Alex in order that Alex could stay within the family. Following a positive viability assessment, CCM, and later, CCF were accepted to go forward with full assessments to become permanent carers of Alex. CCM had three children with her previous husband and had two children with CCF. CCM had moved from another county, where she had lived with her husband, to move back with her mother when her marriage ended. CCM and CCF did not live locally to Alex's immediate birth family. At the time of writing this review CCM and CCF had been in a relationship for nine years. They did not live together.

4.2. The assessment was commenced when Alex was three months old.

5. Key Phases

5.1. For the purposes of setting out the story related to Alex's life from foster care to connected carers, key phases will be used to identify the factual information available to the review. This will then form the basis of the analysis that will then generate key themes for learning and recommendations.

Phase one: pre-placement

5.2. Whilst CCM and CCF were being assessed, Alex remained in the care of local authority foster carers who were described by the local authority as extremely experienced. Alex was seen by the health visitor monthly, as is required for a child who is looked after. Alex was taken to all routine appointments by FCM and received all the usual childhood immunisations. The health visitor had expressed no concerns about Alex's care, growth or development. At Alex's adoption medical (parallel planning was underway) the paediatrician identified that

Alex was developing appropriately and had reached all developmental milestones expected of a four-month-old baby.

5.3. The assessment of CCF and CCM was very positive. Positive references were received from CCM's previous partner, and the children's schools. GPs for both CCM and CCF provided reports. It was not possible to get a reference from CCF's previous partner, but an additional reference was received from a friend who knew CCF when he was with his previous partner. All statutory checks were undertaken and no contra indications to continuing with the assessment were found. Albeit that the assessing social worker was concerned regarding the number of children already in the household, the assessment found that CCM was someone who was organised, proud to be a mother and very family orientated. CCM's own children were described as happy, positive about family life and looking forward to Alex joining them.

5.4. Assessments and observational visits pointed to CCM being a very capable and caring mother who put the needs of her children first, was able to provide a child friendly environment, a wide range of outdoor and indoor activities to suit the ages of the children, and a healthy diet.

5.5. There was less contact with CCF but the assessing social worker observed that he was very good with the children and he responded appropriately to them. CCM and CCF were seen together as a couple and no concerns were identified. They were also seen individually and again this was very positive.

5.6. Three months after the assessment began, CCM and CCF presented to the foster panel and were approved as connected carers for Alex. The next day the agency decision maker endorsed the panel decision. Two weeks later transition planning commenced. The transition plan was approved a week later when the local authority was granted a Full Care Order in respect of Alex.

5.7. Nine days later the introductions to Alex commenced.

Phase Two: transition to connected carers; the first six weeks

5.8. CCM and CCF had not met Alex during the assessment process. The introduction took place at the home of FCM and FCF. FCM supervised the visit. CCM and CCF told the author that they spent a few hours playing and giving Alex dinner. Having stayed in a hotel overnight they returned the next morning and again spent some time getting to know Alex.

5.9. Four days later, FCM and FCF travelled to Area B to the home of CCM. CCM and CCF spent some time caring for Alex. Alex was included in the usual routines of the household and was then got ready for bed. FCM and FCF then arrived, collected Alex and returned the next day

having spent the night in a hotel. The next day Alex spent the day with the family (it was school holidays) and Alex also spent the night with them. The next day the social worker visited for an hour for a statutory visit. It was agreed that as the introduction had gone so well that Alex's full-time placement with CCM and CCF would commence from that point. FCF and FCM returned to say goodbye to Alex.

5.10. The notification to Area B health and social care partners was not received by the Area B social work department, although there is evidence that it was sent. CCM registered Alex with the family GP six days post placement and made contact with the health visiting team two weeks later.

5.11. A notification was received by Area A health visiting services of a movement out of area for Alex via routine tracking as a result of Alex being registered with a new GP. Area B health visitors indicated that they would not require Alex's records due to being a paper light service. The following day, the previous health visitor made contact with Area B's health visiting single point of access service and spoke to a health visitor to verbally hand over to the new area. The Area A health visitor was again told that the records were not required due to being a paper light service.

5.12. Visits took place by Area A Children's Social Care as expected; there was a handover visit from the assessing social worker to the supervising social worker two weeks after placement (CCM and all children were seen) and a routine post placement visit one month later by the supervising social worker. At the later visit CCM was seen with the youngest of her two children and Alex (the older children were now back at school). In between both of these visits a Looked After Child Review was undertaken with a visit by the Independent Reviewing Officer and Alex's Social Worker. CCM was present, CCF was at work.

5.13. A week later, CCM took Alex to the health visiting clinic, Alex was noted to be a looked after child, weighed and the attendance was recorded in the clinic book. Nothing else is recorded about this contact. The contact is not recorded in Alex's electronic record. The health visitor in this clinic was not Alex's allocated health visitor.

5.14. The allocated health visitor telephoned CCM the next day to arrange a home visit. The visit took place 11 days later. As Alex was a looked after child, the family were assessed as having needs at Universal Partnership Plus (UPP) level of service delivery in line with organisational policy and the Healthy Child Programme (HCP)[1] . This would have meant monthly contacts. The home visit by the health visitor took place just under six weeks after Alex was placed with

[1] The HCP offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices – all services that children and families need to receive if they are to achieve their optimum health and wellbeing.
Healthy Child Programme - Gov.uk

CCM and CCF. CCM gave the health visitor a family history of why Alex had been placed with her as a connected carer, that Alex had settled well into the family and that she would be applying for special guardianship. The health visitor noted no concerns; the family were well known to the health visiting service locally due to the number of CCM's children that they had contact with. The health visitor planned to review Alex monthly and to attend all looked after review meetings.

Phase Three: post placement; the last four months

5.15. There was a delay in the looked after health review being set up as the consent form on file was related to the previous foster care placement. A new consent form was signed and sent to the Area B health visiting team. This delay lengthened as there was a backlog of health assessments for looked after children in Area B, and despite a chase being sent from the Area A looked after children nursing team, this remained outstanding at the time that Alex presented to hospital.

5.16. An invitation was sent the following month for Alex to be brought to clinic for a 9-11month developmental review in three weeks' time. This was an oversight as, for a looked after child, this should have been a home visit.

5.17. The allocated health visitor then coincidentally telephoned CCM as part of a routine contact to ask her to bring Alex to clinic the following week as part of the routine monthly contact. CCM made contact on the day of the planned clinic visit to say that she could not attend as one of her own children was unwell. The appointment was rearranged for two weeks later. This appointment was not kept and there was no follow up arranged by the health visitor.

5.18. Alex was brought to the clinic as planned for the 9-11 month developmental review at 10 months old. No concerns were expressed by CCM. Alex was observed by the health visitor to be very vocal. Alex's development was showing some delay in three areas, gross motor, social and problem-solving skills. There was a plan in place to review this in 3 months.

5.19. Three weeks later the allocated health visitor, handed over to a new health visitor due to the existing health visitor moving to a new area. Two weeks later, the new health visitor contacted CCM to arrange an introductory visit. CCM reported that Alex was recovering from chicken pox, so the visit was arranged for the following week. The telephone call had been made on the same day that Alex later became critically ill.

5.20. During this phase there were a few visits from Area A social workers. CCM telephoned the social worker to cancel a statutory visit that have been planned. This was six weeks after the previous visit. There was then a change of allocated social worker, who contacted CCM to arrange an introductory visit. The visit took place ten weeks after the last statutory visit.

There were no concerns noted; the environment was reported to be similar to others had found and that Alex was making progress. The next visit from the supervising social worker was cancelled by CCM as she had an appointment at the school related to one of the other children. Alex was then seen the following week for a Looked After Child Review and a statutory visit the same day.

5.21. The supervising social worker then visited the following week and saw Alex with the two younger children.

5.22. Four weeks later CCM phoned to cancel the statutory visit as one child had chicken pox and Alex and another child were 'under the weather'. A week later CCM cancelled a further visit as Alex now had chicken pox, the visit for the supervising social worker was also cancelled the same day for the same reason. It was the next day that Alex became critically ill.

6. FAMILY AND FRIENDS CARE

6.1. In order to understand the learning from this review more fully it is important to consider some aspects of family and friends care (placement with connected carers).

6.2. Over 8,000 looked after children are placed with family members who have been approved as their foster carers[2]. Family and friends' carers provide a way for a child to stay within a family if their parent/s cannot care for them. Many of these carers are close relatives of the parent e.g. grandparent, aunt, uncle etc. In the case of Alex, CCM was an extended family member of mother.

6.3. There are some important differences noted in the Statutory Guidance document[3] that make family and friends carers suitable for placing children with family or a connected person when compared with an unrelated foster carer. The benefits are that the child may already be known to the identified carers and already have a strong bond and relationship with the carers. This was not the case for Alex as there was not an existing relationship with Alex; CCM and CCF had never met Alex.

6.4. The guidance identifies that legislation promotes the finding of a placement within a family where it may be safe to do so, as a preferred option to unrelated foster care. The decision to assess and place Alex with connected carers was therefore best practice and in accordance with legislation and statutory guidance.

[2] 8,830 on 31 March 2017. Department for Education Statistical First Release September 2017, Table A2.
3 Department for Education (2010) Family and Friends Care: Statutory Guidance for Local Authorities (Also in Draft under consultation May 2018 update)

6.5. A recent systematic review[4] of the research into this type of care highlighted benefits and improved outcomes when compared to those in registered foster care (i.e. unrelated and unknown to the child). The research does conclude that connected persons placements often require additional support and training for those carers.

6.6. For several of the partners involved in the review, there was a recognition that the significant differences between a looked after child in registered foster care and a looked after child in the care of connected carers was not fully appreciated.

6.7. The Area B GP practice had recorded that CCM had registered Alex as a foster child. It is not clear at that point if the practice understood that this was not a placement with trained foster carers in the way that placement with registered foster carers would be. In discussion, health visitors questioned whether there is still a view amongst professionals that once a child is placed in foster care, that they are hence out of danger and safe.

6.8. A report by the NSPCC in 2014 based on research by the University of York[5] concluded that:

"The care system generally provides a safe environment for children, and many children and young people say that they think that their care is good. Despite the efforts of social workers and other professionals to remove children from abusive environments, there is nevertheless a risk that they may inadvertently place them at risk of abuse or neglect within the care system." P35

6.9. Alex was being placed into a new family who were a well-established family unit and it was therefore going to take a period of adjustment for all family members and Alex. It is important to understand the differences, motivations, and family dynamics that may be involved in such arrangements.

7. THEMATIC ANALYSIS

Assessment and understanding of connected carers

7.1. There were only two agencies involved in this review i.e. Health and Social Care albeit that health involved three organisations; GP in Area B, Area A and Area B Community Health

[4] Winokur, M A. Holtan, A. & Batchelder, K.E. (2018) Systematic Review of Kinship Care Effects on Safety, Permanency, and Well-Being Outcomes. Research on Social Work Practice 2018, Vol. 28(1) 19-32 available at https://journals.sagepub.com/doi/pdf/10.1177/1049731515620843 Accessed 18 September 2019

[5] Nina Biehal,N. et al (2014) Keeping children safe: allegations concerning the abuse or neglect of children in care. Final report. NSPCC Impact and Evidence Series

Trusts.

7.2. The review spent some time looking at the robustness of the assessment. Albeit the assessment process on initial view appeared comprehensive and followed statutory guidance, there were some areas identified where learning has been found.

7.3. One of the first issues that was highlighted was the engagement of CCF in the assessment process. When he spoke to the author, he indicated that he took quite some time to come around to the idea of taking Alex into the family. He was concerned that they already had five children and he wasn't sure that it was right for him to take on another. CCF told the author that his resistance to the idea changed when he suffered a personal issue that made him rethink his life and made a decision that he wanted to give something back. It is important to note that once he changed his mind, he was fully supportive of taking Alex into the family.

7.4. CCM had a very different view and told the author that she was very keen to take on Alex right from the start. She had been already contacted by Alex's Birth Grandmother encouraging her to consider taking Alex before she had received the call from social care. It is of note that CCM had previously commenced assessment to take a previous child of Mother but had then become pregnant herself and withdrew. It is of note that a previous child of Mother had been adopted as there were no identified family carers available to offer a home. This had had an impact on the family and CCM was clear that she did not want this to happen to another child within the family.

7.5. Whilst these issues were known about within the assessment, it was agreed during the review, that more exploration of the resistance from CCF could have been explored and further assessed.

7.6. CCF was not present for the first two assessment visits undertaken by the assessing social worker. On the first occasion that he was not present due to being at work, CCM was reminded that the assessment was for both of them and therefore he needed to be present. On the second occasion he was again absent as he was at work, so the social worker returned later in the day when he had finished work and spent some time talking with him, the social worker reiterated the importance of his involvement in the assessment and there were no further issues of non-engagement.

7.7. When CCF was observed with the children on the following occasion, there were no concerns. He related well to all children, his stepchildren as well as his own with no differing treatment noted. The issues raised above regarding CCF were known to the panel and were not identified to be an ongoing concern due to the above positive observations.

7.8. Another issue that arose during the review was any family dynamics that may place pressure on connected carers to be put forward for assessment. Motivation to undertake care of Alex was explored during assessment. It was clear that right from the time that Mother became pregnant that she would not be able to care for Alex. The experience of having one of the previous children adopted had upset the family and there was a determination not to let this happen again. CCM may well have felt pressured as the only viable option for keeping Alex within the family. CCM, however indicated that even if she did not take on the care of Alex, she would go on to have a further baby of her own.

7.9. It was noted by Alex's IRO, that there was two other IRO's for the other children of Mother. This would not be best practice but does happen on occasion due to either oversight or workload issues for IRO's. This situation could have meant that family dynamics that may have had an impact on the decision to place within the family were not analysed further. Since this review, the IRO's in question have been meeting together and with the children's social workers. This will lead to recommendations for future practice.

7.10. The general assessment observations were very positive with the family appearing to be a happy one with lots of child friendly evidence and comments from CCM very positive in the way she approached parenting. CCM was described as an 'earth mother' type parent who had breastfed all her children for lengthy periods and wanted her children to experience the outdoors and nature. Growing vegetables in the garden and harvesting them and preparing them to eat were some of the activities CCM described to the author.

7.11. All the references that were received were positive. Although there were no issues with the people that had been approached for references, there were possibly some omissions of note.

- There was no recorded response from school nurse for the older children
- CCF was a football coach for a local children's football team; no reference was sought from the club
- It was not possible to get a response from CCF's previous partner due to there being no up to date contact details

7.12. Whilst there is little that could be done about contacting the previous partner, the other two references should have been pursued.

7.13. In trying to gather reasons why the above issues had not been more fully explored there were several explanations.

- The distance from Area A to the connected carers address was 225 miles round trip; this resulted in less visits than would be usual

- The positiveness of other aspects of the assessment resulted in an optimistic view of family life.
- Both connected carers were being assessed as a couple. Although CCM would be providing the majority of care, as CCF did not live in the household, she was reported to be well supported by her own mother.

7.14. Those at the workshop who were involved in the assessment recognised that there may be occasions where there could be a self-challenge when an assessment appears to provide evidence of an exceptional family life. Professionals questioned whether this presentation was 'too good to be true'. It is important not to use hindsight bias here; there is no suggestion that the assessment outcome should have resulted in a different placement decision. It is, however, an opportunity to consider learning based on reflection.

7.15. There is some post incident evidence that the family may have been a more 'normal 21st century family' than that which was portrayed. On speaking to CCF, he told the author that the older children had hardly noticed Alex's addition to the family as they rarely were off their gaming devices and tablets. None of the visiting professionals, before or after the placement witnessed children on tablets. It could be suggested that unannounced visits (or at least one), may have provided for a better view of a real picture. It is not part of assessment policy to undertake unannounced visits unless there are concerns. It could be argued, therefore, that families who are desperate to provide an overly optimistic view are able to depict a perfect life. The author would suggest that unannounced visits should always be undertaken during assessments.

7.16. Both connected carers commented on the speed of the assessment. From when they were approached until the time that Alex went to live with them was four months. This would not be unusual for a case of this nature where it is important to consider the needs of a baby in ensuring a permanent care placement as soon as possible. They also commented that they had a very positive experience of the assessment process with all those that they came in contact with offering support and guidance throughout.

7.17. The review noted that there is often pressure from the family courts to expedite the assessment process; there is no evidence that this was true of this case. Social work professionals stated that this has led to cases where the quality of assessments that are often complex and take time, are compromised in order to comply with court deadlines. 26 weeks is the regulated time allowed to undertake assessments; it can be argued that this not likely allow professionals time for thorough assessments, particularly where placements are a distance from the placing authority.

Learning Point 1: Distant placements can impact on assessments and visits
Learning Point 2: Family dynamics may impact on motivation to care for a family child
Learning Point 3: Reticence to foster a family child is an indicator that needs full exploration
Learning Point 4: It is important that engagement in assessment needs clarification at assessment commencement and any non-engagement receive robust challenge
Learning Point 5: Expediting assessment timescales may impact on the quality of the assessment.

Post Placement Support

7.18. Once approval had taken place things moved quite quickly, again this was felt to be in Alex's best interests and not contraindicated in policy and guidance. There is however more learning in this element of the review. Some of the issues that occurred post placement will be addressed in the next section as they are relevant to communication.

7.19. One of the main comments from CCF and CCM when they spoke to the author was the surprise that they had not met Alex or FCM during the assessment process. It is of note that until approval had taken place it would not have been in Alex's best interests to be introduced to strangers who may not be approved to become carers. Once the court had granted a full care order and approved the plan for Alex, introductions began thirteen days later.

7.20. The statutory guidance and local procedures[6] do not go into detail about introductions to the child. It is more usual for the child in question to be known to the family and friends' carers who will be taking on the full-time care of a child. In this case, CCM and CCF did not know and had not met Alex.

7.21. There were two periods of time spent with Alex over a two-week period. The most notable element is that this was mostly unsupervised by social workers and was managed by the foster carers. When this was questioned in the review, it was stated that the foster carers were very experienced local authority carers. There were in fact no issues with the transition but CCF and CCM had expressed surprise at this, given the contacts and assessment process they had experienced as being quite different. Professionals involved in the review identified that this was not best practice and should have been subject to more social work oversight.

[6] Walsall Children's Services Procedures Manual: Chapter 3.2.3 Placements with Connected Persons; available at https://walsallchildcare.proceduresonline.com/chapters/p_place_rels.html Accessed 18 September 2019

7.22. Again, one of the reasons suggested in the review for this was the distance. It is arguable that there could have been more introductory visits in Area A before Alex was taken to Area B for any visits. It is of note that another child in the same foster placement was being prepared for a move of placement and that the timing of this impacted on the speed that Alex was moved. This was not in Alex's best interests and should have been challenged.

7.23. It is fair to say that it would be very unsettling for Alex to have been taken back and forth between area A and B very often, but there was no other reason not to have more observation over this period by social workers, apart from the distance. Use could have been made of social workers local to Area B. As social workers are very busy professionals, there could be more use made of reciprocal arrangements to support some observational visits. This was not explored as it is not usual practice.

7.24. As a result of this review, however, the adoption and fostering team are now undertaking this and making more contact with social workers and other agencies in the placement locality to support their work with out of county placements.

7.25. There are parallels with adult services where adults with special needs are placed out of county. As a result of several high-profile reviews of adults abused in care, there have been more reciprocal arrangements for reviews to be carried out by the host authority where distances are prohibitive for regular travel. Whilst it may not be possible for all statutory visits to be of that nature, there is certainly conversations and agreements that could be had regarding localised support and visits for connected carers.

7.26. Notwithstanding the communication issues that will be discussed later, it is of note in this period that activity from professionals was reduced. The assessment had been positive and there were no concerns identified with the transition or at any point in the five months before Alex became critically ill at home.

7.27. The first couple of statutory visits, the looked after review and the visit from the supervising social worker all took place without any issues being identified and all happened as planned in the first six weeks.

7.28. CCM had been proactive in registering Alex with the GP, making contact with the health visitor and attending the health visiting clinic.

7.29. Issues of note include that CCF was never seen following Alex's placement as he was always at work and the older children were not spoken to alone following Alex coming to live with them. The reason for this was that as there were no concerns and everything was going as expected, it was not considered necessary. Although the children were often at school it

may have been beneficial as part of recording post placement observations that the children remained settled in school and that there was nothing negative to note.

7.30. There were also no unannounced visits, although it is only a requirement for one in the first 12 months and again there was no reason to suspect that it was necessary to undertake one sooner.

7.31. The health visiting service made contact with CCM following her call to the service to notify them that Alex had been placed with them and a home visit was arranged. Again, there were no concerns identified; the health visiting service knew the family well and had no concerns. CCM did not raise any concerns regarding caring for Alex.

7.32. Health visiting contacts were problematic and not coordinated:

- When CCM took Alex to clinic the following week, the contact was recorded in the clinic attendance book but not the electronic record.
- The notification from Area A Looked After Child team that Health Assessment was due, did not result in a prompt assessment, in fact it was not undertaken by the time of the critical illness of Alex, due to significant backlog of reviews.
- Alex was unwell on an arranged clinic appointment; the rearranged appointment was not attended and there was no follow up.
- Alex was seen in clinic for the 9-11 month review rather than being seen at home as would be required for a child in receipt of UPP health visiting service.
- There was then a change of health visitor. The new health visitor made contact to arrange a home visit; Alex was admitted to hospital before this visit took place.

7.33. It can therefore be seen that Alex was only seen at home once and in clinic twice by the health visiting service in the five months in Area B.

7.34. There were a variety of reasons for these issues that were identified in the health visiting service agency review report. There were staffing issues that were largely responsible for the lack of contact from the named health visitor. It was reflected that the health visiting service knew CCM well from the other children, and that there had been no concerns. The health visitor felt that as Alex was a Looked After Child that other children on the caseload took priority as Alex was deemed to be in a place of safety that had been assessed as such.

7.35. The Looked After Child health assessment was not undertaken. The priority in clearing the backlog of assessments was for those that were initial assessments.

7.36. The areas above have all received attention from the health visiting service and recommendations have been made in the single agency review report to overcome these

issues. It is noted that the staffing issues in the health visiting service had been noted on the service risk register at the time.

7.37. Whilst it is acknowledged that the above has been addressed, the author would add that there is a misconception that children who are looked after are always safe. It is also the case that the case of connected carer placements should be viewed differently.

7.38. These types of placements are not from carers that have put themselves forward to become foster carers but have been identified in order to keep a child in the family. It is of note in this particular case, that CCM and CCF did not know Alex, Alex was not a close family member. The author would suggest that there could have been, (although not evidenced) a degree of pressure placed on CCM and CCF to take on the care of Alex, given that a previous baby had been adopted out of the family. There was no one else within the family who could care for Alex, therefore CCM was the only option to prevent Alex being adopted like the previous sibling. Whilst CCM appeared to be keen, the author notes that this was to be CCM's sixth child and that CCF was initially less keen.

7.39. In relation to the looked after child health assessment, the paperwork to consent and request the assessment, does not detail the nature of the fostering arrangement. This means that it is not clear to professionals planning and undertaking assessments that this is a placement with family and friends. It also means, in prioritising the backlog of assessments, children placed with family and friends' carers could not be identified and prioritised. The Area A Looked After Children's Health Team have now made amendments to the paperwork to allow for type of placement so that increased understanding and support can be offered.

7.40. The developmental delay, albeit not seen as a major concern, had been noted for review in three months. The medical undertaken five months before as part of the fostering process, noted that developmental progress was on track with no concerns. At the review at 10 months there was some delay to development. Without previous records to review, it was not possible for any relevance to this delay to be picked up. The author would suggest that a follow up in the home environment sooner than three months could have been triggered based on:

- An assessment that is usually required at home was done in the clinic setting
- Information from records indicating that developmental delay had not been a feature at four months

7.41. The issues raised by CCM when she met with the author regarding significant difficulties in feeding, the way that Alex slept and the concerns with Alex constantly bumping into things

was not identified by the health visitor and was not mentioned to the health visitor by CCM. Visiting professionals did not note these issues when they saw Alex in placement.

Learning Point 6: Statutory visits should provide a robust assessment of ongoing placements. Unannounced visits also provide a window on the placement.
Learning Point 7: Children who are Looked after may be at risk of harm; being looked later in foster or connected care situations does not automatically mean safety
Learning Point 8: Children benefit from the status and type of fostering relationship being known by the professionals that they come into contact with.
Learning Point 9: The nature of connected carer arrangements may lead to a better understanding of any risk.
Learning Point 10: It is important that professionals recognise the difference between various fostering arrangements and prioritise visits and reviews accordingly.

Coordination and Communication Within and Between Areas

7.42. This case featured a placement that was a considerable distance from the placing authority. It appears that this led to some communication issues that may not have been a problem had the placement been local. Hence there is further learning here.

7.43. The first noticeable communication issue was related to the notification of placement of a child out of area not being received by Area B social work services.

7.44. It is not clear why this was the case. The review has identified that with electronic systems being relied on more and less hard copy paperwork that there ought to be a trigger within the electronic recording system that provides for confirmation of receipt from the receiving area. This is more important in the current financial climate where administration roles have been reduced and a reliance on social workers to manage administrative tasks and therefore triggers are seen as helpful. Area A social workers have undertaken to contact the receiving area by telephone to confirm receipt due to learning from this review.

7.45. There was a change of provider of health visiting service in Area B that led to significant service changes that had been ongoing for two and a half years at this time through a planned programme of change. There is evidence that there were some issues related to that change that affected service delivery and communication both within and between services.

7.46. The health visiting service in Area A, found out about Alex's placement through electronic systems as a result of Alex being registered with a new GP. There was a prompt telephone call to hand over to the new health visitor. This was made to the Single Point of Access (SPA) health visiting duty line. This was also a new service delivery model and a new way of working for the health visiting service. The message to Area A was that Area B health visiting

service was paper light and therefore paper records were not required. This is not recorded as a conversation that had taken place by the SPA in Alex's electronic records. This was a misconception by the SPA health visitor and is not the case. At the time there was a backlog of records waiting to be uploaded to the new electronic system and had been outsourced. It was not the case that paper records were not required, particularly where a child had special needs or was subject to child protection, child in need or was looked after. It appears that communication from management regarding expectations on receiving records into the new systems was not clear. This is now being rectified as a result of risks highlighted in this case.

7.47. There were further communications issues regarding the Looked After Child Health Assessment. This, in part, started because of the delay in notification. When the consent for the assessment had been completed, it was related to Area A as it had been due a month after the transfer out. There was a delay in gaining consent for the assessment in the new area. A more proactive approach by ensuring that the right consent has been completed in cases where children move placement is required and again should be part of the prompt system to ensure that human error factors are reduced.

7.48. One of the main communication factors in this case was that health visiting and social care did not communicate over the cancelled visits over the last few weeks of the placement. There were various reasons given for the cancelled visits all of which were plausible but by not having a combined picture and due to the short timeframe that this happened, it was not possible to identify a pattern. There was only one occasion where Alex was not brought for a health visiting clinic appointment with no explanation. Most of the children had suffered from chicken pox and then Alex did. This was over the Christmas period when all the children were off school. This must have been a very stressful time for the family and in particular because CCF did not live in the family home. The author would suggest that the fact that the children had chicken pox did not preclude a visit unless there was a known pregnancy or vulnerability (in a professional) that would be a contraindication to visiting. This was a family where more support might have been helpful at this time. Professional curiosity was needed to understand and question the pressures that might have been present.

7.49. It is a known issue in supporting families and recognising patterns, that having a visual simple chronology within records that is easily accessible when you open a record (paper or electronic), can help to build a picture of any emerging patterns, support assessment, aid supervision and support multi agency working. Both Professor Jay and Lord Laming's [7], [8] reports on inquiries into child abuse identified that the lack of up to date chronologies was a

[7] Jay, A (2014) Independent Inquiry into Child Sexual Exploitation in Rotherham, 1997-2013
[8] Laming, H (2003) The Victoria Climbié Inquiry, London: Cmnd 5730 HMSO

barrier to recognising concerns.

7.50. Chronologies' are often used retrospectively to collate historical information in order to inform inquiries and decision making after a child incident. It is also possible and necessary to have an active live chronology for the reasons stated above. Chronologies should record key changes (e.g. address, worker) events (e.g. reviews, assessments, missed appointments). In order that a chronology is effective it is important that it is not too detailed and that the full recording is still in the right place within the record.

7.51. Although there is recognised learning here, the cancelled visits and appointments with health and social care started 10 weeks before Alex was admitted to hospital. In that period Alex was seen by the IRO, the supervising social worker and the allocated social worker, Alex was also seen in clinic for the 9-11 month review. It was the three weeks after Christmas that Alex was not seen when all appointments were cancelled by CCM. This may not have been enough time to recognise any pattern of cancellations in a family where there were no previous concerns of not bringing children to appointments.

7.52. Communication regarding statutory looked after reviews was also problematic. The health visitor in Area B was not invited to the reviews and did not actively seek to understand when these were taking place. Without being a full multi agency review it could not have been robust. The indication that there was some developmental delay identified at the 10-month review was not shared with the social worker or the IRO. There was an action for the health visitor to visit monthly from the first looked after review in placement. As the health visitor did not attend and the minutes were not sent, the health visitor was not aware of this.

7.53. Area A Looked after children health team have added the name of the IRO and the date of the next Looked after Child Review to the paperwork for health assessment in order to improve communication to allocated health professionals.

7.54. Both health visiting and social care cited reasons for these errors. As previously indicated, there were health visiting vacancies impacting on the service, recent changes were still embedding and there were teething problems with new systems. Social Care have indicated that as resources have reduced, administrative support has been diminished. This means that many of the above communication issues that were previously administrative tasks are now being undertaken by social workers.

Learning Point 11: Changes to service delivery can lead to unexpected risks and challenges. A forum for identifying issues quick with a prompt response is necessary in order to safeguard children.
Learning Point 12: Proactive professionals ensure that there is no service breakdown when a Looked after child moves placement
Learning Point 13: Active chronologies in the front of records provide a valuable oversight tool in assessment and risk management.
Learning Point 14: Communication between health and social care regarding looked after reviews and outcomes must be robust to ensure children are safe and that the Looked After Childcare plan is compiled with.

8. GOOD PRACTICE

8.1. It is important to note that many practitioners offer a good level of service to the families that they work with and follow policies and procedures that are provided to guide practice. Whilst recognising gaps in practice, serious case reviews can also provide evidence of good practice.

8.2. On reviewing this case, there is evidence of some very good assessments and understanding of the connected carers and the home and care that they would be able to offer Alex. Attendees at the workshop were asked to identify further good practice from their own and other agencies involvement. It is important to highlight these as areas where learning can occur.

- There was good communication between the assessing social worker and the child's social worker.
- The fostering panel were in receipt of all reports and assessments that were undertaken in order to inform their decision.
- Information within the social work records indicated that when the family were seen that there was a good level of observation and interactions recorded.
- There was a verbal handover from Area a to Area B health visiting service.
- The family reported being very well supported throughout the assessment process.
- Where this case has identified issues in systems, agencies have already responded and made relevant changes.
- Alex was placed in a timely manner.
- Statutory Looked After Child reviews were completed in timescale.

9. CONCLUSION

9.1. Notwithstanding the good practice identified throughout this review, it can be identified in drawing together conclusions in this case, that most learning relates to the use of systems

to support multi agency working.

9.2. The majority of connected care placements for looked after children provide a positive solution to alternative care within a family. There is, however, learning regarding the assessment and placement of children with connected persons that differs from those placed with registered foster carers, that professionals did not appreciate.

9.3. Professionals viewed the looked after status of Alex in the same way that they would have done from a registered foster carer. CCM and CCF were robustly assessed but had not undergone any of the formal training that foster carers would. Missing in the post placement ongoing observations were hearing the voices of the other children and not seeing CCF with any of the children or Alex after the placement. CCF's initial reticence to take Alex was not completely understood by assessing professionals.

9.4. CCM and CCF had no contact with Alex prior to placement and unlike many connected care placements, Alex was not known to them. The number of visits post placement by health and social care were not in line with requirements and there were no unannounced visits either pre or post placement. The distance of the placement played its part in not making contact easy but alternative solutions could have been sought.

9.5. There was a common view that this was an excellent placement choice for Alex. Alex was being kept within the family and the assessment had been extremely positive. Despite the initial reservations that the assessing social worker and the IRO had about the number of children in the family, they found that the environment was extremely positive and child friendly with all the children looking forward to welcoming Alex into the family.

9.6. In hindsight, professionals have now questioned if this view was too good to be true and have wondered whether there should have been more professionally curious to understand whether there were any family dynamics that placed pressure on CCM and CCF to take Alex. The need to portray an environment and home for Alex that was never in question may have taken precedence over the need to be honest about any difficulties that may have ensued. The concerns that CCM discussed with the author regarding Alex's development and behaviours were not highlighted to any professional.

9.7. Post placement, the health visiting service knew CCM well and therefore knew her to be a competent mother. The social workers were confident that this was a positive placement and did not question cancelled visits and neither did the health visitor. The health visitor and the social worker did not communicate post placement and the health visitor was not invited to, nor proactively sought attendance at Looked After Child reviews.

9.8. It has to be noted that even if there had been more professional curiosity regarding the seemingly perfect placement, that it may well have still been considered a satisfactory environment for Alex. The author would question whether the addition of Alex to the number of birth children that CCM already had was too much given that CCF was not resident with the family. Whilst all children were well and being well behaved it could be seen that this would not be an issue. However, when illness affects a family and usual sibling squabbles and behaviour challenges of older children and toddlers are included, parenting becomes more of a challenge and needs additional support particularly in a case where there is a looked after child added to a large family.

9.9. Nothing, however, that came to light during this review would have led to any professional being concerned regarding the care that CCM and CCF would give Alex and there was no indication that Alex would suffer significant harm whilst in their care.

9.10. There is learning, however, that can inform and improve future practice for children placed in family and friends care.

10. RECOMMENDATIONS

10.1. The findings identified above has been included in learning points throughout this report and lead to recommendations/actions for improvement for both areas' Safeguarding Partnerships.

10.2. Where agencies have made their own recommendations in their Agency Review Reports, the relevant area Safeguarding Partnership should seek assurance that action plans are underway, and outcomes are impact assessed within those organisations.

10.3. The following multi agency recommendations/actions are made to the relevant area Safeguarding Partnership as a result of the learning in this case:

1. Assessment

a. Area A Safeguarding Partnership must be assured that local practice guidance to supplement social work procedures chapter "Placements with Connected Persons' and other relevant chapters are updated to include the following guidance and clarifications:

i) Assessments for connected carers must include a thorough review of family dynamics and explore motivation to undertake the long-term care of a distant relative's child.

ii) Unannounced visits should be undertaken during the assessment phase and six-monthly post placement.

iii) Where children are placed a distance away, social workers should seek support from the local authority where the child has been placed and should reciprocate those arrangements with other local authorities.

iv) Once approved, there should be a child centred period of introduction to the connected persons where the child is not already known to them.

v) In keeping with Walsall Council's Policy on Supervision and Support of Foster Carers, as part of Supervisory Visits to Foster Carers, children living in the household are to be consulted on a bi monthly basis. Their views should also be sought and health and well-being reviewed post placement and as part of the annual review.

vi) Other approved connected persons absent at statutory/supervisory visits must be seen bimonthly.

vii) Expectations for ongoing training and development of approved connected persons.

viii) Rationale for not having the same IRO for all birth siblings looked after should be recorded. Where there are two or more IRO's they must work, meet and communicate together to share information.

2. Regional and National Issue to be Raised

Area A Safeguarding Partnership should raise with the Family Justice Board and the Department for Education the points highlighted in Recommendation 1 to ensure that regional and national protocols and guidance take account of the learning from this SCR.

3. Connected Persons/Family and Friends Care Understanding

Area A should produce a seven-minute briefing regarding connected carers, highlighting the difference between connected carers and registered foster carers.

Area B Safeguarding Partnership should determine the relevance and implementation of this learning for their area.

4. Chronologies

Area B Safeguarding Partnership should determine how they can be assured that chronologies are routinely updated in records for families, subject to Universal Plus and Universal Partnership Plus Health Visiting offer.

5. Multi Agency Working

Area A must seek assurance that where a child is looked after:

a. All professionals relevant to the child's care, actively seek to be involved with and/or provide information for Looked After Child Reviews**.** Minutes must be circulated to all even if the professional did not attend the meeting.

Area A Safeguarding Partnership must seek assurance that where a child is looked after:

b. Notifications of placement and request for health assessment must have space to identify type of placement (differentiating family and friends care from foster care), next health assessment due date and date of next looked after child review.
c. Notifications of placement must be followed up with confirmation of receipt.

Area B Safeguarding Partnership will also need to determine how they should implement learning in recommendation 5a.

6. Audit

Area A Safeguarding Partnership must undertake a multi-agency audit of Looked After Children placed in Family and Friends Care within 12 months based on learning in this review. This will assess practice and outcomes for those children.

Appendix One Terms of Reference (REDACTED)

Serious Case Review
Terms of Reference and Planning Document

1. Introduction:

The request for a Serious Case Review was agreed by the Independent Chair of WSCB following a Rapid Review meeting.

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.

Serious Case Reviews and other case reviews should be conducted in a way in which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

(Working Together Chapter 4 para 11, March 2015)

As set out above this SCR will be undertaken in line with Working Together to Safeguard Children 2015, it will also comply with the Working Together: Transition Guidance (July 2018). Once the LSCB ceases to exist the completion of the SCR will be overseen by the new safeguarding partnership arrangements.

2. Case summary

Alex was 11 months old and was placed with connected carers in Area B subject to a full Care order placed by Area A. Alex was taken to Area B Hospital by ambulance with

suspected non accidental injuries, where she had a CT scan of her head and a full skeletal X-ray. She was admitted with cardiac and respiratory failure.
The tests found that Alex had a bleed to the right side of her brain which was causing pressure, a bleed within her adrenal gland, an old fracture of her rib, and evidence of a past bleed in her lungs, which could have been injury or past infection. Added to this Alex also had extensive bruising reaching from her forehead, now to her body arms, legs and sole of her foot.
As a result of these injuries, Alex remains in hospital. Plans are underway for transfer to a Children's Hospice. A Do Not Attempt Resuscitation order has been agreed and signed by relevant parties.

3. Terms of Reference for the SCR

3.1 Subject

Alex

3.2 Scope

The SCR will cover the period **Just prior to placement with connected carers- Date of Incident**

4. Methodology

This Serious Case Review will be undertaken using a hybrid methodology that will analyse the complex circumstances that practitioners work in and provide opportunities for shared learning and lead to improvements in the way in which agencies understand their roles and responsibilities and work together to promote the safety and well-being of children. Agencies will be asked to review their own involvement with the family and to produce an Agency Review Report. This will be followed by the sharing of the written material in order that learning can be shared in and analysed taking into account the view of the professionals that were involved at the time. This process will involve 2 round table Practitioner Reflection and Learning Workshops to ensure practitioner and first line manager involvement in the review. This methodology takes into account the requirements in Sec. 1 above.

5. Areas of consideration:

In addition to the scoping period, agencies are asked to provide any relevant background information that they consider will be important in setting the context for the later family situation. Also, the following questions should be addressed:

Out of Scope Contextual Consideration:

a. What did your service know of the plans for Alex both Pre and Post birth? How was your service involved in the assessment and planning for Alex's placement with connected carers? If relevant, please analyse the detail of the assessments undertaken by your service?

In Scope considerations:

b. Prior to placement of Alex, what contact did your service have with the other children of the connected carers? Did any of these contacts raise any concerns?

c. How was the transition managed from foster care to placement with connected carers? What arrangements were made to ensure transition was smooth for Alex and the new family?

d. Following the placement of Alex with the connected carers, how and when was your service notified? What action was taken by your service and what assessment/contact did your service have? Please include all contact and assessments from beginning of July up to date of incident.

e. Did practice within your service meet the required standards set by your agency? (Please expand on your answer providing evidence).

f. Please comment on liaison between professionals and record keeping in the case generally.

g. Were more senior managers or other agencies/professionals involved at points where they should have been? Provide appropriate examples

h. Is there evidence that this case was subject to the appropriate supervision and managerial oversight?

i. Please identify examples of good practice, both single and multi-agency.

6. Family Engagement

An important part of a Serious Case Review is the involvement of family members so that their thoughts and viewpoints can be incorporated both to the review itself and any learning. The overview author will make contact with relevant family members once agreed and authorised. Family members to be considered and included will be both birth parents, foster carers and connected carers. Feedback will be offered at the end of the Serious Case Review process.

7. Overview Author

Walsall Safeguarding Children Board have commissioned Karen Rees, an Independent Safeguarding Consultant to undertake this SCR.

8. Organisations to be involved with the review:

- Area A Council Children's Social Care

- Area A Health and Care Trust (Midwifery, Health Visiting and Looked After Children Team)
- Area B CCG/GPs for both connected carers and children of connected carers
- Area B NHS Foundation Trust (Salisbury Hospital)
- Area B (Health visiting and School Nursing)
- Area B Police

9. Timeline for Review: The SCR will follow the following timeline:

Safeguarding Board Rapid Review Meeting	11 February 2019
Letters to Agencies/Authors etc.	TBC
Scoping Meeting	29 April 2019
Authors' Briefing via telephone	TBC
Agency Reviews submitted to WSCB	1 July 2019
Quality Assurance of Agency Reviews by Chair/Author	2-5 July 2019
Agency Reviews Reports distributed	10 July 2109
Practitioner Learning and Reflection Workshop (Whole Day)	Tuesday 16th July.
1st Draft of Overview Report Distributed to all attendees	10 September 2019 (1 week before workshop)
2nd Review Learning and Reflection workshop (½ Day)	17 September 2019
V2 Overview Report Distributed to all attendees	7-9 October 2019
Comments on V2 latest by	21 October 2019
Version 3 to Subgroup members	28 October 2019
Subgroup meeting	4 November 2019
V4 to subgroup and Board	18 November 2019
Final Overview report presented to WSCB	4 December 2019