



# **SERIOUS CASE REVIEW: BABY PETER**

**Date of Birth: 1<sup>st</sup> March 2006**

**Date of Death: 3<sup>rd</sup> August 2007**

**Executive Summary**

**February 2009**

# 1 INTRODUCTION

## 1.1 RATIONALE FOR SERIOUS CASE REVIEW (SCR)

- 1.1.1 Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires Local Safeguarding Children Boards (LSCBs) to undertake reviews of serious cases in accordance with procedures set out in chapter 8 of *Working Together to Safeguard Children (2006)*.
- 1.1.2 When a child dies, and abuse or neglect is known or suspected to be a factor in the death, the LSCB should conduct a Serious Case Review (SCR) into the involvement that organisations and professionals had with that child and their family.
- 1.1.3 The purpose of an SCR is to:
- 'Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
  - Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result and
  - As a consequence, improve inter-agency working and better safeguard and promote the welfare of children' *Working Together to Safeguard Children (2006), Ch 8; 8.3*

## 1.2 FAMILY MEMBERS & SIGNIFICANT OTHERS REFERRED TO IN THIS REVIEW

Baby Peter  
Ms A                      Baby P's mother  
Mr A                      Baby P's father  
Mrs AA                  Baby P's maternal grandmother  
Ms M                      Mother's friend and informal carer of Baby Peter  
Mr H                      Ms A's boyfriend  
Mr L and his 'girlfriend' F, resident at the time of death

Peter was not the only child of the household. To protect the interests of those children, no further detailed information regarding them is provided in this summary report.

### **1.3 CIRCUMSTANCES OF BABY PETER'S DEATH**

- 1.3.1 On 3<sup>rd</sup> August 2007 at approximately 11.30 am Ms A called the London Ambulance Service (LAS) to her home address. The attending paramedics took the apparently lifeless body of a child (aged 17 months) to the North Middlesex University Hospital (NMUH).
- 1.3.2 Ms A is the mother of Baby Peter, a white male child variously described in child protection conference records as being of Irish and Irish/Scottish origin. It is not possible to reach any conclusions about the nature of the family's cultural beliefs from the limited information available in records.
- 1.3.3 In spite of efforts by Ambulance and hospital staff to revive him, Peter was pronounced dead at 12.10 pm. On initial examination, he was seen to have bruising to his body, a tooth missing, a torn frenum and marks to his head.
- 1.3.4 The Police Individual Management Review (IMR) referred to a post mortem completed on 6<sup>th</sup> August 2007 which revealed further injuries (a tooth was found in Peter's colon and eight fractured ribs on the left side and a fractured spine were detected). The provisional cause of death was described as a fracture / dislocation of the thoraco-lumbar spine.
- 1.3.5 Police enquiries established that at the time of Peter's death, Ms A's boyfriend Mr H lived at her address; Mr L, his fifteen year old 'girlfriend' F and his children had been staying there since 17<sup>th</sup> July 2007.
- 1.3.6 Ms A, Mr H and Mr L all faced criminal charges. Following a trial that concluded in November 2008, all three were acquitted of murder but Ms A pleaded guilty to causing or allowing the death of a child. Mr H and Mr L were convicted of the same offence. Decisions regarding the date for sentencing will be made by the Central Criminal Court in April 2009.

### **1.4 ARRANGEMENTS MADE FOR THE SERIOUS CASE REVIEW**

- 1.4.1 Haringey LSCB initiated this SCR in response to the direction of the Secretary of State: Department of Children, Schools & Families, in December 2008. A previous SCR on the case had concluded in final draft in July 2008. The Executive Summary of this SCR was published immediately following the conclusion of criminal proceedings in November 2008. The Ofsted evaluation found it to be 'inadequate'.
- 1.4.2 A new, independent Chair was appointed to the LSCB in December 2008. He convened a new Serious Case Review Panel, membership of which was almost completely changed and at a higher level of seniority than that of the previous SCR. Final terms of reference for the SCR were agreed by the Panel on 6<sup>th</sup> January 2009 and the scope of the review widened to include the period when Ms A was first pregnant.
- 1.4.3 Each agency represented on the SCR Panel commissioned independent writers to draft Individual Management Reviews (IMRs). Mr Alan Jones (an independent consultant and ex—Assistant Chief Inspector of the SSI) was commissioned by the Panel to collate the IMRs into an Overview Report.

- 1.4.4 Peter's mother, father, maternal grandmother and a family friend, Ms L, were given a written invitation to contribute to the review. Mr A took up the opportunity. No response was received from the others. Mr A was interviewed by the report author and the administrator took a note, which Mr A approved as accurate.
- 1.4.5 The Panel met seven times between 11<sup>th</sup> December 2008 and 25<sup>th</sup> February 2009 and agreed the draft overview report and executive summary. Alan Jones met the IMR writers separately on one occasion. Haringey LSCB agreed both reports in draft on 27<sup>th</sup> February 2007.

## 1.5 INVOLVEMENT OF LOCAL AGENCIES

- 1.5.1 At the time of his death, Peter (then aged seventeen months) was the subject of a child protection plan. His name had been on Haringey's child protection register under the category of physical abuse and neglect since 22<sup>nd</sup> December 2006
- 1.5.2 During the period covered by this SCR, the following agencies were involved with Peter and/or his family:
- Haringey's Children & Young People's Service (CYPS) (conducting enquiries and subsequently implementing agreed child protection plan)
  - Haringey's Teaching Primary Care Trust (HtPCT) (providing health visiting, general practice, primary care mental health and school nursing services and supporting the child protection plan)
  - Whittington Hospital NHS Trust (providing A&E, outpatient, day patient and in patient care and diagnostics including pathology and radiology)
  - North Middlesex University Hospital (NMUH) (providing A&E, ante- and post-natal care)
  - Great Ormond Street Hospital (GOSH) providing on behalf of HtPCT paediatric medical services in Haringey including the designated and named doctors for child protection and the paediatric A& E and inpatient services at NMUH
  - Metropolitan Police Service (MPS) (working with and alongside the CYPS to jointly investigate reported injuries to Peter)
  - The Epic Trust and Family Welfare Association (FWA) (via the HARTS service offering specific tenancy and family support using an Individual Support Plan)
  - Two Haringey schools
  - Haringey's Legal Services (providing legal advice to CYPS)
  - Haringey's Strategic & Community Housing (organising provision of long term temporary Housing Association accommodation for the family)

## 1.6 MEMBERSHIP OF SERIOUS CASE REVIEW PANEL

1.6.1 The membership of the SCR Panel was changed for this Review and determined as follows:

- Graham Badman (Independent LSCB Chair and Chair of this SCR)
- Eleanor Brazil: Interim Deputy Director Children & Families (CYPS)
- Jan Doust: Head of Children's Networks (CYPS)
- Caroline Bates: Detective Superintendent Metropolitan Police SCD5
- Dave Grant: Borough Commander, Metropolitan Police
- Dr. David Elliman: Consultant Paediatrician / Designated Doctor for Child Protection Haringey PCT & Great Ormond Street Hospital
- Penny Thompson: Deputy Chief Executive HtPCT
- Judith Ellis: Director of Nursing GOSH
- Deborah Wheeler: Director of Nursing, Whittington Hospital
- Julie Halliday: Director of Nursing, North Middlesex University Hospital
- John Suddaby: Head of Legal Services Haringey Council
- Denise Gandy: Head of Housing Support & Options
- Howard Jones: Director of Services, Family Welfare Association (renamed Family Action in September 2008)
- Sarah Peel: LSCB Training & Development Officer (CYPS)

## 2. FAMILY BACKGROUND

- 2.1 Ms A was born in Leicester in 1981, where she lived until 1984 when her mother and step-father separated. Their relationship was reported to be violent and both she and her brother witnessed domestic violence. Her brother stayed with his father in Leicester while Ms A came to live in London with her mother. Ms A understood her step-father to be her real father throughout her childhood.
- 2.2 Her step-father died unexpectedly in March 1988, and her brother joined his mother and sister in London. He had difficulties settling, with 'challenging' behaviour. He was reported to be violent at school, and towards his sister at home. He truanted and started offending.
- 2.3 In May 1990 he was placed on the London Borough of Islington's child protection register following physical abuse by his mother. In 1991, aged 10 years, Ms A was placed on the child protection register, under the category of neglect. There were concerns about her appearance and her hygiene; the parenting she received was inconsistent and there is evidence that it was abusive. She was removed from the child protection register in June 1992. She was referred to Child Guidance and thought to need a special educational setting. She was known to be attending a residential placement in 1993, described by Islington Social Services as a boarding school.
- 2.4 She met her future husband, Mr A, in 1997 when she was 16 years old. Nothing is known from records about his background. In interview he said that he had not had any involvement with statutory services before meeting Ms A.

### 3. SUMMARY OF AGENCY INVOLVEMENT UP TO PETER'S DEATH

- 3.1 In order to manage an account of agencies' involvement with Peter and his family, the author has divided the period into six phases. The separate involvement of each agency and the inter-agency involvement with the family is summarised.

#### **The first phase: To the strategy meeting of 12<sup>th</sup> December 2006**

- 3.2 The agencies in Haringey involved with the family for most of this period were HARTS (Epic Trust), general practitioner and primary care mental health worker, health visiting, housing and the school.
- 3.3 In May 2001, Mr and Ms A presented themselves for housing assistance. They were offered temporary bed and breakfast accommodation. They were granted larger accommodation later that year, following the birth of a child and while at this accommodation Mr and Ms A married.
- 3.4 Prior to the birth of Peter, Mr and Mrs A had had other children (who are not the subject of this SCR and, in their interests, are not identified). It was known that Ms A struggled to cope with small children and that after one birth she suffered from post-natal depression.
- 3.5 In mid 2005, Ms A became pregnant with Peter, who was born on 1<sup>st</sup> March 2006.
- 3.6 Ms A and her children were registered with the same GP. They were first registered on 15<sup>th</sup> April 2003. In July 2005 Ms A's current GP referred her to the PCMHW. There had been concerns that Ms A would experience post-natal depression following Peter's birth but this was not diagnosed.
- 3.7 On 3<sup>rd</sup> August 2006, Ms A was referred by the PCMHW at the GP practice, to HARTS - a voluntary sector service funded through Haringey Council's Supporting People Programme, providing housing related support. The purpose was to support her in relocating from her accommodation.
- 3.8 The family's first contacts with the health visiting service were when the family lived in Islington and Ms A was 18 years old. They knew that Ms A was known to social services and had been on the child protection register.
- 3.9 Following Peter's birth at the North Middlesex University Hospital (NMUH) on 1<sup>st</sup> March 2006, a health visitor undertook a new birth visit. She found Peter to be developing well and breast feeding. Nevertheless, in the light of the family history, the case was placed in a 'blue folder', denoting a cause for concern.
- 3.10 Ms A brought and collected the older children from their school. Mr A was more involved in the early years of their attendance. During the summer of 2006 Mr H was seen with Ms A at the older children's school and introduced as a friend. On one occasion, Mr H came into school with two younger children in a buggy, to collect one of the children who was unwell.

- 3.11 On 18<sup>th</sup> September 2006 Ms A took Peter to the surgery with a cough and nappy rash. The GP recorded that in the course of the consultation she complained that the baby bruised easily, and that she might be accused of hurting him. Peter was six months old.
- 3.12 On 13<sup>th</sup> October 2006, Ms A again brought Peter to the surgery saying he had fallen down the stairs the previous day. The GP examined him and he had a bruise to the left breast and left cranium. He advised Ms A to install a stair gate.
- 3.13 On 11<sup>th</sup> December 2006 Ms A telephoned the surgery and spoke to the GP. She said that Peter had a swelling on the head and asked what she should do. The GP invited her in so that he could examine the child. He told Ms A that he was going to refer Peter to the hospital.
- 3.14 At the Whittington Hospital a number of bruises were seen on his body and documented on a body map. Ms A said she did not know when or how the swelling on Peter's forehead had occurred. She attributed the other bruises to him climbing and falling and bruising easily, as well as slapping his body in play.
- 3.15 The body map made at the time shows extensive bruising to his buttocks and other bruises to his face and chest, including the swelling to his forehead which had triggered the referral from the GP. The test results indicated that he was not suffering with any condition which would mean that he would be susceptible to bruising easily.
- 3.16 While these enquiries continued, Peter remained in hospital.
- 3.17 A strategy meeting was held the next day (12<sup>th</sup> December 2006). A contemporaneous note of the strategy discussion in social care records referred to "pummelling" as a possible explanation for the significant bruising on his buttocks.

**The second phase: from the strategy meeting on 12<sup>th</sup> December 2006 to the Initial Child Protection Conference on 22<sup>nd</sup> December 2006**

- 3.18 The strategy meeting was attended by a social worker and a detective constable from the Metropolitan Police. There was clear concern about Peter's welfare and a decision was made that he could not return to the family home until the s.47 enquiries and police investigation had been completed. Mr A offered to take time off from work to care for his son but this was not taken up because Ms A claimed he had slapped the children in the past. The notes of the meeting indicated that the parents were separated and that 'mother has a friend, Mr H. He is not alone with the children'.
- 3.19 On 13<sup>th</sup> December the police officer and the social worker made a joint visit to the school to interview two of the older children. They were seen separately. Neither the school nor health services had concerns about their physical safety.

- 3.20 In a detailed letter dated 14<sup>th</sup> December the consultant paediatrician stated that the combination of bruising seen 'is very suggestive of non-accidental injury'.
- 3.21 Peter was discharged from the hospital ward on 15<sup>th</sup> December to the care of Ms A's friend, Ms M.
- 3.22 During the visit to the hospital, the police officer interviewed Ms A under caution. Ms A provided the police officer with a number of hypothetical explanations for what may have caused the injuries to Peter. Ms A was unable to provide the police with any clear explanation for the injuries and denied that she or her mother were responsible.
- 3.23 On 19<sup>th</sup> December the police arrested Ms A and Mrs AA. During their interview neither gave any specific explanations of how the injuries occurred but gave the same possible causes as previously. They identified only Ms A and the children as living in the home, with Mrs AA staying occasionally. However there was no direct questioning of either of them about who else might access the home or any associates. The police were aware that Mr A and Ms A were separated, and there was a man called Mr H who was mentioned but only as a 'friend'.

### **The third phase: the initial child protection conference**

- 3.24 An initial child protection conference of those agencies involved was held on 22<sup>nd</sup> December 2006.
- 3.25 The GP did not attend because he was not invited. The paediatrician from the Whittington Hospital was invited but gave her apologies because she had an outpatient clinic and contributed a detailed written report. Nobody was sent instead to represent her views. A doctor from the Child Development Centre (CDC) was also invited but gave apologies. The social worker presented a report that included information about Ms A's background history obtained from LB Islington.
- 3.26 A legal representative of the local authority was present. Ms A also brought a legal representative. The police were represented by the investigating police officer. Their investigation into the injuries to Peter was continuing. The police say that they understood that Peter would not be returned home until the police investigation was completed, and noted that this is not recorded in the minutes.
- 3.27 Ms A was not able to give any explanation of how Peter's injuries had occurred.
- 3.28 Peter had a good relationship with his father, which was seen when he went for his bone scan when only his father could calm his distress.
- 3.29 In summarising, the Chair reminded the conference that the paediatrician at the Whittington Hospital was of the opinion that the injuries to Peter were non-accidental in nature. No adult had given any explanation of how Peter had sustained these injuries and who was with him when he sustained them. This was very concerning for a nine month old baby. Peter was eventually registered for both physical abuse and neglect.

- 3.30 Most participants agreed that one of the other children should also be registered for neglect. None of the conference members supported the registration of other children in the family.

**The fourth phase: from 23<sup>rd</sup> December 2006 to the first review child protection conference on 16<sup>th</sup> March 2007**

- 3.31 During the period following the initial child protection conference, Peter and another child were seen regularly by the social worker, and collectively very frequently by the health visitor, the FWA project worker and the GP. The older children were seen almost daily during the week as they attended school regularly. What was seen of the relationship between mother and the younger children was assessed positively.
- 3.32 Ms M, with whom Peter was staying, reported that he had bruises on his testes and claimed that these had been caused by hospital staff doing a scan. The bruising on his buttocks had gone.
- 3.33 Social workers visited the family home on 24<sup>th</sup>, 27<sup>th</sup> and 29<sup>th</sup> December 2006. Ms A saw her son three times on Christmas Day.
- 3.34 The legal view, given orally immediately following the child protection conference and confirmed by email on 29<sup>th</sup> December 2006, was that the threshold for care proceedings had been met, but this did not prompt the Children & Young People's Service to initiate care proceedings in respect of Peter.
- 3.35 The first core group meeting was held on 10 January 2007 and Ms A attended with Peter. A review strategy meeting was held on 24 January and agreed that if the injuries were non-accidental, it was not clear who the perpetrator was. The police agreed that Peter could go home once Ms A made alternative arrangements for the dogs.
- 3.36 Peter returned home on 26<sup>th</sup> January 2007. The family moved to their new home on 19<sup>th</sup> February 2007. There was a change of social worker.
- 3.37 Over the next month all the children were seen by another GP in the practice – they were judged to be well and happy. There was a social work visit on 20<sup>th</sup> February and all the children were seen; the social worker observed a good relationship between Peter and his mother.
- 3.38 On 5<sup>th</sup> March, the school nurse phoned the social worker to say that she had observed Ms A that day shouting loudly and slapping the cheek of one of Peter's siblings outside the school. The sibling was seen alone and confirmed the assault. Ms A had already agreed to attend a parenting programme and the social worker proposed no further action.
- 3.39 On visits to the home on 5<sup>th</sup> March and on 8<sup>th</sup> March the social worker saw Peter happy and smiling.
- 3.40 On 13<sup>th</sup> March the social worker interviewed Mr A. This was the first time that he had been seen since the December admission to the Whittington Hospital. Mr A wanted more contact with his children and he was advised by the social

worker to get legal advice. He said that Ms A had a boyfriend whom he had seen at the family home. Later, Ms A angrily denied this to the social worker. Mr A said that he did not believe that Ms A would hit the children.

- 3.41 At the review child protection conference on 16<sup>th</sup> March the social worker was to increase the frequency of her announced and unannounced visits to weekly. The plan now was for monthly contact with the health visitor, either at the home or at the clinic.

### **The fifth phase: from the first review child protection conference to 18<sup>th</sup> July 2007**

- 3.42 On a visit to the PCMHW on 23<sup>rd</sup> March, Ms A was angry and upset with the social work service because she said that the high frequency of visits she was receiving were preventing her from relaxing and enjoying her children.
- 3.43 A core group meeting was held on 29<sup>th</sup> March 2007.
- 3.44 At 4.40 pm on 9 April Ms A took Peter to A & E at the North Middlesex Hospital. The triage nurse noted a large boggy swelling to the left side of his head. Mother's account was that four days earlier he had been pushed against a marble fire place by another child of his age. Apart from being grizzly over the next two days he had seemed fine but he had woken that morning with neck pain, holding his head to the left side. He had a small round bruise on his right cheek, a rash on the back of his arms and obvious head lice. Tests were done for meningitis because of the rash and neck stiffness, although this was eventually ruled out. Body maps indicated bruises and scratches on his face, head and body.
- 3.45 Ms A said that she had a friend in the waiting room who had witnessed the fall, and she was fearful that Peter would be taken into care because he was on the child protection register. The friend is now thought to have been Mr H. Peter was admitted to a ward for 48 hours' observation. A man referred to as his father was present on two evenings but didn't stay. Ms. A was reported to have stayed with him throughout his stay. It is not certain who was caring for the other children during this time.
- 3.46 A hospital nurse confirmed to the social worker that the child had been brought in because he was injured but that it was not viewed as non-accidental because the mother had stated that the injury had been caused by another child. It is reasonable to infer that staff had been misdirected as to the possible cause and they speculated that he had experienced some kind of allergic reaction. By this time there was no sign of the original injury. The social work team agreed the discharge. No referral was made to the police.
- 3.47 Peter was discharged home on 11<sup>th</sup> April 2007. The discharge report of 17<sup>th</sup> April from the hospital referred to Ms A reporting a trivial head injury, caused by playing with siblings, a few days before admission.
- 3.48 The social worker next visited the home on 24<sup>th</sup> April and saw Peter and the other children. Peter appeared unsteady on his feet and the social worker discussed this with Ms A.
- 3.49 A core group meeting was held on 2<sup>nd</sup> May.

- 3.50 On 9<sup>th</sup> May the health visitor saw Peter at home and he was observed as a lively and active toddler. He was clean and appropriately dressed. On 16<sup>th</sup> May the FWA project worker made a home visit and saw Peter and one of the other children playing happily. On 21<sup>st</sup> May all the children were seen by the social worker and were well and playing happily.
- 3.51 On 1<sup>st</sup> June the social worker made an unannounced visit to the home and observed a bruise under Peter's chin. Ms A said it was caused in a squabble with the child of a friend. The social worker requested that Ms A take Peter to the GP. Peter was taken to A&E at the NMUH, who were aware that he was on the child protection register.
- 3.52 At the hospital, a history was taken. Ms A's account was that a friend had been staying between 25<sup>th</sup> and 28<sup>th</sup> May and she thought the bruises were caused by rough play with the friend's 22 month old child. During the consultation he banged his head once and fell twice onto his bottom. There were multiple bruises and scratches of different ages on his body, and only some could be explained by normal rough play and falls. There was a grab mark bruise on his lower right leg that doctors were particularly concerned about; Ms A said that she had grabbed him on his leg to prevent him falling off a sofa. The social worker was happy for Peter to be discharged home because a friend would be staying with the family over the weekend. The social worker said she would pick things up on the following Monday.
- 3.53 The police were informed and elected not to undertake a joint investigation but to allow the social worker to look into it and to call them in if she felt that they had a role.
- 3.54 On 3<sup>rd</sup> June, when the health visitor contacted the hospital, they added that Peter also had an infected finger when seen, that the findings were inconclusive, and that Ms A was observed to have bonded well with the child.
- 3.55 The police were convinced that the injuries were non-accidental and requested that a strategy meeting be arranged. This took place on 4<sup>th</sup> June 2007. Agreement was reached to: undertake s.47 enquiries; hold an urgent legal planning meeting to consider care proceedings; fast track a paediatric assessment; make arrangements for Peter to be supervised at the family home by the family friend Ms M; agree a contract with Ms A; and find a childminder to assist with childcare during the day. A joint investigation by the police and children's social care was ongoing. Ms A was interviewed by the police and she offered a variety of possible causes for the injuries and no admissions were made.
- 3.56 On 5<sup>th</sup> June, Ms A and Ms M, the family friend, met the team manager to sign a written agreement to the effect that Ms A and Peter would not be left alone together. There would also be a childminder for Peter and one of the other children on particular days. The agreement was to be reviewed in two weeks.
- 3.57 The police felt that while their investigation into the injuries was still taking place Peter should be removed from his mother's care.

- 3.58 On 8<sup>th</sup> June 2007, the review child protection conference was held. The social worker took the conference through the injuries of 1<sup>st</sup> June and said they could not all be explained by Ms A's account. The reasonable conclusion from the medical examination was that the injuries were probably non-accidental. The meeting was informed that a legal planning meeting was to be held within the next week to inform future decision making. The conference Chair expressed her concern that Peter was experiencing the same injuries for which he was originally placed on a child protection plan. In addition, if they were caused by Peter's own behaviour as his mother claimed, then they should be occurring continuously rather than in a pattern of serious but intermittent injury.
- 3.59 On 15<sup>th</sup> June the FWA project worker made a home visit. Ms A's friend Mr H was present. Ms A was upset at being arrested for the injuries to Peter. She was happy to speak in front of Mr H because he knew everything.
- 3.60 On 19<sup>th</sup> June Baby Peter and one of the other children were seen by the social worker at the childminders. Both children interacted well with the three other children being looked after. The childminder did not convey any concerns. A core group meeting was also held on 20<sup>th</sup> June.
- 3.61 On 29<sup>th</sup> June the social worker had a message from the childminder that Ms A had taken Peter away. The SW tried to contact Ms A on three occasions that day without success. On 2 July the SW made contact with Ms A who said that she was looking after her uncle in Cricklewood. She would be returning on either 4<sup>th</sup> or 9<sup>th</sup> July depending on his health.
- 3.62 The school electronic attendance printout shows that two of the older children were away from school between 29<sup>th</sup> June and 5<sup>th</sup> July.
- 3.63 On 9<sup>th</sup> July the social worker made contact with Ms A, who was back in Haringey. She was at a Walk In Clinic (WIC) for Peter. At a home visit that day the social worker saw all the children. Peter's ear was red and looked sore. Ms A showed the social worker the medication which had been prescribed at the walk in centre.

**The sixth phase: from 18<sup>th</sup> July to 3<sup>rd</sup> August - the final two weeks of events leading to Peter's death**

- 3.64 On 18<sup>th</sup> July, Ms A and Peter were seen at the clinic by the health visitor. Peter's weight had reduced to the 25<sup>th</sup> centile although his appetite was described as good. It was reported by Ms A that he had been seen at the Walk In Clinic on 16<sup>th</sup> July (although it was in fact on 9<sup>th</sup> July) and treated with cream for his head scabs. It was noted that Peter was on a child protection plan and was well groomed and nourished and that there were no unexplained physical injuries. He had also been given antibiotics for his ear infection. His left ear was red on the outside and his lobe appeared to be infected. Ms A explained that she had caused the bruising around his ear while she had been trying to clean it. Ms A was advised again to go to the WIC at the NMUH. The health visitor contacted the social worker, who tried without success to contact Ms A to discuss her concerns.
- 3.65 On 19<sup>th</sup> July Ms A took Peter to the WIC at NMUH where they were referred to A&E. A history was taken and he was assessed and described as alert

and looking around. He had an infected scalp with bloody scabs, head lice and blood around the left ear where he had been scratching. He looked grubby and the middle finger of his right hand was infected in the nail bed. Ms A said that he had developed a hives reaction on his head to red Leicester cheese which became infected from scratching. The infection was not investigated by doctors. A&E phoned the emergency duty team.

- 3.66 On 23<sup>rd</sup> July the childminder phoned the social worker to say that she could no longer care for Peter and the other child because of his scalp infection and their head lice. The social worker phoned Ms A and expressed concern that the infection was taking too long to clear up and that Ms A should take him to see the GP. On 26<sup>th</sup> July the SW phoned Ms A after she had taken Peter to see the GP. According to Ms A the GP was unable to prescribe more antibiotics, was not concerned, and thought Peter might have had an allergic reaction to the head lice treatment. The GP recognised the need for concern, but did nothing because he thought others would do something, and the child was being seen at the Child Development Centre in a few days.
- 3.67 On 25<sup>th</sup> July the legal planning meeting took place, and the decision was made that the case did not at present meet the threshold for care proceedings but that the position should be reviewed in light of further reports expected.
- 3.68 On 30<sup>th</sup> July all the children were seen on a planned home visit by the social worker on their own and with Ms A. Peter was in the buggy, alert and smiling but overtired. His ear was sore and slightly inflamed. He had white cream on the top of his head and Ms A thought the infection had improved. Peter's face was smeared with chocolate and the social worker asked that it be cleaned off. The family friend took him away to do so and he did not reappear before the social worker left. Ms A said she had a GP appointment and mentioned grab marks on Peter. She was worried about being accused of harming him.
- 3.69 On 31<sup>st</sup> July the police met with the Crown Prosecution Service (CPS), who advised no further action on both of the investigations.
- 3.70 On 1<sup>st</sup> August Ms A took Peter to the CDC appointment, accompanied by her friend Ms M, whom the doctor took to be a foster carer for Peter. The referral had made clear that Peter was on the child protection register but not that he was the focus of current enquiries for injuries. Peter was unwell with a temperature and a runny nose. He had visible bruises. Ms A shared her concerns about his behaviour. A paediatric social, developmental and family history was taken. Ms A became tearful when reporting that CYPS had accused her of causing the bruises to Peter. She said that he was a much wanted boy. His weight was now on the 9<sup>th</sup> centile – a considerable weight loss.
- 3.71 The doctor concluded that he was unwell and miserable due to a possible viral infection. He had a history of recurrent bruising and recurrent infections; a history of abnormal behaviours – aggression, head-butting, head banging and hyperactivity – and there was a possibility that he might have some underlying metabolic disorder. In her notes of 8<sup>th</sup> August, the doctor said that she had advised Ms A to go to the GP or the hospital A&E if Peter did not get better. He was not examined by the GP. No reports had been provided of his

previous admissions and attendances at the Whittington and NMUH for possible non-accidental injuries, nor were they sought.

- 3.72 On 2<sup>nd</sup> August Ms A was seen by the police at the social services offices and was told that neither prosecutions would be pursued.
- 3.73 On 3<sup>rd</sup> August the London Ambulance Service responded to a 999 call at 11.35am. The caller was Ms A, who reported a 17 month old child, taking antibiotics, who was now not moving. She reported to the crew that she had last seen him at approximately 1 am and that he had been unwell recently with a fungal infection. Ms A travelled in the ambulance to NMUH with Peter. He was pronounced dead at 12.19 pm.

## **4. LESSONS TO BE LEARNED**

This section outlines the main lessons to be learned which when applied, should prevent significant harm occurring to future children in similar circumstances.

### **4.1 THE NEED FOR AUTHORITATIVE CHILD PROTECTION PRACTICE**

- 4.1.1 The only leverage which the inter-agency response has in a situation in which a child is believed to have been harmed by those unknown, is the motivation and sense of responsibility which the parents/carers have for the child. The s.47 enquiries by CYPS, the investigation by the police, and the child protection conference, were all opportunities to discover the extent to which the parents /carers loved the children and were able to demonstrate their responsibility to care for and to protect Peter.
- 4.1.2 Although perhaps not consciously, a parent/carer in Ms A's situation is testing the resolve of the safeguarding and child protection systems. She had not yet found it necessary to disclose what has happened to Peter, and in particular who had caused the injuries. From the beginning she was given every indication that she may not need to do so.
- 4.1.3 Agencies were too willing to believe Ms A's accounts of herself, her care of the children, the composition of her household, and the nature of her friendship network. Such an account may well have proved to be accurate when tested over time, but at that stage it should have been assumed that it might be self-serving. The danger is an over-identification with the service user in a wish to support and protect the child's place in the family. There was already reason to believe that she was not being truthful about the injuries to her child.
- 4.1.4 Peter was the subject of a child protection conference in December 2006, with injuries so serious that they met the threshold for care proceedings. Although it cannot be known for certain how the injuries occurred, the medical view of the causes of the injuries went as far as it could in offering a non-accidental opinion – and it was gradually discounted. The likely explanation is that the injuries were not regarded as sufficiently serious and that there was an over-identification with the parent whose account of possible explanations was perceived to be plausible. Too little significance

was given to Ms A's own childhood experience of serious physical and emotional abuse and the possible impact of it both on her own parenting and her ability to manipulate the system .

- 4.1.5 Neither the paediatrician nor a representative of the hospital medical team was at the child protection conference to advocate for the reality of the child's injuries. There was the real possibility that force had been used on Peter by an adult, that nobody was accepting responsibility, and that somebody was covering up. That was the reasonable inference and it should have guided the initial inter-agency response. It is difficult to understand how Peter could be returned to the family home after he has been seriously injured, possibly deliberately by an adult, and there is no resolution of who did it. It is reasonable to presume that Ms A was hoping to get away without either admitting to it herself or disclosing the identity of the perpetrator. It is the view of the author that just as the services have been testing her, she is testing the resolve of the services.
- 4.1.6 It is important to reflect on the process which took place at the conference. The majority of the members of the conference were not specialists in child protection. Their function was to bring safeguarding awareness to their daily work with children (e.g. the school) or to work in promoting the children's welfare (e.g. Family Welfare Association). They do not carry the main responsibility for protecting Peter and it was unwise for the conference Chair to give them the responsibility for deciding the basis of the child protection plan. It is the role of Chairs, with their experience and expertise, to guide the members to a conclusion and note where there are any dissenters.
- 4.1.7 There may not have been sufficient awareness on the part of the participants, and particularly the Chair, of the dynamics of the relationships between the participants, and the part which procedures could play in minimising any adverse effects. Ms A's presence in the meeting would have an influence on the agency representatives, who may feel that they need to protect their relationship with her as they have to work with her in the future. The impact of her presence would be compounded by the fact that she was accompanied by a solicitor. Ms A was apparently a dominating and forceful personality who may have intimidated people in the meeting and certainly had done so outside of it. Most importantly, there was reason to believe that she had not been frank about the injuries to Peter and who had caused them. There is provision to ask a parent to leave a meeting for part of the time, to check that there are not things being held back because of her presence.
- 4.1.8 Child protection plans were not required for all the children. It is true that no concerns had been expressed by the agencies about the care of the older children, and there was no indication of neglect or of injury when they were examined shortly after Peter's injuries came to light. However, two children were on child protection plans. Either these children were being selected deliberately for maltreatment or they exhibited the vulnerabilities of generally neglectful parenting because they were younger. As the adults had refused to disclose what had happened to Peter, it was reasonable to conclude that all the children could be at risk of significant harm, and all of them should have received the added security of a child protection plan.

- 4.1.9 The fact that children are on a child protection plan is an important signal to other agencies that they should carefully monitor their welfare. Discriminating between children in this manner can be a way of agencies trying to be fair or to reward the parent by saying that not all her parenting is poor. Not only were all the children experiencing a degree of neglectful care but it can give the wrong message to parents: that they only need to improve their parenting in respect of some of their children.
- 4.1.10 The components of the child protection plan were never developed, at least in writing. The plan was wrongly conceived and if it was carried out literally then it would not have the desired impact on Ms A's parenting. It was unlikely to prevent further neglect or injuries to Peter if the element which had caused it in the first place was still present. Instead, Peter was regarded as a routine case, with injuries expected as a matter of course, and the case was given the standard and well-tried approach to a family in need of support. Clearly nobody knew what the psycho-social problems/needs possibly were, reflected in Peter's injuries and the neglect of at least one other child.
- 4.1.11 Placing Peter with a family friend was a clear indication to Ms A that services wanted, if possible, to keep the child with the family, despite his injuries. The injuries are not being taken too seriously. She can reasonably infer that the services need her to care for Peter more than she needs to be honest with them. The implications of the inter-agency and local authority actions appeared to be that this kind of occurrence was not surprising in a family like this. The level of concern was too low; little significance was given to the possibility that a small baby had been injured deliberately, with no account given of it by the adults involved; the expectations of parental care in the family were low; as were the expectations of the services of their own ability to influence events in the family.
- 4.1.12 What was required was an authoritative approach to the family, with a very tight grip on the intervention. Ms A needed to be challenged and confronted about her poor parenting and generally neglectful approach to the home. Clear targets should have been set with short timescales, particularly in respect to the way she turned the older children out for school, and the upkeep of the home. What needed to be achieved were not those goals in themselves, as important as they were, but understanding her response to the demands placed on her; to discover her motivation and capacity to be a responsible parent. It is likely that these demands would have proved to be stressful for Ms A to achieve. It would have brought to the surface the emotions deriving from her deprived background and would probably be reflected in anger, evasion, resentment and protest. She was angry with the services even though they made no demands on her apart from her time. The passive acceptance of her continued poor parenting was a fundamental problem in the inter-agency approach.
- 4.1.13 A significant deficit in the first intervention with the family, which was then perpetuated, was the failure to establish the identity of Mr H, interview him, and conduct checks on his background. He was the friend that Ms A claimed was peripheral to the family and had no involvement with the children. One of the potentially dangerous scenarios in child protection is an unrelated man joining a vulnerable single parent family. Ms A's account of his role was accepted too readily. The SCR Panel has agreed that in future it will be the

standard practice in relevant cases for both the police and CYPS to interview and thoroughly establish such a man's identity, his background and his involvement with a family. It will be the responsibility of the wider safeguarding agencies to report the existence of these men when they become aware of them.

- 4.1.14 The incident in March where Ms A struck one of the children on the face, in public with very little provocation, should have been responded to much more authoritatively. The response gave Ms A the wrong message; that the authorities were not too bothered. This was not smacking or considered parental discipline but a shocking loss of control directed to the most vulnerable part of a child's body. It was an assault, and the police should have been informed and a strategy meeting called. Even if that had been a first incident in another family it would have justified a strategy meeting and possible s.47 enquiries.
- 4.1.15 The value of an unannounced visit by the social worker was demonstrated in bringing the injuries to Peter to light on 1<sup>st</sup> June. The worker acted correctly and assertively in not accepting Ms A's explanations at face value, and insisting that Peter's injuries be assessed by a doctor at the hospital. Although the view developed that the injuries were inconclusive in respect of being non-accidental, it was reasonable to infer that they were not the result of an accident. Although Ms A had explanations for all the injuries, she had not been sufficiently concerned about them prior to the visit to seek advice and help.
- 4.1.16 The challenge of the unannounced visit was not to last. The review child protection conference in June followed closely after the injuries to Peter were seen on 1<sup>st</sup> June. The attendance at the review conference was very poor under any circumstances but given that there had been two sets of serious injuries to Peter since the previous conference in March it is difficult to believe that child protection was given priority in Haringey's child protection and safeguarding systems. Those assigned tasks in the child protection plan should have been invited and present. The FWA project worker was not invited, nor was she informed of the dates of this or other professionals meetings after May 2007. Of the four protecting agencies only the social workers were represented, with doctors, lawyers and police officers absent. They did not send substitutes and the administration of the conferencing system was so unclear that it is not certain that all were invited. The police did send a written report.
- 4.1.17 This meeting was an opportunity to review what had happened between March and June; for the doctors to speak of Peter's injuries directly and to advocate for him if necessary. The police believed that the injuries to Peter were non-accidental and they could have strengthened their case for a legal planning meeting by attending. The lawyer could have heard the evidence and discussion first hand from the people present. It was a critical meeting but there is no sense that it was given due weight either in the way that it was organised or in the way that it was responded to.
- 4.1.18 Another example of the failure of the child protection system to act authoritatively in respect of Ms A and protecting Peter, was the failure to arrange an early legal planning meeting to consider the need for care proceedings in respect of Peter. It took seven weeks to arrange the meeting,

due to a combination of administrative failures on the part of legal services and a lack of urgency on their part and on the part of the social work managers. To make a wrong decision is regrettable, but to lack urgency in facing up to making it is unacceptable. Legal services now completely accept that and they have put in place systems and safeguards which should prevent it recurring in the future.

- 4.1.19 Where there is authoritative practice that makes demands on a parent it is the function of family support services to provide the compassion, empathy and encouragement to enable the parent to persevere in meeting those demands. The FWA assumed a family support role in attempting to safeguard Peter and his siblings. They became involved from the first child protection conference and were part of the core group aimed at safeguarding the children and supporting Ms A's parenting. However, despite being in contact with the family until Peter died, FWA were not invited to, or informed about, any professionals meetings after May 2007.
- 4.1.20 The panel consider that the FWA staff only had a peripheral impact on the functioning of the family. The main problem was that it was never established that there was a basis to work in a family support mode with Ms A. This mode was assumed to be self evident from the beginning, whereas events demonstrate that Ms A marginalized the worker as she did with every agency who was involved with her, including most importantly, the social workers. The only way in which a family support worker could succeed in this case, was if the local authority as the lead agency was authoritative, in charge of the intervention, and if the parent understood that the family support agency was their opportunity to improve their parenting.
- 4.1.21 Part of the terms of reference for this SCR was to examine whether any models of practice had an influence on the way that the case of Peter was managed. A model of practice being partially used in children's social care was Solution Focussed Brief Therapy (SFBT); a method of intervention which attempts to improve the parents' care of their children by emphasising a focus on their strengths. It has a value base as well as its own methods and skills and adherents go through a period of training and their practice skills are mentored.
- 4.1.22 The senior management of CYPS introduced SFBT as a pilot project within the Safeguarding Team, on the basis of an offer of training which would equip their staff for family support work and create a common ethos around which social workers in the department could work in supporting families. It was seen by some senior managers as appropriate to child protection and at one point they supported a pilot to develop the approach in S.47 enquiries and child protection conferences. Not all staff adopted it, including SW1 and TM1 in Peter's case, and the child protection advisor considered it unsuitable for child protection in general and certainly for S.47 enquiries and conferences.
- 4.1.23 It would be reasonable to infer that this approach may have had some influence as it was being piloted in the social work team that was working with the family from February 2007. Their STM was one of the key drivers for the pilot and conducted an interview with Ms A using the approach in March 2007 as part of her own training to complete a Diploma in the approach.

However, there is no evidence from scrutiny of case records or interviews conducted that it had a direct impact on this case or its outcome.

- 4.1.24 The SFBT approach has a place in family work and emphasising the strengths of parents is important, but it is not compatible with the authoritative approach to parents in the protective phase of enquiries, assessment and the child protection conference if children are to be protected. When the social worker, their manager, the conference chair and the core group are confident that the parents are giving genuine cooperation with the staff, then a family support approach alone like this one is appropriate, as long as there is continued awareness that the assumptions may be mistaken.

## **4.2 IMPROVE INTER-AGENCY COMMUNICATION**

- 4.2.1 Nothing illustrates the agencies' failure to communicate effectively more than Ms A's attendance at the Mellow Parenting programme. This health-led programme offered an intensive day long experience of social learning and support to parents with relationship difficulties with their children. The social workers who commissioned the programme saw Mellow Parenting as an important current arrangement in protecting Peter and the other child on the register, and also for the longer term in helping Ms A to be a more thoughtful parent. The social workers and the programme providers had different expectations of each because they were not clarified, and Peter was left for long periods on the programme days with somebody unknown. There was no arrangement to inform the social worker if Ms A did not attend, and crucially no alert if, when she did attend, Peter did not accompany her. Ms A attended 9 of the 13 sessions with the other child but Peter only accompanied them on 4 of those sessions. Nobody knew who was looking after him on those days when he did not attend.
- 4.2.2 The failure to offer Peter an early appointment at the CDC was caused in part by a failure to communicate the true position of his risk of harm by those requesting the appointment. CDC were informed that he was on the child protection register and thus subject to a child protection plan, but in addition they should have been told that he was currently subject to s.47 enquiries into recent injuries. This was his status, but he was not regarded as such. The CDC say that if this had been made clear when the team manager pressed for an early appointment, they would have seen Peter within 48 hours. The basis on which he was being referred to the CDC was to rule out an organic reason for his head-banging and head-butting behaviours.
- 4.2.3 In the view of the SCR panel, the main reasons for which he should have been referred to the CDC was for an assessment of the seriousness of his neglect, the impact of it on his development, and whether it was likely that there was any other explanation for the head banging and head-butting than the pain and frustration he was experiencing at the hands of those caring for him. Even the family friend noticed that the head-banging disappeared while he was in her care. Given the seriousness of the injuries which Peter had been experiencing all along, the referral looks like casting around for any kind of explanation for his injuries other than that he was being harmed by someone with access to him.

4.2.4 Peter was unwell and miserable at the assessment and there were even visible bruises. The doctor may have meant well in deferring the examination but even without the bruises there can be only one absolute rule when a child subject to a child protection plan presents in this way to a health professional: he must be examined.

### **4.3 ENSURE SAFEGUARDING AWARENESS IN UNIVERSAL SERVICES**

4.3.1 The Children Act 2004 and related guidance under the Government's Every Child Matters agenda emphasises the need for early intervention in the lives of vulnerable children in order to support parents with social needs, so that those needs are addressed early to prevent them from becoming more serious. Every local authority and its children's Partnership or Trust is required to develop local delivery of services, though increasingly multi-disciplinary teams, using the Common Assessment Framework (CAF) and a lead professional. The CAF is not being used by social care staff in Haringey although it has been adopted by education and health services supporting children in universal settings. It is currently used more as a referral tool than it is for assessments.

4.3.2 By any reasonable measure these children were vulnerable: that is, they were entitled to an offer of an assessment to see if the family were in need of additional services. However, there appeared to be a view in the school that the standard of family care of the school-age children was not any different from that of many other families that they knew. This suggests that professional expectations of parents are too low, and that many children may be experiencing unacceptable levels of neglect and emotional deprivation, without testing whether parents would improve their parenting if offered constructive challenge and support.

4.3.3 In many primary care teams there is much closer liaison between health visitors and GPs. In this practice it was exceptionally distant because the arrangements to ensure good communication and a close working relationship between the two professions were not in place. Even without knowing what was to happen subsequently, Ms A's first presentation to the GP about Peter in September 2006 should have suggested that she had anxieties about the care of her son or even fears that she might harm him. The threshold of concern at this point was the vulnerability of the child, and should have led to consideration of the need for a CAF to be undertaken.

4.3.4 The second incident in October 2006 was even more concerning than the first, because the mother was reporting that her child had actually become injured and she wanted him checked by the doctor, although she did not believe that he had suffered any broken bones. Taken together with the first incident, a more concerned view should have been taken of it by the GP. Instead it was treated as a separate coincidental happening, and the mother's account was accepted at face value. The threshold now should have been safeguarding, and it justified the involvement of a colleague, a health visitor, who could make a visit to the home and assess both the home setting and Ms A's relationship with her child. The panel is of the view that the majority of GPs in Haringey would have taken action but there may still be a training need.

- 4.3.5 Peter was seen with Ms A by his GP on 26<sup>th</sup> July 2007. The GP has said subsequently that he had considerable misgivings about Peter's appearance and demeanour at that appointment. He felt Peter was in "a sorry state". However, he did not take any action to alert others to his concern. He assumed that others would have similar concerns and would be in a better position to take action. He knew that Peter had an appointment at the CDC in a few days.
- 4.3.6 It is important for professionals to trust their feelings when they perceive children to be suffering, and not make assumptions that others have also perceived it and are better placed to act. It is simpler to lift the telephone than to live with the regret of not having done so.

#### **4.4 OVER-RELIANCE ON MEDICAL AND CRIMINAL EVIDENCE**

- 4.4.1 Whether the parent is prosecuted or not can become conflated with the degree of risk to the child, and whether care proceedings should be initiated. They are different considerations with different thresholds for action. The police are concerned with evidence and place importance on the indications of injuries and the weight which doctors will give to them. Other services can also place too much importance on the medical opinion on the injuries and too much importance on what the police and CPS make of the medical opinion. If these agencies do not prosecute, the injuries can come to be regarded as uncertain and even accidental.

#### **4.5 JOINT POLICE AND SOCIAL WORKER INVESTIGATIONS**

- 4.5.1 The police were only informed and involved at two stages. At other times matters were assessed by the social worker alone or by a doctor alone, denying the police the opportunity to assess whether a crime had been committed and deciding whether to investigate it. This was a wrong emphasis in the context of this case, where injuries reaching the threshold for care proceedings had previously been identified. In relation to the 1<sup>st</sup> June visit, the police were informed but asked the social worker to assess the situation and inform them of the outcome, when they would decide whether an investigation was justified. This helps to create an unhelpful culture in which other services use discretion about involving the police.
- 4.5.2 On 11<sup>th</sup> December, both a social worker and a police officer assessed the situation and the police officer investigated an alleged crime. Subsequently the police officer and social worker jointly interviewed the older children at the school. They did not do it with a video record because at that point no offence had been alleged in respect of them. In cases of alleged maltreatment of children, guidance requires that police and social workers collaborate in bringing together the complementary aspects of evidence-seeking and risk assessment in the interests of protecting the child.

#### **4.6 PLACING CHILDREN WITH FAMILY AND FRIENDS**

- 4.6.1 In the context of a police investigation and s.47 enquiries by the social worker, to place Peter with the family friend was the wrong judgement and gave Ms A the wrong message: that the authorities were not too concerned about the injuries to Peter. However, the managers were literally following the

instructions in their own operational guidance of the time, which directs that before using one of the department's foster placements every effort should be made to place the child with family or friends. It does not qualify the guidance for children who are considered to have been the subject of non accidental injuries. The practice should change for these circumstances, as should the guidance.

- 4.6.2 The family friend was chosen to provide a temporary home for Peter after considering and rejecting Peter's father because Ms A alleged that he had slapped the children in the past. It is not known whether this was clarified with Mr A, to get his view, or whether his wife's version was accepted. Mr A was prepared to take time off from work and to get a reference from his employer. There had been no concerns about his care of the children in the past and he had parental responsibility and the right to care for his son. There should have been very good reasons before refusing his offer of temporary care and his rights should have been explained to him.

#### **4.7 THE ROLE OF CARE PROCEEDINGS IN CHILD PROTECTION**

- 4.7.1 There is a balance to be struck between protecting a child from the risk of further significant harm, and undermining his attachment to his family, in particular his parents, but also his siblings. It needs to take into account his age, the seriousness of his injuries, the quality of his relationship to his parents, and the realistic ability of the child protection system to supervise his welfare sufficiently closely to prevent further harm, as well as to improve the parenting. Where the authorities have reason to believe that the parents are not being frank or are not cooperating they should initiate care proceedings either to remove the child from home or to strengthen their position with the child at home. The process of doing so would signal the seriousness of their concerns to the parents. It would also help in a continuing assessment of the parents' motivation and capacity to care for and protect their children.

#### **4.8 LACK OF CHALLENGE WHEN CONDUCTING BASIC INQUIRIES**

- 4.8.1 At no point did it occur to anyone that the injuries to the children were caused by someone else apart from their mother. On the basis of her observed interactions with her children it seemed to be incongruous and unlikely to be her. Her children did not appear to be afraid of her. However, Ms A was an extraordinarily neglectful parent and antagonistic to authority figures, including at the school. In addition one child was acting out in a very unhappy way at school. Ms A could be compliant particularly in her attendance at Mellow Parenting where she attended most of the sessions. The biggest failure of the intervention with Ms A was not to find out how deeply she loved her children or how far she would go out of her way to care for them properly. Very few demands were made on her, either in her care of the children or her care of the home. She was usually in charge of both the family and of the intervention, which was aimed to protect her children and promote their welfare.
- 4.8.2 Throughout the period covered by this SCR, observations are made of the children and their interaction with each other and with their mother, which were reassuring to the professionals involved with the family. There can be little doubt that these observations were accurate and believed to be

genuine. They helped to reduce the concern created when Peter was injured periodically and they undermined resolve when professionals were prepared to act authoritatively. However there can be little doubt now that all the children were being neglected and some of them were being actively abused.

4.8.3 Professionals need to bear in mind that children of this age are very resilient if the abuse is intermittent. Adults define the world for children in a way which makes it difficult for them to envisage another. Quite apart from the injuries to Peter, there were clear indications that all was not well in the care of the children. It is a big decision to remove a child from the care and ambience of their own family, especially when there is no decisive act which makes the decision for the professionals, and they will have to accept the full responsibility themselves. There will be times when they have to grasp the nettle, using professional judgement, in the knowledge that they may be proved to be mistaken. Better that than the harm that the child will have to experience instead.

4.8.4 The Cricklewood episode is an example of Ms A testing out the child protection system and finding it wanting. A number of her children are under child protection plans, she has recently been arrested for allegedly harming Peter, she is the focus of a police investigation, even the social workers are sceptical of her account, and she decamps with all the children without warning or permission. The police are not informed and it does not appear as if she is asked for the address where she is staying so that the authorities locally can establish that the children are safe and whether the account which she had given is true. She is not tested to see if she is a responsible parent and is not warned of the possible consequences when she returns. She did not want to risk not being given permission or the possibility that checks would be made, and she shrewdly judged correctly that there would be no consequences when she returned.

4.8.5 When she returned, Peter had a sore ear. It was assumed that was due to an infection but this was not checked out with the doctors who examined him. No steps were taken to find out if there may have other explanations for the condition. Ms A could have been questioned about the whole episode and checks could have been done to verify her story that she had been looking after an uncle in Cricklewood (it emerged in the course of the later trial that this story was a complete fabrication). Ms A constantly tested the safeguarding and child protection systems and they were always found wanting.

## **4.9 FIRST LINE MANAGEMENT AND STAFF SUPERVISION**

4.9.1 Conducting S.47 enquiries into possible maltreatment of children is complex and potentially stressful work for the social worker. They are acting on behalf of their agency and require the support and supervision of their immediate manager. The manager needs to be both knowledgeable and experienced, and has the advantage of not being embroiled in the immediate tensions and anxieties of the case management. Case supervision and support should be provided at the time it is needed, but also in predictable and regularly arranged episodes so that progress of cases can be reviewed. The manager should also sample the worker's cases as an element of supervision.

- 4.9.2 The case supervision, particularly for one of the social workers in Peter's case, was ad hoc, inconsistent, and often cancelled. However, even if the supervision had taken place it is unlikely that it would have illuminated the deficiencies in the practice as in this instance the team managers were familiar with the case and themselves had insufficient concerns despite the frequency of injuries to Peter.
- 4.9.3 Although consultation and supervision is useful in itself in providing support to the practitioner in their work, it will not improve the quality of the practice unless the manager has competent knowledge and skills which are relevant to the requirements of the case.

## 5. CONCLUSION

- 5.1 It is reasonable to conclude that, for a case which reflected the highest level of concern that we have for a child's welfare, the interventions were:
- lacking urgency
  - lacking thoroughness,
  - insufficiently challenging to the parent
  - lacking action in response to reasonable inference
  - insufficiently focussed on the children's welfare
  - based on too high a threshold for intervention
  - based on expectations that were too low.
- 5.2 The SCR panel is of the view that all staff in every agency involved with Peter and his family were well motivated and concerned to play their part in safeguarding him and supporting Ms A to improve her parenting. They were deemed to be competent in their safeguarding and child protection roles as they understood them to be, based on their experience and qualifications. They had the appropriate qualifications and experience for their roles and were no less qualified and no less experienced than staff in similar roles in other places. However, in this case they did not exercise a strong enough sense of challenge when dealing with Ms A and their practice, both individually and collectively expressed as the culture of safeguarding and child protection at the time, was completely inadequate to meet the challenges presented by the case of Baby Peter.
- 5.3 The uncooperative, anti-social and even dangerous parent/carer is the most difficult challenge for safeguarding and child protection services. The parents/ carers may not immediately present as such, and may be superficially compliant, evasive, deceitful, manipulative and untruthful. Practitioners have the difficult job of identifying them among the majority of parents who they encounter, who are merely dysfunctional, anxious and ambivalent. However, in this case the interventions were not sufficiently authoritative by any agency. The authoritative intervention is urgent, thorough, challenging, with a low threshold of concern, keeping the focus on the child, and with high expectations of parents and of what services should expect of themselves.
- 5.4 Everybody working as 'safeguarders' in the safeguarding system, especially those working in the universal services provided by health, education, early years provision and local police, needs to become more aware of the

authority in their role, and to use it to safeguard the children as well as to support parents. The mode of relationship with parents, especially on first meeting them, needs to be observing and assessing as well as helpful. Those agency roles which are the protectors – doctors, lawyers, police officers and social workers – need to become much more authoritative both in the initial management of every case with child protection concerns, and in the subsequent child protection plan. It is crucial to be sceptical of the accounts which are given for any maltreatment of the children, and they should be tested thoroughly against the facts. The reasonable inference must be the basis of any action, rather than awaiting care proceedings or prosecution.

- 5.5 Implicit within this report has been the consideration of the resourcing of children's social care in Haringey. It is clear that there were budgetary movements in the periods 2005/06, 2006/07 and 2007/08, but these did not reduce the overall quantum of resource. Within the scope of this review it is difficult to determine whether or not that quantum of resource should have been deployed differently. However, what is clear from the detailed consideration of workload and deployment of frontline staff is that further resources in themselves would not have impacted on the outcome of this case.
- 5.6 It is important to remember that every year many children die non-accidentally in our country, some of them in similar circumstances to those of Baby Peter. This is not a problem restricted to Haringey and we must learn the lessons. The tragedy is not just that of an individual child's death but the fact that many more children may at this moment be suffering hardship because services do not effect sufficient improvement in their parents. Only a small minority of these children will come forcibly to our notice through their deaths or after serious injury.
- 5.7 Baby Peter's horrifying death could and should have been prevented. If the principles and approaches described in this report had been applied by the four protecting professions, the situation would have been stopped in its tracks at the first serious incident. Peter deserved better from the services which were there to protect him, and they in turn deserved better than the ethos which influenced their work at the time.
- 5.8 In reviewing the services' responses to Baby Peter and his family, the Panel concludes that nothing less than injuries that were non-accidental beyond all reasonable doubt would have caused him to be moved to a place of safety. When such injuries did come they were catastrophic, and he died of them. The Panel deeply regrets that the responses of the services were not sufficiently effective in protecting him and his siblings. The Panel and those independent consultants who contributed to the review have done everything they can to identify the lessons which they believe will significantly reduce the possibility of a similar case happening again. The managers and staff of the agencies involved are fully committed to implementing those lessons.

## 6. RECOMMENDATIONS

- 6.1 The LSCB and the Partnership must ensure that staff in the four protecting professions – doctors, lawyers, police and social workers – are appropriately trained, individually and together, in the principles and values of the authoritative practice described in this Serious Case Review.
- 6.2 The LSCB and the Partnership must ensure that staff working as ‘safeguarders’ – the universal services provided by health, education, early years provision and the police – are appropriately trained, individually and together, to recognise the authority in their role and to use it to safeguard children.
- 6.3 The Partnership should give active consideration to the creation of an ‘expert pool’ from the four protecting agencies. This pool, both virtual and real, will be trained to ensure authoritative knowledge of assessment and intervention. It will be a source of learning, advice and support to ensure effective multi-agency working.
- 6.4 The LSCB will ensure that all agencies fulfil their legal or moral duty to safeguard and promote the welfare of children under s.11 Children Act 2004, and train all staff who have contact with children in safeguarding awareness. The board must seek reports on progress and publish them in their Annual Report.
- 6.5 The LSCB will ensure that the system by which child protection conferences are conducted is changed in order to address the concerns which have emerged from this Serious Case Review. The LSCB will assure itself that conferences are administered efficiently, attended assiduously, managed authoritatively and produce decisions which are child-focussed, with child protection plans that are purposeful and authoritative. The findings should be reported in the LSCB Annual Report.
- 6.6 The LSCB must ensure that children and young people are effectively protected and safeguarded through the regular multi-agency audit of all child protection and safeguarding interventions. It should make report to the Partnership on the quality of their safeguarding and child protection work, and publish the results in its Annual Report.
- 6.7 The Partnership must communicate its passion for an excellent safeguarding service and provide the means for its staff to deliver it. An agency’s vision of itself and its sense of drive and purpose is created by its leadership at every level, from the Leader and elected Members down.
- 6.8 The Partnership must fulfil its duty to ensure early intervention in the lives of vulnerable children by addressing with urgency the development of local delivery teams, the widespread use of the Common Assessment Framework (CAF), and the role of the lead professional. It should report on progress to LSCB and invite the Board to audit the safeguarding dimension of the delivery of the services.

- 6.9 The Partnership must challenge the low expectations of parental care widely held by services and assure itself immediately, through audit, that all children subject to child protection investigation and planning are properly protected.
- 6.10 The Local Authority should assure itself that all schools are well trained in the practices associated with welfare and child protection and are clear about their responsibilities in relation to Every Child Matters. This recommendation equally applies to early years and other educational providers.
- 6.11 The Local Authority should secure an external audit of resources made available to children's services between 2005 and 2008, to satisfy themselves that their expenditure was sufficient to meet the needs of those services and with a view to establishing the appropriate level of resource to meet the requirements of the JAR Action Plan.
- 6.12 Haringey CYPS will ensure that social workers and their managers are trained, supervised and supported to fulfil their statutory role, with the skills to purposefully and authoritatively drive forward child protection plans with the support of other members of the core group.
- 6.13 Haringey CYPS should immediately review the use of Solution Focused Brief Therapy in their work with families. Its impact on the present ethos in the department should be checked as a part of the review. The department should ensure proper processes are in place for the initiation and evaluation of any change in approach to social work practice.
- 6.14 All agencies offering a family support service to children who are the subject of a child protection plan or to parents of such children, should train their staff how to work in a complementary role to the social worker who leads and coordinates the child protection plan. The recommendation applies equally to agencies offering parenting programmes and to adult-focussed services.
- 6.15 Haringey LSCB is required to ensure that any outstanding recommendations arising from the previous Serious Case Review (SCR) are fully implemented in accordance with the Joint Area Review (JAR) Action Plan. The JAR Action Plan will sit alongside and take forward the learning from this Review and the LSCB should scrutinise each development to be assured of its co-ordination, implementation and effectiveness.

## Glossary of Terms

A&E	Accident & Emergency
CAF	Common Assessment Framework
CDC	Child Development Centre
CONEL	College of North East London
CPA	Child Protection Advisor
CPS	Crown Prosecution Service
CYPS	Children & Young People's Service
FWA	Family Welfare Association
GOSH	Great Ormond Street Hospital
HARTS	Haringey Tenancy Support for Families
HtPCT	Haringey Teaching Primary Care Trust
IMR	Individual Management Review
JAR	Joint Area Review
LAS	London Ambulance Service
LSC	Learning & Skills Council
LSCB	Local Safeguarding Children Board
MPS	Metropolitan Police Service
NHS	National Health Service
NMUH	North Middlesex University Hospital
PCMHW	Primary Care Mental Health Worker
S.47	Section 47, Children Act 1989 child protection investigation
SCR	Serious Case Review
SFBT	Solution Focussed Brief Therapy
SW	Social Worker
TM	Team Manager
STM	Senior Team Manager
SM	Service Manager
WIC	Walk in Centre