Serious Case Review

Eve

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Contents

1. Introduction

Reason for the Serious Case Review

1.1 This Serious Case Review[1] (SCR) was commissioned by Stockton-on-Tees Local Safeguarding Children Board[2] in November 2018 and is about Eve who was taken to hospital 1 at the age of 2 years by a babysitter with whom Eve had stayed overnight. Eve presented as critically unwell with a significant head injury and extensive bruising and was promptly transferred to hospital 2 where she received extensive medical care and support. The injuries were subsequently found to be non-accidental; care proceedings were initiated, and a criminal investigation started.

1.2 When Eve was well enough to leave hospital 2, she was placed with foster carers, where she received warm and appropriate care. She continued to have lots of supervised contact with her parents and extended family and is now living with family members who have been assessed and approved by the Local Authority. Eve has progressed well and contact with parents / family members has been maintained. The finding of fact judgment[3] in the care proceedings deemed that neither mother or father were responsible for inflicting the injuries to Eve and the likely perpetrator of the physical abuse was the babysitter; there are ongoing criminal processes regarding this. Professionals involved could not have predicted that Eve would have been harmed in this way.

1.3 The SCR process commenced before the finding of fact judgement. The SCR continued after it because of concerns regarding the parent's decision to leave Eve with a babysitter overnight who they, and Eve, knew only briefly, and with whom Eve had not stayed before. Although the parents could not have known that Eve would be harmed, it was not an appropriate decision for a young child who already had multiple adults looking after her to be left overnight with other adults that she barely knew. The decision appears to have been influenced by mother's significant preoccupation with her own health and care needs. Mother and father had relied on a group of caring, but ever-changing personal assistants[4] (PA's) who were employed jointly to meet mother's health needs and support mother with her parenting as a disabled adult. At the time that Eve was left with the babysitter, all the PA's had left mother's employment because of allegations of poor employment practices,

[1] Changes have been recently made to the reviews of serious incidents of concern about children: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[2] Now Stockton and Hartlepool Safeguarding Children's Partnership

[3] A 'finding of fact' in a judgement by the High Court is a binding Judgement of the Court as to which of the disputed facts in a case are true. It is made after evidence has been heard by the Judge. Once such a judgement is made, it is a binding Order of the Court on everyone unless successfully appealed to the Court of Appeal or the Supreme Court

[4] Personal assistants work directly with one or more individuals to help them with various aspects of their daily life, to help them live as independently as possible. They are employed directly by an individual who's managing and paying for their own care through a social care direct payment or personal budget.

bullying and being asked to fulfil inappropriate tasks such as looking after mother's horses. Father was by this time full time at home, but a pattern had emerged over the whole of Eve's life of neither parent providing full time care to Eve. It remains unclear what mother's disabilities or health needs are; she currently lives independently in her own home and receives some support from her parents, but no other care.

Purpose of a SCR

1.4 The purpose of a SCR is to establish whether there are lessons to be learned about the strengths and weaknesses of the local safeguarding system, the way in which professionals and agencies have worked together to address the needs and circumstances of a particular child/ren and to establish whether there are wider systemic issues which have influenced practice.

Methodology and Process of the SCR

1.5 This SCR has been undertaken using a hybrid systems approach. It has been led by Jane Wiffin who is independent of all services and organisations in Stockton. Chronologies were sought from all agencies in contact with Eve and her parents commencing from when mother was pregnant with Eve until the critical incident. Agencies were also asked to provide any relevant background information.

1.6 A panel of senior managers was convened to oversee the SCR process, helped to undertake the analysis of practice and provide critical commentary on the draft SCR reports and findings. The Independent Author and members of this panel conducted interviews with all professionals. All those professionals who worked with Eve came together as a group as part of the analysis process. This was a thought provoking and helpful part of the process. It was clear that many professionals and the PA's had formed a good relationship with Eve, and hearing that she had not been well was distressing for them. Many of the professionals were also involved in the care proceedings, which was incredibly arduous, and we are grateful to them all for taking the time to think carefully about practice and for being open and reflective.

1.7 A number of original documents and assessments were reviewed across agencies, including Children's Social Care and health assessments, reports for the initial child protection case conference and case records/decision making points.

Family Background

1.8 The Family is White/British.

1.9 It is not clear when mother and father met or when they married, because there is little information about this in the records held. Father was not asked about his childhood, and all that is known was that his mother did not live locally.

1.10 Eve is an only child and her parents will be referred to as mother and father. Mother lived with her parents and one sibling as a child, and said she had a happy and settled childhood. She reported that at the age of 17 she had an accident that caused back injuries which were long lasting. Mother had a professional job, and over time she reported that she developed a range of medical conditions and disabilities that she said impacted on her day to day life. She said that at age 27 she was paralysed for 6 months; 3 years later she was assessed by Adult Social Care and reported limited mobility, required support with getting out of bed, washing and dressing for work, help to carry out household tasks and help with shopping. Mother was provided with a financial package/direct payment[5] to employ PA's to meet her care needs. In her mid-30's she self-reported a further deterioration in her health, stopped working and her financial package was increased which enabled her to employ PA's for 22 hours a week. Father was described as her main carer, providing support with household tasks and all finances and care when he was not working Mother was also supported by her own mother and father.

Family Involvement in the SCR

1.11 Mother, father, maternal grandparents and paternal grandmother were invited to contribute to the review. Paternal grandmother did not feel she had anything to add to the review, and father did not reply to the letters sent to him. Maternal grandmother (MGM) did ask to meet with the independent reviewer. At this meeting she said that she had been delighted when mother had found she was pregnant with Eve. The subsequent hospitalisation and injuries had been difficult to cope with and their focus has been on the safety and wellbeing of Eve, both when she was unwell in hospital and subsequently. This meant that she did not remember very much about the time before Eve was injured or her contact with professionals.

[5] Direct payments are for people who have been assessed as needing help from Adult Social Care, and who would like to arrange and pay for their own care and support services instead of receiving them directly from the local authority.

1.12 The independent reviewer and a member of the panel met with mother. Mother talked about being very happy to have found herself pregnant and was determined that she would be a good parent, regardless of her reported disabilities. She believed that she was an anxious mother, caused by Eve's early illnesses and she does not accept that she was overly preoccupied with her own or Eve's health. She also does not accept the finding of fact conclusion that there was little evidence of many of her reported illnesses. Mother said that she was given conflicting information over time by professionals about Eve's health. She also believes that adults with disabilities have the same rights as any able-bodied adult to parent. Initially she questioned whether she had been provided with the right support but agreed that she had been well supported by the HV throughout and neonatal nurse and had received a good funding package. She reported that employing PA's was complex and like having a full-time job. She said that she received more help with this, from a small voluntary organisation, in the period before Eve was born and she missed this later. She reported that the employment issues caused her and father a great deal of stress.

2. Chronology of Professional Involvement

Mother Pregnant with Eve

2.1 In 2015[6] mother sought advice about stomach pains from her GP and after a number of investigations, she was found to be 8 months pregnant; mother and father reported that they had been told they could not have children. Mother received appropriate ante-natal care, which focussed on her medical needs given the late stage of the pregnancy. It is notable that no professional who had contact with mother before and after the birth of Eve considered whether this might be a denied or concealed pregnancy. Given the potential negative implications of a lack of ante-natal care and preparation for parenthood this was a gap in professional thinking which is discussed in Finding 1.

Mother's preoccupation with her own health needs

2.2 During the brief antenatal period mother gave detailed descriptions of a long list of her medical conditions, disabilities and medication (in a written format) to all health professionals she came into contact with regarding her anti-natal care. This struck those professionals as slightly unusual. This was a pattern that occurred across the period of review. Mother would spend considerable periods of time talking to professionals about her health conditions and give them the long, written list of required medications. This information was accepted at face value, and that it was very often unclear from the majority of records held by health professional, what was mother's view or what was a professional opinion. Although many professionals felt that mother behaved in ways, they found complex, challenging and emotionally draining, this was never discussed or analysed until during the process of this review. This is discussed in Finding 2.

Eve's birth

2.3 When Eve was born there were complications caused by the time taken to deliver her under a general anaesthetic and she stopped breathing; cardiopulmonary resuscitation[7] was initiated. Eve was then transferred to the neonatal unit[8] in hospital 1 where she initially made good progress.

2.4 A medical emergency occurred when Eve was 3 days old and she was found lifeless and was resuscitated prior to transfer to hospital 2.

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[6] Specific dates are not provided to ensure anonymisation

[7] This is a lifesaving procedure that is done when a baby's breathing or heartbeat has stopped.

[8] A neonatal intensive care unit, also known as an intensive care nursery, is an intensive care unit specialising in the care of ill or premature new-born infants. Neonatal refers to the first 28 days of life.

Eve had suffered a significant pulmonary haemorrhage[9] and, although a number of tests were undertaken, the cause was not found. It was thought it may have been caused by an allergy to dairy. Mother met with hospital 2 dietician for an assessment of Eve's needs and a milk free diet was agreed for mother to enable her to breastfeed. These early health concerns caused professionals to be empathetic to mother's significant and growing preoccupation with Eve's health and influenced the time it took for a consideration of whether this was proportionate or unusual. There should have been more analysis of the depth of this. (See Finding 8)

Planning for Eve to return home

2.5 A number of different assessment processes started at this time. The Adult Services social worker (ASSW1) started to reassess mother's care and support needs[10]. The ASSW1 made a referral to Children's Services for additional support for mother with her parenting role and a single assessment was started; mother complained this process was intrusive because she thought that it would only involve discussion of increased financial support. The Health Visitor (HV) carried out the primary visit to see Eve. These different assessment processes concluded that:

- The relationship between mother, father and Eve was observed to be warm, confident and caring;
- Mother's reported poor physical health and disabilities would impact on her ability to care for Eve, that she would need support to meet the physical demands of the parental role and could not be left alone with Eve;
- The parents expressed the view that they had the right to be supported to fulfil their parenting role regardless of mother's disabilities and medical needs and they needed an increase in funded care hours to help them to look after Eve safely;
- The role that father might play was not covered;
- The parents had little family support.

2.6 It was agreed that Mother would be provided with joint funding using direct payments[11] (Adult and Children's Services) to employ PA's for 60 hours a week. The PA's were to provide personal care to mother, cook meals, clean the house and help with shopping. It was stipulated that the PA's should not provide care for mother's 2 horses or the rabbits in the home; this had been a recent concern. The joint funding from Children's Social Care was to support mother to care for Eve.

[9] Pulmonary haemorrhage is rare. It happens when blood leaks from blood vessels in the windpipe or airways into the main lung.

[10] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[11] https://www.carersuk.org/help-and-advice/practical-support/getting-care-and-support/direct-payments

There was an overall lack of clarity or any detailed plan about this, how the PA's were to support mother in her parenting role and what father's role would be. This is discussed in Finding 3 regarding supporting disabled adults in their parenting role.

The Child in Need process

2.7 Eve returned home after 4 weeks in hospital 1. Mother, father and Eve were offered support from the Neonatal Community Nurse (NCN) from hospital 1 and she visited three times in October 2015. Support was also provided by HV, ASSW1 and Children's Services social worker (CSSW2). There was no sense that either mother or father were overly anxious about Eve in these early days.

2.8 Children's Services agreed to support the family through a child in need plan. There were regular child in need meetings for the next 19 months, which were well attended by all involved professionals and family members. However, the child in need plan lacked clarity of what was to be achieved for Eve and no goals were set or objectives agreed. The meetings were reactive, and discussions were often dominated by mother's own health and financial concerns; no boundaries were put around this. The importance of effective child in need processes is discussed in Finding 4.

Complaints from PA's

2.9 In the period between November 2015 and early February 2016 there were 5 complaints made by the PA's to the personalisation team. These related to allegations that mother asked them to care for her two horses, poor employment practices related to pay, and they said they had been bullied by mother and father. These concerns were addressed by ASCSW1 and CSSW2 through meetings with mother, who always refuted the allegations. Her denial was accepted, because they were viewed as one person's word over another, despite previous concerns of a similar nature. The solution formulated was that the personalisation service[12] would take over the management of mother's direct payments, meaning the poor employment practice could be addressed. Other issues were not addressed.

2.10 Two of the complaints related to allegations that Eve was left unsupervised by mother and the carers in her pram at the stables, or was left alone in mother's care, leaving her at risk because of mother's assertions about the seriousness of her neurological difficulties.

[12]Stockton Personalisation Support Service (SPSS) provides a wide range of information, advice and guidance relating to Personal Budgets for adults in the Borough. SPSS offers a variety of practical services. https://www.stocktoninformationdirectory.org/kb5/stockton/directory/service.page?id=HmAuqzPhqtQ

Overall, the time spent by the PA's on care tasks which were outside what was being funded would have impacted on the care of Eve. Mother often complained that her care needs were being neglected because time was spent with Eve and she cited infections and hospital admissions as a result.

2.11 There was insufficient reflection on the impact of allegations of mother misusing her care hours which were meant to support mother in her parenting role. She should have been challenged about this. This issue of the boundaries around the role and activities of the PA's, and what this meant for Eve as a vulnerable child, or for mother as an adult with care and support needs was never addressed; it was not discussed in the child in need meeting held during this period, and the complaints were not shared beyond Adult and Children's Social Care. The complaints by the PA's of bullying were also not addressed, and the implications for the safety and wellbeing of Eve not considered. This is discussed in Finding 5.

Concerns about the clutter in the home; was this the early signs of neglect?

2.12 There were concerns about the cluttered nature of the home from when Eve was 8 weeks old. The HV was concerned about Eve's safety and her future ability to move around the house and raised this as an issue at the first developmental review and mother agreed to address this. The role of father in this was less clear. The PA's spent a lot of time cleaning the house, but they were also not asked why the house was cluttered given their role. If this had been discussed with them, they would have said that they left the house neat and tidy and would come back the next day and the house would have descended back into chaos. The nature of their relationship with mother and father meant that they felt unable to address this.

2.13 The clutter was of concern to all professionals, and the HV carried out a formal assessment of neglect (The Graded Care Profile[13]) which highlighted no concerns. The clutter remained, and there were only small improvements leaving professionals concerned about Eve's safety. There was no further discussion of why the clutter existed or whether this was a sign of hoarding which needed addressing. There was also no discussion about why there were only small improvements, despite the concerns about the likely harm to Eve. This was the significant issue here. Mother and father were either unwilling or unable to make changes in the best interest of Eve.

[13] https://learning.nspcc.org.uk/research-resources/2018/implementation-evaluation-deliver-graded-care-profile-2/

2.14 In addition to the concerns about the safety of the house, the PA's also raised concerns that Eve was routinely being left unsupervised in her pushchair from the age of 8 weeks old at the stables and that she was left in the sole care of her mother from the age of 12 weeks old because mother had asked the PA's to attend to the horses. It had been agreed that mother was not to be left alone with Eve because the level of her neurological needs. This indicated that mother's needs dominated. The PA's reported this to the personalisation service, and this was shared with children's and Adult Services. This was not shared with other professionals and the HV was not made aware of these concerns, and so could not contextualise them alongside other issues regarding potential neglect.

2.15 There was evidence that Eve was developing well, and that mother and father demonstrated emotional warmth to Eve who had an observable positive relationship with her parents. It is now clear that the PA's provided most of the daily care to Eve. Over time mother started to talk about her own needs not being addressed by the PA's because they were so focussed on Eve's needs and she complained to all professionals she had contact with about this. Mother asserted that this led to her having untreated infections and unnecessary hospitalisations. It was never very clear whether this was an accurate picture, but there was a growing indication that mother could not keep the needs of Eve in mind, because she was so preoccupied with her own. These were the early signs of neglect which were not addressed. The importance of addressing the early signs of neglect is discussed in Finding 6.

Mother raises concerns about allergies and possible neurological difficulties for Eve

2.16 From December 2015 to April 2016 mother raised concerns about Eve having extensive allergies to a range of foods, beyond a possible dairy intolerance. Additionally, she also started to raise concerns that Eve may be suffering from the same neurological condition as herself. Mother told the HV when Eve was 8 weeks old that she could not attend groups because of the risk of contact with anyone consuming animal proteins. From this time on, all professionals were required by mother to be careful what food they touched or had contact with before they visited the family home and not to bring in any of the products that Eve was reported to be allergic to. There was no discussion about this or reflection about who had diagnosed these new allergies and when; mother's own report was accepted at face value by most professionals. The HV did ask mother about the impact on Eve of her contact with rabbits in the home, and horses at the stables, but mother was dismissive of this.

2.17 Mother took Eve to see GP 2 a week after the conversation with the HV and reported that Eve had multiple allergies; no detail or evidence was given or asked for.

Mother requested a referral for Eve to a clinical immunologist at hospital 2; this was completed. This led to an allergy test/food challenge[14] planned for July 2016. Mother told the HV about this food challenge 4 weeks before it was due to take place and the HV contacted hospital 2 and asked that she receive all past and future correspondence; this was good practice. This correspondence was provided and clearly stated that the parents had been overly cautious regarding milk protein intolerance and that Eve could go to playgroups and mix with other children. The HV raised this in the next child in need meeting. The parents did start to take Eve to playgroups, but still talked about allergies and neurological difficulties. At this time, it was agreed that there was no need for the child in need plan to continue, and that Eve and her parents would be supported through an early help plan. It was agreed that there would be a review of funding arrangements.

2.18 At the beginning of July 2016 Eve was admitted to hospital 2 for a food/dairy allergy challenge and it was found that Eve did not have any allergies; the parents were told in person that a normal diet could be introduced immediately; it was also confirmed that there were no neurological concerns. The GP practice was informed, but not the HV, ASSW2 or the dietician at hospital 1. Mother did not accept these results and told professionals that Eve had reacted to some foods and was to remain on a limited diet. This was again accepted at face value, with the exception of the HV who sought further information; this was effective practice.

2.19 Gradually the information regarding no allergies and no neurological difficulties was shared with all agencies, except hospital 1. This meant that the dietician continued to talk to mother about food allergies and offer advice. This stopped because mother had not brought Eve for her appointments she was discharged.

2.20 Mother continued to raise concerns about extensive allergies and neurological difficulties for Eve over the next 9 months with all professionals she had contact with. There was no discussion recorded about this, but it appears that mother's self-report that somehow hospital 2 had been wrong about the allergies was accepted by all except the HV. In August 2016 Mother challenged the outcome of the allergy testing and hospital 2 made a referral to the paediatric allergy clinic; an appointment was made for October 2016.

[14] A food challenge test is the best way to confirm a food allergy or to see if your child has outgrown a food allergy. They begin with placing a very small (trace) amount on the lips, if no reactions are observed the child will be given increasing amounts of the food over a period of time until a standard portion size is eaten. If any reaction is seen the challenge will be stopped and appropriate medication given. Only one food can be tested at a time and challenge tests are always performed under close supervision of medically trained staff.

2.21 The HV appropriately sought information about any planned investigations regarding Eve having neurological impairments and was informed that the recent admission (July 2016) had confirmed no concerns. This was shared with other professionals, but mother continued to express her worries about it and the need for further investigations.

2.22 Eve was seen in the joint gastroenterology and allergy clinic at hospital 2 in October 2016. Mother reported that she continued to exclude dairy, pork, and soya from Eve's diet. It was again reiterated that Eve had no allergies and these exclusions were unnecessary. The next appointment was planned for two months' time.

2.23 In January 2017 Eve started to attend nursery 1. Mother told the nursery that Eve must not be given dairy, soya, pork or egg products and that she could not sit next to a child eating food containing any of these products because of the serious consequences for Eve's health and wellbeing. Mother moved Eve from this nursery in March 2017 because she felt cross contamination concerns had not been taken seriously. Mother provided a large dossier of information about Eve's allergies and the need for her to avoid a range of foods to the new nursery; mother reported the consequences of Eve being in contact with these foods could be fatal. She also reported disturbed sleep and night terrors which mother said indicated neurological concerns. The issue of recognising early concerns about health anxieties which have escalated and might be indicative of Fabricated Illness is discussed in Finding 7.

The professional response to Fabricated and Induced illness

2.24 At the end of April 2017 Eve was seen by a consultant gastroenterologist at hospital 2. The consultant gastroenterologist[15] felt that mother had an undue preoccupation with both her own health and Eve's health needs and considered this might be a case of fabricated and induced illness (FII). The consultant gastroenterologist organised further tests rule out any underlying causes for the health concerns that mother had raised.

2.25 On 3rd July 2017 Eve aged 18 months was admitted to hospital 2 for her second food challenge. Mother's behaviour during this period of Eve's inpatient stay was of concern. She raised concerns about Eve vomiting extensively, nappy rash and diarrhoea caused by the introduction of food as part of the allergy trial; these incidents were not observed by staff who observed eve to be well.

[15] Gastroenterologists have extensive training in the diagnosis and treatment of conditions that affect the oesophagus, stomach, small intestine, large intestine (colon), and biliary system (e.g., liver, pancreas, gallbladder, bile ducts).

2.26 On the 6th July 2017 a Health Professionals meeting was convened to discuss concerns and decide on next steps; it was agreed that a safeguarding referral would be made to children's services. Children's services organised a strategy meeting[16] on 13th July 2017 and this was attended by all relevant professionals from hospital 2. None were invited from hospital 1; it is unclear why but was significant in coordinating the health response. The GP was also not invited. At this meeting information was shared about the history of events from when Eve was born, including early health concerns, mother's preoccupation with her own health needs and her growing concern about Eve's health needs despite evidence to the contrary. It was reported that during the current inpatient admission for Eve there had been concerns that

- mother had asked staff not to change Eve's nappy overnight, despite expressing concern regarding chronic nappy rash; this nappy rash was also not observed by staff;
- Mother had reported that Eve experienced night terrors, but ward staff had noted a normal sleep pattern for a child of Eve's age;
- Mother also reported extensive vomiting by Eve which had not been observed by any staff.

2.27 It was agreed that child protection enquiries[17] would be undertaken and an initial child protection case conference (ICPCC)[18] might be convened; this was tentatively timetabled for the 26th July 2017. There was also no discussion of who needed to block out the date in their diaries and which other health professionals were required. Guidance[i] suggests that a "responsible paediatric consultant" should have been identified, who would have been responsible for ensuring that an integrated heath chronology be completed. This was not discussed or commissioned. This should have been agreed at this point given the time needed for them to be completed.

2.28 Children's Social Care team manager and the hospital Named Doctor for Child Protection met with the parents to inform them of the concerns about fabricated and Induced illness and next steps. Guidance[ii]

[16] A strategy meeting/discussion takes place between Children's Services, the police and possibly other child care agencies at the beginning of child protection enquiries. The purpose of the discussion is to decide whether and how the child protection enquiries should be carried out; and whether any immediate steps need to be taken to keep the child safe while the child protection investigation is underway.

[17] Children's Services have a legal duty to look into a child's situation if they have information that a child may be at risk of significant harm. This is called a child protection enquiry or investigation. Sometimes it is called a "Section 47 investigation" after the section of the Children Act 1989 which sets out this duty. The purpose of the enquires is to gather information about the child and their family so that social workers can decide what action, if any, they need to take to keep a child safe and promote their welfare.

[18] This is a meeting which takes place between social workers, other professionals and family members when a child is considered to be at risk of significant harm because they have suffered physical abuse, emotional abuse, sexual abuse or neglected. The conference meets to discuss the risk to the child and decide whether the child needs a child protection plan to protect him or her from harm in the future.

highlights the need for the responsible paediatric consultant to be present when FII is discussed. This is to ensure that all information can be shared, and there is a medical consultant who is aware of all the concerns and the evidence for them. See Finding 7.

2.29 The Children's Services single assessment was completed by the social worker on the 20 July 2017. Information had been sought from hospital 2, the HV and nursery 2. Hospital I was not contacted. Father had taken part, but mother refused to be interviewed because she said she was too unwell. This report (see footnote[19]) amalgamated all the information and concerns from professionals about mother's assertions about Eve's health needs and the contradictions in the claims made by her. Father had said that he had not been aware that medical professionals had told mother that Eve was a well child and he said he was happy to hear this. A discharge letter form hospital 2 was sent on this day outlining that there were no health concerns regarding Eve.

2.30 The child protection report posed the question whether mother was medicalising normal childhood behaviour and if this was evidence of fabricated and induced illness or whether she was an over cautious mother because of early concerns about Eve's health; there was also a query about whether she was experiencing mental health difficulties. The conclusion was that an initial child protection case conference should be convened, and this was planned for the 26th July 2017.

2.31 The CSSW4 and her manager visited the parents to inform them the conference was to take place and to share the child protection report. Mother said she was amazed by hospital 2's concerns and suggested that these may have been made as a result of complaints she had made herself about the hospital and the safety of Eve. If this was true it was a serious issue which needed substantiating. Mother had made no formal complaint. If this had been clarified by CSSW4 and her manager they could have understood that this appears to have been a strategy to undermine the concerns being expressed.

2.32 The consultant gastroenterologist, the gastroenterology dietician and the consultant respiratory consultant from hospital 2 were invited to the ICPC conference three working days before the conference was due to take place. The consultant gastroenterologist made it clear that she would not be able to attend but would send a report. This report was received the day before the ICPC. This provided a comprehensive overview of concerns and a chronology. Further thought should have been given as to whether the conference should have been rescheduled to ensure that the consultant gastroenterologist (who was

[19] In Stockton one report is produced for the ICPC and subsequent review conferences by the social worker, drawing on information from all involved professionals and the family.

by definition the responsible paediatric consultant) could attend. The Guidance from both the Department for Education[iii] and the Royal College of Psychiatrists[iv] regarding F11 makes clear the importance of the responsible paediatric consultant attending the initial child protection conference. Neither set of guidance makes clear whether the statutory timescales set out in Working Together 2015[v] of a maximum of 15 working days from the strategy meeting to the initial child protection case conference can be disregarded in these circumstances. This is discussed in Finding 7.

2.33 The gastroenterology dietician also produced a report the day before the conference; evidence was provided to support the lack of any allergic reaction. The report also outlined discrepancies in mother's food diary; she had reported a strictly dairy free diet due to breastfeeding and the serious risks to Eve. Mother's food diary showed that she has consumed foods which contained cow's milk, soya, pork and egg. The consultant respiratory consultant from hospital 2 provided a comprehensive report the day before the conference which reported there were no neurological concerns and this information had already been shared with mother. Reports from hospital 1 had not been sought. The GP was asked for a report for the ICPC and informed of the date which was in two days' time. The GP provided a list of consultations but was not able to attend at such short notice.

2.34 On 26 July 2017 the ICPC was held and chaired by an independent conference chair[20]. All reports were shared with professionals at the start of the conference, with 30 minutes to read them; not enough time to absorb complex information or make sense of it. In Stockton only one report is produced for the conference by the social worker undertaking the child protection enquiry. All the information from the different agencies involved with the family is incorporated into this report. This meant that the views of the HV and nursery were all amalgamated into the social workers views. They had different perspectives, and particularly the HV had extensive knowledge of the family. There were three health reports from hospital 2 to read.

2.35 At the start of the conference, Mother reported that Eve had been unwell as a baby, which was why she was so anxious. She said she had been advised by the dietician at hospital 1 to cut out pork, dairy and soya from Eve's diet and she produced a letter to evidence this. The lack of an invitation of professionals from hospital 1 to the conference, and therefore no report or chronology, meant that this discrepancy was not discussed or well understood. The dietician at hospital 1 had given advice that contradicted hospital 2 because she was not made aware of the findings of the first allergy test.

[20] The chair of a child protection conference is a senior social worker whose job it is to run the conference. They will be independent of the child's case and will not be involved in managing the child's social worker or their manager.

2.36 It is of concern that mother said that hospital 2 had only raised concerns of F11after she had made a complaint about Eve being at risk whilst in hospital due to being able to access needles and cannulas and that a room where medicines were held did not have a child gate on it. This was not discussed or verified as a complaint; this was a serious complaint that either needed further investigation or to be analysed as a possible tactic by mother of transferring responsibility from herself to the referring agency. Neither happened. Mother had never made a complaint, and there is no evidence to suggest what mother said was true.

2.37 Within the conference mother questioned the conclusion regarding a neurological condition for Eve, but when the relevant section from the medical report from hospital 2 was read out, she said she accepted the conclusion that there were no concerns.

2.38 Father said he was happy to hear clearly that there were no health concerns regarding Eve and that she was a well child. Professionals considered this was a genuine response.

2.39 The conclusion of the conference was that there were some concerns about mother's response to medical opinion, but also a belief that mother and father had been given contradictory information. The very significant concerns raised in the three reports provided by hospital 2 do not appear to have influenced professional opinion. This may have been because professionals only had a brief time to read them, or they accepted mother's view that hospital 2 had raised concerns because of mother's alleged complaint. Either way this comprehensive information should have had a greater influence on the analysis and the subsequent decision. All professionals agreed using signs of safety approach[21] that Eve was not at risk of significant harm and she should be supported through a child in need process. The child in need plan outlined expectations and next steps. This included:

- mother agreeing not to self-diagnose illnesses for Eve and to take the advice provided by professionals;
- a parenting assessment would be completed to see if the parents needed the high level of support currently in place;
- Mother's care package would be reviewed;
- health chronologies should be sought from hospital 2 (unclear why given they had already been provided);
- there would be a review of the potential impact of mother's medication (much of which was opiate based) on Eve through breastfeeding. The impact on mother of the high doses of opiates

[21] The Signs of Safety is an innovative strengths-based, safety-organised approach to child protection casework. https://www.signsofsafety.net/signs-of-safety/

and whether she was in fact addicted to painkillers should also have been considered.

The second period of Child in Need planning

2.40 The first child in need meeting after the initial child protection meeting was held in September 2017. Mother and father were told that Children's Services funding was to cease, but support for the nursery would continue. The review of Adult Services funding was ongoing, and the 30 hours continued.

2.41 At the next child in need meeting in November 2017 Eve was reported to be doing well and there were no concerns about mother reporting medical concerns. At this point Children's Services proposed that the child in need plan would cease and Eve and her parents would be supported by an early help plan; this was accepted by the HV and nursery who were part of the CIN process. This was very soon after the initial child protection case conference and many aspects of the CIN plan had not been completed. The parenting assessment had not been undertaken, the issue of communication between the parents had not been addressed and the concerns about how mother would receive health information had not been tested. The review of mother's care package and medication review were also not complete. It is hard to evaluate the impact of this decision, because soon after Eve was injured.

2.42 At this time Father was made redundant and it was appropriately expected that he would provide care to Eve. However, the lack of clarity about exactly how much care the PA's provided to Eve meant that there was no discussion about whether father was equipped to fulfil this parenting role; this should have been subject to a Children's Services assessment. All meals were cooked by the PA's and all household tasks completed by them; they got Eve up, dressed and washed. It has also emerged that Eve stayed overnight with them on occasion. The premature closure of the child in need plan, and the rearrangement of appointments with the HV meant that no professional was aware of the deteriorating relationships between the parents and the remaining PA's. At some point in November 2017 the PA's all left mother's employ. This led to mother desperately looking for help with the care of Eve, approaching a number of people she vaguely knew.

2.43 The PA's who had recently left mother's employment asked for a meeting with Adult Social Care and this took place on the 18 December 2017. At this meeting they talked about previous concerns which were the basis of complaints. In addition, they reported how they had been asked by mother to exaggerate her symptoms and care needs when

professionals were in the home and they also stated that mother had bullied them.

2.44 On the 18th December 2017 Eve (aged 2) was taken to hospital with a head injury and other bruising.

3. Conclusion and Findings

3.1 Eve was harmed whilst in the care of an adult with whom her parents had placed her, without sufficient scrutiny and without due regard to her age, developmental and attachment needs or recognition that she was cared for by multiple carers throughout her young life. This decision was made by mother because all the carers who had been working for her had left; they left because they were treated inappropriately. Father had not taken a role in parenting Eve, so despite being available to look after her, he did not. There is no evidence that any professional could have predicted that Eve would be harmed in the way she was, but there are a number of Findings regarding the actions of the parents and the professional response, which have relevance for future safeguarding practice and if left unaddressed have implications for the safeguarding of children locally. These are outlined below.

Finding 1: The importance of professionals evaluating a mother's circumstances when seeking ante-natal late in pregnancy

3.2 There is evidence that women can unexpectedly find themselves pregnant at a late stage without any signs or symptoms and very often they only know they are pregnant when they start the process of giving birth. However, this is not a common occurrence and this late presentation is more likely to be either a concealed or denied pregnancy[22].

3.3 The reasons for women denying or concealing their pregnancies are multiple[vi]. It may be that these are defence mechanisms for the physical and emotional adaptations that need to be made during pregnancy and into parenthood. The reasons are important and need to be evaluated in terms of ongoing risk to the unborn and born baby.

3.4 The concealment and denial of pregnancy poses significant risks to the mother and unborn baby[vii]. The mother and baby may not get the medical care they need antenatally and health needs and risks may not be identified. The baby can be born in unsafe circumstances, posing a risk to mother and baby. The mother may not have formed an attachment to the unborn baby, which can continue after birth and mother may not have developed an identity as a parent causing problems with parenting into the future.

3.5 These outcomes highlight the importance of all professionals considering whether there are concerns about denied or concealed pregnancy

[22]A concealed pregnancy is described as one in which a woman knows that she is pregnant but does not tell anyone, or those who are told collude and conceal the fact from health professionals. A denied pregnancy is when a woman is unaware of, or unable to accept the fact that she is pregnant.

when a woman books late for ante-natal care. This was not considered for mother. It remains unclear whether mother knew about her pregnancy or had denied it to herself, but the importance of professionals reflecting on the circumstances of women who come late to ante-natal care, talking to them about this and taking appropriate action in the context of a clear denied and concealed pregnancy pathway.

Recommendation 1: A policy and pathway regarding denied and concealed pregnancy needs to be developed by the Tees Procedures Group.

Finding 2: Working with adults whose behaviour and demeanour concern professionals; making sense of this in the context of professional judgments and decision making

3.6 In the process of undertaking this serious case review all professionals described mother's demeanour and behaviour as unusual. Though they found it hard to be more specific. She was described as "*emotionally draining and intimidating"* and at the heart lay her concerns about her own health needs, Eve's heath needs and finances. These issues dominated meetings and discussions about Eve; and professionals found it hard to move conversations within meetings beyond these issues. There were a number of incidents which were described later as '*unusual'* and '*hard to make sense of'*, but which were not recorded or discussed.

3.7 There is much research on working with hostility and aggression and adults who cannot or will not engage[viii]. There is less written about the legitimacy of talking about, or thinking about, working with adults whose presentation and demeanour seem unusual or odd and who provoke an emotional response in professionals. It is clear that at times professionals feel unable to talk about this, because it feels disrespectful, judgemental and challenges the fundamental principles underpinning most professional practice.

3.8 However, a number of high-profile public inquiries into safeguarding have highlighted the need for professionals to reflect on, and critically analyse the attitudes, demeanour, responses and actions of family members, other professionals or themselves[ix]. Professionals are often told they must focus on hard facts, and not express professional opinions or consider their emotional responses. However, research[x] shows that although strong emotions can impair or skew professional judgements (without analysis) professional judgements without recognising the role of emotions are ineffective.

3.9 It has become clear that professionals in their work need to balance intuitive reasoning (gut feelings, practice wisdom, emotional responses) with analytic reasoning (formal processes, research findings, guidance, hard facts). Munro (2011)[xi] in her review of the child protection system argued that professional judgement needs to utilise both intuitive and analytical reasoning.

3.10 The emotional dimension of working in adult and child safeguarding plays a critical part in how professionals' reason, make sense of situations and people's needs and should inform judgments and decision making. If this dimension is not explicitly addressed and analysed then its impact can be harmful and can lead to fixed thinking, stereotypical ideas and can also hide factors that are important in understanding risk and need. Mother's unusual demeanour and behaviour needed to be explored and taken account of in a respectful way, which recognised it might have indicated something about her owns needs and provided information about the risk posed to Eve.

3.11 It is clear that there was some confusion across the professional network about what were facts that could be recorded, what were self-reports from mother (which were often recorded as fact) and when to seek corroboration of what mother said and cross reference with other available information. Professionals relied too heavily on mother's descriptions of events and concerns, without discussion or seeking further information.

3.12 There were also times where information was sought without clarity regarding what was required; ASSW2 sought information from mother's medical consultant who provided care for her neurological difficulties. This was in the context of the complaints made by the PA's and doubts (not articulated or shared) about mother's level of disability. It is not clear whether the Consultant understood this or sought to clarify the required information and he sent back an ambiguous reply. ASSW2 was disappointed with the reply but did not appear to have followed this up with a more specific inquiry.

3.13 Professionals need to be clear about distinguishing between what adults say (self-report) and professional judgement/opinion. Where adults cause concern in their presentation and behaviour, professionals need to take appropriate steps; for example, via supervision processes, to discuss the meaning of these behaviours in the context of the current plan. Professionals need to understand the importance of including analysis and professional judgement within any information shared with other professionals; in order that others may make sense of a child and adults' circumstances, rather than it being just a flat exchange of information.

Recommendation 2: There is a need to ensure that there is consistent recording across the Tees partnership taking particular note of evidence of a self-report. The partnership should:

a) organise awareness training and briefings regarding the learning points from this review;

and

b) check the clarity across organisations about analytical reasoning evident in recording and information sharing through a themed S11 spot check.

Finding 3: Supporting Disabled Adults in their parenting role

3.14 Legislation and Guidance makes clear the importance of ensuring that adults with disabilities are supported to fulfil their parental role[xii]. The Convention on the Rights of Persons with Disabilities (2006) article 23 (2)[xiii] *states "Parties shall render appropriate assistance to persons with disabilities in the performance of their child-rearing responsibilities*. This right needs to be set alongside the duty of the State (through local authorities) to safeguard and promote the welfare of children, as set out in the Children Act 1989[xiv] with the welfare of the child being the paramount concern. In essence the support provided to parents' needs to be child centred and child focussed. It must not replace the parenting role or introduce a number of adults into the life of a child which can disrupt attachment and the development of core relationships. The support must be consistent, predictable and reflective of normal family life, as far as is possible. This requires a clear plan detailing expectations and boundaries. This did not happen for Eve.

3.15 When Eve was born, mother was assessed as needing support to fulfil her parenting role and significant funding was provided. Funding to support her independence was to continue. There was confusion from the start about the difference between these two types of funding and their necessary oversight. The funding provided by Adult Social Care was self-directed through direct payments. Mother made decisions about how the funding hours worked and who was employed, and this was in line with the Care Act Guidance[23]. The other half of the funding came from Children's Social Care and should have been part of a child focussed plan, for Eve. There should have been a clear plan about what the hours of funding were to pay for, what plan needed to be in place to ensure that mother was supported in her parenting role, rather than this role replaced. There should have been a plan which was multi-agency in approach and reviewed regularly.

[23] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

3.16 The Health Visitor did raise concerns about exactly how mother was to be supported in her parenting role, how much direct care the PA's would be providing, whether they were trained or experienced enough to look after a young baby and whether they were DBS[24] checked.

3.17 Despite the presence of at least one PA in the home every day for 12 hours, no professional talked to them formally about their roles and responsibilities for Eve; they were in essence invisible to those professionals concerned with overseeing Eve's welfare. It remains unclear exactly how much care they provided but it appears this was much more significant than was thought and the PA's took over the parenting role, rather than supporting mother to fulfil it.

3.18 There was no reflection regarding Eve's possible attachment relationship with the PA's. It was well known that from November 2015 when Eve was two-months old there was significant instability which meant a high turnover of PA's because they felt undervalued, used inappropriately and so left. There was no discussion of the implications of all this instability for Eve, her care and her attachment relationships. The HV appropriately queried whether there were attachment implications for a young baby being looked after by a number of different adults. These were all important questions which were not answered.

3.19 Despite the PA's being responsible for the care of a child, they were not required to attend safeguarding training, but they did identify concerns about neglect, and reported those concerns. These concerns were not responded to appropriately and the PA's were not aware of their responsibilities to escalate when they were dissatisfied with the response of other agencies.

3.20 The role of father in parenting Eve was never discussed. It was accepted that he had the right to work long hours. This should have been assessed in the context of consistency of care for Eve.

3.21 Where disabled adults are to be supported in their parenting role there needs to be a clear plan in place, negotiated in partnership with all family members including fathers, about the detail of how parents will be enabled to parent, how stability and consistency will be ensured and there needs to be clarity about funding arrangements, the boundaries of the use of monies and a regular review of the whole package. This did not happen for Eve.

[24] A Standard DBS Check is processed by the Disclosure and Barring Service (DBS). It searches an applicant's criminal history to identify any convictions, both spent and unspent, cautions, warnings and reprimands.

Recommendation 3: A joint protocol needs to be developed between Children's and Adult services to provide guidance regarding situations where there is a child(ren) with support, care or protection needs and a parent with care and support needs.

Finding 4: The importance of effective child in need processes

3.22 Addressing the needs and circumstances of children requires effective multi-agency child in need processes. The Children Act 1989[xv] defines Children in Need (CIN) as those children whose vulnerability is such that they are unlikely to reach or maintain their necessary health and development without the provision of services. This is a serious issue for all children, and particularly for those under 5 for whom development is rapid and critical for their future. The emphasis on the importance of good quality assessment to determine the level of a child's need is reflective of the potential risks for a child's future. Once an assessment is undertaken and needs are identified, it is expected that a child focused plan is formulated which addresses those needs with a clear outline of the outcomes expected, services to be provided and the reviewing mechanisms identified. An assessment was undertaken, but it was unclear what the child in need process or plan was hoping to achieve for Eve.

3.23 It was agreed that Eve and her parents would be supported under the auspices of a child in need plan from when Eve was born. The early child in need meetings were held regularly, but the lack of a clear plan meant that there was no framework for the support to mother in her parenting role, so there was no vison about what progress or the lack of it would look like. There were ongoing concerns about the house being cluttered, and many discussions about this needing to be addressed for the safety and well-being of Eve. The meaning of this, why it was occurring and why it was not changing were not addressed.

3.24 There was evidence that mother and father were not coping, they often reported this to professionals, but this was a point of discussion rather than something to analyse and monitor in the context of parenting and Eve's outcomes. The same was true regarding financial concerns. Mothers concerns about Eve's heath needs were reported, but no sense made of them and the lack of analysis meant there was no professional view developed.

3.25 It is of note that over time, whenever there were concerns or complaints, these were discussed within a different meeting process such as a professionals meeting or joint meetings between Adult and Children's Services. This caused confusion about what tasks needed to be completed, by when and by whom. The role of the child in need

meeting was undermined by these different meetings and meant some professionals, such as the HV were unaware of some concerns.

3.26 Each professional recorded the child in need meeting under a different title, a care team meeting, a core team meeting, a planning meeting, a case review and sometimes just a meeting. Although professionals involved understood that these meetings were held under the auspices of a child in need process the use of different names caused confusion across the multi-agency network and could undermine the focus which is primarily the needs of children.

3.27 There was a second period of child in need processes after the initial child protection conference which lasted for a period of three months, before it was agreed that the child in need plan would cease. This decision was agreed by all professionals but was taken at a time when the parenting assessment had not been undertaken, the issue of communication between the parents had not been addressed and the concerns about how mother would receive health information had not been tested. The review of mother's care package and medication review were also not complete.

3.28 Child in need processes are there to promote the health and development of a child through multi-agency plans in partnership with parents, where the parent's circumstances are understood and addressed within the plan for the wellbeing of children. There needs to be goals set, outcomes for the child clarified, services which promote the needs of the child and whole family and a reviewing mechanism which ensure progress is being made and lack of progress addressed.

Recommendation 4: The child in need process in Stockton needs to be made more robust to address the concerns raised in this SCR.

Finding 5: The Treatment of PA's

3.29 Mother was in charge of her own personal budget, and alongside all adults with care and support needs it is intended that these budgets are a key part of ensuring person centred care and self-directed support. The process is intended to be enabling and empowering in line with the social model of disability[25]. The personalisation support service in Stockton supports this self-determinism by providing advice and guidance about employment issues and managing employment regulations.

[25] https://www.scope.org.uk/about-us/social-model-of-disability/

3.30 PA's were–expected to provide care by mother to a young, and seemingly unwell baby for a considerable period and they did this without training. They made numerous complaints about the other inappropriate duties they were required to complete, concerns about the care Eve received from mother, poor employment practices and bullying. As a consequence, they eventually left mother's employ. This created instability for Eve.

3.31 The employment issues were addressed by the personalisation services, but not resolved. Where a PA has problems with their employers (the adult with care and support needs) these must be addressed through established employee grievance procedures, and where these issues are not resolvable that ACASS will be the responsible agency.

3.32 The concerns the PA's raised about the neglect of Eve with the personalisation services and shared with Adult and Children's Services were not addressed. The PA's were not required to attend safeguarding training or given advice about how to report safeguarding concerns when it is your employer about whom you want to raise concerns regarding child abuse. The PA's did not know how to escalate their concerns when no action has been taken and feel confident to raise issues of exploitation, coercion and control when being employed as a PA.

3.33 The issue of the bullying of PA's by their employers not sufficiently covered in the PA staff handbook. This is left to the employer to deal with or for this to be escalated through ACASS. This does not take account of issues of possible exploitation, coercion and control when being employed as a PA.

Recommendation 5:
A whistleblowing policy needs to be developed for PA's
Where PA's are working in homes with children present, they should undertake safeguarding training.
The Findings from this SCR to be incorporated anonymously into a briefing for PA's.

Finding 6: Addressing the early signs of child neglect

3.34 The neglect of children by their parent's (primary caregivers) is a serious issue which has a significant and long-lasting negative effect on children's developmental outcomes, their safety, their emotional wellbeing and the impact often lasts into adulthood[xvi].

3.35 Child neglect is a complex area of practice which requires a structured and analytical response. Of primary importance is that neglect is picked up early, in order to prevent cumulative harm to children and to prevent

entrenched patterns of poor parenting developing which become more and more difficult to change. Interventions to address neglect need to be focussed on the causes, and to target specific developmental change for the child which is evidenced over time. If the early signs of neglect are not addressed robustly, they can become entrenched and harder to resolve. This analysis was not completed for Eve.

3.36 Neglect is multi-faceted. It is not just the physical circumstances that the child lives in or the physical care they are provided with. It is a parent's commitment to change behaviours and negative parenting approaches in the best interests of the child. It is the ability to put adult needs secondary and to be able to hold a child in mind. The evidence here was that mother could not always do this. She did not take Eve to groups because of allergies that she had been told did not exist. Father was absent and provided little care. There was evidence of chaotic home circumstances and either an unwillingness or inability to change.

3.37 The Hartlepool and Stockton-on-Tees Safeguarding Children Partnership have already undertaken work to improve the response locally to child and adolescent neglect (via their 'Active Learning' model and the production of a 'Neglect Statement of Intent'). It is suggested that the findings from this review is incorporated into this work.

Recommendation 6: Hartlepool and Stockton-on-Tees Safeguarding Children Partnership should evaluate the effectiveness of work already undertaken to improve the local response to child and adolescent neglect; in order to understand the impact on outcomes for children and young people and to inform any additional work to be undertaken.

Finding 7: Addressing Fabricated and Induced Illness (FII)

3.38 The Fabricated and Induced Illness of children by their parent (usually mother) is complex, controversial and difficult to diagnose/assess. It is defined as the behaviour of a parent who presents their child for medical attention with an injury or signs of illness which they either falsely report and/or exaggerate or deliberately cause and/or induce. Recent research and analysis have highlighted the importance of seeing FII as existing along a continuum from overanxious parents to misrepresentation of symptoms and exaggeration to inducements and deliberate harm. There is less evidence about whether parental behaviour develops across the continuum, gradually getting more extreme but there is good evidence that it is important to address suspected FII at an early stage and to use the phraseology of perplexing presentations[xvii].

3.39 There was early evidence that mother was preoccupied with her own needs (an indicator of possible FII)[xviii]. There was also evidence of mother's escalating anxiety about Eve's heath, specifically focused on a growing number of allergies with increasingly serious outcomes and she also cited signs of neurological difficulties indicative of Eve having inherited her own condition.

3.40 Initially professionals understood this anxiety to be because of Eve's early heath issues. Mother was provided with support through the dietician, the neonatal nurse and the HV. She was told that Eve was developing well.

3.41 Professionals need to notice when parental anxiety is out of proportion to the assessed need and provide help to address the anxiety. There is a need for professionals to make an assessment when these anxieties grow in the face of evidence of no health concerns. This happened partially for mother. Mother reported widespread allergies when Eve was 12 weeks old. There was no diagnosis of this. It was a constant issue for mother, causing limitations to Eve's life, and there were elements of mother controlling the PA's and professional behaviour. There was a sense that this was not quite right, held by all, but never clearly articulated (see finding 2). Later, it was clear that Eve had no allergies and there were no neurological concerns. Mother disputed this and carried on withholding food and putting stringent arrangements in place. Eve continued to miss out on toddler activities and unnecessary time spent on securing her environment when it was not necessary. The escalation of mother's behaviour went unanalysed and unaddressed and not understood.

3.42 If professionals had tried to make sense in the early stages of mother's anxieties there could have been a more clearly articulated professional view about whether this was extreme parental anxiety which needed addressing, or was the early signs of FII which also required a response, with the aim of addressing the concerns before they escalated.

3.43 The consultant gastroenterologist at hospital 2 correctly assessed in April 2017 that there were concerns about fabricated and Induced Illness and this was effective child focussed practice. However, she did not make a referral to Children's Services at this time; she organised for there to be further medical testing. Whilst this further medical testing to rule out medical causes is recommended by existing guidance for F11, both the DfES and Royal College of Psychiatry guidance make it clear that this should not delay a referral to Children's Services. This is because when there is evidence that FII is a concern it is important that a clear investigation is planned, appropriate safeguarding processes are enacted, and that there is time for all information (not just health) to be collated and analysed. This takes time, clarity of roles and responsibilities,

time to ensure that all appropriate professionals can attend meetings and when people come to meetings, they have had time to read all reports and make sense of them.

3.44 Once the allergy testing was underway in July 2017 there were immediate concerns about mother's behaviour and her response to medical advice. This led to a health meeting and then a referral to Children's Services and a strategy meeting. This meeting did not agree who would be the "responsible paediatric consultant" or lead consultant as outlined in both sets of FII guidance. This would have established who would lead the process, who would ensure that a comprehensive health chronology was commissioned and who would meet with the parents to discuss the concerns and next steps.

3.45 The strategy meeting did not discuss who would need to attend the initial child protection conference. The Royal College guidance says that the lead health consultant for the child must be in attendance; the guidance does not make clear that this is more important than meeting the statutory timescales of 15 working days between the strategy meeting and the initial child protection case conference. This guidance also suggests the lead consultant should be included in the child protection enquiries or at least provide advice; this did not happen.

3.46 The child protection enquiries commenced. A good assessment/child protection report was completed which covered the key issues but did not make use of the consultant gastroenterologist's expertise and did not focus on some of the key issues regarding FII.

3.47 An initial child protection case conference (ICPCC) was organised, but the consultant gastroenterologist, the gastroenterology dietician and the consultant respiratory consultant from hospital 2 were asked for a report and invited to the ICPCC conference three working days before the conference was due to take place. The GP was asked to attend and provide a report two days before the conference. Given the complexity of the issue and amount of health information this was not enough notice to produce health reports (although hospital 2 produced three comprehensive reports with an attached chronology) and not enough time for the Chair or other professionals to read and digest. The departments at Hospital 1 involved with Eve were not asked for a report or invited to the conference, which meant mothers' assertion about contradictory information being provided could not be addressed.

3.48 The consultant gastroenterologist (Hospital 2) made it clear that she would not be able to attend but would send a report. Her absence was significant and there should have been discussion about whether the conference date should have been changed.

3.49 At the ICPC professionals only saw the reports on the day and would not have had a chance of understanding the full information. These reports provide clear evidence to support the concerns in relation to FII.

3.50 Whilst it is important that parents are enabled to give their perspective and counter concerns in safeguarding meetings, in this case, mother's arguments were allowed to undermine the significant evidence from hospital 2. Mother alleged that the referral from hospital 2 was malicious and this went unchallenged and unaddressed. This evidence of a parent undermining the expertise of professionals, particularly medical professionals should be an important consideration within an assessment of FII; there was considerable evidence of mother previously undermining the credibility of professionals without challenge.

3.51 All professionals agreed that Eve should be supported under a child in need plan. It is not unusual for situations where there are concerns about FII to be managed effectively under the auspices of a child in need plan; what is important is that the concerns about FII remain at the heart of why the plan is in place, and there is robust monitoring. The lack of the lead consultant, who had provided clear evidence of FII for Eve, which had the potential to have a negative impact on Eve's health and wellbeing, and mother's effective undermining of hospital 2 and hospital 1 and their information, meant that ongoing concerns about FII got lost. The child in need plan focussed on actions that mother and father needed to take. There was an action to get a hospital chronology, but the reasons for this are not apparent and undermined the extensive information already provided. There was no request for information or a chronology of contacts from hospital 1 or other health professionals involved with the family e.g. GP.

3.52 This finding highlights the need for professionals to have a detailed understanding of F11. There was confusion about the meaning and application of guidance, insufficient time for reports to be produced and professionals to read and digest.

Recommendation 8: The Stockton and Hartlepool Children's Safeguarding Partnership a Tees-wide procedure for Fabricated and Induced Illness. This procedure requires review in the light of this SCR. This work should take into account the findings from this review and the learning emerging from Stockton Children's Services in addressing the needs of Eve. This should include a review of the arrangements for identification, assessment and the conduct, timing and representation of appropriate professionals at Child Protection Case Conferences and consider the gaps in information sharing found.

Recommendation 9: Currently in Stockton, one report is prepared for Child Protection Case Conferences by the allocated social worker, and all professionals who know the child and family contribute to this. This does not allow for each agency to be clear about their own analysis of a child(ren) circumstances. This is important in the context of fabricated and Induced Illness, but the need for separate reports, which utilise the knowledge and experience of each professional is also a key finding from many Serious Case Reviews.

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