NEWHAM LOCAL SAFEGUARDING CHILDREN BOARD

Serious Case Review

Child L

Overview Report	November 2018

Serious Case Review (SCR) commissioned and completed for Newham Safeguarding Children Board (NSCB) in order to establish whether any lessons can be learned and to promote and develop good practice following a serious Incident for Child L

Lead Reviewer and Independent Report Author – Jane Doherty

1 Introduction

1.1 This Serious Case Review was commissioned by Newham Safeguarding Children Board (referred to as the Board in the report) to examine the practice of the multi-agency network surrounding Child L and her family. The following is a brief resume of the circumstances leading to the review.

1.2 Child L is a child with complex needs. She has two older siblings who live at home with her. She has limited speech and her level of cognition is very limited. Child L has been well known to health services throughout her life by virtue of her complex health needs but the family have also been known to Newham Children's Services since 2008 (prior to her birth). These concerns were in regards to neglect, including lack of supervision, poor home conditions, limited engagement with professionals, poor school attendance and concerns about the children's presentation. In light of these issues the children were subject to two sets of Child Protection Plans during the review period in 2010 and 2015.

1.3 In October 2017 Child L was found trapped under her profiling, adjustable height bed[1] and had suffered a cardiac arrest. She was taken to the Royal London Hospital where she was placed in an induced coma.

1.4 The home was noted to be in poor condition and particularly the bedroom of Child L. There was no working light in the bedroom; there was an open bleach bottle on the floor and an overwhelming smell of urine. Child L's mother was not arrested but at a later date interviewed under caution. Her account of what happened changed over time. She admitted that she had been out shopping that day and had left Child L in the care of her two older siblings. At the time she said that she was back in the home when the incident happened. However, later she acknowledged that she was out of the house when the incident occurred. After some consideration a decision was made that no further action police action was to be taken with regard to neglect.

1.5 Child L has made a full recovery. After the incident she was placed in foster care whilst the Local Authority made an application for care proceedings. Her siblings were made subject to Child Protection Plans for the third time. At the time of writing the report, Child L had been returned to the care of her mother under a Supervision Order and her siblings remained subject to a Child Protection Plan.

[1] Special electrically operated bed for children with disabilities

2 Arrangements for the Serious Case Review

2.1 After the serious injury to Child L occurred, Newham Safeguarding Children Board took the view that the criteria for a Serious Case Review had been met which is entirely consistent with the guidance in 'Working Together to safeguard Children[2] 2015. In this case the following applies as abuse of a child is either known or suspected and the child was seriously harmed (5(2)(b)(i): and there are concerns about how organisations or professionals worked together to safeguard the child.

2.2 Working Together (2015) Chapter 4 Para 11 states a Serious Case Review should be conducted in a way which:

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

2.3 The purpose of the review is to;

- look at what happened in the case and why and what action will be taken to learn from the review findings
- identify actions that result in lasting improvements to those services working to safeguard and promote the welfare of children.
- provide a useful insight into the way organisations are working together to safeguard and protect the welfare of children.

2.4 Arrangements were made to appoint the independent people who are required to contribute to the conduct of Serious Case Reviews. Tony Jobling was appointed to chair the Independent Panel. Tony is the Director of Operations, Adult Social Care in Newham and as such has had no direct management responsibility for the case. Ms Jane Doherty was appointed to produce this overview report. Jane is an Independent Social Work Consultant with a considerable background in Child Protection and Quality Assurance. As an Independent Consultant she now specialises in multi-agency learning reviews including partnership reviews and Serious Case Reviews. Jane is accredited as a reviewer using the Social Care Institute of Excellence (SCIE) Learning Together model.

[2]Working Together to Safeguard Children (Working Together) is the government's overarching guidance on safeguarding.

2.5 Newham Safeguarding Children Board appointed a Review Panel to oversee the review and ensure that the final report reflected their views as well as those of the independent overview author. The panel was made up of senior representatives from those agencies involved in working with the family, but members were not directly involved in the management of the case. Membership is in the table below.

Agency	**Representative**
Independent Chair of the Panel	Tony Jobling Director of Operations Adult Social Care, Newham.
Independent Overview report author	Jane Doherty, Independent Social Work Consultant
London Borough of Newham Children's Social Care	Director of Operations for Children's Social Care Newham
Education	Head Teacher
Newham Safeguarding Children Board	Business Manager
Metropolitan Police Service,	Lead Officer, Specialist Crime Review Group
Newham Clinical Commissioning Group	Designated Doctor for Safeguarding Children
London Community Rehabilitation Company	Contracts and Partnership Manager
BARTS Newham University Hospital	Named Midwife for Safeguarding/ Named Nurse for Safeguarding
London Borough of Newham (ASC & CSC)	Director of Delivery, Compliance & Transformation, London Borough of Newham
London Borough of Newham 0-19 Children's Health Service. Health Visiting & School Nursing	Named Nurse for Children's Safeguarding

2.6 It was determined through the emerging facts in the case that the following agencies should contribute to the review. These agencies submitted Independent Management Reviews and contributed through practitioner events and providing further documents to the reviewers.

Agency	Contribution
School	IMR and chronology
General Practitioner (GP)	IMR and chronology
East London Foundation Trust (ELFT)	IMR and chronology
Children's Social Care (CSC)	IMR and chronology
Housing Needs, Newham	IMR and chronology
London Metropolitan Police Service	IMR and chronology
School Nurse and Health Visiting	IMR and chronology
Community Rehabilitation Company (CRC), London	IMR and Chronology
BARTS Newham University Hospital	IMR and Chronology

2.7 The Terms of Reference developed by the panel and agreed by the Independent Chair of The Board were that the period under detailed review would be from the birth of Child L in 2009 until the date Child L was injured in October 2017. Agencies were asked to summarise any other relevant information pre-dating this period, to add context and background to their report. The period of review is lengthy and some notes about this are contained in section 3.

2.8 The methodology used by The Board in this review is a hybrid model. Each agency was asked to complete a chronology, and undertake an Independent Management Report. The reports are an opportunity for individual agencies to describe and analyse their contact with the family and their analysis forms the basis of the Overview Report. Practitioners who knew the family are also asked to contribute their views to the agency via the Independent Management Report.

2.9 Newham Safeguarding Children Board held a series of panel meetings, chaired by the Independent Chair, where all the agencies and the overview author contributed to the process of gathering and analysing the material provided. The panel considered at all stages how early learning could be shared with relevant agencies and staff. The recommendations and action plans were shared with staff and implemented immediately where possible. Agencies were made aware that the learning from their reports along with recommendations for action should be shared quickly and without delay.

2.10 Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including serious case reviews states that:

'Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children". (Working Together to Safeguard Children 2015, 4:7)'

2.11 A consultation and learning event was held early on in the process to enable those practitioners who worked with the family to contribute to the overall findings and lessons from the review. Where relevant their views have been incorporated throughout the report.

3 Comments and limitations/process of the review

3.1 The Board experienced difficulties in recruiting an Independent Chair to the review, which meant the process was halted and interrupted a number of times. It also meant a lack of consistency in the early stages. This was rectified in the latter half of the review when an Independent Chair was appointed and the process ran much more smoothly after this.

3.2 Second the lengthy review period has thrown up challenges in the availability of documentation and relevant information. Practice and processes have evolved in the review period and many practitioners have moved on. Inevitably this also meant practitioners' memory of the family, their actions and the context of their work has faded or changed over time. This has made some of the historical decision-making and actions taken difficult to understand. Members of the review panel worked hard in trying to find information or consult with colleagues who may have been able to provide context to the many unanswered questions. The author would like to acknowledge their efforts in helping to make sense of some of the systems in place and how these have changed and evolved over time.

3.3 There were numerous panel discussions about professionals' ongoing concerns for the safety and wellbeing of Child L. These were dealt with by the Chair of the panel and led to a number of actions being taken to safeguard the child during the course of the review period. A significant proportion of the panel time was dedicated to current issues, which is an unusual occurrence in a review.

4 Family Involvement

4.1 In line with expectations laid down in Working Together consideration was given to involving the family in the review process and family members were advised that the review was underway. Accordingly the report author and the Business Manager from The Board went to meet Child L at school and had a consultation

meeting with Child L's mother. This is reported in section 8. Additionally, school provided a pen picture of Child L which is captured at section 6

5 Methodology used to produce this Overview Report

5.1 This report is informed by;

- The agency chronologies, Independent Management Reviews and other reports
- Background information from agencies involved in the review
- Panel discussions and analysis
- Dialogue with Independent Management Review authors
- Input from practitioners via the 'Learning and Consultation' events

5.2 The report consists of

- A factual context
- Analysis of how the agencies worked together from the information provided in their IMRs
- Key themes and lessons learned
- Recommendations
- Contribution from the family

5.3 The review has been conducted and written with the benefit of hindsight, which often distorts the reader's view of the predictability of events, which may not have been evident at the time. It is important to be aware as Munro (2011) states just how much hindsight distorts our judgement about the predictability of an adverse outcome. Once an outcome is known we can look back and believe we can see where practice, actions or assessments were critical in leading to that outcome. This is not necessarily the case, and information often becomes much clearer after an event has occurred. The review therefore tried to avoid this hindsight bias and consider events as practitioners would have viewed them at the time.

5.4 With the above in mind, the review is also sensitive to pressures on agencies and the demands of the work that are sometimes overwhelming for even the most capable of workers. It is therefore important to disseminate the learning and reflect on how the lessons from this review can help support better practice, rather than apportion blame to agencies or individuals.

6 Summary of Professional Involvement

Names	Gender	Relationship	Ethnicity
Child L	F	Subject	White UK
Child M	F	Sibling	White UK/Black British
Child N	F	Sibling	White UK/Black British
Mother (Ms A)	F	Mother	White UK
Father to Child L (Mr B)	M	Father	White UK
Father to Child M and Child N (Mr C)	M		Black British

6.1 Each of the agencies involved in this review submitted a detailed chronology of their involvement with Child L and other family members in the period under review. Those submissions have been co-ordinated into a combined chronology, which is summarised here. Further factual information is provided in some subsequent sections where relevant.

6.2 A wealth of information was submitted to the review covering the review period that spanned a period of at least 8 years. It is usual that a child with such complex needs would expect to have a myriad of appointments with a range of professionals. In view of this, the information submitted was comprehensive and therefore the factual summary is not intended to be an exhaustive, day to day list of professional involvement but a summary of the most significant events. This provides a framework for the work carried out with the family and offers some context to the challenges faced by both the family and professionals. To help set further context, the following paragraph provides the pen picture of Child L, followed by an explanation of the number of health professionals involved in Child L's care.

Pen Picture of Child L

6.3 Child L is described as a happy and friendly girl who enjoys her time at school. Her disability severely affects every area of her learning and care, including her fine and gross motor skills, her personal skills, her communication skills and her information processing skills. She needs constant and close 1-1 support for all of these needs.

6.4 Child L communicates through facial expressions, vocal sounds, picture cues and choosing objects. She is very inquisitive and loves to explore favourite toys, materials, books and musical instruments with her hands. She is sociable and loves to work alongside her friends and familiar adults. She enjoys activities such as music, tactile and sensory stories, cooking, messy play as well as making regular use of the soft play and sensory rooms. These activities are enabling her to develop a variety of personal and physical skills as well as becoming more confident in making choices. She is a very loving child and is adored by everybody who comes into contact with her. She recognises her family members such as her sisters and mother and gets visibly excited when coming into contact with them.

Explanation of health roles involved with the family and Child L

6.5 In order to try to understand the day to day life of the family and the complexity of Child L's needs, the following section provides the number of health professionals involved in Child L's care.

- 2 paediatricians for her specific conditions and general development
- A dietician to monitor her diet and growth
- An Ophthalmologist for her eyesight
- A dentist
- A team of nurses assess her nursing needs and provisions.
- The Children's Health Occupational Therapy Team assess her specialist equipment
- The Children's Physiotherapy Team advise on exercises and
- The Children's Speech and Language Therapy service provide support for her speech and language
- The Paediatric continence service provide supplies
- The Wheelchair service provide assessment and adjustment to her wheelchair
- The School Health Team advise on general health
- GP

2009 (Child L's birth)

6.6 Child L was born with complex needs. At birth she was discharged but re-admitted to hospital soon after her birth due to health concerns. Staff at the hospital were concerned about her mother's demeanor which was described as abrupt and lacking in insight into Child L's needs. Nursing staff were very unhappy about discharge until a plan could be agreed. A referral was made to Children's Social Care in relation to this and the work with the family was managed under a Child in Need (s17) plan.

2010 (First period of Child Protection Plan)

6.7 In early 2010 significant child protection issues emerged – Ms A alleged that Child L's father had assaulted her and threatened her with a knife. She reported being scared of him and disclosed that he was a drug user. Soon after that Child M was seen with injuries to her face (bruised eyes). Ms A also sustained an injury that was thought to be suspicious due to historical domestic abuse. There were particular concerns in relation to Child L having lost a significant amount of weight.

6.8 In 2010 the family were presented to an Initial Child Protection Conference (ICPC) due to concerns above – the children were not however made subject to a Child Protection Plan at that time and the conference decision was that the children should remain as Children in Need. The police and health colleagues challenged the decision and the conference was reconvened 3 weeks later when all three children were made subject of a Child Protection Plan under the category of physical abuse. In records available it was noted that the parents were not happy about the decision and complained that the plan was having a detrimental affect on their relationship.

6.9 There continued to be a large network of professionals around Child L including Occupational Therapy services, Physiotherapy, Dietician, Child Development Centre, Diana Service, Nursery, Health Visitor and the Speech and Language Team.

Practice Learning Point
It has been difficult to establish why the children were not made subject to Child Protection Plans from the outset and what the rationale for this was. However the network demonstrated good practice in raising their concerns to re-establish the conference and review the original decision.

2011 (Step down to Child In Need Plan)

6.10 The children remained subject to a Child Protection Plan until 2011 when at the Review Child Protection Conference they were 'stepped down' to Child in Need plans. During the course of the plan it was established that Mr B had a longstanding intravenous heroin addiction for which he sought help. At the point of step down, both parents were said to be working with professionals to improve outcomes for the children.

6.11 Later in 2011 the allocated social worker attempted to transfer the case to the Children with Disabilities Team. This was unsuccessful, as Child L did not meet their criteria for access to a service from that team. The worker who dealt with the request declined the transfer because Child L was too young and the team *only worked with children where there were on going safeguarding concerns and/or a formal support package was in place.*

Practice Learning Point
The review has highlighted practitioners' confusion about the criteria to access the Disabled Children and Young People's Service. The panel have concluded that this service would have been beneficial to Child L and there is learning for the organisation that needs to be addressed. More is said about this area of learning in section 7.

6.12 Towards the end of 2011 Child L's play worker contacted the allocated Social Worker as she was concerned about Child L's appearance. She was said to be 'dirty, her clothes covered in food with dirty finger nails'. The Social Worker spoke to mother who denied that she was dirty. Concerns were also raised about the home conditions that were described by a Support Worker (who was coordinating play sessions for Child L) as 'substandard'. This was discussed with the parents during a hospital visit and the detrimental effect that the conditions may have on Child L were explained. The parents were unhappy about being challenged and threatened to withdraw Child L from accessing the play service. Ms. A then cancelled the following three appointments with the play service.

2012/2013 (End of first period of Social Work involvement)

6.13 When the children were stepped down from the Child Protection Plan the family was supported under a Child In Need plan for a further 8 months. A professionals meeting was held in January 2012 where all present agreed that the family could be closed to Children's Social Care on the basis that health professionals were involved with Child L and always would be.

6.14 Child L continued to have a high level of health input throughout this year and although no further safeguarding concerns were raised, there continued to be worries about Child L not being taken to health appointments. NB it is significant to note that missed appointments were not necessarily viewed as a safeguarding concern.

6.15 At the beginning of 2013 a multi-disciplinary meeting was held which highlighted a number of health problems Child L had which were mostly associated with her condition. Plans were made to address these. Again it was noted that Child L had missed a number of health appointments.

Practice Learning Point
Children who are consistently not taken to medical appointments are a well-rehearsed theme from other Serious Case Reviews. The problem is exacerbated when the child has complex needs and the damaging effects can be far more serious. This subject is discussed further in section 7.

2014/15 (Second period of Social Work involvement)

6.16 Further concerns were raised about Child L's hygiene and contact was made between the School nurse and the Special Education Needs Co-ordinator who addressed this with Ms A. The concerns were around Child L coming to school with torn clothes and head lice. This had been raised with Ms A on previous occasions but had not improved.

6.17 In April of 2015 Ms A received a 12 month Community Order sentence with a 60 day Rehabilitation Activity Requirement for racially aggravated malicious communication and racially aggravated common assault. Ms. A pleaded guilty to the offence.

Practice Learning Point
The convictions for racially aggravated assault and assault are particularly concerning given that two of Ms A's children are of dual heritage. The assault does not appear to have been subject of a referral to Children' Social Care and therefore the violent behaviour displayed by Ms A not assessed as a risk factor in its own right in relation to her parenting. This is discussed further in section 7

6.18 On the day of her induction at London Community Rehabilitation Company, Ms A received a Fixed Penalty Notice for possession of cannabis – she admitted to smoking cannabis before her appointment which was at 10.30 in the morning. She received a further Fixed Penalty Notice for the same offence later in 2015.

6.19 In May of that year the care of Child L was observed to deteriorate further and the Occupational Therapist involved in Child L's care made a referral to Children's Social Care. The concerns were similar to those previously noted e.g. non-engagement with the professional network, repeated non- attendance at medical appointments and hygiene concerns. Child L's school attendance was 50%. This was dealt with by providing home to school transport and this seemed to resolve the issue.

6.20 The outcome of the referral was that the Families First Coach (Newham's Targeted Early Help offer) became involved. They were repeatedly unable to engage Ms. A. The London Community Rehabilitation Company dealing with her sentencing, similarly noted that her attendance with them was not consistent.

6.21 In view of the non-engagement, the family was escalated formally to the Assessment Service in Newham in 2015 and in the space of a week Children's Social Care attempted 3 unannounced visits. On the latter two occasions Ms. A refused the social workers access (she wasn't in on the first attempt). On the third attempt the police saw the children as Ms. A was being very aggressive towards the social workers and would not grant access to them. The police found that the house was unkempt. There were however no immediate concerns for any of the children.

6.22 Ms. A however continued to resist intervention from Children's Social Care and as a result their attempts to assess the children's needs were thwarted. They considered applying for a Child Assessment Order (Children Act 1989). In the meantime Ms. A gave permission for the children to be spoken to in school.

6.23 At around the same time the police were called to a public order incident involving Ms A and her brother. The dispute was over money and Ms A and her brother were threatening the other parties and making homophobic comments about them. Ms. A was interviewed under caution and issued with a Fixed Penalty Notice. Her brother received a police caution.

6.24 As a result of these concerns a further Initial Child Protection Conference was held in September 2015 and all three children were made subject to Child Protection Plan's for the second time. The conference noted that there were current and historical concerns regarding Child L's attendance at school, mental health concerns raised about mother and the fact that Ms. A was subject to the Community Order. There were also renewed concerns that Child L was underweight.

6.25 A further concern in regards to the older children came to light soon after the Initial Child Protection Conference. The girls disclosed, at times, they were caring for Child L because Ms. A locked herself in the kitchen. It is not clear how this was dealt with but it would appear that no 'carers' assessment was completed and the amount of care the older siblings gave to Child L was not acknowledged.

Practice Learning Point
There is learning for the NSCB to consider in relation to the issue about the older siblings not being recognised by any agency as possible carers for Child L. The possible impact of this on them was not therefore assessed. More is said about this in S7

6.26 Two core groups were held following the Child Protection Conference and all professionals noted improvements in the relationships with professionals. In addition, Child L was being taken to health appointments. These improvements were noted at the Review Child Protection Conference but there was not yet evidence that these would be sustained, so the children's names were retained on Child Protection Plans. It was also noted that Ms. A had been offered respite care for Child L but she did not want to take this up as it was in another borough.

6.27 **NB** throughout 2015 Child L's father came to the notice of the police a number of times. These incidents were mainly petty disputes or drug related offences. An Adult Safeguarding Merlin was created on one occasion and police assistance was needed to take him to hospital.

2016 (Second step down from Child Protection to Child in Need)

6.28 In May of 2016 the children were stepped down from a Child Protection Plan to a Child In Need plan having been subject to Child Protection Plans for 9 months. The professional network agreed to the 'step down' due to the improvements Ms A had made during the Child Protection Plan.

6.29 In the Review Child Protection Conference, amongst the positive progress that had been made, it was also reported that Child L had fallen out of bed earlier in the year. It transpired that there had been some difficulties in providing Child L with the right bed and these are described in the next paragraph.

6.30 The Occupational Therapist (provided by a commissioned service - Able2) visited the family in February 2016 and it was observed that Child L had a floor bed which posed a potential handling risk to Ms A. Ms A was not raising the bed and instead was lifting Child L directly from the floor. Furthermore, there was a potential entrapment risk for Child L between the mattress and bedside.

6.31 The Occupational Therapist completed a risk assessment and a new profiling bed was delivered with inflatable bedsides which removed the entrapment risk. Ms A confirmed that Child L had not previously been able to use the bedside to pull herself up but had recently done so and had fallen out of the bed (using the sides to pull up on). As an interim measure the original bed (which had been deemed to be unsuitable) was re-issued and the new profiling bed removed to reduce the risk of bed falls and injury. There was some delay in agreeing the most suitable bed and after some discussion, the Occupational Therapist manager in Adult Social Care proposed a Cocoon system, which was a more cost effective solution to reduce the risk of bed falls. There was then a further a delay before placing the request with the Occupational Therapist manager for the Cocoon, in August 2016. Enabled Living Healthcare eventually delivered the Cocoon in November 2016 (some eight months after the bed in situ had been deemed unsuitable). The Occupational Therapist did follow-up visits in November 2016 and January 2017 to check that the Cocoon was set-up correctly and confirmed with Ms A that there was no risk of falls from the bed.

6.32 It is significant to note that a further incident of concern occurred prior to the Cocoon system being in place (see below) and is the same bed in which the incident leading to this review occurred.

6.33 In November, Child L was taken to the Emergency Department at Newham University Hospital as she had a burn to her leg which was caused by her bed. The staff at the Emergency Department did not raise a concern about this at the time. Ms A however, mentioned it to the nurse from the Diana Team in a routine phone call two weeks later. The Diana Team then liaised with the ward staff about the injury. The Diana Team were concerned that Ms A had not given an adequate explanation about how it had happened. It was then passed to the School Nurse to follow up with Ms A and she did so but by now it was over three weeks after the event. Ms. A informed her that Child L had a new profiling bed which was provided (since the burn) by the Able2 Team. Ms. A further reported that the Occupational Therapist had put extra padding round the sides of the bed because Child L moved around/stretches her legs a lot; her foot got trapped between the bed and the padding which caused the burn. There is no further action recorded about the injury. It should be noted that this incident was not reported to Able2 and so they were not able to respond by reassessing the safety of the bed.

Practice Learning Point
For a period of 8 months Child L had a bed that was not deemed suitable for her (or her carer's needs) and at least two incidents of concern happened in that time. There is learning for the organisation in relation to this and more is said about this subject in section 7

6.34 At around the same time Child M disclosed to her school that her father (Mr C) had verbally and physically abused her. She also alleged that he physically abused their mother. Police and a Social Worker spoke with Child M and she confirmed her initial disclosure. However after returning home with the police and Social Worker she retracted her allegations. There was a significant time delay in police and Children's Social Care arranging to complete formal interviews with the children, and police were later notified that Child M did not wish to be interviewed. As Children's Social Care was intending to provide Ms. A with further parenting support, no further action was taken against Mr C.

6.35 Throughout 2017 Child L continued to receive health care from the various professionals involved with her and the family but they did not report any significant events until the events that led to this Serious Case Review unfolded and Child L was placed in the care of the Local Authority.

Practice Learning Point
The role of the Lead Professional, the Team around the Child and network meetings fell away in the period where Child L was not subject to a Child Protection Plan. This meant that there was no effective co-ordinated approach to her care. This is discussed in s7

7 Analysis of Practice from Agencies Internal Management Reviews

7.1 The purpose of this section is to provide an appraisal of the practice that is specific to the case and it therefore includes the panel's views about the effectiveness of practice, including where practice was below expected standards. Such judgments are made in the light of what was known and was knowable at the time of the incident.

Access to Disabled Children and Young People's Service in Newham

7.2 Child L is a child with very complex needs and therefore in need of specialist services across health and social care. The review has concluded that Child L's needs would have been better served had she been allocated in the Disabled and Young People's Service. It is possible that the whole family would have benefitted from the expertise of specialist social workers with direct links to health and medical professionals. That said, the social workers in the generic teams did all they could for Child L but their lack of knowledge of the resources available may have impacted on the family receiving all the help they were entitled to and benefitting from established working relationships. Examples of this are accessing the specialist transport for Child L to attend school, knowledge of respite services

available and recognising the impact of having a child with complex needs on the older siblings.

7.3 It was also evident from consulting with practitioners that they were unaware of the criteria to access the Disabled Children and Young People Team or where such criteria may be published for them to access it. At the time of writing the report senior managers from the service were able to reassure panel members that there had been some recent progress on this and that a policy document has been developed (*Disabled Children and Young People's Team 0-25 Eligibility and Functions 2018).* The document outlines the eligibility for support from the team, the pathways or referral routes and the function of the team. This includes assessment, care planning, reviewing and preparing young people for adulthood. The document will need to be advertised across partner agencies and embedded in practice. As such it is subject to a recommendation from the Serious Case Review.

7.4 This factor may also have been complicated by the fact that the other children in the family who had safeguarding needs but did not have health conditions. Therefore no neat fit existed as to where (as a family) they should be allocated. Newham Children's Social Care work on the premise that each family should have one social worker and the appropriate team will be decided according to the family's circumstances. There was no clear policy in place at the time of the incident but the recent policy document cited above states;

> *The decision as to which Pod or Team (the family will be allocated to) will be based on the individual families circumstances. As a general guide, families where the concerns or risks are focussed on the child's disability will be managed with the Disabled Children and Young People's Team and those where concerns or risks relate to all the family will be managed within one of the Intervention Teams*

7.5 It is positive that the policy is now in place but to avoid replication of the problems encountered by this family, the policy will need to explain how the Disabled Children's and Young People's Team and the intervention teams will work together when cases require a joint approach.

Multi agency approach to dealing with neglect over time

7.6 Over the review period the children were subject to two episodes of being on Child Protection Plans. On both occasions neglect was a significant factor. These times were followed by lengthy periods of continued involvement from the multi-agency network under a Child In Need plan. A third period of Child Protection Plans post the incident was invoked for Child L's siblings.

7.7 Given the trigger incident for this Serious Case Review, the subsequent concerns about supervision of Child L and the poor home conditions it is necessary to look at the issue of neglect in more detail. The cumulative effect of neglect in children is very significant and leads to poor outcomes in terms of their education, health and social interaction. It is also damaging to children's development of their identity, self-esteem and sense of belonging, which are their building blocks as they mature into adulthood. This is exacerbated further in respect of children with disabilities as they rely so much more on the adults caring for them.

7.8 Sadly, neglect features in a significant proportion of Serious Case Reviews and is one of the most common and pervasive types of child abuse. The consideration about whether, when and how urgently children need help, is a challenge for practitioners who work with families. Not least because practitioners can be reluctant to be critical of parents who are striving to do their best and are hesitant to pass judgment on patterns of parental behaviour, particularly when deemed to be associated with relentlessness of caring for a child with a disability.

7.9 It would appear in this instance that the family, whilst disinclined to engage with non-statutory services, did (at least to some extent) co-operate with the plans made during these periods e.g. formal Child Protection Plans. Improvements were noted in a relatively short space of time on both occasions in a way that was enough to reassure professionals that the improvements had been sustained. All noted progress in relation to ensuring that Child L's school attendance was better, appointments were kept and the conditions in the home were notably improved.

7.10 The improvements were however not sustained and the review has highlighted compliance rather than meaningful engagement. In relation to Child Protection Plans, where the primary concern is chronic neglect, nine months of a Child Protection Plan may not be a sufficient amount of time to establish permanent changes, especially where parents are difficult to engage to begin with. It is noted that standards of care provided to the children dropped quickly after the end of each period of statutory intervention. This is not an unusual occurrence and every practitioner will have experienced families whose level of care in relation to neglect goes up and down for a number of reasons. In the periods between the Child Protection Plans and Child in Need plans, the care of the Child L was not always of an acceptable standard and professionals continued to raise concerns about the conditions in the home. Health appointments began to be missed again and Child L's presentation at times caused unease. In 2015 this ultimately led to further involvement from Children's Social Care.

7.11 The incident in November 2016 where Child L had a burn to her foot, which had been caused by her bed, was communicated poorly between agencies. Staff on the Emergency Department did not raise it immediately and momentum was lost when the details of the concern only emerged several days later. The issue was therefore dealt with late in the day and without consulting the Occupational

Therapist who was responsible for providing the bed. No safeguarding actions were considered i.e. referral to Children's Social Care.

7.12 To try and tackle the issue of neglect, in 2017 Newham Safeguarding Children Board launched the Graded Care Profile (v2) and Neglect Strategy. A number of practitioners have now been trained to use the tools and have found it useful in being able to be more direct and honest with parents about their concerns and how to deal with them. The aim of the strategy is to reduce the number of the children in the borough suffering neglect and agencies getting involved at an earlier stage to avoid the need for statutory services.

7.13 A more structured approach (e.g. regular meetings and a co-ordinated plan and the use of the Graded Care Profile v2) may have assisted professionals in this case to be more consistent in their monitoring of the family. Families in Newham can now benefit from the use of this tool and the Board will need to evaluate its effectiveness.

7.14 Considering Child L's particular needs, another avenue to ensure a multi-agency approach would be through the facilitation of an Education, Health and Care Plan for Child L. This is a statutory requirement under The Code of Practice[3]. Its function is to bring the child or young person's Education, Health & Social Care needs into a single, legal document. Within Newham, high needs school funding is provided to a number of children without the use of an Education, Health and Care Plan and as such Child L was not provided with one. This was discussed within the panel and was noted as a gap in the system, not just in this case but in Newham in general. An assessment of this kind would have necessitated a multi-agency approach and assisted the family in knowing what to expect about each aspect of Child L's needs and who would carry these out. The plan is also designed to ensure that barriers to learning caused by health or other complex needs are tackled to enable children to reach their full potential.

7.15 The root of the issue appears to be in Newham's historical practice of not providing 'statements' for children with Special Educational Needs under the old system. Since this system changed to Education, Health & Social Care Plans, not all children with disabilities or complex needs in Newham have been provided with a plan. The recent focus in Newham has been those pupils who are in a transition period (i.e. from primary school to secondary school) so would not have included Child L at this time. Due to 'High Needs' school funding which supports children, parents do not routinely request Education, Health and Care Plans and would not necessarily see the benefits of them. In this case, if Child L had been issued with an Education, Health and Care Plan ahead of her accident, it would have been a

[3] **Special educational needs and disability code of practice: 0 to 25 years Department of Education 2015**

further mechanism under which all professionals involved in her care and progress would have regularly met to review this plan.

The Importance of a Lead Professional to oversee and co-ordinate services

7.16 During the periods in between the Child Protection Plans the multi-agency co-ordination although present, was not as consistent or structured as it was when the family were allocated within statutory services. The multi-agency approach that had been effective during the period of social work intervention suffered from the loss of a dedicated Lead Professional e.g. the social worker, which had a significant impact. Practitioners at the practice learning event were unaware who (or which team) was acting as the Lead Professional during the times that there was no allocated social worker and this may have contributed to the multi-agency engagement being weaker. At the step down phase the family were not handed over formally to any one person or team. Having an effective Lead Professional to take responsibility for co-ordinating a child's healthcare should ensure that everyone working with the family has a single point of contact, and that the child's needs are met.

7.17 As stated earlier, a transfer to the Disabled Children and Young People's Service may have assisted here. It is also important that professionals working with families have a structure to their work to enable them to support families in a co-ordinated way. A number of Multi-Disciplinary Meetings took place in 2013 which were facilitated by the school but these seemed to fall away and there are none recorded after July 2013.

7.18 The Lead professional is a key role in ensuring that the family are involved in the process and understand what the plan means and how services will work together to provide them. Other advantages of the Lead Professional role are;

- The Lead Professional should be a person who the parent, carer and/or young person feel comfortable working with - and vice versa.
- The Lead Professional will have some professional or therapeutic expertise from which the family can learn as they navigate their path through SEND support.
- It is helpful for the Lead Professional to know and understand the background of the family. This can be particularly helpful for the family in reducing the need to re-tell their story.
- Following meetings, the Lead Professional can re-visit the discussion with the family and reassure them about agreed actions, rationale and next steps (as appropriate).

- The Lead Professional can raise concerns on behalf of the family with relevant services (although it is necessary to note that they are not accountable for the actions of other professionals or services).

7.19 Newham Safeguarding Children Board issued guidance about the role of the Lead Professional after a similar issue arose in a previous Learning Review about a child with complex needs. The issues highlighted resonate with this case as it was found that a lack of co-ordination meant that there was no single point of contact for the family. Further, professionals had no clear direction when concerns were evident and needed to be escalated, and no one professional was overseeing the plan of agreed health and social care actions.

7.20 As there are similar issues in this case the Board may want to reassure themselves that this is not a systemic problem and that the guidance is well known about and embedded.

Recognising the impact of violence and aggression in adults who are also parents

7.21 There are a number of instances throughout the period under review when Ms A's aggressive behaviour came to light and this process has highlighted a lack of assessment on the impact of that on the children's lived experience. This may be because there is no clear process in place to assess children of adults who are aggressive or abusive to other adults and this is problematic in this case.

7.22 In 2015 Ms A was charged and convicted of a racially aggravated assault. This was particularly concerning as two of her children are dual heritage. Within the information provided there is a suggestion that Ms A had stated that 'both girls were white and she treated them as such' thus denying the children expression of their dual identity. More is said in relation to this in paragraphs 7.34-7.36.

7.23 In relation to the offence, information from London Community Rehabilitation Company would indicate that statutory safeguarding checks, normally gathered by The National Probation Service for the purposes of informing the pre-sentencing report were not collected in time to be included in the analysis and therefore fell short of expected agency standards. The account relied on information from Ms A and should have been clarified. The report also failed to address the racist element of the offence but the court addressed this in their sentencing.

7.24 Information from Children Social Care was available to the officer a week after sentencing had taken place. Given that this information would have highlighted vulnerabilities for the children and a history of neglect, there is a missed opportunity to make a referral to Children Social Care for them to assess the risk within the household.

7.25 In the event a referral was received into Children Social Care soon after this by the Occupational Therapist who was concerned about the level of care received by Child L. The family were allocated to early help services as a first step but when this was not successful the family were re-referred to Children Social Care.

7.26 This was immediately followed by an escalation of Ms A's hostility towards social workers who tried to visit her at that time. On at least one occasion she refused to let them in and the police had to be called to assist. She continued to resist intervention until the child protection plan was made. Even then she would not sign a written 'working together agreement' to facilitate an open working relationship.

7.27 It is well established from research that children living or in close contact with violent adults are likely to be damaged by their experiences. Adults capable of violence towards others should be considered not only as a direct risk to children but also in the context of their parenting capacity and suitability to care for children. It is important therefore that all practitioners have a broad understanding of the risks posed by adults who display violence and that they assess risk based on the level, frequency, motivation and history of violence in its many forms. Failing to recognise this and assess accordingly using formal multi agency child protection procedures could expose children to risk.

7.28 Section 7 of The London Child Protection Procedures (*Managing work with Families where there are obstacles and resistance)* provides a useful guide to dealing with these issues. The procedure sets out how agencies can support each other whilst continuing to work with the family in question. It gives examples of strategies that can be used to ensure a co-ordinated approach such as holding professionals meetings without the family present in order to keep the child in mind. In respect of this family, there were many multi agency meetings but none specifically addressed Ms A's hostile and threatening behaviour towards social workers.

Commissioning, reviewing and maintaining specialist equipment for children with complex needs

7.29 Members of the panel expressed some worries throughout the review about equipment provided for Child L. Their particular worries were about whether the many and varied bits of specialist equipment were suitable for Child L. Further, they were concerned to ensure that equipment was subject to timely and effective review as Child L's needs developed and changed as she grew older and bigger. Some historical concerns were raised in regards to this and this led to the panel questioning current arrangements and whether the process for families who need specialist equipment needs to be reviewed.

7.30 The author concurs with the panel's view and Child L's bed is an effective example of their worries, as since 2016 there have been at least 3 issues which have caused concern. The most recent concern is the reason for this Serious Case Review. In 2016 Child L was provided with a new profiling bed with inflatable sides she fell out because she was able to use the sides to pull herself up on. This had never happened before and illustrates how Child L's needs and abilities were changing as she grew older and more exploratory. In view of this Ms. A, understandably, was concerned that this was not safe. An Occupational Therapy assessment confirmed that the bed was not safe and arranged for a new profiling bed to be ordered and delivered. In the meantime, the old bed, which was floor based and considered to be a risk to Ms. A when she lifted Child L, was put back. The replacement bed took 8 months to be installed. The delays were due to a number of separate elements – delay in agreeing the right bed, delay in signing off and placing the order and a delay in delivery. The new profiling bed and Cocoon were not delivered until mid-November by which time there had been another incident of Child L being injured. The bed delivered in November 2016 was the one which caused Child L's serious accident leading to this review, so there is also a question mark about how suitable that is.

7.31 In terms of Child L being enabled to live a full of life as possible the equipment and adaptations provided to her have been poor and these need to be rectified. Child L needs to be safe and to be given every opportunity to reach her potential both at home and at school. Equipment also needs to be suitable in terms of Child L's development and changing needs over time, hence the necessity for the needs of the child to be reviewed regularly alongside the continuing suitability of the equipment.

7.32 In trying to understand this issue for the purposes of this Serious Case Review, it would appear that the process for commissioning children's Occupational Therapy assessments via Adult Social Care and reviewing the needs of the child has changed in that it became the responsibility of Special Educational Needs Department and was outsourced to a provider service. Previously it was provided 'in house' via Adult Social Care. Professionals involved with Child L struggled to know how the system had changed and who to contact if issues arose. Furthermore it would appear that in re-commissioning the service, reviews of children were not routine (review of equipment was not included in the commissioning arrangements). Other specialist equipment such as Child L's wheelchair and seating arrangements also were not regularly reviewed. Ms. A informed the Overview Author that Child L's current wheelchair is not fit for purpose and nor was her current bed (see section 8). Other professionals echoed these concerns and the Serious Case Review process allowed them to reflect on these and think about changes that need to be made.

7.33 Practice in relation to the specialist equipment and its provision, falls short of expected standards and Child L was left vulnerable by the delays in ensuring she had the right bed. There were some systemic issues i.e. changes in personnel and inability to recruit to posts that may have contributed to the poor practice but the Newham Safeguarding Children Board will need to be reassured that the systems now in place are fit for purpose and transparent to families and practitioners. Currently, (although according to operational staff there is a protocol), there is no written guidance for practitioners when parents complain or there is an incident involving equipment. Some recent work has taken place to try and improve communication from the services to other professionals and families but is not yet embedded.

The Children's lived experience - Child L

7.34 The three children in this family had many contacts with professionals over the review period and their voice does not stand out strongly in the information provided.

7.35 Child L's cognitive ability would have made it difficult to consult her directly but the expectation would be that any assessment undertaken would have the child at its centre. Assessments and plans should include the child's voice and information about the impact of the parents' lifestyles e.g. the child's lived experience. Most of the information from agencies provided to this review is silent on this issue suggesting it was not heavily present in the records.

7.36 Ensuring that the voice of the child is assessed and analysed becomes trickier when the child is non-verbal as was the case with Child L. In situations where children are not verbal, professionals rely on other cues such as observations, eye contact, physical contact between parent and child and the level of care given. It is to the Social Worker's credit that she attempted to learn some sign language to try to communicate with Child L. The school also had a good understanding of her behaviour in order to interpret her needs. It is significant to note that school reported a marked improvement in Child L's demeanor and alertness when she was placed in foster care.

7.37 One important way that children with disabilities can have their voice heard is through an advocate. It would appear however that this was not considered and that practitioners were unaware if this is provided by any service within Newham. It has been established though the review that advocacy services are available so it is concerning that workers were unaware of the service available.

7.38 Child L's medical and developmental needs were neglected throughout the period under review. Ms A failed to take Child L to a significant proportion of routine appointments though she did respond appropriately when Child L presented as ill. These missed appointments were not challenged sufficiently by the professional network and meant that Child L's health needs were not always met. Practitioners were able to reflect that this may have been because they appreciated all too strongly how difficult life was for Ms. A and getting to appointments was a challenge for her. Attendance improved during periods of social care intervention and provision was made for her to have appointments in the same place to avoid the need to get from one place to another.

Child's lived experience – Children M and N

7.39 In relation to the older children in the family it appears to be a similar story, though the review has been furnished with less information in relation to their needs. This was due to the review concentrating mainly on Child L however they are worthy of comment in their own right in this section.

7.40 The family live in a diverse community and their make-up reflects this. Child L's older siblings' (M and N) father is Black British and the children are of dual heritage. In consultation with practitioners many of them were unaware of their ethnicity. This may be because the focus of their work was Child L and her siblings went to different schools, perhaps limiting the opportunities for them to meet.

7.41 Ethnicity is an important factor in assessing the holistic needs of a child especially in regards to a child's identity. An opportunity was missed in 2015, when Ms A was convicted of a racially motivated assault, to assess the impact of this act on the day to day experiences of these children. Ms A was quoted as saying (not clear who to) that the children were 'White British and that she treated them as such'. It is not clear what Ms A meant by this comment or if it was challenged by professionals. Despite management guidance, it was not possible to find any individual direct work with the children to ascertain whether issues around their identity had been explored.

7.42 In 2017 when Child M made allegations about her father both in relation to herself and her mother Children's Social Care were slow to respond in giving her the chance to speak formally (e.g. via Achieving Best Evidence interview) about her worries. As a consequence the window of opportunity to investigate fully was lost.

7.43 According to documentation Child M and N's relationship with Child L was very positive and they 'adored' her. A question that has arisen from the Serious Case Review is how much of the care they provided to her. A disclosure in 2015 about carrying out tasks beyond their expectations did not result in a Carers Assessment and the issues do not seem to have been explored in any depth. We are also now aware that at the time of the incident both Child L's siblings were alone in the house with her and it is unlikely that this was an isolated occasion. This is a huge responsibility to place on such young shoulders.

8 Family Contribution

8.1 Ms A was informed about the review and was keen to participate. To facilitate the meeting, the author and the Business Manager from Newham Safeguarding Children Board met with Ms A in Child L's school in June 2018. The meeting started with a brief observation of Child L with her classmates and teachers. Child L appeared comfortable and confident in her environment and was visibly excited when her mother entered the classroom.

8.2 The Business Manager had met Ms A on a previous occasion and so had been able to explain to her the purpose of the review and the consultation with her. Ms A found it hard to be positive about a number of services and was more able to speak about the things that she was worried about now rather than reflect on her past involvement. She expressed her disappointment at the level of extra support she had in the household to help her with Child L (three hours a day). She complained about them cancelling at the last minute and the fact that if they were staying overnight they still woke her to tend to Child L. She does not receive support to shower Child L even though this requires two people. Ms A reported that the workers sometimes leave earlier than they should.

8.3 Ms A stated that Child L's wheelchair was currently not fit for purpose and she described it as a 'safety hazard'. Wheelchair services have not been forthcoming in sorting the problem. At the time of the meeting she had deactivated the chair as she felt it was not safe for Child L to use and so it had effectively become a static chair. She has the same issue with the current bed and doesn't feel that it is safe – it is unplugged all the time.

8.4 Ms A felt that Child L should have had an allocated social worker form birth and that she should have been allocated in the Disabled Children's and Young People's Service. She was unclear as to why this service was not available but thought that the extent of Child L's needs was not recognised. On reflection Ms. A acknowledged that she was not always easy to work with and that she was angry and could have done things differently. Her anger was about the lack of recognition of Child L's needs. She learnt to deal with multi agency meetings by

keeping her ‘mouth shut’ and ‘keeping (her) cool’ so she didn’t ‘lose it’. Ms A repeatedly felt ‘picked on’ and thought that they (social workers) ‘had it in’ for her. She now admits she didn’t always understand what was going on and found that difficult. If she saw some papers before meetings she felt she couldn’t change what it said once it was on paper and therefore couldn’t add her side. She did not feel her children trusted social workers.

8.5 Ms A was positive about the Family Group Conference process and gets a great deal of support from her family now especially since child L has returned home. They take the older girls out and do shopping when it is needed.

8.6 Ms A was also pleased about the progress that physio had enabled Child L to make – she is able to pull herself up and generally becoming more independent. School have also been good at helping Child L improve.

8.7 Due to there being so many services involved, one of her biggest frustrations was not knowing who to contact to help her with the various things.

9 Key Lessons

9.1 The review has highlighted good historical practice in relation to escalations from the multi-agency network.

9.2 Prior to this incident, Child L was never allocated in the Disabled and Young People’s Service and as a result she did not receive the wrap around service that catered specifically to her needs as a disabled child. Although there is now a draft policy addressing this there was no clear pathway for access into this service that was understood by practitioners or the professional network. Work has taken place to ensure that the Disabled Children and Young People’s Team is more integrated in to the mainstream safeguarding services and this good work needs to be developed.

9.3 The policy of one worker, one family is good practice but needs to take into account the nuances of families where the needs of a disabled child have parity with their (and possibly other siblings) safeguarding needs. Further, the fact that disabled and non-disabled children in the same family may be using different resources or have differing needs (e.g. may be at different schools; may be classed as ‘young carers’) makes it even more essential that the professional network take all the children’s needs into account.

9.4 Good practice in response to children who are consistently not taken to health appointments is not evident in this case. This indicates that Newham does not yet have a reliable system for identifying, and responding to, vulnerable children who are not having their health needs met. GP practices hold the ring in terms of having all the information available to them but do not consistently act to recognise them and act accordingly. Newham Safeguarding Children Board

need to consider how this could be strengthened and the approaches that could support this. This may include holding multi-disciplinary meetings in the GP practice and / or revisiting the role of a lead paediatrician or Child Development Specialists. This would increase oversight of the ongoing health needs for children with vulnerabilities such as complex health needs

9.5 Ms A was convicted of a racially aggravated offence during the review period that was never assessed in its own right. It would appear that this is because the violence was in relation to another adult and happened out of the family home. Another, (albeit more minor) incident happened later in the period which was not treated as a safeguarding issue. Adults capable of such assaults towards others should be considered in the context of their parenting capacity and suitability to care for children. It is important therefore that practitioners have a broad understanding of the risks posed by adults who are violent and that they assess risk based on the level, frequency, motivation and history of violence in its many forms.

9.6 The review has highlighted that the specialist equipment provided to Child L and her family was not always fit for purpose and there were no clear arrangements for it to be reviewed either routinely or after an incident. Furthermore information from Ms A would suggest that she did not know how to go about getting the equipment checked. The review has prompted a review of how specialist equipment is procured, delivered and maintained and the relationship between commissioners in the local authority and Disabled Children and Young Persons Service has been re-established. This problem was exacerbated by the lack of a co-ordinated approach (discussed in next section) present in the latter stages of the review period.

9.7 The review has highlighted the importance of a co-ordinated approach for children with complex needs. This resonates with other Serious Case Reviews both locally and nationally. The panel accepted that there is more work to do in this area to make it more effective and as such is subject to a recommendation for The Board to oversee. Newham's policy of not providing Education, Health and Care Plans to children in specialist provisions potentially acts as a barrier to multi agency networking as this is a natural forum on which to build the Team Around the Child. Children with complex needs are entitled to request an Education, Health and Care Plan and the Local Authority should provide these.

10 Recommendations

10.1 Newham Safeguarding Children Board should review its Neglect Strategy to ensure that there is clear guidance on thresholds for intervention for children with complex needs.

10.2 To ensure holistic and co-ordinated care for children with complex needs, Newham Safeguarding Children Board to be assured that a system for identifying a Key Worker/Lead Professional for all Children with Complex Needs is in place i.e. this should be the case for all children not just those with an allocated social worker.

10.3 Newham Safeguarding Children Board should be assured that advocacy services are available for disabled children, young people and their parents. Further, **that services** available are widely advertised and accessible.

10.4 Newham Safeguarding Children Board to receive regular reports on the progress and timeliness of Education, Health and Care Plans provided to children with complex needs. The Board needs to be satisfied that plans are in place to ensure that each child entitled to an Education, Health and Care Plan has one.

10.5 Newham Safeguarding Children Board to seek assurances that the commissioning arrangements for specialist equipment for children with complex needs are;

- fit for purpose,
- transparent to families and practitioners and;
- have due regard for safeguarding of children.

10.6 Newham Safeguarding Children Board to ensure that practitioners in the children's workforce are equipped with the appropriate tools to be able to assess risk to children from violent adults.

10.7 Newham Safeguarding Children Board to ensure that there is a robust system in place to identify and assess those children who are consistently not taken to health appointments and particularly how these are managed by GP practices. The Board should also lead and embed a change in terminology for children who consistently miss health appointments from 'Did Not Attend' to 'Was not Brought'.

10.8 Newham Safeguarding Children Board to ensure that the new policy document *Disabled Children and Young People's Team 0-25 Eligibility and Functions 2018* is widely publicised and circulated to all relevant parties.

10.9 The Independent Chair of Newham Safeguarding Children Board to write formally to the bed manufacturer. The purpose of this is to make them aware of this incident and request that they explore the possibility of adding safety features such as a sensor to help prevent further accidents.

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