Serious Case Review

Child H

OVERVIEW REPORT

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1 Introduction to the Significant Incident Learning Process (SILP)

1.1 SILP is a learning model which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted in a certain way at the time. This way of reviewing is encouraged and supported in the new Working Together to Safeguard Children published in March 2013.

1.2 The SILP model of review adheres to the principles of;

- proportionality
- learning from good practice
- the active engagement of practitioners
- engaging with families, and
- systems methodology

1.3 It has been generally accepted that over recent years the Serious Case Review agenda had become over-bureaucratic and driven by Ofsted ratings. The practitioners in the case have often been marginalised and their potentially valuable contribution to the learning has been under-valued and under-utilised.

1.4 SILPs are characterised by a large number of practitioners, managers and Safeguarding Leads coming together for a learning event. All agency reports are shared in advance and the perspectives and opinions of all those involved are discussed and valued. The same group then come together again to study and debate the first draft of the overview report, and to make an invaluable contribution to the learning and conclusions of the review.

1.5 Nottinghamshire Safeguarding Children Board (NSCB) has requested that the SILP model of review be used to consider the circumstances surrounding the injuries, and potentially the death of a child known as Child H. Also being considered is a healing rib fracture found on an older sibling during a child protection medical instigated by the death of Child H. This systems review is being undertaken in order to learn lessons about the way that agencies in Nottinghamshire work together to safeguard children.

1.6 Working Together 2013 states that SCRs and other case reviews 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.

1.7 This serious case review has been undertaken using the SILP model, which ensures that these principles have been followed and provides a systems review of the case.

2 **Introduction to the Case**

2.1 The subject of this review is Child H, a 4 month old girl who died in 2012. Child H died of currently unknown causes, but had a number of injuries of varying dates which are thought to be non-accidental. She had one sibling who was 17 months old at the time Child H died. She lived with her Mother, her Mother's Partner and her sibling throughout her life.

2.2 Mother's Partner was thought to be the Child H's father until DNA tests were undertaken after Child H died. All of the professionals involved during Child H's life were under the impression at the time that Mother's Partner was the baby's father. The DNA tests show that her previous partner is actually the father of both children.

2.3 The family had been known to a number of agencies as a result of serious domestic abuse between Mother and her previous partner, the father of the children. There were no reported incidents of domestic abuse between Mother and Mother's new partner during the period covered by this review.

3 **Family Structure**

3.1 The subject child is to be referred to as Child H. Her sibling is to be referred to as Sibling or HS. There are no other children in the immediate family.

3.2 The parents of the subject children are referred to in this report as Mother and Father. The man who was living with the family at the time of Child H's birth until her

death will be referred to as Mother's Partner. Mother and her Partner married shortly after the birth of Child H. Other family members will be referred to by their family title e.g. Father's father.

3.3 Mother had been married previously but her first husband died before the scope of this review. They had no children together. Mother began a relationship with Father shortly before the death of her first husband.

3.4 Mother's Partner has an older child, but there was no contact and they are therefore not considered in this review, other than a reference being made as to why there was no contact.

3.5 The children, both parents and Mother's Partner are white British.

4 **Terms of Reference**

4.1 The Terms of Reference and Project Plan were drawn up and agreed at the start of the process. The purpose, framework, agency reports that were commissioned and the particular areas for consideration were all described therein. A format template for the agency reports setting out what the agency authors were asked to analyse was provided to each agency involved.

4.2 It was agreed that the scope of this review would be from 10 May 2011, which is the date of the first multi agency risk assessment conference (MARAC) held in regards to Mother and Father, until the date of Child H's death in December 2012.

5 **Process**

5.1 The mother of Child H was contacted in order to ensure her views were considered and heard as part of the review. A letter was sent and the author, along with a Nottinghamshire Safeguarding Children Board representative, visited Mother the day before the Learning Event. Mother was cooperative and keen to assist in the review.

5.2 The information provided by Mother and her views have been included throughout this report.

5.3 It was agreed after the visit to Mother that Partner should be spoken to as part of the review. He was living with the family from the birth of Child H to the date of her death, and it was thought that he might have information about the professional involvement at the time that would contribute to the learning. However the review was made aware of information about his current circumstances that led to a change in the plan to consult with him at the time that the review was being undertaken (January – March 2014.) However it is planned that after appropriate consultation with any professionals involved with him, Mother's partner will be contacted before this report is published.

5.4 After consultation with the Police and with Children's Social Care (CSC) it was agreed that direct contact would not be made with Father, as he had made it clear to CSC after the death of Child H that he did not want to be involved in the care proceedings on HS. It has been agreed however that a letter will be sent to him at the conclusion of this review, and after the criminal investigation has been completed, to inform him of the review and the plan to publish this report.

5.5 The Department for Education (DfE) expects full publication of Serious Case Review overview reports, unless there are particular serious reasons why this would not be appropriate. Working to that requirement, some confidential historical family information will not be disclosed in this report. It is written in the anticipation that it will be published, and contains all of the information that is relevant to the professional responses and contact with Child H and her family. The decision to disclose information has been taken with reasonable caution to prevent the identification of the children concerned and other family members, and to protect the right to an appropriate degree of privacy for the family.

5.6 A meeting for authors of individual agency reports was held on 10 December 2013, where the SILP process and expectations of the agency reports was discussed. A full day learning event took place on 7 February 2014. Most of the agencies involved were represented by both the report author and staff, including managers, who had been involved during the scope period. Absences were accounted for by valid explanations, including certain professionals who were no longer employed and or had moved away. One key professional was on leave at the time of the learning event but attended the recall day. All the agency reports available had been circulated in advance, to ensure all staff attending were able to fully understand the

multi-agency information and focus of the review. Two agency reports were outstanding before the learning event but were available to the author before version 1 of the overview report was completed and to other professionals involved before the recall day.

5.7 The recall day was held on 13 March 2013. Participants who had attended the learning event considered the first draft of this report. They were able to feedback on the contents and clarify their role and perspective. All those involved contributed to the conclusions about the learning from this review. The final version of this Overview Report was presented to the Nottinghamshire Safeguarding Children Board on (ADD) 2014. It has been agreed that some additions may be included in this report once the criminal investigation has been completed, and if any further information becomes available during that process.

5.8 The Coroner has investigated the death of Child H. This serious case review ran parallel to the Coroner's enquiries. The Coroner was informed that this review was being undertaken. An open verdict was made.

5.9 The Police investigation was on-going at the time of the recall day with both Mother and her Partner charged with an offence contrary to Section 5 of the Domestic Violence and Victims Act 2004 - causing/allowing serious physical harm to Child H. Mother was found Not Guilty and her partner received a custodial sentence after pleading guilty.

5.10 The sibling (HS) was the subject of child care proceedings, and is not currently living with either of her parents.

5.11 The reviewer in this case and report author is Nicki Pettitt, an independent child protection social work manager and consultant. She is an experienced chair and author of serious case reviews, and is a SILP associate reviewer. She is entirely independent of NSCB and its partner agencies.

5.12 Working Together 2013 does not require the completion of a health overview report which considers the commissioning of health services and in some circumstances may be helpful in pulling together the related health information. It was agreed with the NSCB that an additional review of this type is not required in this case, as there were no complex health issues that needed to be addressed.

5.13 There has been a delay of approximately 10 months in starting this review after the death of child H. This was due to the wish to clarify if the child's death had been due to suspected abuse or neglect. A number of tests and investigations were undertaken over a period of time, and the post mortem eventually concluded that it was unable to ascertain the cause of death. The NSCB SCR sub-group maintained an overview of the case while the post mortem process was on-going. It was agreed in November 2013 that a serious case review should be undertaken despite the uncertainty of the cause of death. This was a positive decision as the NSCB wished to ensure that any lessons should be learned in regards to the multi-agency work with Child H and her family.

5.14 This process has been effectively administered by the NSCB.

6 The background prior to the scoped period

6.1 Agency authors were asked to consider all of the records held on the subject child, and relevant records on other family members. While they were asked to provide detail and analysis on the period of the scope of this review, they were also asked to provide a summary of information known to them from before the period in question in order to ensure that relevant and pertinent background information was available to the review.

6.2 Mother became pregnant with HS shortly after meeting Father. She told the reviewer that she did not think she could have children, so it was a very welcome surprise that she was expecting a baby. Mother told us she had a happy childhood, and described her family as supportive. Mother had some mental health issues when she was a teenager however, and has suffered with depression on occasion throughout her adult life. She told us she had taken an overdose after the death of her first husband. Mother also told us that she was a 'regular drinker', and that she used alcohol to 'relieve stress', but didn't feel she had a 'problem'.

6.3 The GP report for this review provided helpful information on Mother's history, including her early history of eating disorders and mental health concerns. It was confirmed she had taken paracetamol overdoses in September and October of 2010.

She has received prescriptions for anti-depressant medication on a number of occasions and was referred to psychological services in 2010.

6.4 In September 2010 Mother was arrested for drunk driving, and the Police stated in their first referral for a MARAC the following month that they felt Mother had issues with alcohol use. They also had concerns about her mental health, resulting in them getting a nurse to assess her before they interviewed her for the drunk driving offence. Information was available from the Police that Mother had been in a number of other domestically abusive relationships before she met Father. Mother told us she thinks men recognise that she is vulnerable. In respect of her relationship with Father, the Police informed the review that there were 15 domestic abuse incidents between Mother and Father prior to the first MARAC referral in October 2010. It is not clear why there was a delay in bringing the case to MARAC, and it is outside of the scope of this review to pursue this.

6.5 The first MARAC meeting held on the couple was in May 2011, by which time Mother was pregnant with HS, who was born 2 months later.

6.6 Father is very well known to the Police. He has been in prison a number of times, for assaults on Mother and for other non-related crimes. He was not known to Children's Social Care (CSC) in his own right. He was in prison from before the scope period of this review until May 2011. He was also issued with a Restraining Order by the court in December 2010. It stated he was not to contact Mother directly or indirectly, and was not to enter the road where she resides.

6.7 Mother's Partner was known to the Police briefly due to an incident, outside of the scope of this review, where an allegation was made that he had physically assaulted his sister. He was known to CSC due to issues in his own childhood. He had periods of time on the Child Protection Register as it was then, and it has been established that there were concerns about the parenting he received and his exposure to domestic abuse as a child. His school also reportedly arranged for him to have some help with managing his anger.

7 Key Practice Episodes

7.1 There were 3 key practice episodes identified in the scoping period. They were:

I. May – July 2011. Mother's pregnancy with HS.
II. July – December 2011. The birth of HS and escalating concerns.
III. January – August 2012. The pregnancy with and birth of Child H and limited engagement with services.

Key practice episode I – Mothers pregnancy with HS:

7.2 Mother was 20 weeks pregnant with her first child when she first saw the midwife early in 2011. She told the midwife she had not realised she was pregnant until she was in the second trimester. She explained some of her back ground, particularly that her husband had died and that she had been depressed. She appeared to have a supportive partner, who was said to be the father of the child. This was later ruled out when the advanced duration of her pregnancy was determined, and the relationship ended. Father was in prison at this time. The midwife asked a routine question about alcohol consumption, and no issues were identified. On a subsequent home visit by the midwife, after the MARAC (see below), Mother disclosed a high level of alcohol consumption prior to the confirmation of her pregnancy and that she had lost her driver's licence. However she said she was not drinking anymore.

7.3 The midwife contacted Children's Social Care (CSC) to make a referral about Mother and the unborn child after the MARAC meeting, which she had received feedback from. The midwife shared the concerns identified at MARAC with the duty social worker. A decision was made by CSC to take no action as there was no suggestion that Mother would reunite with Father, who was not thought to be the father of the baby. The CSC records also listed the support Mother was receiving in relation to the previous domestic abuse and any on-going threat from Father. A letter was sent to Mother to stress the importance of her not having any contact with Father when he was released from prison. It is not recorded that any suggestion was made that a Common Assessment Framework (CAF) piece of work should be considered at this stage, however an assumption may have been made that it would be obvious to professionals that a CAF was suitable in a case where a number of different agencies were providing services. This was not the case however. (See 8.23 below for an explanation of the CAF process.)

7.4 A referral to perinatal psychology was discussed with Mother by the midwife, she initially agreed, but later appears to have changed her mind, stating that she did not

require that level of intervention. At the meeting with Mother at the start of this review process, she stated that she was feeling very positive about the birth of her child and did not feel that depression was an issue any longer.

7.5 At this time Mother had a lot of support and involvement from various domestic abuse agencies and professionals. Over the course of the scoped period she had regular contact with a number of specialist workers and various alarms and safety devices were available to her, including a Home Office alarm, a Sky Guard (a handheld personal safety device which sends a message to the Police when triggered by a victim of domestic abuse) and Sanctuary, which provides various safety features being fitted into the house, which may include safety measures such as strong locks and window grilles.

7.6 Father had been the subject of restraining orders and the Integrated Domestic Abuse Programme (IDAP), which is a court ordered group work programme, on a number of occasions. However both when in prison and when he was released from prison he continued to harass Mother, resulting in the agencies who were supporting Mother genuinely fearing for her safety on occasion.

7.7 There was planned pre-birth liaison between the midwife and the health visiting service before the baby was born at 37 weeks gestation. The health visitor and midwife involved work geographically and discuss any cases of concern. They spoke about Mother's pregnancy in one of their regular meetings. This type of liaison was appropriate and a joint visit would have been justified in this case due to identified issues around maternal mental health and the domestic abuse, and Mother's information about her previous level of drinking. The early birth of HS meant that a joint visit did not happen in this case.

7.8 When HS was born she had a low birth weight (2nd centile) but had no identified health or development issues. Mother and HS were discharged home the day after she was born.

7.9 This has been identified as a key practice episode as a number of professionals were involved with Mother and were aware of her pregnancy. Despite evidence of serious domestic violence, and concerns about Mother's alleged use of alcohol and mental health issues, there was no consideration of conducting a CAF at this time, or of CSC opening the case for an assessment. The presenting issue of Father's release from

prison and the MARAC was the main focus, and the belief that Mother would not reconcile with him led to a view that no further assessment or plan was required in regards to the expected baby.

7.10 Key practice episode II - The birth of HS and escalating concerns:

7.11 The health visitor carried out a new birth contact within the home two weeks after the birth. The midwife, who was still involved, visited a week later and she found the door to the flat propped open. Mother told the midwife that it was inconvenient for her to visit as she already had a visitor. The health visitor told the Learning Event that she suspected that Father may have been there, but did not explore this with Mother. A different health visitor visited again six days later when the Family Health Needs Assessment was completed. A decision was made that extra support was required and the family were placed on an enhanced Health Visiting Service – Partnership Plus (Level 3 as it is now known)[1]. This decision was made due to concerns of reported domestic abuse from Father who was said to be continuing to harass Mother, maternal low mood and anxiety, and Mother's wish to move house to avoid Father.

7.12 In the month after HS was born there is evidence that the health visitor and the community midwife spoke, and that they shared information in regards to the concerns about domestic abuse and the MARAC meetings. The health visitor then spoke to the health representative on the MARAC (the Domestic Violence Specialist Practitioner), to the Women's Aid worker involved, with Mother's permission, and to Fathers probation officer. In light of this liaison the health visitor received copies of the previous MARAC meetings (there had been 3). She noted that there were concerns about Mother's drinking, with one reference to her being an alcoholic. However the health visitor had very recently completed the health needs assessment with Mother, who had said she had no current issue with alcohol. The health visitor rang drug and alcohol services to see if Mother was known to them. She was not.

[1] Universal Partnership Plus provides on going support from the health visiting team plus a range of local services working together and with the family, to deal with more complex issues over a period of time. These include services from Sure Start Children's Centre, other community services including charities and where appropriate the family care nurse.

7.13 The health visitor and a community health assistant practitioner visited Mother on 19 August 2011. Mother was described as very low. She described continued harassment by text and phone from Father, problems with benefits and her home office alarm being removed which made her feel unsafe. She didn't feel suicidal and was not drinking, but the health visitor was concerned. She spoke to the Domestic Violence Specialist Practitioner and suggested the case return to MARAC.

7.14 In light of this visit and the information gained by the health visitor, she decided to contact CSC with her concerns, which she did that day. She stated that Mother had made 2 previous suicide attempts and during a visit that day had presented as tearful and depressed. An appointment had been made to see the GP whom the health visitor hoped might refer Mother to the crisis team. Mother was described as having some support from family members and had been referred to the Surestart children's centre. The social worker asked how Mother was coping with the care of the baby and there were no concerns about the baby itself. The DSW consulted with the team manager and they agreed that there was no role for CSC at this time as Mother was receiving a lot of appropriate support. A CAF was suggested. This advice was confirmed in writing to the health visitor. Despite being concerned the health visitor accepted this decision and did not escalate the matter.

7.15 The CAF did not go ahead at this stage however. In Nottinghamshire at this time the take up of CAFs was low, with around 50 being started per month, which was low compared to a much higher number of initial assessments being undertaken by CSC. The review was told that the paperwork for the CAF in this case was evident in September 2011, and that it was 'registered' as a CAF, but that the assessment and any subsequent plan and meeting of a team around the child did not go ahead. It was also confirmed that at the time there was not a clear process for notifying and recording the key professional in a CAF. The system and process for CAF was later improved, but this case shows that the system in place at the time was insufficient. At the learning event there was a degree of understanding about why the CAF did not go ahead at this time, it appears that Father being in Prison had an impact and Mother was said to be cooperating with all agencies. At the time in Nottinghamshire there was said to be a degree of anxiety amongst professionals regarding the lead professional role. Again this is said to be much improved in the last year.

7.16 The Health Visitor was also clear that she had no concerns about the care of HS. The interaction between Mother and child was said to be positive, the home was well maintained, the physical care of HS was good, she was meeting developmental milestones and although her weight was low, she was maintaining her centile position. Mother appeared to be stable and no attachment or bonding issues were evident. Mother would often cancel appointments without good cause, but this was not felt to be a significant issue.

7.17 Mother saw the GP twice during August 2011. She appeared to be struggling emotionally and reported financial difficulties. Anti-depressants were prescribed. Mother told the GP at the second appointment that she was not taking them consistently however because of the side-effects. There is no evidence that the GP and the health visitor had a conversation about Mother and HS at this time, despite them both recording concerns about Mother's well-being, and contradictory evidence in regards to the previous statement that Mother's mental health was stable.

7.18 In August 2011 CSC were contacted by a housing worker to state that they had suspicions that Father had been visiting the family home. When challenged, Mother had told the housing worker that it was her brother. The housing officer stated they would take the case back to MARAC (see 7.19 below). The notes from the MARAC were placed onto the CSC file a week later, with no actions for them. The CSC agency author quite rightly questioned the lack of any further checks by CSC at this time to what would be child protection concerns had the housing officers suspicions been right.

7.19 The MARAC was held on 25 August 2011 and it was recorded that Mother was 'very frightened, very vulnerable, with deteriorating mental health, financial concerns and under continual harassment from Father'. It was noted she had a Women's Aid worker and a social worker. It has not been identified who this was referring to as CSC were not involved at this time. It is presumed that the SW mentioned in the recommendations was in fact a Surestart worker. The recommendations were:

- Mother to be re-issued with a Sky Guard for a 4 week period.
- Issues with neighbours to be looked into.
- Discussion with Mother regarding a CAF referral.
- SW to encourage Mother to report incidents to the Police.
- IDVA to discuss her housing / possible move situation.

There was no consideration of CSC getting involved at this stage, despite the continuing concerns about domestic abuse and Mother's vulnerabilities.

7.20 The Surestart Children's Centre had became involved around this time. Most of the contact was in Mother's home, and it proved difficult to get her to attend the centre. Taxis were offered when Mother stated she was afraid of leaving the house in case she ran into Father. These were refused by Mother. The Children's Centre staff made a huge effort to engage Mother, who they contacted a number of times a week from September 2011. At one stage Mother showed an interest in becoming a Surestart volunteer. This did not happen however, and Mother told the reviewer that her Partner had later stopped her pursuing this opportunity.

7.21 In September 2011 Mother and HS were seen for the baby's routine 8 week check with the GP. No concerns were identified with the care of HS. It is recorded that Mother explained that her depression was not having an impact on looking after HS. However it was recorded that the health visitor was to keep an eye on the baby's weight. The health visitor could not confirm if she had a conversation about HS with the GP, but stated it was possible. The poor weight gain was again considered in October 2011, with the GP recording that the baby should be weighed regularly in clinic. As stated in the GP agency report, 'There is no evidence in the GP record entry that the poor weight gain had been viewed in the context of the household in which there was a clearly documented history of domestic violence'. It has been confirmed that there were numerous domestic abuse notifications evident in the Mother's records which the GP had access to.

7.22 Systems for communication between GPs and health visitors in the area where Mother lived at this time were not clear, and have not improved significantly since the time of HS's birth. Health visitors are not GP attached in this area which makes communication more difficult. In the north of the County they have SHARE where GPs can see health visiting records, but not visa versa. This review has requested that the issue of GP and health visitor communications be reviewed, and a recommendation has been made to this effect.

7.23 On 15 September 2011, the Police contacted CSC to inform them that a police officer had visited the home and was concerned about the impact on Mother of the threat from Father, she was said to be physically shaking. She had reported an incident

where Father had allegedly been to the house and tried to force his way in, making threats to Mother and saying her 'baby would be dead'. (13 September) The police officer also shared that Father had been to the house previously (10 September) when Mother had allowed him in resulting in him assaulting her while HS was present.

7.24 The Social Worker telephoned Mother the same day to clarify the support she was receiving. When the CAF was discussed it became evident that it had not been followed through by a CAF meeting and a plan that was understood by all and was being progressed, so was not effective as a plan for the child. However it was recorded that the support available was extensive and understood by Mother. She was made aware that CSC would become involved if she reconciled with Father. There does not appear to have been a challenge about the incident on 10 September when Mother willingly allowed Father into the home however, and no consideration of the threat to kill Mother and HS. (It was also noted that the Police did not specifically respond to the threat to kill which is a criminal offence). The outcome recorded for this contact was that the threshold for CSC was not met as Mother had not reconciled with Father, that she had acted appropriately to safeguard her child and was seeking support from the Police. The social worker recorded that Mother was well supported by family and professionals, and that HS was well cared for. This was an opportunity to undertake an assessment of this 2 month old baby and her Mothers ability to protect herself and her child from on-going domestic abuse and threats from Father. If the assessment had been undertaken it may not have established any risk to the child, however the high number of domestic abuse referrals and the other factors which were likely to have an impact on Mother's care of the baby were not recorded and explored, with CSC accepting an optimistic view of her coping abilities and the support being accepted.

7.25 In September 2011 Father was arrested, charged and remanded in custody for breaching the restraining order. The Police agency report for this review states that Mother was most concerned during this period and appeared very anxious and frightened of Father.

7.26 Mother saw her GP on 10 October 2011 and she was prescribed anti-depressants. The GP recorded she was 'postnatal with stress'. Mother told her Surestart worker (a Health and Family Support Worker, to be called the Surestart worker throughout this

report) the same day that she did not intend to take the medication as she did not want to become addicted. There is no evidence that this information was shared with the GP or the health visitor. However the Surestart worker spoke to her manager the same day and they agreed a referral should be made to CSC. There is no evidence this happened. This could be because during a conversation later the same day with the Women's Aid worker the Surestart worker was informed that CSC had closed the case recently as it did not meet the criteria for their services while Father was not living at the home.

7.27 The health visitor visited on 13 October 2011. The purpose of the visit was to weigh HS and support Mother. HS's weight had dropped from the 2nd to the 0.4 centile, which was of concern. The health visitor was worried that the amount of feed being offered was insufficient and advised Mother that this be increased, and that HS be given 6-8 feeds in a day. She arranged to visit and re-weigh HS in two weeks and asked Mother to make an appointment with the GP. Mother presented as anxious throughout the visit, and as concerns remained about how this and the domestic violence would impact on HS, the health visitor recorded that targeted intervention was to continue.

7.28 The health visitor liaised with the Surestart Worker and asked her to provide feeding support to Mother. When the Surestart worker rang Mother to discuss that Mother was very upset and stated that she felt undermined by the health visitor and that she was fed up of so many professionals being involved in her life. The agency author rightly asks whether this was an attempt by Mother to play one worker off against another.

7.29 Whilst Father was in prison, Mother contacted the Police following alleged threats made against her by Father's father. They went to the home and during this visit a concern is raised about her mental state and a decision was made to contact CSC Emergency Duty Team (EDT). The planned contact from the Police with EDT happened on 25 October 2011. The Police told the CSC Emergency Duty Team that Mother had contacted them to report that Father had telephoned from prison and threatened her. The Police were concerned for Mother's mental health. There were no concerns for HS. The EDT social worker noted there was a very young baby in the household, and also made a referral to the Community Mental Health team.

7.30 A duty social worker (DSW) from the CSC duty team for the area contacted Mother later that day to inform her of the EDT referral and to see if she required support. She refused the offer of a Domestic Abuse Link Worker[2] as she was already receiving support from Women's Aid. She gave permission for checks to be undertaken, and the DSW spoke to the health visitor to share information, to make health checks on HS and to enquire about the CAF. The DSW recorded that a Women's Aid worker would be the lead professional on the CAF. The health visitor advised that HS's weight was low but there were no other concerns. She stated that Mother had said she had no intention of returning to Father and had taken steps to protect herself and HS. CSC took no further action, as the CAF was said to be imminent and there was a lot of agency support going into the family.

7.31 The adult mental health worker (AMHW) received the contact from EDT and looked on Frameworki (the CSC database) noting that CSC had been involved but that there was a history of closure and no child protection issues. Mother was telephoned by the AMHW on a number of occasions over the next few weeks and was offered support. The AMHW also undertook a home visit to Mother. Mother spoke mostly of her grief at the death of her husband. She was asked about drinking and Mother said it was not a problem. Mother spoke of her concern that the CAF had been 'cancelled', that she was often overwhelmed by the number of professionals involved, and that she had issues with the way she had been treated by the Police. She initially declined counselling, but later agreed. The AMHW contacted CSC to enquire about the 'cancellation' of the CAF. The SW said it was still open and appeared confused about what was happening.

7.32 After a number of attempts the AMHW spoke to the GP and they agreed to make an urgent referral for grief counselling to both CRUSE and psychology services. The referral letters were written, but Mother then refused her consent, saying it was not the right time as she felt stressed about Father's imminent release from prison, and they were not sent. Although she could not come to the learning event or recall day the AMHW spoke to the reviewer and stated that she did not have serious concerns about Mother. She appeared to be coping well with her baby, her home and her self-care, despite the stress of her bereavement and the threats from an abusive ex-partner. She also appeared to have support from professionals and identified

[2] A DALW works with or on behalf of children. They were employed at the time by Women's Aid and would work with families that did not meet the threshold for CSC.

members of her family. She thought Mother showed good insight into her situation and was adamant she was not going back to father. The AMHW was not aware of concerns about Mother's drinking or the drink driving incidents. Having cross-referenced with the CSC agency, it does not appear that this information had been recorded on the Frameworki database by CSC.

7.33 The GP records contain a copy of an urgent referral for psychological therapy, made in November 2011. The issues highlighted in the referral include Mother's recent bereavement, her overdose attempts, the history of an abusive relationship, that she was caring for a baby and that she had a pending court case for driving whilst under the influence of alcohol. There is no further reference to this referral on the GP files and no evidence that Mother received any assessment or assistance. It seems that Mother withdrew her consent, as stated by the AMHW. The agency report from Nottinghamshire Health Care Trust (NHCT) clarifies that Mother was not known to their adult mental health service.

7.34 A MARAC meeting was held on 27 October 2011. On 1 November 2011, the Police forwarded a domestic violence notification to CSC stating that the MARAC Chair requested that a referral be made to CSC because of the concerns about domestic violence, alcohol, concern about lack of engagement from Mother, and concerns that HS was at risk of both physical and emotional harm due to her parents lifestyle and the domestic abuse. It was recorded that Father was currently remanded in prison for offences against Mother, and that there were concerns that Mother's lifestyle was chaotic and not conducive to the welfare of HS. The CSC agency report author rightly points out that concerns regarding Mother's lifestyle are a new development, but that the concerns were not supported by the information from the health visitor gained two days before.

7.35 A duty social worker (DSW) again spoke with Mother who claimed to be confused as she felt that nothing had changed, that HS was safe, and that the case had been closed just a few days beforehand. Mother complained that she had not received support in feeling safe from Father, stated that she was due to give evidence against him in court, and that she was going to be starting counselling regarding her bereavement.

7.36 Checks were also undertaken by the DSW with the Sanctuary Worker involved, which was a positive action. They had no concerns about Mother's parenting but

described her as vulnerable in regards to Father and the risk he posed, stating that she had allowed him in to the house in the past despite telling the involved agencies that she would not. The Team Manager with responsibility for the duty service decided that the information received would not be treated as a referral and no further action was taken. It was appropriate that this decision was made by a manager, however the review thought that an assessment should have been undertaken at this time, due to the strongly worded request from the MARAC chair that an assessment be undertaken and the lack of progress of the CAF. The absence of GP checks was also noted.

7.37 In December 2011 Mother told her IDVA that she had a new partner, who worked shifts but often stayed with her. She expressed fear about the threat from Father and stated he might have access to firearms. This allegation does not appear to have been reported to the Police but resulted in the issue of a Sky Guard to Mother. Again this was an opportunity that could have been taken to reconsider the needs of and risks to the child in the family.

7.38 Over the Christmas period 2011 there were a number of incidents reported to the Police by Mother and her partner in respect of threats and harassment from Father. These were listed to the IDVA in the New Year by Mother, who also stated she was concerned at receiving a letter from a prisoner claiming to have met Father in prison and asking for personal information from Mother. The IDVA wrote to the Police Public Protection Unit about the concerns and spoke to the local police officers. She also spoke to a number of other domestic abuse professionals involved with Mother, and while this was a good attempt to both share and receive information, there is a confusing picture of who was involved, why and what extra support they brought to the case. It has been difficult for the reviewer to see who had responsibility for both coordinating and taking action in regards to support for Mother and for the investigation of further allegations. When compiling a map of professional involvement for the review, there were over 10 professionals having regular contact with Mother around this time.

7.39 On one occasion, on 28 December 2011, the police contacted CSC EDT. They reported they had responded to a call from Mother stating that Father was harassing her. The Police were concerned about Mother's reactions to them and to the incident. They stated she appeared to be very immature and they questioned her capacity to

look after a child. The house however was described as comfortable and there were no concerns about how HS presented. They also said Mother's partner was acting responsibly. The EDT social worker recommended an assessment, particularly in light of the previous concerns. However the day-time duty team manager recorded that the issues were in regards to Mother and there were no concerns for HS. A letter was sent to Mother advising her to see her GP if she felt stressed and 'unable to cope. No checks were undertaken with other professionals and there was no communication with adult mental health, although it was recorded that Mother was referred to them in the past.

7.40 This is a key practice episode because there were on-going concerns about domestic abuse and harassment, about Mother's vulnerability and mental health, unexplored concerns about Mother's drinking, and some unsubstantiated concerns about the extent of Mother and Father's contact with each other. There is evidence of multi-agency working, and good communication between the health visitor, Surestart and some of the domestic abuse professionals. However there was also some drift in making the CAF a meaningful way of coordinating support for a very young child and in ensuring the matter is kept on the agenda at MARAC. There were missed opportunities for a fuller and coordinated assessment, involving CSC, of Mother's ability to meet HS' needs and to keep her safe from Father and from witnessing domestic abuse.

7.41 <u>Key practice episode III. Pregnancy and the birth of Child H, and the gradual withdrawal from support services.</u>

7.42 There was relatively little professional involvement with the family early in 2012. On 25 January 2012, a police notification was received by CSC regarding an incident on 12 January 2012 of verbal abuse from Father to Mother. No action was taken by social care. Although this incident was in relation to verbal abuse, in light of the previous serious domestic abuse incidents that had resulted in Father receiving custodial sentences, and Mother's high anxiety about any contact with Father, this verbal abuse could be said to be more significant than it might be in other cases.

7.43 The following day Mother reported seeing Father on the street, but was told by the Police that this was not a breach of the restraining order as it was a chance meeting. However on 4 February 2012 Father was again charged with breaching the order and was remanded for Court.

7.44 In February 2012 the GP records have a note of a positive pregnancy test. HS would have been 6 months old at this time. At the learning event it was stated that Mother attended all appointments with the midwife but missed 3 separate appointments with the consultant obstetrician. The reasons given were not documented. This was not flagged as a concern at the time. Mother told the reviewer at the start of this process that she had a difficult pregnancy with a lot of sickness. She also stated that her Partner was reluctant for her to meet with professionals when he was not able to be present. He had a particular issue with male professionals, according to Mother. Professionals at the learning event confirmed that they always saw Mother with her Partner there. At the time however he was felt to be a protective factor and all focus was on the risk from Father.

7.45 In March 2012 Mother's Partner contacted the Police to say his tyres had been slashed and he believed Father was responsible. No evidence was provided of Fathers involvement however, and on reflection the Police agency report author considers that Mother's Partner may have been exacerbating the situation. There were also allegations made that Father had set the family's rabbits free, which were unproven.

7.46 On the weekend of the 8 April 2012 Mother reported Father for following her into shops. Her Sky Guard was to be removed from her a week later as she had not been using it. The following day she made a further referral of harassment and threats to her and her partner from Father. She told the IDVA at this time that she didn't actually use the Sky Guard when the incidents happen. At a cost of around £7000, a Sky Guard is an expensive resource, the allocation of it to someone who is not benefitting from it was therefore questioned. It is not clear why Mother was not using the alarm.

7.47 On 24 April 2012 the IDVA had supervision and the issue of so many people being involved was discussed and recorded, giving Mother the potential to undermine some professionals to others. It was agreed that this should be considered at the MARAC due to be held in May. During April there was good communication between the numerous professionals involved with Mother regarding their growing concerns about Mother's Partner, who they felt was showing signs of being controlling and manipulative. However there was felt to be little evidence and the professionals were

reluctant to rely totally on instinct. Mother also consistently defended her partner to her domestic abuse worker.

7.48 On 26 April 2012 there was liaison between the Children's Centre and the IDVA and it was recorded that a CAF was still not completed after the previous MARAC, and that Mother had been overwhelmed by all of the agency involvement. It was agreed that a CAF needed to be prioritised. The Children's Centre agreed to get Mothers permission to go ahead with this.

7.49 The case was again heard at the MARAC on 10 May 2012, it was the 4th MARAC where Mother had been discussed. The recommendations included enquiries to be made into Mother's partner and any relationships he has with children, that Women's Aid should assist with an application for re-housing, should instigate the CAF, should raise the concerns with Mother following the MARAC, and that the Police should take the matter back to court and get the breach addresses changed. Professionals at the learning event remembered concerns being discussed at this MARAC about the way that Mother's Partner spoke to her. The review was told that these concerns were not documented in the body of the MARAC report however. It was clarified at the learning event that checks subsequently undertaken on Mother's Partner did not raise any issues of concern. The review was provided with the notes from this MARAC meeting. It is clear that there were a number of concerns about the threat that Father continued to pose, however it was also stated by Women's Aid that Mother was doing everything she could to disassociate from the relationship and was reporting all incidents. It was recorded that Father had made a statement that Mother continued to contact him and wanted contact however. This statement does not appear to have been believed by any of the professionals.

7.50 On 11 May 2012 CSC received a police notification stating that Father had been harassing Mother in the street. It was stated that she was pregnant. The Police provided the evidence to the CPS, who did not pursue it as it was their recorded view that the CCTV footage undermined Mother's allegations. (This information had been shared at the previous days MARAC). As a result of this notification, a letter was sent to Mother informing her of this latest referral and asking her to contact the department to discuss concerns and what support she was receiving for herself and HS. Mother made contact and said she was being supported by her worker at Sanctuary and had requested a CAF, which she was confident would now happen

after the May MARAC. CSC took no further action, and did not make any checks to confirm that professionals were engaged with Mother and HS and that the CAF was an effective tool for meeting the family's needs. If this were a one off incident this would have been an appropriate reaction to the police notification, but as this was yet another incident, a manager should have been consulted and consideration given to undertaking an assessment.

7.51 Following the MARAC the case was closed to WAIS (Women's Aid Integrated Services), one of the agencies involved with Mother, as there was on-going involvement from NWA (Notts Women's Aid) and Outreach. This should have made some difference to Mother having a clear idea of who was providing support in relation to the domestic abuse. However on 20 August 2012 Mother was visited by a new WAIS floating support worker (FSW) and Mother herself voiced her anxiety about having another new worker and having to repeat the history. The FSW explained the changes were a result of recent changes to funding arrangements. At this visit, where partner was present throughout, Mother stated Father was not the father of her child or the baby she was expecting. No further visits took place as the FSW had to rearrange a meeting, and then Mother decided in September that she did not want any further involvement or support.

7.52 During August 2012 a CAF (team around the child) meeting was held. Mother, her partner and his Mother attended, along with the health visitor, the Surestart worker, the Women's Aid worker, the Sanctuary worker and the Occupational Training and Recruitment worker (OTR). The health visitor showed good challenge when she expressed her concern that HS would be impacted on negatively due to concerns about Mother's mental health issues, which are exacerbated by the stress of the harassment from Father. It was agreed that the Surestart worker would be the lead professional for HS. However it was noted that she then planned to stop her involvement and close the case 2 weeks later, as there were felt to be enough professionals involved. It was agreed during this review that the CAF meeting was not timely and the impact was not robust.

7.53 Despite concerns about the number of professionals involved, at this time a new domestic abuse professional was introduced, the WAIS Floating Support Worker. When she first visited Mother, as recorded above, she noted that Mother had been anxious about meeting yet another professional and having to repeat her history.

7.54 Child H was born prematurely at 32 weeks gestation. Despite her prematurity she needed no breathing support and there were no medical concerns. It is not known why Mother had gone into premature labour. There was no obvious medical reason. Prior to discharge Child H spent three weeks on the neonatal unit.

7.55 In the days after her birth Mother married Partner and he was registered as Child H's Father on the birth certificate. The community midwife attempted to visit Mother at home, but was turned away at the door, with Mother stating she did not have any issues and did not want to see her. When it was asked during the review how common this sort of response was in the general experience of the health visitors and midwives involved, they stated it was not common.

7.56 No pre-discharge planning meeting was held at the hospital. It was considered by the Safeguarding Nurse, but it was not felt to be needed as the concerns regarding domestic abuse were felt to be historical, there was well documented support in place for the family, and there was also no current CSC involvement. While Child H was in hospital there were no concerns identified in regards to the 'parents', who spent most days on the unit and rang during the evenings. They received help and advice in caring for a premature baby before Child H was discharged from hospital.

7.57 On 3 September 2012 Mother's Partner complained to the Surestart worker that the WAIS Floating Support Worker had asked to see Mother alone, without him there. He said he felt that she was implying that he was controlling Mother. The Surestart worker told her manager that Mother's Partner appeared to be speaking for Mother as well as himself.

7.58 On 10 October 2012 the health visitor visited at 11.30 am she found Mother, Partner and Child H asleep in bed. HS was not seen, her whereabouts were not noted, and no reference was made to her weight. When Child H was weighed she had a slight drop in the centiles on the growth chart. The health visitor suggested the GP was spoken to and arranged to visit again on 17 October 2012. At the next visit Child H was again weighed by the health visitor, she had gained weight well and there were no concerns regarding her health or development.

7.59 On 8 November 2012 Child H was seen at a paediatric out-patient appointment, presumably arranged due to her prematurity at birth. The baby was weighed and

measured. She was said to be healthy, alert, with no developmental concerns and was gaining weight and growing appropriately.

7.60 The Police have a report from November 2012 regarding anti-social behaviour issues between Mother and her neighbours, which allegedly had been going on for a lengthy period, with the Local Authority involved. Mother is described by the police officer involved as vulnerable at this point but feeling positive about an imminent house move.

7.61 On 16 November 2012 a children's health assistant practitioner (CHP), on behalf of the health visitor, saw Mother, her partner and Child H at the family home. She recorded that the baby had only gained 1 oz in a week and was crossing down a centile. Mother reported that Child H had seen the Paediatrician the week before they were satisfied with the weight gain. The CHP provided advice and reminded parents that Child H's immunisations were overdue. The groups at the Surestart Children's Centre were also discussed. Mother had shown interest in attending but had not yet done so. Support to attend was offered and encouragement to get involved.

7.62 The family moved home in November 2012. The move had been supported by a number of professionals due to the concerns from Father. Mother's Partner contacted the Police and asked them to remove the alarm from the property, stating they would not need it in their new home. The following day Mother stated she wanted to keep the alarm and remained very concerned about the threat from Father.

7.63 On 29 November 2012 a CAF meeting was held. Mother and her Partner did not attend, telephoning in advance of the meeting to say that they were ill. There was a detailed discussion recorded regarding support for the family, and the action plan from the previous meeting was reviewed and it was recorded that it appeared to have been actioned appropriately. A decision was made to close the CAF after one more meeting, which was to be held after the family moved home. The purpose of the final meeting was to confirm all appropriate supports were in place in the new area. It is recorded that the parents had still not accessed the children's centre groups due to illness and other meetings.

7.64 An invitation to the CAF meeting had been sent to the WAIS Floating Support Worker, but as Mother did not confirm that she wanted her to attend, she did not. She

later closed the case to her service as Mother said she no longer required support, and expressed her annoyance that the WAIS Floating Support Worker had implied that her partner was controlling. A letter was sent to Mother to confirm that the case was to be closed and included an open invitation for Mother to make contact should she need to.

7.65 On the same day (29 November 2012) Child H was seen by the GP and they undertook a full undressed physical examination. No concerns were noted.

7.66 Mother was seen by the GP a week later and had a injury to her gums and teeth. She stated she had fallen out of bed. There is no record of whether any question of potential domestic abuse was raised with Mother by the GP, no record was made about the likelihood of this explanation causing the injuries, and information on these injuries was not communicated to the health visitor.

7.67 Child H was seen by the CHP on 3 December 2012. She was weighed and had not maintained an increase in weight. Increased feeds were advised along with an appointment with the GP to be made by Mother. The new health visitor (due to house move) then made a 'transfer in' visit on 17 December 2012. Baby was not weighed at this visit due to her being asleep and settled. The learning from this, which was clearly identified in the agency report, is that when there are concerns about weight gain and the HV is seeing the baby it is worth considering that waking the baby up may be necessary in order to weigh, particularly when the baby is premature. It is particularly of interest in this case due to the events of the following day. However at the time the health visitor could not have known that seeing the baby awake and naked for weighing may have been significant. There were no concerns however and the health visitor recorded there was good interaction between the parents and the children's needs were being met. She had been unable to enquire about domestic abuse, as is the procedure, because Mother's Partner was present throughout the visit. A follow up appointment was made for four days later.

7.68 The following day an ambulance was called, it arrived in 8 minutes and Child H was taken to hospital. She was pronounced dead 45 minutes after arriving at the hospital.

7.69 This is a key practice episode because the focus of services remained on Father and the risk he posed to Mother and the family. Child H was born two months early, and Mother was looking after 2 very young children with a new husband who appeared to

be a protective factor, but who did not encourage Mother to engage with agencies for support and advice, and about whom very little was known. At the time professionals had some concerns about Mother's Partner and his seemingly controlling nature, but there was no evidence of any domestic abuse and Mother certainly appeared to be coping better. It is significant that at the very time agencies were speaking of closing the CAF and the domestic abuse professionals were withdrawing due to Mother's lack of engagement, Child H was probably being subjected to physical abuse.

8 Themed Analysis

8.1 The analysis section of the review will consider the information above, which was gained from the Agency Reports and from the staff who had worked with the family and attended the Learning Event, by identifying the key themes and providing thematic analysis. The questions in the terms of reference were considered and answered in the majority of agency reports. The information included in those reports have been considered as part of this analysis.

8.2 The themes that have emerged and will be considered are:

- Communication and information sharing
- The Common Assessment Framework (CAF)
- Domestic abuse and the MARAC
- Dominance of Mothers issues, including her mental health
- Thresholds for social work assessment and S47 enquiries.

8.3 <u>Communication and information sharing</u>

8.4 The question asked in the terms of reference for this review is 'from an inter-agency perspective, were processes, communications and information sharing effective? Did services operate in silos rather than being "joined up" with each other? Were any concerns escalated?' As these issues are often identified in reviews of this kind, it is an important consideration.

8.5 In this case there were examples of good communication between professionals, however this was not the case with all professionals at all times. There was regular good communication between the health visitor and the Surestart worker. There were also examples of good communication from the Surestart worker and the health

visitor with domestic abuse professionals. The Surestart worker in particular took it upon herself to ensure that she spoke to the right person and regularly fed back to the health visitor regarding Mother. The GP however did not make contact any other professional, although they provided a good response when contacted by the AMHW.

8.6 There appears to have been some degree of confusion regarding who was providing a lead role with Mother from the complex domestic abuse services who had contact with her during the scope period. This led to the Surestart worker and health visitor having to have a number of conversations with different people in order to establish the latest information.

8.7 Both the midwife and the health visitor made appropriate referrals to CSC in regards to HS. The health visitor and the Surestart worker also appropriately asked for the case to go back to MARAC.

8.8 As well as leading to difficulties in working out who was the right person to speak to, a lot of repetition of information sharing occurred on a number of occasions, for example in July 2011 the health visitor and midwife had a conversation and recognised they did not have the latest MARAC meeting minutes and were not clear who was involved with Mother. It took a number of phone calls to find out about the MARAC meetings and who was working with Mother in regards to her domestic abuse. There was also some confusion regarding who knew what information about the allegations Mother was making about continued harassment from Father. As the picture slowly emerged about Mother not consistently reporting contact from Father and not engaging with services put in place to support her, this lack of clarity of role provided Mother with an opportunity to avoid professionals and to not be totally open about what was going on. The lack of regular meetings where Mother and professionals attended together, as would be the case with an effective CAF or with a child in need plan, allowed Mother to decide what information she wanted to share with the professionals around her. If the CAF meetings had been in place earlier, issues with Mother's engagement may have been exposed, possibly leading professionals to push for the involvement of CSC.

8.9 The systems of sharing police information with CSC appeared to be working well. The checks made by CSC prior to deciding whether the threshold for their involvement was met were adequate, other than the lack of GP checks, and

information was shared appropriately with the DSW. However they focused on the threat from Father as an indicator of risk to the children, without considering the wider concerns about Mother's vulnerability (which included issues with alcohol and metal health concerns). No assessment of her ability to meet her children's needs herself and to protect her children from Father or any other inappropriate adult was undertaken. While an assessment was unlikely to have resulted in on-going involvement from CSC, an assessment could have been warranted because of the number of domestic abuse notifications and because of the additional factors of Mother's anxiety and vulnerabilities.

8.10 Historically communication has been identified as an issue in a number of serious case reviews. In Ofsted's 2008 report '*Learning lessons, taking action'* it was concluded that there were clear weaknesses in a large number of reviews in regards to record keeping and communication across universal services, that 'allowed vulnerable children to be missed by services'. In *Learning lessons from serious case reviews 2009–2010,* which is Ofsted's evaluation of serious case reviews undertaken between 1 April 2009 to 31 March 2010 it is stated that in the cases where practice was inadequate, the issues were:

- poor communication
- failure to include key professionals or agencies
- insufficient training or engagement of some professionals
- ineffective meetings
- incomplete record-keeping
- a lack of follow-up of the agreed actions.

8.11 While this case did not highlight many deficiencies in these areas, on some occasions there was a lack of appropriate communication. For example from the GP to the health visitor and/or the Surestart worker and visa versa, particularly regarding Mother's medication for depression. It has been identified that while health needs were discussed with Mother by the health visitor and Surestart worker, and that she was urged to see the GP with any health issues for the children or her own mental health, it is unclear within the health visiting records if Mother accessed this support. After the birth of HS the GP recorded that the health visitor was to monitor the baby's weight as a concern had been identified, however there is no evidence that this expectation and the concern about HS's weight was communicated to the health visitor. Much of the information provided about the GPs advice was self-reported by

Mother. It would have been appropriate and good practice in this case for the GP and the health visitor to have a conversation about Mother and whether her issues would have an impact on her parenting capacity.

8.12 A study published by the Department of Education in 2009 'The Child, The Family and the GP" found that GPs preferred to consult with Health Visitors and other Health colleagues rather than with CSC where they had concerns. The study found that there was a general reluctance by GPs to approach CSC to make referrals unless there was a clear injury, disclosure or evidence of failure to thrive. The conclusion of the study stressed 'the important role of the Health Visitor in safeguarding children, and as a key fellow professional for the GP to refer to'. Building relationships between GPs and Health visitors is therefore key. The situation in Nottinghamshire is that health visitors tend to work geographically, but also there are GP link health visitors, who would be the person that the GP could speak to and they would pass on the information to the relevant heath visitor for the family. This does not appear to be straightforward, and it was clear to the reviewer that staff do not like the system.

8.13 In April 2012 the 'Guidance on Information Sharing and Issuing Alerts to Safeguard Children in Primary Care' was developed and published by a working group on behalf of the NHS Nottinghamshire and Nottingham City Data Advisory Group. It states that it is 'intended to safeguard children by supporting GP practices and community health teams to share information relating to vulnerable children'. It helpfully states that the Caldicott review 'identifies a new Caldicott principle, that the duty to share personal confidential data can be as important as the duty to respect service user confidentiality'. However, if the practical links between professionals are not straightforward, and relationships are not meaningful, the policy will only go part of the way to ensuring information is shared and concerns are communicated.

8.14 There was evidence of effective communication between the MARAC and the safeguarding midwife, and subsequently the community midwife, who also made the first referral to CSC after identifying some potential safeguarding concerns for the new baby. There was regular communication between the community midwife and the health visitor, however it is not clear that all of the information was handed over at transfer between services, with the health visitor not appearing to have all of the information about Mother's mental health history and vulnerabilities, other than that which was self-reported by Mother.

8.15 When Child H was in the neo-natal unit there was good communication with the health visitor regarding her discharge, and good use of the safeguarding lead.

8.16 There was a particular issue identified regarding communication between the primary health providers for HS (other than the GP) and the mental health services. Around October 2011, when Mother was struggling as a single parent to HS and was very stressed due to Father's on-going harassment, a social worker from adult mental health (AMHW) got involved briefly. She completed an assessment and concluded that Mother required bereavement counselling. She liaised with the GP regarding this, who referred Mother to psychological services. She also planned to refer to a bereavement charity, however Mother withdrew her consent. There is no evidence that the heath visitor was aware of these referrals or involvements.

8.17 The Police agency report states that there was good communication and following of processes in place regarding safety planning for Mother in respect of the domestic abuse. Referrals regarding the children were made appropriately, however there is no evidence anyone in the Police checked if any action was being taken in respect of safeguarding the children. There is also limited consideration, by the Police, to making a specific referral in regards to the impact on HS (and later Child H) of the concerns the Police had about Mother's mental health and drinking, although they did contact EDT in October 2011 with concerns about Mother's mental health after the allegations of harassment from Fathers father.

8.18 Mother clearly did not report all of the incidences of harassment from Father directly to the Police. On occasion she would inform other professionals, such as when she informed the Surestart worker on 8 September 2011. Mother would always be told that she must inform the Police of all incidents, however it was rare for the involved professionals to also report the incidents they had been made aware of directly to the Police, or to check that Mother had made the Police aware of concerning incidents. During the review the professionals involved in this case highlighted a systemic issue in Nottinghamshire in regards to contacting the Police in any specific case. They said that in this case, and others they hold, it was not clear who they should ring if they have questions or concerns about a family and needed to communicate with the police. They agreed that if CAF meetings had been held earlier, and the IDVA had attended, this would have provided a good link into the Police. However the meetings

were not held and the IDVA does not appear to have taken an active role in liaising with child care professionals in this case.

8.19 There is no evidence that discussions were held between CSC and the AMHW. CSC staff had access to the AMHW's records on Frameworki (the local CSC and adult services client database system) and there is evidence that these were considered when CSC were making a decision regarding whether they should open the case for an assessment, and by the AMHW when undertaking her assessment. It would have been good practice to not just rely on the written records however, but to speak to the AMHW both to establish her assessment of Mother's current state of mind, and also to share information held by CSC and reported to them by other agencies. It is clear however that the AMHW did not have concerns about Mother's parenting, but arguably this was partly due to noting that CSC did not have any concerns recorded on Frameworki.

8.20 As has been pointed out in a number of the agency reports, an effective process for coordinating and sharing information in regards to the children would have been the CAF. In this case however the CAF did not appear to commence in a timely manner, and regular meetings and reviews did not appear to be held. Despite a number of agencies identifying the lack of action on the proposed CAF, no one escalated their concerns.

8.21 Despite some minor concerns being identified about information sharing and communication in this case, there are also examples of good practice. It can therefore be concluded that there were no major lapses in information sharing and communication.

8.22 <u>The Common Assessment Framework (CAF)</u>

8.23 The Common Assessment Framework is a part of the previous Government's *Every Child Matters: Change for Children* agenda. It was developed as a tool for early intervention for practitioners working with children and young people. The CAF was designed to ensure timely and integrated responses to children and young people at risk of not achieving a positive outcome but who may not meet traditional thresholds for statutory or specialist services. A CAF should help in the early identification of needs, ensure the provision of services is coordinated, promote the sharing of

information, fully involve the family themselves, and reduce the need for service users to have to keep telling their story to different professionals.

8.24 There was clearly some confusion and uncertainty from the point of view of the professionals involved, and from Mother herself, regarding the CAF in this case. There appears to have been delay in both starting the CAF administrative process and in compiling the assessment, communicating the content of the CAF, and confirming the identity of the lead professional. Mother changed her mind about whether she wanted a CAF to be completed on a number of occasions, and professionals confirmed at the learning event that they did not really see, at the time, what additionality would come from a CAF when so much support was going into the family.

8.25 The health visitor provided some information to the review regarding the CAF process in this case. She stated that professionals were trying to move forward with the CAF for the family. She had records to show that she had chased the Women's Aid worker who it had been agreed would be completing the CAF in September and October 2011. A meeting had been arranged then cancelled in November 2011. As Father was in prison at this time, it is recorded on the health visitor records that Mother had not wanted to pursue with a CAF. It is not clear how much persuasion had been attempted to convince Mother of the benefits of having a CAF at this stage. The next time that a CAF had been discussed in regards to this family was when it was requested by Mother in May 2012 and Surestart completed the required form. The meeting was then held in August 2012.

8.26 It was identified fairly early on that a more timely and persistent CAF would have been helpful in this case however. The integrated chronology completed to assist in this review makes references to a CAF being needed on at least 33 occasions before a CAF or 'team around the child' meeting is actually held to share information and discuss a plan for the children. This delayed the chance of ensuring a joined up approach that considered the needs of the child/ren as its main priority.

8.27 There were opportunities which could have provided the impetus for ensuring that the CAF was completed and a CAF meeting was held. Including; after the early referrals were made to CSC in September and October 2011; when Father had been discharged from prison and Mother was showing signs of being much stressed; and later when Child H was discharged from the neonatal unit at the hospital.

8.28 There were some CAF meetings held towards the end of the scope period of this review, and Mother was certainly under the impression that her children were subject to the CAF previous to these meetings, although she was not necessarily sure what this meant. For a CAF to be effective the parents need to cooperate and engage in a meaningful way with professionals. Mother's lack of meaningful engagement would have been exposed earlier had regular meetings with all of the relevant professionals been held more often. This could have led to a re-referral to CSC for an assessment and the potential for a time limited child in need plan.

8.29 Mother voiced her frustration, when consulted as part of this review, in regards to having to keep repeating her history and information about Father and the domestic abuse time and again. There appears to be a degree of confusion throughout the professional network in relation to the involvement of services that support the victims of domestic abuse, and who was involved at any one time. The existence of a timelier CAF with regular meetings may have helped in regards to these issues.

8.30 It has not been possible at this stage to meet with Mother's Partner, who was a important person in the lives of both children during the period of the scope of this review. What is clear is that he was spoken to a number of times by a number of agencies at this time. What did not happen was a conversation, by the majority of agencies, with Father. As the threat from him was the main concern throughout this period, it would have been good practice for professionals involved with the children to have spoken to him. Both to clarify expectations about him not contacting Mother and the children, but also to hear his view of the situation. In this case Father was in contact with the police and probation, but was not spoken to by any of the agencies involved with the children or the team around the child. The threat from Father in this case was very evident, but he was absent in the assessments and subsequent work being undertaken.

8.31 It should be stated however, that even if regular CAF meetings had been held, and Mother had not cooperated with the plan, there were probably not grounds for a S47 investigation or to convene a child protection conference, and certainly there were no grounds for care proceedings in respect of the children. It must also be noted that the review found evidence of professionals communicating effectively with each other about the children and Mother in the most part, albeit not in a CAF meeting setting.

8.32 All of the professionals who attended the Learning Event spoke of the support Mother and Partner received from extended family, a number of whom had been present on occasions when professionals visited to the family home.

8.33 Conclusion 1:

That information sharing and communication between agencies in cases that have a number of professionals involved due to concerns about a child is most effective when the child is subject to a plan which clarifies in writing and through regular meetings what the concerns are, who is involved/responsible and what needs to change. All children who are identified as in need of a plan, (be that a CAF, a child in need plan or a child protection plan) should have parents and professionals working closely together, sharing information, meeting regularly, and working towards stated and shared outcomes. These plans should include extended family members. In this case the information sharing was generally good, but it would have been helpful to the professionals, and to Mother and the children, to have held a CAF meeting earlier.

8.34 Domestic abuse and the MARACs

8.35 The MARAC meetings were a good opportunity to consider the threat posed by Father to Mother and indeed it was agreed at the meetings held that Father posed a high risk a lot of the time. MARACs have been a positive development in recent years in ensuring that the threat of domestic abuse is considered, assessed and shared between key agencies. CAADA (Co-ordinated Action Against Domestic Abuse) is a national charity who promote a strong multi-agency response to domestic abuse. They explain that 'Multi-Agency Risk Assessment Conferences (MARACs) are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, and ensuring that whenever possible the voice of the victim is represented by the IDVA (Independent Domestic Violence Advisor), and a risk focused and co-ordinated safety plan can be drawn up to support the victim. There are currently over 260 MARACs operating across England, Wales and Northern Ireland managing over 57,000 cases a year'.

8.36 In December 2013 and January 2014 CAADA undertook an inspection of the local MARAC and domestic abuse services in Nottinghamshire. They concluded that

practice is good. It was clear to this review that a lot of good work was provided to Mother and her family, and that Mother received some helpful services in relation to the domestic abuse she experienced from Father and positive support in regards to the threat he continued to pose to her and the children. However the large number of domestic abuse professionals involved was questioned by Mother and by other professionals as part of this review.

8.37 How effective the role of the IDVA was in this case has been considered. It is an expectation that each victim referred to the MARAC will be allocated an IDVA, whose role it is to prioritise the safety of the victims assessed as being at high risk of harm. Those attending the learning event and recall day considered their expectations of the IDVA and the MARAC meetings in this case and it was clear that there was a degree of confusion about the roles and the responsibilities of the IDVA and the status of the MARAC plan. Neither the IDVA or their manager attended the meetings held as part of the review, so it has been difficult to include their views on what happened and why. It is not clear how well Mother engaged with the IDVA. What is clear is that it is the role of the IDVA to consider the victim's safety, not to assess or advocate on behalf of the children. However they would be a helpful part of a team around any child, as they provide a clear link to the MARAC and the Police.

8.38 Although Father was not living with the family at the time of the death of Child H, the focus of the risk for the family was clearly thought to be in regards to him. In fact he has not been implicated in regards to the injuries that Child H was found to have after her death. It was the domestic abuse between him and Mother, and the resulting vulnerability of Mother however that alerted professionals to the children in this family having additional needs. While he was not involved in the care of the children at the time of Child H's death, he remained an important element of any assessment, if only because of the stress that Mother and her Partner claim they were under due to his harassment and the history of violence to Mother.

8.39 In December 2011 the NSPCC, as part of their research for the '*All Babies Count'* campaign, analysed their collection of SCRs relating to children aged less than one year. Of the 130 babies in England and Wales who had been the subject of a serious case review from 2008 – 2011 domestic abuse was a factor in at least 60 of these cases, and parental mental health was an issue in at least 34 of the cases. There should be little doubt amongst child care professionals that children who live in

families where domestic abuse is an issue are more at risk of physical injury and emotional harm than most other children.

8.40 In a briefing paper published in November 2013 the NSPCC outlined a number of other factors which can increase the risk to children who live in families where domestic abuse is present. They include mental health problems, alcohol, and lack of engagement in the support services being offered. All of these were evident in this case. In regards to Mother's mental health issues, it is likely that her depression, low self-esteem and anxiety would have impacted on her ability to protect herself and the children from physical harm, and from the impact of domestic abuse inside the home, along with the ongoing and persistent threat of domestic abuse from Father.

8.41 The role of alcohol in problematic relationships is well documented. In '*Grasping the nettle: alcohol and domestic violence'* (2010) Sarah Galvani states that while alcohol does not cause domestic abuse, in such cases alcohol is often present. As well as considering the perpetrators use of alcohol, the study also looks at the victims drinking, asking two questions; 'one is whether it increases the risks of victimisation, the other is whether the victim uses alcohol to cope with the domestic violence'. She states that victims of domestic abuse had 'higher levels of alcohol consumption than non-victims and that the risk of violence increased with increasing levels of drinking'. It is important for professionals to remember that alcohol plays a role in both the suffering and perpetration of domestic violence. In this case Mother admitted to using alcohol to cope with stress. So at the time of the continued harassment from Father, and what with hindsight appears to be her continued relationship with him, it is suspected she was probably drinking heavily. This was not identified at the time however, other than by the Police who were aware that Mother was drinking in the evenings.

8.42 The NSPCC 2013 briefing paper also states that in cases of domestic abuse it is common that Mothers do not take up or disengage with support services, and that social workers may be under the impression that services and support are going in that are not. This can put the children at risk. In this case the belief that a CAF was on-going led CSC to tell the MARAC chair that they felt the family was receiving the required level of support. While there were a number of agencies involved, many of whom were offering high levels and standards of support, it was not as integrated and coordinated as would have been helpful in this case. While CSC were right to be reassured by the activity being undertaken, their colleagues from other agencies

were not considering risk and challenging Mother in the way that CSC might have done if they had become involved, even for a short time.

8.43 The above NSPCC report also outlines the triggers for domestic abuse. It lists pregnancy and threats to kill as being high risk, and suggests that a risk assessment is undertaken in these cases. Domestic abuse during pregnancy is also associated with adverse pregnancy outcomes including premature birth and having a low birth weight baby, as was the case with Child H. However, as the risk was all felt to be from Father and he was not living with the family, any additional risk factors in the household were not considered in an assessment of the care and protection being given to the children. The only risk assessment undertaken was in relation to Mother via the MARAC.

8.44 The NSPCC study outlines the learning from the reviews they considered. And many of them are relevant to this review. Firstly there is the need to consider the complex nature of relationships which feature domestic abuse, particularly those characterised by separations and reconciliations. In this case however it was only suspected that Mother may have had some on-going contact with Father. This was only confirmed after the death of Child H and the DNA testing. While there was some challenge of Mother regarding her relationship with both Father and her Partner, on the whole the view was largely that Father was dangerous, that Mother had successfully separated from him, and that her relationship with her Partner was a relatively positive one for her and the children.

8.45 Women who have a history of domestically abusive relationships often get involved in new relationships that are also abusive. Unless they have undertaken a lot of work to understand the nature of their relationships and their own vulnerabilities, they are likely to be the victim of future domestic abuse. In this case Mother had not attended the Freedom Programme[3] and had not shown professionals that she had insight into why she had been involved with a number of violent men. The learning event was told that the Freedom programme had been offered to Mother on a number of occasions but that she had not engaged. Professionals should therefore have been

[3] The Freedom Programme is a support project for female victims of domestic abuse. The aim is to help them to make sense of and understand what has happened to them. It also explores how children are affected by being exposed to domestic abuse and how their lives are improved when the abuse is removed.

alert to the possibility of domestic abuse in her relationship with her Partner. As it was not possible to see Mother alone since her partner had moved in, it was difficult to explore these sensitive issues with Mother. Mother's Partner being at all the visits and meetings in itself was an indicator that he may be abusive. He would also answer Mother's phone regularly and tell professionals that Mother was either not available or unwilling to talk to them. A number of professionals felt that Mother's partner was controlling and potentially abusive, but they did not feel they had any proof.

8.46 At the time of undertaking this review, a previous serious case review undertaken on behalf of the NSCB, but not yet published, was shared with the reviewer. The case of EN12 had domestic abuse in the history and the family was subject of a MARAC. The two cases were actually the subject of MARACs at the same time in 2011 and 2012. The EN12 review highlighted an issue with how and to whom the minutes of MARAC were distributed. The same issue was identified in this case, with the health visitor stating that it took a number of months for the MARAC minutes to reach her. In this case it was not a significant concern as the midwife had the minutes from the MARAC and met with the health visitor. There has been a recommendation made in respect of this issue in the other SCR, also in a recent Domestic Homicide Review undertaken in Nottinghamshire. The NSCB are clear that the MARAC guidance has been revised and there are much clearer expectations in place, so it is not necessary to revisit this recommendation in light of this case.

8.47 Another issue identified in EN12 was the focus of the MARAC on risk to the adult and not the children. It states that 'the actions address the risks to (the victim) rather than the risks to (the child) and although it is understood that MARAC is a victim focussed system, children are also potential victims and it would be better practice if the MARAC discussions and records included a focus on risks to children'. This review supports the learning and subsequent recommendation within the EN12 SCR. It also recognises the advances made in Nottinghamshire in regards to the effectiveness of the MARAC in these identified areas.

8.48 <u>Conclusion 2:</u>

This case shows that the risk to children who live in homes where there is or has been domestic violence are intensified where there are additional risk factors present such as problematic alcohol use or parental mental health issues. Even when the

violence is thought to be historic, as in this case, the victim may continue to have issues and their vulnerability can lead to poor choices of future partners and them being targeted by abusive men, which will impact on their children.

8.49 Dominance of Mothers issues, including her mental health

8.50 Mother had a history of mental health concerns in her adolescence and early adulthood. She suffered with depression at various points during her adult life, and had been prescribed anti-depressants. After the death of her first husband, and shortly before she became pregnant with HS, Mother twice attempted suicide. She told a number of professionals that she had also been drinking too much as a way of coping with her feelings. A large amount of the time professionals spent with Mother focused on how she was coping with the harassment from Father, and supporting her with this and her past issues. Her vulnerability was well recognised, and she was clearly very needy. Despite Mother's needs professionals like the health visitor and the Surestart worker usually recorded how the children presented, noted progress with their development and made observations about their attachment with Mother, and comments on her parenting were recorded. However with Mother's often overwhelming needs, particularly during practice episode 2, it would have been very hard for the professionals to keep their focus on the children's needs. CAF meetings would have been a way of ensuring that the children were the focus of the support being provided.

8.51 Considerable attention was paid to Mother's issues around her past history of domestic abuse and bereavement. There was awareness amongst some of those involved that Mother could be manipulative and was possibly showing disguised compliance however. 'Disguised compliance' is a term that can be attributed to Peter Reder, Sylvia Duncan and Moira Gray in 'Beyond blame: child abuse tragedies revisited' (1993). It involves a parent or carer giving the appearance of co-operating with agencies to avoid raising suspicions, to allay professional concerns, and ultimately to diffuse professional intervention. Mother's dominance of professional attention was an effective way of avoiding scrutiny of her parenting, her drinking and her relationship with Partner. There are clear signs of disguised compliance from Mother throughout the period of this review.

8.52 At the learning event there was agreement that Mother's own needs dominated much of the support provided. The involved professionals also reported having to visit

Mother and the children at home because she would not come to the office, clinic or centre. Mother claimed to be too scared of Father to leave the house, but on other occasions cancelled visits because she was going shopping. This appears to have been largely accepted by professionals and was not challenged as forcefully as it might have been. The reason for her not wishing to leave the house was never really pursued with Mother or challenged, it was accepted that she was scared of meeting Father. However it might also have been due to lack of interest, or due to Mother's low mood and state of mind. Professionals working with Mother allowed her to dominate discussions and for her needs to have priority rather than the children's, who would have benefited from attending child focused groups at the Children's Centre, for example.

8.53 Mother's partner also attempted to manipulate professionals. Mother did not meet with any professional without him being there, and she told the reviewer that he would not allow her to do so. The Midwives told the review of their various attempts to speak to Mother alone, to no avail.

8.54 In April 2011 Ofsted published their fifth report evaluating Serious Case Reviews. Titled 'the voice of the child: learning lessons from serious case reviews' it has a single theme, the importance of hearing the voice of the child. One of the themes identified in this report was that practitioners focused on the needs of parents, especially vulnerable parents, and overlooked the implications of the parent's issues for the child. In this case both children were seen by professionals regularly, but Mothers needs dominated the contact and the threat posed by Father dominated the consideration of risk. Mothers partner, while thought to be somewhat controlling of Mother, did not appear to pose any risk to the children. His care of them was noted to be positive and Mother described him as helpful and a good father.

8.55 Working Together 2013 has legislated to ensure that the 'voice of the child' is addressed more fully by professionals working with children and their families. It states that 'Children should be actively involved in all parts of the process based upon their age, developmental stage and identity. Direct work with the child and family should include observations of the interactions between the child and the parents/care givers'. In this case there is evidence that the children were observed with Mother and Mother's partner, and that the positive relationships seen were felt to be a protective factor in this case. On occasion however HS was not observed during

the visits to Mother and it is not recorded where she was at the time. Recording was dominated by Mother's issues and concerns about her own state of mind and her fear of Father, but despite this the children were evident within the records.

8.56 The CAF in this case was delayed and was predominantly determined by Mother's wishes and needs. It included an expectation that Mother take HS (and then Child H) to stay and play and messy play activities at the Children's Centre, but Mother did not attend and refused all offers of support to get there. Again, Mother's own needs took precedence over the best interests of her children. However when observed Mother was said to be warm and caring with the girls and no concerns were identified about her care or that of Mother's Partner. At the learning event the health visitor stated that HS presented as being a healthy child, her development was good and she appeared to have a good bond with Mother with appropriate levels of warmth and love demonstrated. The issues with her weight were not thought to be significant. Mother did not appear to be depressed, and as the health visitor was not aware of the visits to GP regarding her depression, the health visitor did not consider of the additional strain this would put on Mother and the potential impact on her parenting.

8.57 None of the agency reports stated that the family's background or culture played a significant part in the review. However it should be pointed out that Mother had financial and housing issues around the time of HS's birth. These matters and the impact of the resulting poverty put an additional strain on her and could have had an impact on HS's care in the early months. Professionals involved with Mother were clear however that they recognised that the label of 'mental health' when being considered in respect of Mother needed to be seen within the context of her being terrified and traumatised by the abuse she had suffered from Father. It should also be pointed out that there was a culture of domestic abuse within the wider families, which was not explored to any degree with Mother or her partner.

8.58 <u>Conclusion 3:</u>

It is difficult for staff to remain focused on the needs of the child when parents have complex and demanding needs of their own. As stated in Working Together 2013 'Ultimately, effective safeguarding of children can only be achieved by putting children at the centre of the system, and by every individual and agency playing their full part, working together to meet the needs of our most vulnerable children.' In this

case those involved did record their observations of the children and provided services aimed at supporting Mother with the children as well as with her own issues.

8.59 Conclusion 4:

All professionals working with children and families need to be trained and supported to ensure the needs of the child remains paramount. This should include the provision of reflective supervision, provided by experienced managers who have additional training in safeguarding children, which enables staff to identify and challenge parents who lack the capacity or motivation to change, or who use manipulation and disguised compliance. In this case Mother received services and support on her own terms. While staff did all they could to ensure she engaged with services, the support was not as coordinated as it might have been and this allowed Mother to appear more cooperative then she actually was.

8.60 Thresholds for social work assessment and S47 enquiries.

8.61 There were opportunities for CSC to open the case and undertake an assessment and give consideration to a time-limited child in need plan, such as after Father had made threats to kill, and after the MARAC chair requested a referral be made to CSC and that an assessment be undertaken. It appears that part of the reason that CSC did not open the case at this time was due to the belief that a CAF was in place and in the belief that Mother was cooperating with the team around the child. In hindsight, both of these were optimistic assumptions, and show a degree of uncertainty among the professionals involved regarding whether a CAF was in place in this case, what a CAF involved, and what support and protection it would bring to the children. When considering the decision made by CSC not to undertake an assessment on this case however, it must be acknowledged that CSC receive a high level of referrals regarding domestic abuse on a daily basis, and they have to make difficult judgements regarding whether each case meets the threshold for their intervention. It is the view of the review that in this case, due to the high number of police notifications and the view of the MARAC chair, CSC should have undertaken an assessment.

8.62 In 2010 the Pathway to Provision Multi-Agency Thresholds Guidance was launched in Nottinghamshire. The document states that the purpose of the handbook is to '*support practitioners to identify an individual child's, young person's and/or family's*

level of need and to enable the most appropriate referrals to access provision. It is especially critical that appropriate referrals are made to Children's Social Care to ensure the safety of children and young people in Nottinghamshire'. A number of versions have been published since, but the threshold level stated in the guidance has remained the same in each version. The guidance includes '*definitions and indicators for practitioners to assist in the identification of levels of need for children and young people. It also includes guidance on when to commence the Common Assessment Framework process and/or make a referral to the appropriate service within Nottinghamshire's Pathway to Provision'*.

8.63 When considering the definitions and indicators in the document, it is clear that HS was a child in need of targeted services during the key practice episodes 1 and 2, which is what she received. What is not clear is whether HS or Child H would have met the threshold for level 4 specialist services at any stage, with what was known at the time. Level 4 provision could have included an assessment by and support from CSC. The lack of clarity about whether the threshold was met is due to the following factors:

- Mother was separated from the perpetrator of domestic abuse,
- Mother did not appear to be drinking heavily after the birth of the children,
- Mother did not disclose current mental health issues, other than an understandable degree of anxiety, and possibly some depression, which was said to be around the harassment from Father,
- Mother was apparently cooperating with professionals most of the time,
- the children did not appear to be suffering harm, and certainly not significant harm, and
- Mother's partner appeared to be a stabilising factor, despite some professional concern about his controlling behaviour.

8.64 Despite the above, and despite the MARAC meetings and the proposed CAF, it would have been good practice for CSC to undertake an initial assessment (as it was then) due to the amount of referrals being received. A more comprehensive and multi-agency assessment was never undertaken on the children, or on Mother and Partner's capacity to parent. The occasion where the MARAC chair requested that the case be opened to CSC would have been a good opportunity to consider the wider issues in the family, rather than continue to see Father as the main issue.

8.65 If the assessment had reflected on the impact on the children of Mother's vulnerabilities and extensive needs, and had explored the new relationship between Mother and her Partner, more information may have been available to consider the needs of the children and any risks. If a well managed and executed time-limited child in need or CAF plan was then put in place it would have been evidence based and outcome focused. It could also have involved the extended family as well as the parents. It would have clarified exactly who was involved with the family, and could have made optimum use of the professional's time and expertise.

8.66 Undertaking an assessment of this type would have also ensured that the domestic abuse incidents and Mother's many calls to the Police were not seen in isolation or as one-offs which did not, on their own, meet the threshold for child protection procedures or the involvement of CSC. An assessment would have considered all of the incidents and would have taken into consideration everything that was known about the family across all of the different agencies involved, from the point of view of the children and the parenting they were experiencing or likely to experience, rather than with the domestic abuse focus provided by the MARAC. The CSC agency report points out that at the time the process within that agency was that three contact/referrals in respect of domestic violence would trigger an Initial Assessment. This did not occur in this case. The duty team manager told the agency author that it appears the history was not considered fully when decisions regarding outcomes of contacts/referrals were made.

8.67 There was some evidence of professional curiosity regarding Mother's partner, as a number of professionals had some concerns about him, mostly based on professional instinct and some limited observations of him speaking to Mother in a way that was felt to be harsh and opinionated. The MARAC requested that police checks be undertaken on Mother's partner, and a number of professionals made a point of speaking to each other to find out what was known about him. However no assessment was undertaken that would pool the information and find out more about the relationship between Mother and her Partner and his relationship with the children. The MARAC instigated checks raised no concerns about him.

8.68 There is some question about the extent of the assessments undertaken in regards to Mother's mental health. It is clear she received some sort of assessment at A&E when she came in having taken overdoses after the death of her husband, probably being seen by a psychiatric registrar. Mother was not referred to neonatal or perinatal

psychiatry in or after either pregnancy. This could be because she did not meet the criteria, despite the overdoses, or because she did not wish to receive the service. The Midwife identified a history of mental health issues and the GP diagnosed depression and prescribed anti-depressants after the birth of HS. The adult mental health worker undertook an assessment which led to a recommendation that Mother attend bereavement counselling.

8.69 Conclusion 5:

It would have been good practice, considering the number of referrals, for an assessment by Children's Social Care to have taken place in this case.

9 Conclusions and lessons learned

9.1 The following is a summary of the conclusions and learning from the review, as stated within the analysis above. This is followed by a list of the good practice identified, and consideration of whether the death of Child H was predictable and/or preventable.

9.2 Conclusion 1:

That information sharing and communication between agencies in cases that have a number of professionals involved due to concerns about a child is most effective when the child is subject to a plan which clarifies in writing and through regular meetings what the concerns are, who is involved/responsible and what needs to change. All children who are identified as in need of a plan, (be that a CAF, a child in need plan or a child protection plan) should have parents and professionals working closely together, sharing information, meeting regularly, and working towards stated and shared outcomes. These plans should include extended family members. In this case the information sharing was generally good, but it would have been helpful to the professionals, and to Mother and the children, to have held a CAF meeting earlier.

9.3 Conclusion 2:

This case shows that the risk to children who live in homes where there is or has been domestic violence are intensified where they are additional risk factors present such as problematic alcohol use or parental mental health issues. Even when the violence is thought to be historic, as in this case, the victim may continue to have

issues and their vulnerability can lead to poor choices of future partners and them being targeted by abusive men, which will impact on their children.

9.4 Conclusion 3:

It is difficult for staff to remain focused on the needs of the child when parents have complex and demanding needs of their own. As stated in Working Together 2013 'Ultimately, effective safeguarding of children can only be achieved by putting children at the centre of the system, and by every individual and agency playing their full part, working together to meet the needs of our most vulnerable children.' In this case those involved did record their observations of the children and provided services aimed at supporting Mother with the children as well as with her own issues.

9.5 Conclusion 4:

All professionals working with children and families need to be trained and supported to ensure the needs of the child remains paramount. This should include the provision of reflective supervision, provided by experienced managers who have additional training in safeguarding children, which enables staff to identify and challenge parents who lack the capacity or motivation to change, or who use manipulation and disguised compliance. In this case Mother received services and support on her own terms. While staff did all they could to ensure she engaged with services, the support was not as coordinated as it might have been and this allowed Mother to appear more cooperative then she actually was.

9.6 Conclusion 5:

It would have been good practice, considering the number of referrals, for an assessment by Children's Social Care to have taken place in this case.

9.7 Good practice identified:

It should be noted that by 'good practice' the author wishes to identify things that agencies did that we would wish them to continue doing. In some instances it would be good practice that went beyond what is expected, in others it would be expected practice in the agency.

- It is clear that the professionals involved worked hard to engage Mother and showed an unwavering commitment to her and the children.
- The family were offered a comprehensive package of support which was flexible and accommodating to the family's needs.

- There was a degree of challenge evidenced. For example domestic abuse workers spoke to Mother about her partner when they believed he was being controlling.
- The plan to protect Mother and the children from Father was timely and the relevant resources were available.
- Positive action was taken by Police against Father. This was supported by the CPS. A report published on 27 March 2014 by the HMIC[4] criticised police forces in England and Wales for failing the victims of domestic abuse by not prioritising domestic abuse cases. In respect of Father in this case however, the review found that Nottinghamshire Police were effective in prosecuting him as appropriate.
- The EDT social worker made a recommendation for further action in the context of the history of referrals and known information about the case.
- Consideration was given by the MARAC to Mother's additional vulnerability when she was pregnant.
- Good practice identified between the MARAC liaison, safeguarding and community midwife. Good liaison between the safeguarding nurse advisor and family health visitor.
- The Health Visitor undertook checks with drug and alcohol services to see if Mother was known to them.
- The concerns were taken to safeguarding supervision by health professionals when advice was needed and most of the advice given was followed.
- The MARAC chair arranged for a referral to be made to CSC.
- Checks were undertaken on Mother's partner and established that nothing of significance was known about him across agencies.

9.8 When considering if Child H's death could have been predicted or prevented, a clear conclusion has been reached by this review that the death could not have been predicted and as such would have been very difficult to prevent. The professionals involved recognised that had Father been in contact with the children they would have been right to be very concerned about the risk that he posed to the children. The reviewer was reassured that had this been the case action would have been taken. Mother, had a more detailed assessment been completed, may have been identified as posing a risk of emotionally neglecting her children due to her own

[4] Her Majesty's Inspectorate of Constabulary - who independently assess police forces and policing.

unresolved issues and her drinking. However there was no evidence held by any professional that Mother's partner would be a risk to children.

9.9 As stated above, there was no assessment, child protection investigation or consideration given to a child protection conference by CSC, as there was no evidence available to professionals, either at the time or with hindsight and with all of the information available to this review, that would lead professionals to believe that Child H would have experienced physical abuse from her carers. These children were not considered at risk of harm at any point in the case history, other than in regards to their Father, who was thought not to have any contact. This was an acceptable conclusion for professionals to come to at the time, and this review recognises that the death and probable abuse of Child H was not predictable.

9.10 This review has identified some points in the work with the family which could have led to an assessment into the family's situation by CSC. However, even if an assessment had been completed it is unlikely that Child H's death would have been prevented.

10 Recommendations

10.1 Each agency report submitted to this review has included reflection on its individual learning, and some have made recommendations that are agency specific. The lead reviewer welcomes this and recommends they are followed through and that progress is reported to the NSCB.

10.2 The following changes have been made subsequent to Child H's death:

- Nottinghamshire Police have implemented (February 2014) the Repeat Victim Reduction Plan. This gives Domestic Abuse Investigation Team officers personal responsibility for the management of an individual identified as being a high risk repeat victim. It is expected that it will also ensure that concerns around children in these situations are continually raised, and escalated where necessary.
- The date of child safeguarding update training is now checked routinely as part of the annual GP appraisal process across Derbyshire & Nottinghamshire.
- The Multi-Agency Safeguarding Hub (MASH) became operational in December 2012 and is staffed by professionals from social care, education, health, police (CAIU and DASU), early help, probation and adult safeguarding. The MASH is

the county's first point of contact for new safeguarding concerns and has significantly improved the sharing of information between agencies, helping to protect children and adults from harm, neglect and abuse. The MASH in Nottinghamshire is one of only a handful of MASHs nationally that handles concerns about both children and vulnerable adults, taking a holistic family approach.

- The MASH receives all safeguarding concerns (called MASH enquiries) and for those that meet the threshold for social care involvement, representatives from the different agencies in the MASH and outside will collate information from their respective sources to build up a holistic picture of the circumstances of the case and the associated risks to the child or adult. Timescales for agencies to provide this information are set. A process of 'social work triage' takes place whereby systems will be checked and all background information, including previous contacts/referrals/enquiries will be read. All MASH enquiries have oversight from a team manager who will decide upon the outcomes of enquires.
- There was significant investment in CSC in 2011 and 2012, and additional social worker and team manager posts were created as it was acknowledged that there was insufficient capacity to respond to demand. Improvements were made, and the duty and assessment service was subsequently judged adequate by Ofsted.
- In March 2014, the NSCB and the Children's Trust partnership introduced the Early Help Assessment Form (EHAF) to replace the CAF documentation. The EHAF is much shorter than the previous Family CAF documentation. The EHAF still uses the Common Assessment Framework to underpin its structure and promotes the involvement of children and families in agreeing what positive change is required. The EHAF aims to provide practitioners across the children's workforce a tool to help them quickly assess need, plan their own interventions and to make onward referral for other services if required. The EHAF has been specifically designed for those practitioners working in universal services such as schools, maternity services and health visiting. The form was consulted on with all partners during November and December 2013.
- A review of the step down processes for cases between Children's Social Care and early help or universal services has been undertaken recently. A new role has been developed, a step down co-ordinator, whose responsibility is to co-ordinate the step down plan. Feedback from front line practitioners in Early Help Services and Children's Social Care felt that this was a more useful job title than Lead Professional. It is envisaged that these changes will improve the uptake

and responses to the early help assessments which have replaced the CAF in Nottinghamshire.

- Following a drive to improve inter-professional communication around safeguarding in primary care (health visitor GP communication) a survey was undertaken in June 2013. This identified that in all of the practices contacted, good systems were in place to share significant information with health visitors and to flag children who were subject to safeguarding concerns. The results of this survey were shared with the NSCB in March 2014. It was therefore felt that the issues identified in this case were not necessarily systemic, but were likely to have been due to practice in the specific GP practice. A meeting has therefore been held with the individual GP practice involved with the family to share the lessons learned from this review and to reaffirm the communication systems within the practice.

10.3 The review considered a recommendation in regards to the need to review the Pathway to Provision to provide clear guidance on the criteria for an assessment by CSC in respect of children who are the subject of Police domestic abuse notifications, and about the threshold for the involvement of CSC in MARAC cases. However the processes around responding to domestic abuse have improved in Nottinghamshire recently. The MASH outlined above is now fully operational and referrals relating to domestic violence are more robustly dealt with. This has been strengthened by the co-location of different agencies, and by the clear escalation process which is now in place for cases where referrers feel appropriate action has not been taken.

10.4 Under the current MARAC procedures each meeting is attended by a manager from Children's Social Care and therefore safeguarding issues are taken back by that manager for further consideration and action. This is significantly different from the previous processes. It was therefore agreed that a further recommendation was not required in either of these areas.

10.5 The recommendations of this overview report are to be monitored by the Serious Incident Review sub-group of the NSCB, along with those made in the agency reports. They are:

<u>Recommendation 1</u>:

NSCB to share the learning from this review with staff across all partner agencies and with the Safer Nottinghamshire Board for wider dissemination.

Recommendation 2:

That the NSCB commissions a multi-agency case file audit that focuses on children who are subject of a CAF (or early help plan) where domestic abuse is an issue, to audit whether the needs of the child are sufficiently considered by professionals involved, whether a key professional is identified and is appropriately coordinating services, and whether any issues of disguised compliance or avoidance of services are being challenged and addressed.

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