DORSET
SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW S25

CHILD M

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November 2017

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PART 1 - INTRODUCTION

Events Leading to this Serious Case Review

1. This Serious Case Review concerns a 2½ year old child who died in 2016 following a vicious assault; after a trial the partner of the mother of the child was found guilty of the murder and is currently serving a lengthy prison sentence. To protect the child's privacy they will be known as Child M.

2. Prior to death, Child M's parents had separated and Child M lived with their mother and her new partner, the couple had been living together for about sixteen weeks before Child M died. The post mortem report on Child M showed that in addition to the injury which resulted in death, there had been a number of other injuries considered to have been inflicted over a number of weeks.

3. The family were known to their GP and the Health Visiting Service, there had also been two domestic incidents which had brought them to the attention of the ambulance service and police, one of which had led to an assessment by Children's Social Care. The assessment did not identify any areas of concern about Child M or a need for ongoing services and the case was closed.

4. Eight weeks before death Child M was seen at the local Accident and Emergency Department with a significant cut on the face which required an overnight stay, referral to a specialist surgeon and stitching under general anaesthetic; at the time this injury was thought to be accidental and no follow up action was taken.

Conducting a Serious Case Review

5. When abuse or neglect of a child is known or suspected and either the child has died or been seriously harmed and there is cause for concern as to the way in which services have worked together to safeguard the child, the Local Safeguarding Children Board (LSCB) has to consider whether a Serious Case Review should be carried out.

6. The Dorset Safeguarding Children Board (DSCB) under Regulation 5 of the Local Safeguarding Children Boards Regulations, 2006, decided the criteria were met for a SCR. The recommendation was confirmed by the Chair of the DSCB and notification of the decision was made to the Department for Education.

7. The purpose of the Review as defined by Working Together is:
    - To establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
    - Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result

- As a consequence, improve interagency working and better safeguard and promote the welfare of children[1]

The Process of the Review

8. An Independent Reviewer was commissioned and the process overseen by a Serious Case Review Group[2], this is a sub group of the Local Safeguarding Board comprised of senior managers and clinicians none of whom had had direct involvement with the case; this group set out the terms of reference.[3] Child M's mother and her partner both had complex and well documented social histories, initial briefings found that it was when the couple met, and family dynamics changed, that the risk to Child M increased.

9. The SCR Group considered what was known about the adults' history, particularly that of Mr SF who was well known to a number of agencies; the Group decided that although it would be useful to explore this, the SCR should focus on Child M's experience and agreed the Review would cover the time from just before Child M's mother's partner moved in with the family to the date of Child M's death, a period of 35 weeks.

10. The SCR Group wanted the Review to explore professional involvement in Child M's life, to review current practice and to avoid the risk that this would be overshadowed by looking at work done in the past with Mr SF; although the Group considered this would be useful, they determined that it would done in a different way, not as part of this SCR.

11. In order not to compromise the criminal proceedings, the SCR Group decided to defer the Serious Case Review until they were completed, this took just over a year.

Method

12. The Review must be conducted in line with Government guidance, "Working Together to Safeguard Children, 2015" which states it should be "proportionate and engage practitioners in the learning."[4]

13. Briefing papers, a chronology and a "reflection on practice" paper[5] were requested from all the agencies with whom the family had contact; the information received was compiled into a multi-agency chronology.[6]

[1] Working Together to Safeguard Children, 2015

[2] See Appendix for a list of SCR Group members

[3] See Appendix

[4] Working Together to Safeguard Children, HM Government March 2015

[5] The Reflection document was in addition to the chronology in which the agency reviewers were invited to reflect on their chronology, agency practice and identify any learning themes

[6] For a list of the agencies involved in the case see Appendix

14. Two meetings were convened for the practitioners who were familiar with the case. The purpose of the events was to agree the facts of the case, why decisions and actions were taken or not taken at the time and identify any gaps in knowledge.

    As well as individual actions, practitioners shared information about the context of the work undertaken, for example workload, resource implications, policy directives and any other systemic factors which might have impacted on practice; the practitioner events were key in identifying the learning from this case.

Involvement of Family Members in this Review

15. Child M's mother, maternal and paternal grandparents were invited to participate in the Review and met with the Reviewer; Child M's father chose not to participate but his parent's spoke about his views. Their views are represented within the report.

Findings and Recommendations

16. The Review addresses professional practice asking the question of who did what and why; it looks at procedures and practice guidance which were in place at the time, the work with the family and any challenges and barriers to effective practice. It also recognises that people work in complex organisations where a range of factors can impact on the nature of the work; where relevant the report includes some research and links with other SCRs which contribute to the learning from this case.

17. The report is presented in three parts, an Introduction, the Facts of the Case, and Analysis, Findings and Learning.

PART 2 - FACTS OF THE CASE

18. This section provides some background information about the family and the involvement of the various agencies, what the practitioners did, what they knew and were thinking at the time. In Part 3 of this report these events are analysed in more detail with a focus on learning.

Anonymisation

In order to protect the privacy of the family names have been changed;

19. Significant family members are:

Child M	Subject of the Review, died in 2016 aged 2½ years
Ms M	Child M's mother
Mr F	Child M's father
Mr SF	Partner of Child M mother

Family Background

20. Ms M was in her late teens when Child M was born. She had had a troubled childhood and had been known to Children's Services, the education social work team, various health services and CAMHS[7] since her early teenage years. Ms M's family relationships were disrupted, home conditions were reported as being "poor" and she moved in with her grandmother when she was fifteen months. Ms M had disclosed abuse, drug and alcohol misuse in her teenage years and was known to have been in an abusive partner relationship before meeting Child M's father.

21. Ms M was referred to the specialist midwifery team when she became pregnant with Child M, she had shared some information about her early life but as she seemed settled during the pregnancy, apart from referring her to the midwife for teenage parents, it was considered that she did not meet the threshold for referral for additional services.

22. Child M was Ms M's only child, little was known about Mr F, Child M's father, prior to Child M's death. Although they never lived together, the couple had been in a relationship for about three years before separating when Child M was aged 2 years. During the time the couple were together Ms M was described by health professionals as having engaged with the universal services and sought advice and medical care appropriately. Child M was developing normally and was up to date with immunisations. The couple had come to the attention of the police once, over a dispute with neighbours.

23. As her relationship with Mr F ended, Ms M began a relationship with Mr SF. Mr SF was well known to a number agencies who had worked with him and his family since he was at infant school. He is known to have been exposed to domestic violence, to have suffered physical, emotional abuse as a child; he had been subject to a Child Protection Plan. Mr SF was referred to CAMHS and taken into the care of the Local Authority; he had multiple placements and was frequently missing from care. He has numerous criminal convictions and prior to meeting Ms M had been in an abusive relationship with a previous partner (he was the perpetrator of the abuse.) Mr SF had been released from prison a few months before meeting Ms M, having served twelve months in custody for robbery and theft; his licence period had ended before their relationship began.

[7] CAMHS - Child and Adolescent Mental Health Service

SUMMARY OF EVENTS

This section summarises the events which took place over a period of 35 weeks. There were no significant events during the first 10 weeks.

Week 10	Ms M and Mr SF begin a relationship
Weeks 10 -14	Ms M sees her GP five times in a month, mixed symptoms
Week 15	Child M is seen by Health Visiting at clinic for 2 year check, there are no concerns about Child M's development
Week 17	Ms M reports to the police that Mr F is making threats to harm Mr SF with knife. Although Ms M later withdraws her statement, a knife is found and Mr F is charged and convicted. The police create a SCARF [8]
Week 26	An ambulance is called, Mr SF is shouting at Ms M who has drunk a bottle of wine, is undressed and has difficulty breathing (panic attack) The Ambulance Service raise a Child Safeguarding Alert and the police create a SCARF The Ambulance Service refer the case to Children's Social Care
Week 26	The case is allocated to a Social Worker for an assessment, there are numerous unsuccessful attempts to make contact with the family because of the change of address
Week 26	Ms M and Mr SF move together to a new area; Health Visiting and Children's Social Care are unaware of the move and are having problems making contact with Ms M to arrange a visit
Week 26	Child M is taken to hospital with deep cut to face and is kept in overnight for stitching under anaesthetic The injury is considered by medical staff to be accidental and no further action is taken
Week 29	Ms M contacts Children's Social Care for advice about contact issues between Child M and Mr F Children's Social Care start the assessment, two visits are carried out
Week 33	The assessment is complete, no safeguarding issues are identified and the case is signed off by a manager and closed.
Week 35	Child M is killed by Mr SF

[8] A SCARF, a Single Community Assessment of Risk Form, used to record an assessment of risk after an incident of a domestic nature and sent on to other relevant agencies for information. These have since been updated and are now known as Public Protection Notices, PPN's

PART 3 – ANALYSIS, FINDINGS AND LEARNING

Introduction

24. This section explores the events in detail with a view to finding out what can be learnt from this case. The learning is described thematically, the Learning Themes are:
    - The Relevance of Family History in Risk Assessment
    - Effective Information Sharing Pathways

The Relevance of Family History in Risk Assessment

The Adults

25. Ms M became pregnant in early 2013, she was aged 18. Although Ms M had had a very difficult time as a child and in her teenage relationships, there was little indication of any problems with the pregnancy or with her relationship with Child M's father. Apart from one report of the couple becoming embroiled in a domestic incident with neighbours, they did not attract attention.

Child M's Early Life

26. Child M was born in late 2013; weight was within normal limits. Within a few weeks of birth Child M was diagnosed with a problem which affected the ability to feed and led to a number of hospital appointments; Ms M engaged well with the services, took Child M to appointments, was receptive to advice from the GP and Health Visiting service and engaged well with support provided to help her manage feeding and sleep. Child M gained weight and was up to date with immunisations. In the light of Child M's progress, the need for the Health Visiting Service was assessed as "universal" which means that visits are made as necessary with parents being encouraged to use the local clinic for weighing and advice. [9]In effect, apart from some support with sleep and feeding, the family had very little contact with Health Visiting during the period of this review.

27. Child M's father, Mr F, was living abroad when Child M was born, he returned to the UK when Child M was about ten months old. Mr F's family described Ms M as a dedicated and competent mother and Mr F as a hands on father who enjoyed caring for his child. Mr F and Ms M were described as having an "on and off relationship" and when they finally separated, Mr F continued to see Child M, and sometimes staying over for weekends.

28. There were no referrals to services except for the call to the police following Ms M's dispute with neighbours during which the police described Mr F as being "supportive."

[9] Contacts are offered following the 0-5 Healthy Child Programme

29. Child M's family described Child M as a gentle, easy going child who liked books, bikes and trains and also playing with dolls and prams; they said Child M was a quiet and loving child. Child M liked being out of doors, going to the park and feeding the ducks.

Ms M and Mr SF's relationship

30. From the outset of this Review the SCR Group recognised that there was a significant change in the dynamics of this family when Ms M began her relationship with Mr SF.

31. Having not attracted attention for two years, during the eight months leading up to Child M's death, indicators of change included:
    - Having had little contact with her GP previously, in the early weeks of her relationship with Mr SF, Ms M visited the GP five times in a month
    - Ms M and Mr F were involved in a domestic incident where Mr SF was threatened by Mr F (1st SCARF)
    - Health Visiting found Ms M became increasingly hard to contact, she didn't respond to messages and was not at home for planned visits
    - An ambulance was called to a domestic incident between Ms M and Mr SF which led to a referral to Children's Social Care (2nd SCARF)
    - Child M had a serious cut to the face which required an overnight stay in hospital
    - Ms M contacted Children's Social Care asking for advice about contact issues

32. Taken in isolation, none of these events caused the professionals concerned to consider that Child M was at risk of harm.

33. We now know that Mr SF had a complex and sometimes violent past. He had a long history of mental health issues, he was 21 years old when he started his relationship with Ms M (she was 22) and had just been released from prison; he had been accused of domestic violence in his previous relationship and was known to have drug and alcohol issues. Having been in care had been known to the Leaving Care Team and had been assessed as a potential risk to women.

34. Ms M was a vulnerable young parent, although she appeared to have had a stable two years, her early history indicated that she had issues in her own childhood which were likely to impact on her adult relationships and her choice of partner.

Recognising Risk and Vulnerability

35. Looking back at Serious Case Reviews over the past ten years, Pathways to Harm, Pathways to Protection[10] shows that over half the children who are subject to a SCR "*are below the threshold for Children's Social Care and therefore all those working with children and families need to be alert to a child's need for protection in their every-day work*."

36. Very often the risk to children below the threshold for child protection intervention is not made clear until all the information known about the family is collated during the process of a Review. In this case although there was some information indicating Child M might be at risk, no one agency had a complete picture of the nature of family relationships and what the implications might be for Child M.

The Role of the GP

37. The first indication of a possible change in family dynamics came when Ms M, having had very few attendances in the previous two years, attended the GP surgery five times in a month. In hindsight, the GP reviewing this case pointed out that the presenting symptoms might have been indicative that she was in a new sexual relationship, the victim of domestic abuse or suffering some emotional problems. The GP records clearly set out Ms M's early history and suggest she was vulnerable, however the GP did not ask any questions about a possible change in circumstances and treated each medical condition as it presented.[11]

Learning Point:

- For *all agencies* it is important to notice patterns of behaviour particularly when there are changes and to consider the possible significance of this. This is especially important when considering the parenting capacity of a young parent with a complex history.

First Domestic Incident

38. When Child M was two years old, about five months before death, Child M was seen at the clinic by a member of the Health Visiting Team for the two year developmental check; Child M was developing normally and there were no concerns about this care. A month later the police were called to a domestic incident between Ms M and Mr F;

[10] Pathways to Harm, Pathways to Protection: a triennial analysis of Serious Case Reviews 2011 to 2014 [11] Following recognition of the need for greater awareness of domestic abuse and identification of potential presentations GP surgeries, the role of Domestic Abuse Lead Practitioners is being developed, supported by information sharing and supportive supervision from the CCG.

the couple had separated and Ms M had begun a new relationship with Mr SF. Mr F is alleged to have threatened Mr SF with a knife, although Mr SF was not actually present at the scene. Ms M who called the police, later retracted her statement saying she was trying to cause trouble for Mr F, however the knife was located and Mr F later appeared in court and was convicted of an offence.

39. The police wrote up a SCARF (assessment of risk) which, in line with policy, was passed to the Health Visiting Team and Children's Social Care. In describing the incident, the SCARF focussed on Ms M and Mr F and, because Child M was not actually present, did not include the name of Mr SF against who the threat was made. This meant that, at this stage, none of the professionals knew that Mr SF was living with Ms M. There was no information recorded about why Mr F was angry with Mr SF beyond possible jealousy, enquiries made since the incident suggests the two men did not previously know each other.

40. Health Visiting followed up the SCARF report with a telephone call to Ms M during which Ms M reassured the Health Visitor that all was well. The focus of the conversation was on Mr F and his anger; Ms M allegedly told the Health Visitor that Mr F was accessing help with his anger issues through the police, although this was untrue. The Health Visitor offered a home visit but Ms M said this wasn't necessary, the Health Visitor concluded that the risk to Child M was minimal because Mr F was no longer in the family home.

41. Although practice guidance indicates that following up a SCARF with a phone call is acceptable, two opportunities were lost at this point. Firstly the Health Visitor did not have access to Ms M's history; this was because eighteen months earlier agency recording became electronic and the information which would have indicated Ms M's vulnerability had not been transferred to the electronic file. [11] Secondly, it is debatable whether a home visit should have been made. Although the Health Visitor did not consider this was necessary, had Ms M been seen, it is possible that Mr SF's presence in the family might have come to light which would, in turn, have provided an opportunity to explore the implications of the new family set up at an earlier stage. A home visit would also have provided an opportunity to see Child M; although Ms M said Child M did not witness the incident, both men were actively involved in the child's care, yet little was known about Child M's experience of family life.

42. Children's Social Care receive on average over 500 contacts from the police each month, including notifications of serious risk to children, of domestic abuse and some low level anti social behaviour. Each report is seen by a manager who decides on an appropriate response. In this case, as the team were not able to reach the family by telephone, a letter was sent to Ms M reminding her of the need to protect Child M and to seek help and advice if she needed it.

[11] When the paper records became electronic, some information was transferred on to the electronic files but this was limited to a summary of "significant" information which meant that historical background information was not known to the Health Visitor.

43. The outcome of the SCARF was that it was explored as an isolated incident by both Children's Social Care and the Health Visitor, who on the basis on what was known at the time, took no further action.

Learning Points:

- Relying on self-reporting, particularly from a parent with a previous history of domestic abuse and who is in a new relationship, runs the risk that an incomplete picture will emerge. Effective safeguarding practice requires all professionals to consider their knowledge of domestic abuse, the predisposing factors and most importantly, the impact on children.

- Although Mr SF was not actually present when the threat was made against him, to be effective, enquiries should consider all the adults named in domestic incidents.

Second Domestic Incident

44. Two months after the first domestic incident, Ms M and Mr SF were living together when Mr SF called an ambulance. The reason for the call was that Ms M was having a panic attack and couldn't breathe properly, she was reported to have drunk a bottle of wine and to be undressed and vulnerable, Mr SF was noted to be shouting abuse at her during the 999 call. Child M was not present and advised that child was staying with father.

45. The ambulance staff were concerned about the incident and in line with their procedure, raised a Child Safeguarding Alert which went to Children' Social Care as a referral. The police were notified and completed a SCARF.

46. The police however, in completing their paperwork, did not identify that it was Mr SF (who was well known to them) who was involved in the incident. Because Mr F and Mr SF have the same first name, the police having completed a SCARF two months earlier in which Mr F was identified, assumed the adult male with Ms M was Mr F. This meant that the police, in making background checks on the adults, missed the opportunity to identify Mr SF as a member of the household. Had they have done this, the details would have been on the SCARF and background checks would have alerted both Health Visiting and Children's Social Care to the presence of Mr SF in the family.

Learning Point:

- Background checks on the adults involved in domestic incidents are a vital part of safeguarding practice; the checks need to be based on accurate information in order to be effective and all adults involved in the incident should be clearly named. Appropriate sharing of the information within the professional network can then enable a picture to be built up over time leading to a more accurate assessment of risk.

Response of Health Visiting

47. On receiving the SCARF, Health Visiting made several unsuccessful attempts to contact Ms M, not knowing that she had moved. There were two Health Visitors working this case at the time and the agency's own review has concluded that, in hindsight, there should have been a more robust response to this incident. When Children's Social Care indicated they would be carrying out an assessment, the Health Visitors decided to wait for the outcome of the assessment before visiting again. Although the Social Worker carrying out the assessment did contact the Health Visitor for information, the agency did not ask for or receive any feedback from Children's Social Care about the outcome of the assessment.

48. There were two factors which hindered the Health Visitors practice, one was the transfer to electronic recording mentioned earlier in this report, and the other was the practice of corporate case load management in place at the time. This meant that cases were shared between two workers and the team. In this case messages were passed between the two Health Visitors when attempts to contact Ms M were unsuccessful, but it was not clear who was going to follow up the information. When it became known that the family had moved to a different area, Health Visiting were waiting for the new address and Child M died before the new Health Visiting Team became involved.

49. The Health Visiting Service has reviewed the practice of corporate case load management and put systems in place to ensure lead workers are clearly identified and to improve team communication.

50. The GP did not receive a copy of the SCARF and remained unaware of the domestic abuse incident. Communication pathways are discussed later in this report.

Learning Point:

- For all agencies, if more than one worker in the same agency is involved in a case there needs to be clarity about who is responsible for what and clear lines of communication.

- Effective communication is a two way process which requires the agencies involved to both seek and share information.

- Multi-agency working and co-operation is central to safeguarding practice, each agency brings different knowledge and experience to a case. Care should be taken to avoid relying on Children's Social Care to follow up incidents; joint visiting can be very effective when following up domestic abuse referrals involving young children.

Hospital Admission and Risk Assessment

51. A week after the ambulance had been called to the domestic incident, an ambulance was again called by Mr SF, this time because Child M had a serious cut on the face running from the top of the ear to the corner of the mouth. Ms M accompanied Child M to hospital where there was an assessment in the Emergency Department, transferred to a paediatric ward and referred to a specialist surgeon for the cut to be stitched under general anaesthetic. Mr SF did not go to the hospital; Ms M was accompanied by several other family members.

52. At each stage of the examination and treatment of Child M, the health and medical staff asked about the cause of the injury. Each time they were given the same explanation by Ms M, which was that Child M had fallen onto a plate which had then broken, cutting the face. Each time Ms M described the incident as if she was there and had observed what had happened.

53. During the practitioner event, some medical staff reported that it was not particularly unusual in their experience for a two year old to have an accident which resulted in facial injuries. Having considered the nature of the injury and spoken with Ms M none of the health staff considered it necessary to refer the matter as a possible nonaccidental injury, however the seriousness of this injury should have prompted staff to think more broadly.

54. Hospital staff asked Ms M if she had a social worker, reporting that she replied that she didn't. (At this point a referral had been made by the ambulance service following the domestic incident however, during this review, Ms M alleges she was unaware of the referral until she contacted Children's Social Care two weeks later)

55. Hospital staff were alert to any inconsistencies in the story but none were noticed; to Child M's demeanour, child was content and played happily, and to Ms M's parenting, she was calm and loving and reassured Child M throughout the hospital stay. Ms M's family appeared appropriately supportive. In conclusion and after careful thought about the possibility of any non-accidental injury, hospital staff concluded Child M's injury had been caused accidentally and there was no reason to make a referral to Children's Social Care.

56. The hospital in making their assessment of risk to Child M had no information other than that given by Ms M; they were not aware of Mr SF's presence in the family. Following Child M's murder eight weeks later, and after an exhaustive police investigation, we now know that Ms M had misled staff into thinking she had been present when Child M was injured but in fact Mr SF had been alone with Child M.

Was this a missed Opportunity?

57. From the chronologies and discussion in the Practitioner Events it became apparent that none of the hospital staff asked Child M about the injury and how it had happened. The staff report that they were anxious to avoid causing Child M any distress and in the busy hospital setting during a relatively short stay, no one had the opportunity to form a relationship with Child M which might have encouraged Child M to speak about the incident. Had they had any concerns about the injury they might have sought an opportunity to pursue this.

58. Child M was aged 2½ at the time and according to the family, was able to express themself quite well. It is noted that just after the hospital visit Child M told a relative very clearly that Mr SF had caused the cut, describing the event with actions to emphasise the point. Child M's family did not take any action because**,** they said, they were unsure whether or not to believe Child M and didn't want to cause any friction or make already tense family relationships worse. Child M's family report that, in hindsight, they could never have imagined Child M was being deliberately hurt.

59. The nature of the injury and whether it was likely to have been deliberately inflicted formed part of the criminal trial which took place after Child M's death. There are differing views about whether the injury to Child M's face was likely to have been accidental and during the trial an expert witness gave evidence which stated in his view, it was almost definitely non-accidental.

60. Along with causing Child M's death, Mr SF was charged with causing the cut to Child M's face and although he was found not guilty of that offence[12] the SCR Group concluded that, given the site and nature of the injury and the fact it happened in the child's own home, it should have been regarded as concerning, that safeguarding advice should have been sought and a referral to Children's Social Care considered. Even if the injury had been an accident, Child M had been seriously hurt and this should have prompted action to address accident prevention.

Learning Points:

- The 2011 – 2014 Analysis of Serious Case Reviews shows that over half of children killed or seriously hurt are below the threshold for the involvement of Children's Social Care; whilst agency checks are an important part of assessing risk, the information available may be very limited and care needs to be taken not to be falsely reassured.
- We now know that Ms M was not present when Child M's face was cut, it is important that when assessing an injury that all professionals are thoughtful about the possibility of being misled by parents and making assumptions about who was present at the time. It may be necessary to ask family members direct questions.
- In this case Child M was observed at the hospital to be a happy, contented child however Child M had sustained a very serious injury; asking a child directly to describe how the injury occurred through simple, natural conversation, has the potential to elicit valuable information.

Discharge Summaries

61. When a child is discharged from the paediatric ward, a discharge summary should be sent to the GP who will have broader understanding of the family and can review the incident in a wider context. This also has the benefit of logging information which can be shared with the Health Visitors or Children's Social Care if they make an enquiry about the child.

62. In this case the information was logged at the GP's surgery "weeks after the discharge" but at the time, there was no system in place to determine who had seen it or for the information to be shared in a consistent way with the Health Visitors.

[12] The standard of proof for a criminal conviction is that to find the defendant guilty of an offence the jury must be convinced "beyond reasonable doubt."

63. The hospital reported that, having reviewed this case, they would have expected to see that a telephone call had been made to the Health Visiting team to inform them of the injury and treatment. Although this was on the patient notes as an action to be taken, it was overlooked and the call was never made; this meant that the Health Visiting team were unaware of the incident.

64. During the practitioner events some staff reported longstanding problems with the communication of discharge summaries indicating they were not sent out consistently or in a timely way. The reason for this failure is unclear, possibly the system failed because it was a bank holiday; the conclusion is that systems were not sufficiently robust. Since this case, changes have been made and GP's now receive the discharge information electronically.

65. Had the Health Visiting Team received this information, they report that this would have "significantly altered how they managed this case" and that they would have made a home visit and discussed the injury with Ms M and possibly with Child M. Although we cannot know if a visit at this time would have changed the direction of this case, the lack of effective information sharing meant an opportunity was lost.

66. During this review, The GP reported that although Child M's presentation at the hospital seemed unusual, they assumed that the hospital had made the necessary checks and were satisfied that there was no need for a referral to Children's Social Care and therefore no further action was required.

67. Since this case the Clinical Commissioning Group (CCG)[13] have led an initiative to ensure all GP surgeries are maintaining their safeguarding responsibilities and highlighting updates within safeguarding practice. This includes the need to collate safeguarding information in a nominated place and for clinicians to promptly review the information, decide on what action needs to be taken and make a note of decisions.

Learning Points:

- Discharge summaries provide an opportunity for community health staff to consider events in a broader family context. In order to be effective, the summaries need to be communicated to the right people in a timely way.

- All agencies should be alert to the risk of making assumptions about the judgements and decision making of others. Practitioners should keep an open mind and, if concerned, ask questions, particularly when a baby or young child presents with an unusual injury.

[13] The Clinical Commissioning Group oversees the work and practice development of GPs

Assessment by Children's Social Care

68. The assessment by Children's Social Care was in response to the Ambulance Service referral following the domestic incident during which Ms M was noted by the service to be drunk, naked and having a panic attack with Mr SF shouting and verbally abusing her. Although this had occurred before Child M's face was cut, difficulties in contacting Ms M meant the assessment started after that incident.

69. It is usual practice to consult other agencies when undertaking an assessment and the allocated Social Worker contacted the Health Visitor. The Health Visitor had little information to offer because they had not had recent contact with Ms M, were unaware of the hospital admission and the cut on Child M's face and did not know Mr SF was present in the household.

70. The police SCARF, which came at the same time as the Ambulance Service referral, had assumed the male in the household was Mr F, therefore the Social Worker was also unaware that Mr SF (who was well known to Children's Social Care) was living in the household.

71. The referral information led the Social Work Manager to consider the case was relatively straightforward and it was allocated to a newly qualified social worker.

The Assessment, Quality and Outcome

72. The Social Worker was tenacious in attempting to contact Ms M, by leaving telephone messages, by letter and by making unannounced visits. After two weeks Ms M had not responded, she had in fact moved house but none of the agencies was aware of this. Ms M alleges she did not know the Social Worker was trying to contact her but, by coincidence, telephoned the Social Work office in the area where she was now living to ask advice about the contact arrangements between Child M and the father. Ms M was worried about Mr F being inconsistent and also about his housing arrangements which she felt were unsuitable for a child.

73. Having obtained the new address, the Social Worker was able to visit and carry out the assessment which was completed over two visits, Child M and Ms M were present during the visits, the Social Worker did not meet or speak to Mr F or Mr SF.

74. When the Social Worker first arrived, Ms M immediately thought the visit was about the cut to Child M's face. The Social Worker immediately saw the scar on Child M's face and asked Ms M about this; the worker was reassured by Ms M that Child M had been seen by hospital staff who considered the cut to be accidental and that there was no need for a referral. The Social Worker, like the hospital staff, assumed Ms M was present when the incident occurred.

75. The Social Worker explained to Ms M that the focus of the assessment was the referral concerning the domestic incident and they also discussed Ms M's concern about Mr F and the contact with Child M.

76. Ms M told the Social Worker about her relationship with Mr SF, she reported that they had been in a relationship for about four months. Ms M spoke about Mr SF positively, she said he was helpful when Child M had the accident; Ms M reported the domestic incident which led to the referral was an argument "over nothing" and she had no concerns about domestic abuse. The conversation then shifted to Mr F and the contact arrangements and the Social Worker gave Ms M some advice. The Social Worker made a note of Mr SF's details and Ms M agreed that some background checks would be made. The assessment was recorded using the prescribed format which indicated Child M was seen alone; comments describe Child M as as "happy" and "chatty" there is no indication that the Social Worker asked about the cut to the face. The assessment format includes "Family History" and information about Children's Social Care's involvement in Ms M's early life had been lifted from the files.

77. The assessment "analysis" is brief and too narrowly focussed, it makes no mention of Ms M's history or any relevance it might have regarding her parenting capacity; it indicates that managing contact in an appropriate way was the priority for Ms M.

78. Following the visits the Social Worker attempted to make background checks about Mr SF but the information available on the system was not seen. It appears that the Social Worker was unfamiliar with the IT system and wrongly assumed that old paper files needed to be requested.

79. The assessment concluded that there were no safeguarding concerns regarding Child M and that Ms M was "acting appropriately in regard to contact." The Social Worker did request the paper files but the case was signed off by a manager and closed before they arrived.

80. Child M was murdered by Mr SF two weeks after the case was closed.

Was this a Missed Opportunity?

81. There is no evidence that Child M's death could have been predicted. There was information available, but not seen by Children's Social Care which would have indicated that Mr SF posed a risk to women and potentially to children; even if this had been seen before the assessment was signed off, any further action or work within the Child Protection framework would have taken time to get underway.

82. The Assessment however was not sufficiently robust; Ms M dismissed the domestic incident as unimportant and the Social Worker didn't feel it was necessary to explore the matter further. Although Ms M and Mr SF had a history of domestic abuse as children and in adult relationships and there had been a previous SCARF report, these

factors were not addressed in the assessment analysis. The decision not to see the alleged perpetrator of the domestic abuse meant that a valuable opportunity was lost. Ms M appears to have set the agenda for the visit and, by discussing her concerns about Mr F, dictated the focus of the assessment; Ms M was observed to be warm and caring and this helped lead the Social Worker to conclude she was able to protect Child M.

83. The information Ms M provided about Child M's facial injury indicated that there was no concern. However the site and severity of the injury might have prompted the Social Worker to check with health staff that Ms M's account was reliable. We now know that Ms M wasn't at home when Child M was injured and although Ms M misled the professionals into assuming she witnessed the incident, further enquiries might have shed more light on the situation.

Learning Points:

- For an assessment to be effective, details about past history and current circumstances must be considered together in order to achieve a complete picture. Understanding who is in the child's life and the nature of the child's relationships is essential when assessing risk.
- Chronologies and genograms are useful tools which can enable practitioners to gather information about family members, relationships and earlier events. For assessments to be effective, referral information needs to be looked at within the context of family life.
- Research indicates that women tend to minimise the significance or impact of domestic abuse; they may not realise that, what they perceives as care and attention, can be coercive control. If a parent is in an abusive relationship it is important to consider the potential impact of the relationship on parenting capacity and the possibility that children might also be subject to physical abuse.

Hearing the Child's Voice

84. Following Child M's death, the investigation showed that Child M had a number of injuries of differing ages indicating there was "physically abused over a number of months."[14] Also during the investigation Child M's family made several references to changes in Child M's behaviour, some of which, Ms M said, led her to consider installing a camera in Child M's bedroom to observe when she wasn't there.

85. As part of the Social Worker's assessment Child M was "seen alone;" this is encouraged within the assessment process in order that the child's voice can be heard through observation and/or direct conversation depending on their age and

[14] From Post Mortem Report

development. The assessment makes direct reference to Child M's appearance and how Child M "chatted" with the Social Worker however this appeared to add little of value to the assessment.

86. The NSPCC in their paper *Ten Pitfalls and How to Avoid Them*,[15] state:

> *"... seeing the child in the early stages of work must equate to more than just "ticking a box" and should constitute a detailed qualitative observation (Aldgate et al, 2006). Hart and Powell (2006) stated that a case file should give "a real sense of the day-to-day experiences" of the child. The practitioner should be able to picture what life is like for particular children in their families."*

87. The use of vague or subjective language has also been identified as a potential pitfall for all agencies in assessment practice, for example describing a child as "cheerful" or "happy" *at the time* of the assessment adds little to the evidence without information about the child's health and development. For example in this case asking about any accidents or injuries or unusual behaviour, or asking Child M directly how the face was cut might have elicited more information.

88. Alyson Leslie in Serious Case Review, CH, 2015,[17] gives some useful guidance, she says:

> *"The most important theme to emerge from the extensive documentation of (the CH case) is the importance of* ***understanding and responding to the child's perspective.*** *This is perhaps a more helpful way of thinking about "listening to the voice of the child" which suggests a conversational approach to a child. She goes on to say that "professionals must be attuned to understand the impact on a child" of their experience of the place where they live and the people with whom they spend most of their time."*

89. The learning from this case reinforces the risk of relying solely on a parent's self reporting and importance of retaining a child focus during an assessment.

Learning Points:

- Asking the question "what is life like for a child in this family?" will help practitioners retain a child focus; this is especially relevant when there are changes in the child's significant family relationships.

[15] Ten Pitfalls and How to Avoid Them, what research tells us. Dr Karen Broadhurst, et al, September 2010 www.nspcc.org.uk/inform [17] Haringey LSCB, 2015

Invisible Fathers

90. Following discussion of the referral information, the focus of the assessment shifted on to Ms M's agenda, Mr F's contact. The Social Worker's observations about the need for this to be a positive experience for Child M were well thought out. Missing from the assessment was any communication between the Social Worker and Mr F about the contact or with Mr SF about the domestic abuse referral; this had the potential to shed light on the first domestic incident, when Mr F had threatened Mr SF, on the adult relationships, parenting capacity and potentially on Mr SF's relationship with Child M.

91. During the assessment Ms M spoke about Mr SF in positive terms, describing him as helpful and supportive. The Social Worker was diligent in asking for Mr SF's details and telling Ms M she was going to make some checks on the data system but, before this happened, the assessment was signed off by a manager who agreed with the Social Worker that there was no ongoing role for Children's Social Care.

92. The NSPCC research, Hidden Men, Learning from Case Reviews[16], summarises the benefits of involving fathers and male carers in assessments and planning, pointing out the need to inform them of any concerns, offer services where appropriate and identify circumstances where non-resident fathers may be providing family support. The paper highlights two possible scenarios:

- Men who posed a risk to children which resulted in them suffering harm
- Men for example, estranged fathers, who were capable of protecting and nurturing the child but were overlooked by professionals

Learning Points:

- "Men play an important part in children's lives and have a great influence on the children they care for; despite this they can often be overlooked by professionals who focus almost exclusively on the quality of care children receive from their mothers and female carers." (NSPCC)

Contextual Factors

Assessment Format

93. The information from the assessment carried out by Children's Social Care was incomplete, fragmented, hard to follow and not sufficiently evidence based; the reason for this was partly due to the format used. For example, in the view of

[16] Hidden Men, Learning from Case Reviews, NSPCC, 2010

Children's Social Care, the format does not sufficiently prompt the Social Worker to consider the impact of the adults own history on parenting capacity. A new format for assessing parenting capacity is currently being developed.[17]

94. The assessment process also missed out the stage known as a "progress review" intended to take place within 10 working days of the decision to carry out an assessment. This review would have provided an opportunity for the Social Worker and the Manager to discuss the case and, for example, to decide the depth of assessment required, ensuring it was "proportional"[18] and the timescale for completion. It appears that this discussion did not take place because at the time it was due, it had not yet been possible to contact the family. Even though the family had not yet been seen, an early review would have provided an opportunity for Children's Social Care to consider more fully what was known about this family and how the assessment should proceed, who needed to be seen and how the information would be gathered and analysed. A further review date could have been agreed at this point to consider the work required beyond the initial visit, this was especially important as the allocated worker was newly qualified.

95. The case was assumed by Children's Social Care from the outset to be a low level Child in Need case and the assessment was seen as confirmation of this view. "Confirmation bias" has been identified as a human factor which, in the context of safeguarding, is evident when practitioners form a hypothesis on limited information and do not seek out evidence which may not fit the original view.

Learning Point:

- Research has shown that staff can develop a fixed view about a case early on in the process and seek information which confirms this view, known as "confirmation bias"; with an awareness of this tendency, practitioners can challenge themselves to ask what they don't know about a family or if there is any information which might challenge their view.
- Rigorous supervision, safeguarding advice and management support is essential to ensure practitioners have adequate knowledge of risk factors, to help them reflect on their cases, think systemically about risk and avoid over optimism.

[17] This is a new tool developed to give greater emphasis to parenting capacity. Ongoing work also includes recognition of the need to include fathers and male carers.

[18] Since the concept of Initial Assessments and Core Assessments had been replaced by a single assessment, the worker and manager are expected to discuss the case and agree how detailed the assessment needs to be and how long it should take to complete.

Information Sharing Pathways

96. In addition to some missing detail in individual documents it became evident during this review that that there is urgent work to be done on developing effective information sharing pathways. This is of particular importance for the flow of information between health staff, from hospital to the community and between GPs and Health Visitors.

97. In this case:

- The discharge summary from the hospital where Child M's cut face was treated was received by the GP three weeks after the incident and there is no record of who saw it. The Health Visitor did not receive any notification of the hospital visit
- As a consequence an opportunity for the Health Visitor to follow up the event with Child M and the family was lost. When the Social Worker contacted the Health Visitor for information for Children's Social Care assessment, the Health Visitor didn't know about the hospital visit
- The first SCARF reports were sent to the Health Visitor in the expectation the information would be shared with the GP which didn't happen in this case

98. Child M died in 2016 and work is in hand within health systems to improve communication; IT is gradually improving and systems are becoming more compatible and more robust. In GP surgeries systems are being implemented for the receipt and acknowledgment of all safeguarding information.

99. There is further work to be done on information sharing between GPs and Health Visitors and between hospitals and the community.

SUMMARY OF LEARNING

i) For *all agencies* it is important to notice patterns of behaviour particularly when there are changes and to consider the possible significance of this. This is especially important when considering the parenting capacity of young parents with a complex history.

ii) Relying on self-reporting, particularly from a parent with a previous history of domestic abuse and who is in a new relationship, runs the risk that an incomplete picture will emerge. Effective safeguarding practice requires all professionals to consider their knowledge of domestic abuse, the predisposing factors and most importantly, the impact on children.

iii) Although Mr SF was not actually present when the threat was made against him, to be effective, enquiries should consider all the adults named in domestic incidents.

iv) Background checks on the adults involved in domestic incidents are a vital part of safeguarding practice; the checks need to be based on accurate information in order to be effective and all adults involved in the incident should be clearly named. Appropriate sharing of the information within the professional network can then enable a picture to be built up over time leading to a more accurate assessment of risk.

v) For all agencies, if more than one worker in the same agency is involved in a case there needs to be clarity about who is responsible for what and clear lines of communication.

vi) Effective communication is a two way process which requires the agencies involved to both seek and share information.

vii) Multi-agency working and co-operation is central to safeguarding practice, each agency brings different knowledge and experience to a case. Care should be taken to avoid relying on Children's Social Care to follow up incidents; joint visiting can be very effective when following up domestic abuse referrals involving young children.

viii) The 2011 – 2014 Analysis of Serious Case Reviews shows that over half of children killed or seriously hurt are below the threshold for the involvement of Children's Social Care; whilst agency checks are an important part of assessing risk, the information available may be very limited and care needs to be taken not to be falsely reassured.

ix) We now know that Ms M was not present when Child M's face was cut, it is important that when assessing an injury all professionals are thoughtful about the possibility of being misled by parents and making assumptions about who was present at the time. It may be necessary to ask family members direct questions.

x) In this case Child M was observed at the hospital to be a happy, contented child however a serious injury has been sustained ; asking a child directly to describe how the injury occurred through simple, natural conversation, has the potential to elicit valuable information.

xi) Discharge summaries provide an opportunity for community health staff to consider events in a broader family context. In order to be effective, the summaries need to be communicated to the right people in a timely way.

xii) All agencies should be alert to the risk of making assumptions about the judgements and decision making of others. Practitioners should keep an open mind and, if concerned, ask questions, particularly when a baby or young child presents with an unusual injury.

xiii) For an assessment to be effective, details about past history and current circumstances must be considered together in order to achieve a complete picture. Understanding who is in the child's life and the nature of the child's relationships is essential when assessing risk.

xiv) Chronologies and genograms are useful tools which can enable practitioners to gather information about family members, relationships and earlier events. For assessments to be effective, referral information needs to be looked at within the context of family life.

xv) Research indicates that women tend to minimise the significance or impact of domestic abuse; they may not realise that, what they perceive as care and attention, can be coercive control. If a parent is in an abusive relationship it is important to consider the potential impact of the relationship on parenting capacity and the possibility that children might also be subject to physical abuse.

xvi) "Men play an important part in children's lives and have a great influence on the children they care for; despite this they can often be overlooked by professionals who focus almost exclusively on the quality of care children receive from their mothers and female carers." (NSPCC)

xvii) Research has shown that staff can develop a fixed view about a case early on in the process and seek information which confirms this view, known as "confirmation bias"; with an awareness of this tendency, practitioners can challenge themselves to ask what they don't know about a family or if there is any information which might challenge their view.

xviii) Rigorous supervision, safeguarding advice and management support is essential to ensure practitioners have adequate knowledge of risk factors, to help them reflect on their cases, think systemically about risk and avoid over optimism.

CONSIDERATIONS FOR THE DSCB

100. The process of this Review worked smoothly, the Individual Agency Reviews (IARs) identified the key issues from the case and reference has been made in this report to agencies who have begun to disseminate learning and make necessary changes to strengthen the safeguarding systems.

101. Attendance at the practitioner events was good and those attending participated actively in assisting with analysis of events and identifying learning from the case. Most of the learning applies to all the agencies who worked with Child M and the family.

102. For the DSCB the predominant features of this case are the importance of:

- robust and relevant information gathering, risk assessment and effective information sharing; all the agencies involved in this case need to improve practice in these areas
- the need for health staff to recognise what constitutes a concerning event for a child within a hospital setting and the need to seek safeguarding advice appropriately.

103. In order to address the findings from this case the DSCB should ensure that all staff have access to relevant, good quality training, supervision and safeguarding advice which is monitored and evaluated as part of the quality assurance framework.

104. In addition the DSCB should satisfy itself that:

- Domestic Abuse training is available which enables the workforce to understand coercive control in relationships, its impact on parenting capacity and the potential risk of harm to children
- all agencies are aware of the need to consider the parenting capacity of young people who have been known to the services during their childhood and how this might impact on their care of children with whom they have significant relationships.

APPENDICES

Terms of Reference

Themes and questions identified:

- How much of a feature was domestic abuse within the mother's relationships?
- Was information shared appropriately?
- Were the increasing risks/concerns in 2016 identified following Ms M beginning a new relationship with Mr SF?
- What was the impact of Mr SF moving in to the household? Was anything missed?
- Was the facial injury sustained by Child M in March 2016 responded to appropriately by the agencies?
- Did the fact that both Mr SF and Mr F had the same first name cause confusion in agencies in terms of identifying which of the men was present or being referred to in key events?
- What weight was given to the history of both adults caring for Child M in terms of the way they had been parented, and their upbringing in terms of assessing their parenting capacity?
- How was Ms M being supported during the 2 years when there appear to have been no concerns?
- Was there a sudden change, or was it gradual increase in concerns over two years?
- Was this a case of "start again syndrome" by professionals?
- Do agencies culturally expect that Children's Services will look into issues of changes of household etc.?

Members of the Serious Case Review Group

- Dorset CCG, Designated Nurse Consultant for Children, Chair
- Dorset County Council, Operational Manager (MASH)
- Dorset Police, Detective Chief Inspector
- Dorset Health Care, Named Nurse and Safeguarding Lead
- South West Ambulance Service Trust, Deputy Director of Nursing
- Dorset CCG, Named GP
- Poole Hospital Foundation Trust, Named Nurse Safeguarding Children

List of Agencies Involved in the Case

- Ambulance Service
- Children's Social Care
- Emergency Department
- GPs
- Health Visiting
- Paediatric Department
- Police