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Limited**



CHILD K

A SERIOUS CASE REVIEW

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1. INTRODUCTION

1.1 Child K, aged seven, was taken to Southampton General Hospital in December 2011 with serious head injuries. His condition deteriorated and he died the following day.

1.2 Doctors were told that Child K had fallen from a sofa while in the care of his mother's partner, Mr X, and Mr X's brother, Mr Y. The initial medical opinion was that his injuries were not consistent with the explanation given. Mr X and Mr Y were arrested.

1.3 The family were known to a number of different services as a result of repeated incidents of domestic abuse and long-term concerns about the safety and welfare of the children, particularly Child K.

1.4 A post mortem was undertaken by a Home Office pathologist who gave an initial opinion that the cause of death was "head injuries" and that these injuries could be consistent with falling onto a carpeted hard surface.

1.5 These events were considered by the Southampton Local Safeguarding Children Board (the Board) to determine whether a Serious Case Review (SCR) should be carried out. The purposes of SCRs are set out in "Working Together"¹. They are to be carried out so that *"lessons can be learnt and services improved to reduce the risk of future harm to children"*.

1.6 At a meeting in January 2012 the Board's Chair at that time, Mr Donald McPhail, deferred a decision as to whether there should be an SCR until

- it was known whether there would be a criminal prosecution, and
- the results of a "Finding of Fact"² hearing from the Family Court were known, in relation to the siblings of Child K, who had been brought into the care of the local authority.

1.7 In June 2012 the police reported to the Board that there would be no criminal prosecution. In January 2013 the Finding of Fact decisions were reported to the committee and the Chair then decided that there should not be an SCR.

1.8 There had been a number of changes to the senior management team in Southampton City Council (SCC) from the spring of 2013. Incoming managers found that there were several cases, dealt with during the same period of

¹ Working Together to Safeguard Children (2013) – referred to in this report as "Working Together" – is a government publication containing statutory guidance on how organisations and individuals should safeguard and promote the welfare of children and young people, in accordance with the Children Act 1989 and the Children Act 2004.

² A Finding of Fact Hearing is a court hearing that considers evidence to decide whether alleged incidents did or did not happen. They are commonly held in Care Proceedings.

time, which they felt met or might meet the criteria for conducting an SCR, but where no review had been initiated.

1.9 In June 2013 the Chair left his post and the SCR decision in this case was re-considered. As a result, in July 2013, the Interim Chair of the Board, Ms Aileen Patterson, did commission a SCR in respect of the death of Child K. This is the Overview Report from that SCR.

2. FAMILY COMPOSITION

2.1 The composition of the family is complex and the facts as finally determined are set out in this table.

Name	Age in December 2011	Relationship to Child K
Child K	7	Subject of this review Son of Mr A
Ms L	25	Mother of all three children
Sibling 1	4	Half sibling Son of Mr C
Sibling 2	2	Half sibling Daughter of Mr X
Mr C	25	Former partner of Ms L
Mr X	23	Partner of Ms L, father of Sibling 2
Mr A	26	Brief relationship with Ms L Father of Child K
Mr Y	21	Brother of Mr X

2.2 Ms L is the mother of all three children. Mr C was the partner of Ms L when Child K was born and for some time before and after that. He believed that he was the father of Child K, and is named as such on the child's birth certificate.

2.3 When Child K died investigations revealed that the father of Child K was in fact Mr A, with whom Ms L had had a brief relationship. It is believed that Ms L was aware of this but chose to deceive Mr A, Mr C and Child K. Child K saw Mr C as his father and had no knowledge of Mr A.

2.4 The mother had also falsely asserted that Sibling 1's father was Mr X, a position she maintained until the truth about paternity was confirmed by DNA testing. This revealed that Mr C is the father of Sibling 1.

2.5 It has always been clear that Sibling 2 was the child of Mr X.

2.6 This case has been the subject of extensive publicity. The probability that individuals will be identified is acknowledged. Nonetheless it was agreed that it was still appropriate and fitting that this report should not disclose the identity of the child at its centre.

3. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

3.1 In the summer of 2013, after re-considering the decisions taken in recent years as to whether SCRs should be carried out, the Board decided to carry out, eventually, five SCRs. Five independent people with substantial experience in the conduct of SCRs were drawn together by the Board and appointed to lead those SCRs. In each case two Lead Reviewers were appointed from this group, one to chair and lead the Review, the other to draw up an Overview Report. The Safeguarding Board appointed Mr Keith Makin as its substantive Chair in October 2013.

3.2 Ms Moira Murray has chaired this review throughout but it was necessary to change the arrangements for the second Lead Reviewer during the course of the review. Mr Kevin Harrington was appointed and started work on this report in May 2014. Information about the Lead Reviewers is attached at Appendix A.

3.3 The Board constituted a panel (the Panel) to manage and oversee the conduct of each review. The membership of the Panel for this review is set out at Appendix B.

3.4 It was determined that the agencies listed in the table below should contribute to the review. Agencies with substantial contact were required to submit full Individual Management Reviews (IMR) whereas agencies with less significant or less recent involvement provided reports for background information.

AGENCY	NATURE OF CONTRIBUTION
Southampton City Council, Children's Social Care Services	Individual Management Review
Southampton City Council, Prevention and Inclusion (Education) Services	Individual Management Review
Southampton City Council, Independent Domestic Violence Advisors	Individual Management Review
Hampshire Constabulary	Individual Management Review ³
Solent NHS Trust	Individual Management Review
Cafcass	Individual Management Review
NHS England, Wessex Area Team – the General Practitioners	Individual Management Review
University Hospital Southampton NHS Foundation Trust	Individual Management Review
Hampshire Probation Trust	Individual Management Review
South Central Ambulance Service NHS Foundation Trust	Individual Management Review requested but not received

³ Hampshire Constabulary submitted a further report, towards the end of the SCR process. It is referred to as the "Addendum Report".

Southampton City Council, Adult Social Care Services	Individual Management Review
Dorset Healthcare NHS Foundation Trust	Report for information
Staffordshire County Council	Report for information
Southampton City Council, Housing Services	Report for information
NSPCC	Report for information

3.6 The government has introduced arrangements for the publication⁴ in full of Overview Reports from Serious Case Reviews, unless there are particular reasons why this would not be appropriate. This report has been written in the anticipation that it will be published but it is appropriate that some confidential information is not disclosed⁵. Consequently the information in the report is limited so as to, as far as possible:

- 1) take reasonable precautions not to disclose the identity of the children or family.
- 2) protect the right to an appropriate degree of privacy of family members.
- 3) avoid the possibility of heightening any risk of harm to these children or others.

3.7 Anonymised Terms of Reference for this SCR are attached at Appendix C. They are drawn from the statutory guidance contained in Working Together, amended to highlight specific issues relevant to the circumstances of this case.

4. METHODOLOGY USED IN DRAWING UP THIS REPORT

4.1 This Overview Report is based principally on the agency IMRs, background information submitted and subsequent Panel discussions. The contribution of the family to the review is discussed at section 6.

4.2 This report consists of

- A factual context and brief narrative chronology.
- Commentary on the family situation and their input to the SCR.
- Analysis of the part played by each agency, and of their IMR – in those sections quotations are from the relevant IMR unless otherwise specified.
- Closer consideration of key issues arising from the review.
- Conclusions and recommendations.

4.3 The conduct of the review has not been determined by any particular theoretical model. The review has been carried out in keeping with the underlying principles of the statutory guidance, set out in Working Together 2013, detailed below: The review

⁴ See Working Together 2013

⁵ This case has been the subject of considerable publicity and the family can be identified from that. Nonetheless this report is written with respect to the children's right to anonymity.

- *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 hindsight⁶;*
- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research and case evidence to inform the findings.*

⁶ This review does not rely on hindsight, and tries not to use hindsight in a way that is unfair. It does use hindsight where that promotes a fuller understanding of the events and their causation.

5. THE FACTS

5.1 Introduction

5.1.1 This section of the report contains background information about the family and a brief summary of their contact with relevant services during the period under review. More detailed information and analysis is then contained in the body of the report.

5.1.2 The first part of this section describes a context of early concerns, before the period under detailed review, which begins in November 2007 when the first allegations of ill-treatment of Child K were made. The review then considers events up to and beyond the death of Child K, until April 2012 when it was initially decided that there be no further action by police.

5.1.3 That police decision was re-considered and overturned in April 2014 and further investigations were carried out, during which Ms L, Mr X and Mr Y were arrested. However in December 2014 the Crown Prosecution Service decided that they would take no further action in this matter.

5.2 Background

5.2.1 When Child K was born his mother had been accepted as homeless by the local authority and was staying with her mother (referred to in this report as maternal grandmother, MGM), awaiting the provision of housing. Ms L had been judged vulnerable by maternity staff during the pregnancy, and had been referred to children's and adult's social care services but both services had judged that there was no need for their continuing involvement at that time.

5.2.2 The relationship between Mr C and Ms L was troubled. The early months of Child K's life were unsettled as he moved between them at various addresses. Mr C was known to be violent to Ms L and had a history of criminal convictions including matters of violence. There is evidence of Child K witnessing Mr C being violent to his mother on a number of occasions. Police were repeatedly involved in responding to incidents of domestic disturbance. Referrals were made to Southampton City Council, Children's Social Care Services (CSC) as a result of this, and assessments were carried out, but did not lead to any continuing contact.

5.2.3 Ms L was rehoused by the council in September 2005 and was to stay at that address until 2009. In October 2005 Child K, aged 14 months, was treated in hospital for facial bruising, said to be caused by a fall, and old burns, said to be caused by accidental contact with a hot iron. The explanations given were judged by medical staff at the time to be consistent with the nature of the injuries.

5.2.4 Child K started nursery in February 2006. In April of that year there was a particularly violent dispute between his mother and Mr C, said to be prompted by Ms L's involvement with another man and allegations that she

was using illegal drugs. Child K was left in the care of Mr C for several days, during which time he excluded Ms L from the home, but the relationship then resumed. CSC were involved briefly, and were again involved the following year as a result of contact from Housing, who had received complaints from neighbours about noise and disturbances at Ms L's home.

5.2.5 Child K was routinely assessed by health visitors when he was 18 months old, and no concerns were noted. Late in 2006 Ms L is believed to have formed a relationship with Mr X, although she also continued to maintain a relationship with Mr C for some time. Mr X had a history of criminal convictions for which he was at the time in contact, but not co-operating, with the Probation Service.

5.2.6 Ms L's second child, Sibling 1, was born in February 2007 and in the subsequent months there are further records of agencies becoming aware of violence towards Ms L from Mr C. Mr X was imprisoned in April 2007 for affray, and again in September of that year, following repeated offending and failure to comply with community sentences. Cafcass became involved in the continuing dispute between Ms L and Mr C.

5.2.7 In September 2007 Child K started attending pre-school provision. He was to continue attending until the end of June 2008. In October 2007 Ms L was referred to the local authority's domestic abuse services and an Independent Domestic Violence Advisor⁷ (IDVA) became involved, but Ms L did not sustain contact with her.

5.3 November 2007 to August 2008

5.3.1 Mr C's violence towards Ms L persisted and in November 2007 formal multi-agency domestic abuse procedures were initiated and an IDVA was again appointed – the same officer as previously involved. Ms L took legal action to protect herself and the children from Mr C. In the course of preparing legal submissions the first overt allegations of direct maltreatment of Child K were made. In October Ms L's solicitor wrote to Cafcass with a copy of Ms L's court statement in which she alleged that Mr C had

“blown smoke into the child's face and that he had been given vodka to drink”.

These matters were not reported to CSC or police and did not lead to any investigations.

5.3.2 There were further concerns as a result of an incident in a supermarket in late December 2007. Ms L was seen to smack Child K violently. MGM was with her at the time and expressed her concern to her daughter who did not accept her concerns. This incident was followed up by police and CSC but did not lead to any substantial continuing involvement.

⁷ The IDVA is a trained specialist in domestic abuse who focuses on victims at high risk of harm.

5.3.3 Ms L took Child K to a GP in January 2008 as she was concerned by his behaviour. She described him being unco-operative and violent to her. She queried whether he might have ADHD and the GP made a referral to CAMHS. This resulted in that agency's involvement with the family between February and May 2008.

5.3.4 In February Mr X was released from prison and went to live with Ms L. He subsequently largely complied with the Probation Service until their post-release involvement came to an end in May.

5.3.5 At a home visit in March 2008 a Family Support Worker (FSW) from CAMHS made a record of Child K saying that Mr X bit him when he put him to bed. The FSW took no further action.

5.3.6 The extent to which Child K was absent from pre-school provision at this time is described as "significant" though this was never raised with Ms L by any agency. However at the beginning of June he attended pre-school with bruising. Ms L herself brought this to the attention of the owner / manager of the service, who took no further action.

5.3.7 The last day of June 2008 was also the last day that Child K attended pre-school provision before starting school. On that day he came to pre-school with more facial injuries. Ms L told the manager that these had been inflicted by Mr C. The manager rang CSC, left a message asking a social worker to call back, but then took no further action.

5.3.8 On the same day there was a referral, via the NSPCC, to police and CSC. Workmen in the vicinity of the family home had seen Child K with evident injuries. SW1, the same social worker who had been involved in following up the incident in the supermarket, visited. He accepted an explanation, without further enquiry, that the injuries had been accidentally caused. Police enquiries resulted in their taking no further action.

5.3.9 At the end of July a Health Visitor saw Child K at clinic with his mother. He had a blood blister to his eye. Ms L told the HV that the child had previously had two black eyes following contact with Mr C. The Health Visitor took no action.

5.3.10 The social worker was contacted by MGM at the end of August, reporting that she had seen Child K with bruising and a black eye. The social worker did not take any action in response to this.

5.4 September 2008 to December 2008

5.4.1 Child K started school in Southampton in September 2008 and was on that school roll until March 2009, when Ms L and the children moved to Staffordshire. He returned to the same school in June 2009, when the family moved back from Staffordshire, and remained on roll there until his death.

5.4.2 A few days before he started school Child K was admitted to hospital with facial injuries and a painful, swollen penis. While in hospital staff on the ward became concerned when Ms L was seen to be treating him roughly. The hospital made a child protection referral and Child K was medically examined. A Consultant Paediatrician felt that there was evidence of inflicted injury. Agencies including police and CSC met that day and agreed that CSC should carry out a Core Assessment⁸, but that there should be no further direct investigation by police of the injuries seen.

5.4.3 SW1 accordingly went to the family home. He did not see the child but told Ms L that there was to be an assessment. There was then a planning meeting some two weeks later at which it was decided that Child K be referred again to CAMHS. Issues of the possible abuse of Child K were set aside and no action was taken by CSC until October when it was decided that the Core Assessment should be “re-started”.

5.4.4 The same Consultant Paediatrician saw Child K in October to follow up the admission to hospital and found no cause for concern, reporting that he *“displayed lovely interaction, was friendly and relaxed, played nicely and good language skills. He appeared healthy and well”*.

5.4.5 Cafcass had remained involved as a result of the continuing dispute between Ms L and Mr C. In October Ms L’s solicitor wrote to Cafcass endorsing a statement from Ms L which contained a photograph of Child K with facial bruising, said by her to have been caused accidentally when in the care of Mr C. A Cafcass social worker then saw Ms L and she reported that the family now had a local authority social worker. The Cafcass officer did not take any further action in respect of the bruising.

5.4.6 Cafcass saw Mr C in November and he made allegations that Mr X had been violent to both Child K and Ms L, but again the officer did not take any further action. Then, in December, in the Cafcass offices, and in the presence of Ms L and Child K, there was a confrontation between Mr C and Mr X, who threatened to stab Mr C. This was referred to the police but neither Mr C nor Mr X wanted any further action taken. The matter was also notified to the local authority but this did not prompt any response.

5.4.7 By now Child K was at school full-time and there were concerns about his behaviour – he was attention-seeking and frequently needed reassurance. The school’s report to Cafcass in December described a child of average ability who was often absent, desperate to please, prone to temper outbursts and struggling to maintain relationships with other children.

5.4.8 The final Family Court hearing took place in December 2008. Mr C did not attend and so the case concluded with no order for contact. This brought the involvement of Cafcass to an end. They had repeatedly requested, but not

⁸ A Core Assessment (Framework for the Assessment of Children in Need, HMSO 2000) is a detailed assessment undertaken by CSC when it is suspected that a child is suffering, or likely to suffer, significant harm.

received, a copy of the Core Assessment said to have been completed by SW1.

5.5 January 2009 to February 2010

5.5.1 Ms L was now again pregnant and spoke to a midwife about being depressed. At a routine ante-natal appointment in March 2009 she told a midwife that she had moved to Staffordshire, although she still intended to have the baby in Southampton. In May 2009, upon learning that the family had left the area CSC closed the case.

5.5.2 There was no significant contact with services in Staffordshire and, in any event, by July 2009 the family had returned to Southampton where Sibling 2 was born. Ms L told a Health Visitor that they had to leave Staffordshire because of violent incidents related to drugs. It appears that the relationship between Ms L and Mr X had continued during the move to Staffordshire.

5.5.3 There was then a period of several months when there was no significant contact with services in Southampton. The family stayed at first with Ms L's sister and then moved into privately rented accommodation, where they remained until the death of Child K.

5.6 March 2010 to December 2010

5.6.1 In March 2010 Child K's school attendance was noted to be poor, explained by his mother as a consequence of disruption in the family arising from trouble with their neighbours. In fact police were called to Ms L's home by neighbours in the same month as a result of a loud argument between Ms L and Mr X. No further police intervention was necessary.

5.6.2 The following month Child K was seen to have bruising to his head in school and told teachers that Mr X had done this by banging his head on a bed and a bicycle. No action was taken by the school.

5.6.3 In October Child K hit another child in the face, saying that this was what "Daddy" did to him, and that he got upset when his parents swore at him and called him an idiot. This was recorded by the school as a child protection issue but no further action was taken by school staff.

5.6.4 MGM spoke to school staff in November, to express her concerns that the children were repeatedly witnessing domestic violence between Mr X and their mother. The school passed this information to CSC. On the same day police attended the home because of a reported incident of domestic abuse but Ms L denied any assault and did not want any further action taken.

5.6.5 Some days later two social workers visited to follow up the school's information. They saw Ms L who again denied any cause for concern and refused permission for agencies to share information about her. MGM was not contacted. A social worker told her manager that Ms L played down any

cause for concern and was not being straightforward with her. However, Initial Assessments⁹ (IA) were completed on the three children and it was decided that no further action by CSC was necessary.

5.7 2011

5.7.1 The school noted bruising to Child K's face in January. Ms L made a point of talking to staff to tell them that he had "clashed heads" with a sibling, who was also seen to have facial bruising. The school noted this information but did not share it with other agencies. The following month they noted that Child K was mimicking sexualised behaviour and talking about sexual activity but they did not pass this information to any other agency. After this, throughout the rest of his life, school staff repeatedly noted evidence of sexualised behaviour.

5.7.2 In March Mr X was arrested following an incident of domestic violence. Police had been called to the home by Ms L's sister. Ms L disclosed long term, very violent domestic abuse which the children had witnessed. Mr X was remanded in custody for some weeks but the case was dropped when Ms L said that she wanted no further action taken. Their relationship had continued and he rejoined the family when released from prison.

5.7.3 Ms L had been referred by police to CSC and to domestic abuse services as a "high risk" case. The same IDVA who had previously known Ms X became involved and a social worker, SW2, visited the home. Ms L said that she had withdrawn her complaint to police but Child K spoke to the social worker directly about violent arguments in the home. CSC decided that an Initial Child Protection Conference (ICPC) should be held.

5.7.4 SW2 liaised with the IDVA who then successfully made contact with Ms L. She confirmed continuing long-term abuse but said that she and Mr X had now definitely separated and were discussing arrangements for his contact with the children. A Multi-Agency Risk Assessment Conference (MARAC)¹⁰ was held where information was shared, including reports from the school about Child K having talked of being hit by Mr X. Various actions were agreed by the agencies.

5.7.5 When the ICPC was held in April it came to light that the school had noted matters of concern which had not been shared with CSC. Many concerns were expressed by all agencies about the level of persistent domestic abuse and its consequences for the children. It was decided that all

⁹ A key part of the former statutory Framework for the Assessment of Children in Need (HMSO 2000). An Initial Assessment is a brief assessment undertaken by CSC following any referral where it is necessary to identify if a child is in need or suffering/likely to suffer significant harm.

¹⁰ MARACs are regular local meetings where information about high risk domestic abuse victims is shared between agencies, with a view to agreeing plans and measures to ensure the victim's safety.

the children of the family should be made subject to Child Protection Plans under the category of “emotional harm” and a range of actions were agreed for the agencies. The case was allocated to another social worker, SW3.

5.7.6 The first visit by SW3 was nearly seven weeks after the ICPC. In the interim period the school had told CSC about a further incident of sexualised behaviour by Child K but this was not raised with Ms L by the social worker. Nor did the social worker make any reference to child protection planning, but told Ms L that a Core Assessment was again to be carried out.

5.7.7 A week after that visit the school contacted CSC to report a conversation between Child K and a member of staff. Child K had said *‘I get bruises off my dad but I don’t care’*. He said they played boxing and his dad tried to be gentle but the floor was slippery so he fell over a lot and got bruises. No action was taken by CSC.

5.7.8 Ten days later, in June, Child K came to school with a black eye. His mother said that Mr X had accidentally hit him while they were playing on a trampoline. Child K’s behaviour also gave rise to concerns that day and he had to be removed from class. CSC were notified and SW3 visited five days later. In the interim period the child had been seen by a school nurse who had noted that he was poorly presented in clothes which were old and torn. He had facial bruising at that interview which was not reported by the nurse at the time.

5.7.9 At the visit SW3 spoke to Child K who confirmed the “trampoline” account given to school staff. SW3 took no further action although Ms L also said that Mr X was avoiding the social worker’s visits. Concerns arose again about Child K’s sexualised behaviour at the end of that month, and, in discussion with school staff, the child spoke graphically about being present while the adults watched pornographic films. He said that this was because he slept on the sofa so he could not go to sleep until the adults had gone to bed. This was notified to CSC but no action resulted.

5.7.10 The first Child Protection Review Conference was held in July. At that meeting the Child Protection Plans on the children were discontinued, with the agreement of all professionals in attendance except a health visitor. Police did not attend the meeting. Two weeks later Child K was seen at school to have a facial injury. He and his mother gave different explanations of how this had been caused. The information was not notified to CSC.

5.7.11 In September Ms L was violently assaulted by Mr X. He punched her repeatedly in the head, in the presence of the two younger children, because of a dispute about a computer game. She said that he had frequently told her that he would kill her and that he enjoyed beating her up. She was treated at hospital, where A&E staff liaised proactively with police and the IDVA and made referrals to CSC and to adult social care services. (This was on the basis that Ms L was seen as a vulnerable adult, though she declined any contact with adult services). Ms L was seen by SW3 who judged that no action by CSC was necessary. Mr X surrendered to police and was remanded

into custody, then bailed at his first court appearance. Conditions of bail included a requirement that he should have no contact with Ms L.

5.7.12 Ten days after that incident Ms L told police that she had decided to retract her allegations against Mr X. (After the death of Child K Ms L continued to refuse to give evidence and the case was eventually discontinued). Mr X went to his GP, asking for help with his mood and anger, and reporting that he felt suicidal after the last incident of violence to Ms L. The GP referred him to psychological services where he was seen quickly and was to be referred on to “high intensity services”.

5.7.13 Child K’s behaviour continued to give cause for concern in school and an exclusion was being considered. The School Nurse continued to liaise with the IDVA, concerned that Ms L was in contact with Mr X who remained on bail which was conditional on his not contacting her. It is now known that the couple were again living together.

5.7.14 There was a MARAC meeting in September. Concerns were expressed about Child K, who was hitting other children and visibly struggling to control his temper. Ms L had told the IDVA that Mr X threatened to kill her most days. Agencies agreed a range of actions to address these concerns. On the same day MGM contacted CSC and spoke to a student social worker. She complained that there had been no response to phone messages left for SW3. MGM said she feared her daughter had resumed her relationship with Mr X and that she would undoubtedly lie to professionals to cover up any cause for concern. The student agreed to pass this information to SW3.

5.7.15 The following day SW3 decided, without reference to managers, that the student, whom she was supervising, should now manage the case. The student then visited Ms L who told her that she had fallen out with her mother because of her allegations about Mr X.

5.7.16 At the end of September MGM wrote to SW3. The letter complained that she had telephoned repeatedly but her calls had not been returned. The letter set out in detail the reasons for her “*grave concern*”. It listed a number of allegations of abuse and neglect of the children and especially Child K. It contained one specific allegation – Child K seen with what appeared to be cigarette burns to his throat – that had not previously been reported, and for which MGM had been given contradictory explanations. This letter did not lead to any action being taken. No reply was sent.

5.7.17 In October Ms L saw her GP, complaining of low mood, thoughts of self harm and poor concentration. She was very irritable with the children and unable to sleep. The GP prescribed medication and referred her for counselling. Ms L told the IDVA about this in a conversation the following week but specifically denied any contact with Mr X.

5.7.18 Around the same time Mr X attended his initial appointment with “high intensity” mental health services. He was offered continuing contact but did not then keep in touch with this service.

5.7.19 Early in December Child K was brought to hospital by ambulance, unconscious with serious head injuries. The ambulance had been called to Mr X's mother's home. Mr X and his brother Mr Y were present. Mr X was in breach of the bail condition that he should have no contact with Ms L. Ms L was said to have left to return briefly to her own home. While she was away it was said that Child K had fallen to the floor and banged his head.

5.7.20 Staff treating the child did not believe this. There were inconsistencies in the accounts given and the explanation seemed incompatible with the injuries sustained. An MRI scan identified "devastating head injuries". Child protection procedures were initiated in respect of all the children of the family. Mr X and Mr Y were arrested and bailed while further enquiries were made. The other two children went initially to be cared for by a relative but were brought into the care of the local authority and placed with foster carers some days later.

5.7.21 Child K did not regain consciousness and died the day after being brought to hospital.

5.8 Events after the death of Child K

5.8.1 There is statutory guidance as to how agencies should respond to the sudden, unexplained death of a child. The steps to be taken are usually referred to as "Rapid Response" procedures. There is also detailed local guidance about this. The SCR found that the actions taken here were not entirely in line with that guidance and that is discussed further below.

5.8.2 It was decided in April 2012 that there was insufficient evidence to bring a criminal prosecution against anyone in this case.

5.8.3 In November 2013 the inquest into Child K's death concluded when the Coroner returned an open verdict. However in the course of those proceedings the Coroner questioned the accounts of the circumstances of the death given by Mr X and Ms L. He described those accounts as a "*plethora of lies*".

Mr X had originally pretended to be Mr Y, in order to conceal the fact that he was in breach of his bail conditions. There was also a significant delay in calling emergency services, during which time Mr X telephoned Ms L. There was a suggestion that he had not wanted an ambulance called, again because of the issue of bail. The Coroner concluded that the adults were guilty of "*a disgraceful failure to prioritise the needs of Child K*".

5.8.4 At the same time as completing the IMR for this SCR, Hampshire Constabulary undertook a review of the criminal investigation into Child K's death. This process is known as a Serious Crime Review. As a result of this Review a criminal re-investigation was authorised in April 2014. The Assistant Chief Constable of the Hampshire Constabulary announced at that time that

"I accept that the initial investigation by the constabulary was unsatisfactory, and for that I apologise".

5.8.5 As indicated above, Mr X, Mr Y and Ms L were arrested but, at the conclusion of the re-investigation, which took several months, it was decided by the Crown Prosecution Service that no criminal charges would be preferred against them.

6. THE FAMILY

6.1 Steps taken to involve the family

6.1.1 It was not possible to interview family members while criminal charges were still under consideration. Following the CPS decision in December 2014 that no charges would be brought, the mother, the legal father (Mr C) and the maternal grandmother of Child K were approached and invited to meet with the Lead Reviewers.

6.1.2 Neither Ms L nor Mr C responded to these invitations. The maternal grandmother, MGM, did respond and met the Lead Reviewers in January 2015.

6.2 The comments of the maternal grandmother

6.2.1 MGM feels strongly that agencies involved with Child K, particularly Children's Social Care, did not do enough to protect him. She recognised from the time of Child K's birth that her daughter needed support and described how Ms L had some initial difficulty in bonding with her new baby son. From the time of Child K's birth MGM expressed doubts as to whether Mr C was Child K's father, and believed that his birth father was Mr A, but Ms L maintained that Mr C was his father.

6.2.2 As a grandmother she had tried to intervene and assist Ms L in caring for Child K and subsequently his two younger siblings, but Ms L rejected her offers of help and support. From the time of Child K's birth MGM had some concerns about Ms L's management of Child K. These concerns continued, as illustrated by the incident in the supermarket, and subsequently when Child K required hospital treatment for a penile injury. MGM had offered to look after Child K, as she felt her daughter was not appropriately caring for him, but Ms L refused.

6.2.3 During her daughter's relationship with Mr C, MGM was concerned about the degree of domestic violence experienced by Ms L, however her anxiety for the safety of her daughter and the children increased alarmingly once Ms L became involved with Mr X.

6.2.4 MGM described how Mr X had a complete hold over Ms L, and despite many vicious beatings, Ms L would always return to him. From the time Ms L and Child K went to live with Mr X, her relationship with her daughter became distanced, as she felt that Mr X did not want her to have any contact with her or the grandchildren.

6.2.5 MGM spoke of an incident when she attended Child K's school sports day and saw the he had a nasty sore on his neck, which she considered to be a cigarette burn. Child K couldn't explain how the injury occurred and asked if he could stay with his grandmother, but this request was refused by Ms L.

6.2.6 This incident along with several others, as has been evidenced throughout this review, was reported by MGM to Children's Social Care. With the exception of one telephone call thanking her for a letter she sent in September 2011, detailing her concerns for the safety of Ms L and the children, MGM received no contact from or acknowledgement of her referrals to Children's Social Care. MGM felt that Children's Social Care and also the school failed to see the risks presented to Child K whilst he was living with Mr X, and did not act to prevent the abuse he experienced continuing.

6.2.7 She felt that Child K was treated differently to his siblings by both her daughter and Mr X. When Child K first started school he was very much like other children, but gradually his physical appearance deteriorated. MGM described Child K as a sweet, loving boy, cheeky and mischievous, but with a lovely smile. When she saw him in hospital the day he died, she was shocked at his appearance, which she described as 'skeletal'.

6.2.8 MGM feels that Child K was let down badly by all the agencies, but he was also let down by his mother who failed to protect him.

7. THE AGENCIES

7.1 Southampton City Council: Children's Social Care Services

7.1.1 The quality and effectiveness of this agency's work throughout the case history raises serious cause for concern. The IMR sets out the scale of the problem:

"There are 18 significant reported events from health, the police, extended family and anonymous callers which should have resulted in CSC action. Ten should have resulted in an initial assessment (IA) being completed... Eight of these eighteen events were indicating that Child K was at risk of significant harm or had been harmed and should have been investigated immediately under section 47 of the Children's Act 1989."

In fact sometimes CSC did not respond at all. When they did take action their responses repeatedly fell well below expected standards of practice. The reasons for this, specific to this agency, lie in the instability of the local authority and its management arrangements, and in poor practice by individual social workers and their managers.

7.1.2 Many of the concerns coming to CSC notice were directly or indirectly associated with domestic abuse. Domestic abuse, its consequences and the agencies' responses and responsibilities are significant issues in this review and are considered separately below. But some of the matters known to CSC were clearly and immediately related to the care and welfare of the children and particularly Child K.

7.1.3 In December 2007 CSC were contacted by police after reports of the incident in a supermarket where Child K had been mistreated by his mother. In public he was said to have been hit, turned upside down, shaken, and threatened. Sibling 1 was present. Unsuccessful joint visits by police and CSC were made the following day, a Friday, and again on the Monday, which was

Christmas Eve. Over the weekend police had made unsuccessful visits. After Christmas there were further visits, both by a social worker alone and by the two agencies together but it was not until the second week in January that SW1 visited alone and saw the family.

7.1.4 The nature of the allegations was such that there should have been a documented discussion between the agencies to plan their response, an immediate joint visit by the two services and probably a medical examination of the child. None of those things happened. Attempts were made, and the Christmas period is always a challenge to services, but it cannot be acceptable that two weeks passed without the child being seen. Then, when the “successful” visit was made, there was no attempt by SW1 to talk to Child K, and it was decided that the events constituted an acceptable “over-chastisement”.

7.1.5 The role of police in this response is considered below. For CSC their intervention was inadequate and that was compounded by incoherent management. The social worker’s manager decided that the case should be closed but then that standard checks and recording should be made after the closure of the case. We now know that MGM witnessed this incident but she was never approached about it. Then the case was not in fact closed but kept open until a joint visit with police in March, three months after the incident.

7.1.6 Three months after that, at the end of June, workmen reported their concerns after seeing Child K with visible injuries and indications of neglect – this four year old child was said to be often left alone, unsupervised, outside the family home. It is clear from police records, though not from those held by CSC, that there was a discussion between the two agencies and an agreement that CSC alone should respond to this. That was inappropriate and again is discussed below in the section of this report dealing with the police.

7.1.7 However the subsequent action by CSC was again inadequate. The allegations were specific and suggested both repeated neglect and potentially serious injury. The source of the allegations – workmen in the vicinity, who had been so concerned as to contact the NSPCC – was significant. Members of the public are often disinclined to raise allegations of child abuse but these workmen had spoken directly to the child and had found his explanation – that he had walked into a door – unlikely. They had heard screaming from the home and seen his mother with facial injuries.

7.1.8 Initially there was no response at all. The referral was received on a Friday and no action was taken until the Monday. Then the response consisted solely of SW1 calling to the home, initially accepting from Ms L that it was an inconvenient time and returning to the home later – thus allowing Ms L time to coach Child K on his response. When the social worker returned he accepted Ms L’s explanation, echoed by Child K, that these were accidental injuries. The issue of the child being alone and unsupervised outside the home was not addressed. The social worker also noted that the child made allegations against Mr C, that he had hit him and blown smoke in his face. (These allegations were also made to Cafcass around the same time). SW1

followed this up – by talking to Mr C – three months later, and asking a Health Visitor to see the family.

7.1.9 The IMR captures the incompetence of this response:

“The social worker’s response is wholly inadequate; the risks to Child K are not clarified and articulated. The view of Mr C is not sought and he is not involved in the assessment. The possibility that Ms L has physically harmed Child K or may be a risk to him is never considered Her failure to protect is also not addressed. He does not receive medical treatment for his injuries”.

Then, as with the previous incident, a manager decided to close the case. No formal assessment had been completed and there had been no sharing of information with other agencies, other than a request that the Health Visitor see the family.

7.1.10 In August 2008 MGM contacted CSC to report that Child K had bruising and black eyes. SW1 said that he would follow this up “when he had time”. In fact there is no indication that this concern – despite its serious nature, the similarity to the previous incident and the fact that it had been reported by a close family member – was ever followed up in any way. It may be that the social worker assumed that the information related to the incident reported in June but there was no evidence to support such an assumption. There is also no evidence of any attempt to seek managerial advice.

7.1.11 Less than 3 weeks later, just before starting school in September, Child K was referred to CSC by Southampton General Hospital after presenting with a bruised penis and facial injuries. This presentation is discussed further throughout this report, as it raises concerns about all the relevant agencies’ actions. It culminated in a meeting held at the hospital that day.

7.1.12 The status of that meeting is unclear. It was led – not formally chaired - by a CSC junior manager. At the meeting further information emerged about injuries seen at the pre-school provision but not reported. Hospital staff also reported “*highly critical and punitive behaviour*” by Ms L towards Child K on the ward – sufficiently concerning to have been recorded on three occasions. The Consultant Paediatrician specifically gave a view that some of the child’s injuries had been deliberately inflicted.

7.1.13 However police decided that there was insufficient evidence of any crime being committed to warrant their continuing involvement. This seems to have led the agencies into a judgment that consequently there need be no child protection investigation. Importantly it was judged that there was no need to interview Child K himself as he had given a consistent story of accidental injury to hospital staff. Instead it was decided that CSC would carry out a Core Assessment.

7.1.14 The discrepancy between the medical advice and the police decision cannot be fully explained. For CSC the concern is that they, the lead child protection agency, displayed such a lack of leadership in not ensuring that this meeting was convened under formal child protection arrangements and

chaired by an appropriately senior officer. This incident was perhaps the most significant missed opportunity throughout the period under review.

7.1.15 The similarities to a key turning point in the history of the events leading to the death of Daniel Pelka in Coventry are notable. The second SCR¹¹ into those events states that

“The conclusion of the meeting in respect of Daniel’s injury was that there was no need to initiate section 47 enquiries but that a core assessment should be carried out under section 17 Children Act 1989. This is an important distinction as it identified Daniel as a child potentially in need of help and services, rather than a child also at risk of, or possibly suffering significant harm. Although theoretically the core assessment process may have been similar whichever route was taken, the fact that this was a child protection case would have allowed potential risk of harm to have been clearly on the agenda in discussion with mother and alerted other professionals to the risks”

7.1.16 Concerns thus far have largely been about the immediate response of CSC to situations. They were now committed to ongoing work, the conduct of a formal assessment, expected to be carried out within 35 days – seven “working weeks”. Their management of that task was equally unsatisfactory. In late November, some 10 weeks after the decision to conduct the assessment, a manager decided to close the case, even though the assessment had not been completed. Indeed it is not clear that anything at all had been done to progress the assessment.

7.1.17 Yet having taken that decision the case was not closed but allowed to drift until May 2009. There is no record that Child K was seen during that time. Then the case was closed after it became known that the family had moved to Staffordshire. An assessment, which appears to have been completed after it was known that they had moved, contains little reference to the needs of Child K, or how his family might meet those needs. There was no attempt to advise Staffordshire agencies of the background of concerns. The assessment seems to have been completed hurriedly so that the case could be closed. This report comments further below on the pressures arising from the overall organisational context in CSC at this time but dealing with this matter in this way was unprofessional and irresponsible.

7.1.18 The stay in Staffordshire was brief. Ms L and the family returned to Southampton. Ms L is said to have told health professionals that this was because of violence related to the sale and purchase of illegal drugs, though this did not lead to any further investigation or information sharing. Concerns that agencies registered for the family were now, and for some time, focussed not on immediate abuse or neglect of the children, but on the domestic abuse of Ms L and its consequences. However there were still serious weaknesses in the performance of CSC, and in the management of child protection processes.

¹¹ [Daniel Pelka: Deeper Analysis](#)

7.1.19 The fact that Child K's school noticed a number of causes for concern but did not report these to CSC is discussed below. However in November MGM reported continuing violence towards Ms L by Mr X, and her fears for the consequences of this for the children. At the same time, reports had been received from police about repeat attendances at the home for similar reasons.

7.1.20 Consequently two social workers visited the home. Ms L denied any cause for concern. She herself had a black eye which she explained as having been caused by her one year old child hitting her with a book. She said that she did not want the social workers to talk to any other agencies. The social workers did not contact MGM. Yet, without reference to these other sources of information, and despite the social worker expressly reporting a view that Ms L was being untruthful and minimising cause for concern, it was decided within a few days that no further action by CSC was necessary. Contextual issues about the organisational health of the local authority at this time – which may go some way towards explaining this inappropriate and premature decision – are discussed below. Yet the decision also suggests a professional naïveté about the causes and consequences of domestic abuse, which is again discussed below.

7.1.21 Domestic abuse continued and in March 2011 there was a particularly serious assault on Ms L, which led to Mr X being arrested. On arrest he threatened to set fire to the home of a neighbour he believed to be responsible for calling police. He was remanded in custody. Ms L disclosed continuing violent abuse, including attempted strangulation, often in the presence of the children. CSC were notified by police and again became involved with the family.

7.1.22 SW2 visited some two weeks after the incident and was told by Ms L that she was withdrawing her complaint against Mr X. This led to the decision to convene an ICPC. The social worker had visited only once before the ICPC, which would not have been unusual at that time. However the social worker did not then prepare reports to brief the conference's Chair. The IMR judges that the case was presented to the conference in such a way as to emphasise a view that previously there had been improvements in the situation which had led to the case being closed. There was a context of unjustified optimism from the outset.

7.1.23 The Chair of the ICPC was one of only two such posts at the time, and the other post was vacant, filled by a succession of temporary / agency appointments. The officer in question told this review that this provision was inadequate and meant that she often did not have time to read all the background information before a conference, as was the case here. She was not fully aware of all the incidents of violence towards Child K. Nonetheless it was decided that all the children be made subject to Child Protection (CP) Plans.

7.1.24 National guidance indicated that it was advisable to use a single category¹² of harm to identify why a child is subject to a CP Plan. The Chair also felt that Ms L might be less likely to challenge an allegation of something less well-defined than physical abuse. These considerations fed into a decision that the category under which the Plans were listed was “emotional abuse”. A principal consequence of that was that the risk of physical harm to the children, especially Child K, came to take a “back seat” to the emotional harm arising from exposure to repeated domestic abuse. The significance of the category of abuse identified featured similarly and significantly in the case of Peter Connelly, who died in Haringey in 2007, and is highlighted in the second SCR¹³ in that case.

7.1.25 The actual plan made at the conference was limited and unspecific, with little detail about what would actually be done and by whom. This was to some extent deliberate – external consultants commissioned by SCC in 2010 had recommended such an approach, where the development of detailed proposals and processes was left to the Core Group¹⁴. The huge weakness in this shift of responsibilities is that, as the IMR bluntly tells us, *“The fact is core groups rarely happened...In 2010 /early 2011 core groups completed on time were less than 10%”*.

7.1.26 The implementation of CP Plans meant that CSC involvement would be expected to be long-term and the responsibility for managing the case was now transferred to a different team, and a new social worker, SW3. The downplaying of physical abuse of Child K continued. SW3 and her supervisor (who was a senior practitioner rather than a manager) have both reported to this review that the focus in the case was on the effects of domestic abuse.

7.1.27 The actual quality of input from CSC now deteriorated further. Recording is inadequate generally but provides evidence of Child K being seen only twice in 12 weeks. There is no evidence that the CP Plan, such as it was, was progressed in any way.

7.1.28 During this period concerns began to emerge that Child K had been exposed to or involved in sexual activity. His school twice reported incidents giving rise to such concerns. On both occasions SW3 apparently asked the school to investigate. SW3, a relatively junior officer, did not seek any advice from managers as to how best to respond. The IMR says *“It is clear that... the social worker was not fully competent... She did not review visits or understand when to escalate severe concerns. She knew that the adults were minimising domestic abuse and were not always honest but had no confidence of strategies for dealing with this. (She) did not communicate clearly with her manager and she says her manager did not*

¹² “The category used (that is, physical, emotional, sexual abuse or neglect) will indicate to those consulting the child’s social care record the primary presenting concerns at the time the child became the subject of a child protection plan”. (Working Together 2010)

¹³ [Peter Connelly -the second SCR](#)

¹⁴ The core group is the group of professionals most closely involved with the family, who are responsible for developing the detail of a child protection plan and implementing it.

supervise her work adequately. Supervision notes do not evidence any progress in the actions identified in the CP Plan”.

7.1.29 However at the first opportunity, the first CP Review Conference after three months, it was decided that the CP Plans were no longer necessary and the children should be seen as “Children in Need¹⁵”. There was no Core Group meeting prior to the Review Conference. During those three months there had been two indications of possible physical abuse which had been reported by the school:

- Child K had told a member of staff that he and his dad played boxing and his dad tried to be gentle but the floor was slippery so he fell over a lot and got bruises.
‘I get bruises off my dad but I don’t care’.
- Ten days later Child K came to school with a black eye. His mother said that this had happened accidentally when playing on a trampoline with Mr X. Child K’s behaviour also gave rise to concerns that day and he had to be removed from class.

In relation to the first incident no action was taken by CSC. After the second incident SW3 visited five days later and accepted without further investigation or discussion that this had been an accident.

7.1.30 Ms L explicitly told SW3 that Mr X was avoiding her visits. During these three months concerns about Child K’s sexualised behaviour had been rising and he himself had spoken graphically about being present while the adults watched pornographic films. This had again been notified to CSC but no action resulted.

7.1.31 So, nothing had improved and there had been further evidence of cause for concern. In all those circumstances the decision to remove the CP Plans, effectively signalling that concerns had lessened, seems unfathomable. The Chair has reported that she felt “uncomfortable” with the proposal but acceded to this predominant view of the meeting – in which only a Health Visitor dissented. This lack of challenge from the other agencies is disappointing and was probably influenced by the presence of Ms L and her mother at the meeting, with Ms L arguing forcefully that there was no need for CP Plans.

The Chair has reported feeling that

“to change the decision unilaterally would undermine the process and disempower the professional group”.

This raises serious concerns. The Chair has a responsibility not just to enable the meeting but to give a professional lead.

7.1.32 There were other factors in play. Preparation for the meeting had been inadequate. The social worker had not drawn up a written report. Her supervisor had not discussed the case or the meeting with her. The

¹⁵ Children “in need” are not necessarily judged to be in need of protection. They are defined in law as children who need local authority services to achieve or maintain a reasonable standard of health or development, or to prevent significant or further harm to health or development, or are disabled

supervisor says that no concerns had been reported to her during the period under review (although, as described above, there were multiple concerns). The supervisor reports that she felt the Chair would make the right decision. The Team Manager recalls this as a time of relentless pressure from more senior managers to “down tariff” – that is, to seek withdrawal from and closure of cases as a way of managing work pressures.

7.1.33 One might feel that the CP Plans had made no impact on the quality of practice and the management of the case so that it made little difference whether or not they were in place. But the decision will have been significant to the family, and this was not just a one-off misjudgment. There was a lack of professional confidence, a lack of challenge and a context where the safety of children was not getting the priority it demands. This was again an important turning point in the management of the case.

7.1.34 If the input had lacked urgency previously, it now slowed further. Nearly 8 weeks passed before the social worker saw Child K. The Child in Need (CiN) Plan required visits at least every three weeks but the failure to do this was not identified and challenged by the supervisor. The CiN Plan had appropriately included contingency arrangements for “re-escalating” the management of the case into formal child protection arrangements if necessary but this was not done, or considered, in September 2011 when Ms L was again seriously assaulted by Mr X in the presence of the children. There is some evidence now that, as well as generally managing the case inadequately, SW3 was losing her professional distance and ability to prioritise the needs of the children – telling Ms L, after a further incident of serious domestic abuse, that she need not worry about “losing her children”. SW3 did not tell her supervisor about this contact.

7.1.35 Later that month MGM wrote to and telephoned SW3 several times to raise her concerns about the situation without any response. The letter, which went unanswered, contained specific new information suggesting physical abuse of Child K – a cigarette burn to the throat. These contacts were not made known to managers or followed up by SW3.

7.1.36 Instead SW3 now arranged, again apparently without reference to managers, for the case to be transferred to a student social worker, asking her to deal with the matters raised by MGM. This raises a range of concerns and is discussed in more detail below, in relation to the deployment of social work students. There was no further significant contact between CSC and the family before the death of Child K.

7.1.37 The management of this case by CSC lacked any professional rigour. There is evidence that the conditions and climate of the organisation at the time will have provided an environment in which chaos could thrive. The Overview Report¹⁶ from one of the other SCRs, written by the author of this report and already agreed by the SLSCB, describes that context:

¹⁶ [SCR Family A](#)

“During 2011/2012 five senior managers left the Council in various circumstances. There had been long standing concerns about the council’s ability to attract qualified social workers. Then, for over a year until the late summer of 2012, the council was involved in a high profile industrial dispute with the workforce as a result of changes to conditions of service. High numbers of staff left the council’s employment. In January 2012 only one qualified and experienced social worker had been appointed in a period of seven months and, in some teams, the use of agency staff was at levels of 40%...There were large numbers of unallocated cases. In the “long term” teams, at July 2011, there were three hundred children whose cases were not allocated to a social worker. Standards of practice were low – at August 2011 the council identified eighty-five children in care by agreement whose cases should have been taken through the courts. During 2011 three children known to CSC died.”

7.1.38 Serious individual errors emerge from this review but this was a demotivated and disorganised service. Staff – particularly at first line manager level - had unusually high and challenging workloads, in which they were juggling their priorities without adequate direction and guidance. To quote again from the earlier SCR

“This was not an organisation in which staff, at any level, could feel secure, and where good practice was effectively championed”.

7.1.39 Moreover, as another of the SCRs¹⁷ already agreed points out *“The problems within CSC were well known across the City and the evidence points to low expectations about the standard of practice by CSC and a failure across all agencies to challenge both CSC and each other”.*

7.2 Hampshire Constabulary

7.2.1 Mr C, Mr X and Mr Y all have numerous criminal convictions, many of which are outside the period under review and are of a nature – dishonesty - which is not directly relevant to the purposes of this review. However Mr X does have one conviction for a violent offence, affray, for which he was imprisoned, while Mr Y has been convicted within the relevant period for possessing a bladed weapon and Class A drugs. A great deal of the police involvement relevant to Child K was the result of domestic abuse. This issue is central to this review and is discussed separately at section 8.6.

7.2.2 The first police involvement arising out of direct child protection concerns was their response to the incident of Child K being mistreated by his mother in a supermarket. As discussed above in relation to CSC, the agencies’ response to this was not adequate. For various reasons, although police did initially make attempts to investigate, as the police IMR says, *“This investigation was clearly not dealt with thoroughly or expeditiously”.*

7.2.3 For police purposes it took nearly three months to complete that investigation, and there were avoidable delays within that time:

¹⁷ [SCR Child I and Child M](#)

“it seems surprising that this well known local family could not be located for 19 days using the combined efforts of police and children’s social care staff”. During the course of the investigation opportunities were missed. Statements were not taken from witnesses, and potential CCTV evidence was not checked before it was routinely deleted.

7.2.4 The IMR, using references to previous local SCRs, identifies structural and organisational issues underlying this ineffective response. There is a lack of continuity in following up matters which do not get resolved promptly. Staffing rotas and shift patterns, combined with the requirement to work jointly with CSC, which is largely a “9 to 5” service, can lead to investigations being passed between officers and consequently losing drive and focus.

7.2.5 The report argues that it is also unrealistic to expect child protection investigations – which are usually by their nature complex, especially when they involve formal interviews of victims – to be carried out by officers without specialist training and expertise. While the force has in part recognised this by a re-allocation of resources to child protection investigations, that move needs to be reinforced by a review and clarification of what constitutes a child protection referral. In this case the overlap between domestic abuse and child abuse was significant, even more so than is always the case. An appropriate recommendation is made in the IMR.

7.2.6 The second child protection referral coming to police attention was the information from workmen suggesting neglect and physical abuse. The serious nature of the allegations made was recognised by the Central Referral Unit (CRU), the section responsible for initial assessment of reports, judging the level of seriousness to be attached to them and allocating the investigation to the appropriate police team. However, because specialist Child Abuse Investigation Team (CAIT) officers were committed elsewhere the report was passed, appropriately, for follow up by the next most suitable unit, the Public Protection Investigation Unit (PPIU).

7.2.7 The PPIU officer dealing with the report liaised with CSC and accepted that there was no need for further police action, on the basis of advice that the injuries were consistent with Child K having walked into a door. This was an individual error by the police officer. The social workers’ enquiries were insufficient to meet the requirements of a police investigation into an allegation of a potentially serious crime. Apart from anything else they simply did not address the nature of the concerns reported:
“the apparent injuries that Child K was seen to have on his back and legs cannot be explained by walking into a door”.

7.2.8 It also seems that the officer dealing gave too much weight, in judging that no further police action was necessary, to the fact that this referral was made “anonymously”. In fact it should have been relatively straightforward for police to identify the source, but, more importantly, the fact that an allegation is anonymous should never be seen as a reason to doubt its reliability.

7.2.9 Although these were individual errors the IMR makes an important connection with broader considerations. The initial decision that this report required specialist CAIT investigation jointly with CSC was overturned by one individual officer and the force had no arrangements for that change of plan to be reviewed. This undermines the specialist knowledge and expertise of the CRU in determining seriousness of reports and how resources should be allocated. The IMR again makes an appropriate recommendation to address this weakness in structural / organisational arrangements.

7.2.10 The third time that police were involved in responding to immediate child protection concerns was when Child K was admitted to hospital in September 2008. As described above the officers dealing decided that there was insufficient evidence of any crime having been committed to warrant a criminal investigation. The police IMR reports, on the basis of police records, that

“The medical examination had identified 13 small, very minor bruises to various parts of the body. None of these were being regarded as inflicted injuries”.

7.2.11 This is not consistent with what is reported by other agencies. The hospital IMR reports

“there were significant inconsistencies provided to explain the bruising on his body and the cut and laceration to mouth and cheek. In addition, Ms L’s account for his facial injury also differed again from Child K’s”.

The report from the Solent NHS Trust advises that

“the strategy meeting minutes documented that (the Detective Sergeant) asked (the Consultant Paediatrician) whether the bruises...were due to poor parenting/rough handling or were more serious abuse, the doctor advised that ...at least some of the bruises were non accidental”.

This is correct – notes of the meeting were seen for this review and unambiguously state

“the Dr advised... that at least some of the injuries are non-accidental”.

7.2.12 The CSC IMR also correctly highlights the history -

“There is no reference to the ...pattern of neglectful and abusive parenting which was having an impact on his physical wellbeing and emotional and psychological welfare”.

7.2.13 It is of concern that police did not give sufficient weight to the medical advice and consequently were not now involved in following up this incident. As discussed throughout this report the management of this presentation raises concerns about all the agencies involved, but the position taken by police was key to this missed opportunity for a forensic investigation into Child K’s situation.

7.2.14 Following this, and until the death of Child K, police involvement was a consequence of domestic abuse, which is discussed more broadly in section 8 of this report. During the period under review five incidents of domestic abuse were reported to police. Generally police dealt with each incident appropriately, correctly carrying out risk assessments and liaising as

necessary with other agencies. Attempts to bring criminal charges were confounded by Ms L's repeated withdrawal of allegations, which persisted even after the death of Child K.

7.2.15 The Serious Crime Review conducted by Hampshire Constabulary after the death of Child K found serious weaknesses in the management and resourcing of the police investigations carried out. The number of officers allocated is described as

"wholly insufficient".

One of the key officers involved did not have the level of training and experience necessary to undertake an investigation into the suspected homicide of a child. Most importantly the Addendum Report submitted to this SCR concluded that

"the investigation should have been allocated to the force's major crime team... (which) would not only have secured more investigative resources but they would be staff and officers experienced in investigating homicides. The investigators would also have been supported by a dedicated major crime administrative team to administrate the investigative process in line with national guidance".

7.2.16. The Serious Crime Review made a number of recommendations, most of which were actioned during the reinvestigation into Child K's death in 2014. Other matters from the Addendum Report, relating to multi-agency processes, are discussed at section 8.10 of this report.

7.3 Southampton City Council, Prevention and Inclusion- pre-school and school provision

7.3.1 The extent to which Child K was abused emerges strongly in the reports submitted by his pre-school and his school. Sadly the failure of those establishments to respond appropriately to child protection concerns can be seen just as clearly.

7.3.2 The pre-school manager (who is also the establishment's proprietor and identified lead officer for child protection) had noted that Ms L's lifestyle was *"chaotic"*. Ms L often presented as nervous and, in the words of the manager *"always came across as a frightened rabbit"*.

However the manager felt that there were no concerns about Child K's behaviour. It is hard to reconcile those observations with what we know of the harm he had already suffered throughout his life.

7.3.3 In June 2008 Child K had bruising which was brought to the attention of staff by Ms L. The manager took no action. Then, on the last day of June, he was seen to have

"facial bruising, black eyes, a scratch on his forehead and purple markings on his right lid".

Ms L prompted the child to say that the injuries had been caused by Mr C. That may be true but she was now in the relationship with Mr X. It may be that Mr X caused the injuries, or that Ms L herself did, and she was covering this up and aggravating her dispute with Mr C, by coaching Child K into what to

say. In any event, whoever inflicted these injuries, the manager did not report this to CSC. She left a message for the social worker to call her but took no further action.

7.3.4 This was a grossly inadequate response. Workmen, without any professional background, saw what were probably the same injuries and recognised the need to ensure that they were investigated, while this childcare manager, with a lead responsibility for safeguarding, failed to do so. The IMR offers no explanation for this. The fact that neither of the June incidents led to appropriate action is extremely concerning. The second occasion was Child K's last day at this establishment which aggravates those concerns. A potential structural weakness – that the same person was the proprietor and the manager and the lead officer for safeguarding – is not addressed by the IMR.

7.3.5 The failure to respond adequately to child protection concerns continued when Child K went to school. When eventually an ICPC was held in April 2011 the IMR reports that:

“there were incidents contained in the report for the ICPC that were not reported to social care at the time, and would have been a significant concern, but were in the school CP file, while there were other incidents that were raised with social care at the time, but were not part of the report for the ICPC”.

7.3.6 There is no sense of order or reason as to why some incidents were recorded / reported by the school and some were not. Two of the incidents not reported were clear allegations from Child K, in April 2010 and October 2010, of physical abuse by Mr X. In November 2010 the school was contacted by Ms L's mother, concerned about domestic abuse in the family. The school recorded this as the first evidence of such concerns when they had already been aware that it was a continuing problem. Importantly, when the school submitted their written report to the ICPC, they made no reference to Child K's sexualised behaviour which they had identified as a matter of concern in school early in 2011. There is further evidence during the 3 months that Child K was subject to a Child Protection Plan of school staff failing to liaise adequately with CSC. The school supported the decision to terminate the CP Plan.

7.3.7 The initial omissions at the ICPC have been explained by the officer from the school who made the report to that meeting – the Child Protection Lead Officer (CPLO) – as a consequence of the school

“not wanting to upset the parent”

whom they knew would be at the meeting. The CPLO also justified this action on the basis that all concerns had been shared with CSC and it was expected that social workers would raise those concerns. In fact, as described above, not all the reports had been passed to CSC and, in any event, it was the school which had first-hand knowledge of the evidence of abuse. As with the pre-school provision, it was the person with lead responsibility for child protection who failed to raise important concerns.

7.3.8 The IMR emphasises that responsibility does not cease when a referral to another agency has been made. The report also correctly emphasises the important position of schools, where staff will see children far more often than other professionals. However again the IMR does not go more deeply into assessing why the school failed to respond appropriately to signs of abuse. It cannot all be attributed to the CPLO taking the view that CSC were dealing and that there was no need for liaison. Some of the concerns were never reported to CSC at all. The extent of Child K's sexualised behaviour and what may have been behind that was not given adequate weight at any time.

7.3.9 There are a number of accounts across the agencies of Ms L presenting as plausible. There are also some descriptions from the school of Child K presenting as lively and well-motivated -

"a popular and friendly boy, kind caring and thoughtful".

These considerations may have misled staff. Yet they cannot adequately explain the lack of alertness to the needs of a child whose neglect and abuse had been evident throughout his time in education, and was formally recognised by all the agencies when the CP Plan was put in place. It is a serious concern that the CPLO arrangements failed Child K, both here and in the pre-school provision and there is a consequent recommendation from this report.

7.4 Solent NHS Trust

7.4.1 This Trust provided a range of community health services to the family during and outside the period under review.

7.4.2 The Health Visiting service became involved after the birth of Child K. They became aware of the issue of domestic abuse in the family at an early point, and raised this directly with Ms L, though she minimised any cause for concern. Health Visitors continued to be concerned about this, although their emphasis was generally on trying to support Ms L rather than always keeping sight of the consequences of domestic abuse for her children.

7.4.3 In July 2008 a Health Visitor, at the request of the social worker, saw Child K in clinic. This was in the wake of the investigation arising from the referral made via the NSPCC. The reason for this request is unclear, as is the basis on which the Health Visitor agreed to it. It was not part of any agreed plan of intervention, and there was no feedback to the social worker.

7.4.4 The Health Visitor noted that Child K had a blood blister in his eye. Such a presentation might have a number of causes but one could be a blunt force injury. The Health Visitor spoke to Ms L who suggested an accidental causation, which the Health Visitor accepted. She did not liaise with any other professional to discuss or "cross check" this and, at an even more basic level, did not establish whether Ms L had sought any medical help or advice about the injury.

7.4.5 We cannot know whether this particular injury was accidentally caused but it is one of many incidents across most of the agencies when an

explanation of accidental causation was accepted from Ms L without question. That must say something about Ms L's presentation, vulnerable yet plausible perhaps, rather than intimidating or alarming to staff. But this was an experienced professional, aware of recent child protection concerns, who did not respond to what could be an inflicted injury. There is, throughout the history, a lack of diligence and thoroughness by the practitioners involved.

7.4.6 This Trust managed the CAMHS service which was involved with the family, as a result of a referral from the GP, between February and May 2008. Their involvement was terminated when they were assured by Ms L that Child K's behaviour no longer gave cause for concern.

7.4.7 There is evidence of some good liaison between this service and other agencies but one significant missed opportunity. At a home visit in March 2008 a Family Support Worker (FSW) specifically recorded Child K saying that Mr X bit him when he put him to bed. The FSW had broad concerns about the family – Child K's overall presentation and the quality of attachment between him and his mother. However the FSW did not identify or respond to the clear child protection implications of this comment from the child.

7.4.8 The FSW reports that she took the view that there was no need to share this information with CSC as they were already involved with the family. That is disingenuous. It misses the point that CSC had become involved precisely because of concerns about the family and clearly needed to be aware of any information which might be relevant to those concerns. In any event the FSW did speak to CSC that month and still did not share this information, despite being informed that CSC were closing the case.

7.4.9 The involvement of CAMHS seems superficial, and the decision to terminate that involvement, based on an assurance from Ms L that things were improving, is of concern. That concern is heightened because the FSW thought that Mr X might have been surreptitiously listening to her conversation with Ms L, who appeared anxious. Confusingly, the IMR reports both that the staff in question felt that managers were appropriately involved in the management of the case but that *"the FSW's involvement with the family was not discussed with her supervisor/manager"*.

7.4.10 The Trust has reported that the specific service that was involved at the time was not well integrated with other services, with no clear arrangements for referring on for more specialist help. Eligibility arrangements have changed since that time and the IMR advises that the reported concerns about Child K would not now meet the threshold for their involvement. Yet the original referral from the GP was appropriate to the concerns raised and it is unclear how families might now be assisted with such difficulties.

7.4.11 There does seem to have been a further referral to CAMHS, from a health visitor in October 2008, after the events in the previous month when Child K was admitted to hospital. The health visiting service has records of making such a referral and of a discussion with FSW, who felt that there was

no need for CAMHS involvement. CAMHS have no records of this referral and response.

7.4.12 It seems most probable that the referral was made which raises concerns about documentation and record-keeping in CAMHS at that time, and also about a lack of clarity as to what services CAMHS were offering. The IMR further reports that the health visiting records *“do not identify the rationale for (CAMHS) not accepting the referral, when this decision was made and how this was communicated back to health practitioners”*.

7.4.13 The Community Paediatric service was most significantly involved when Child K was admitted to hospital with injuries in September 2008. As discussed above, the community paediatrician told the meeting, held on the day of hospital admission, that *“at least some of the bruises were non accidental”*.

The paediatrician’s written report from this medical examination states that *‘the range of bruises were all of different colours, in different sites and implied different ages. It was unlikely that Child K would have sustained all these bruises accidentally and in addition, many did not have a forthcoming explanation.’*

The note taken of the injuries is detailed but there was no challenge to the vague explanations offered by the mother.

7.4.14 If a paediatrician unambiguously informs agencies with statutory child protection responsibilities that a child has unexplained, non-accidental injuries, and, further, when that report is supported by witness evidence of the mother repeatedly behaving harshly towards the child while on the hospital ward, it cannot be right that there is no child protection investigation. Equally the Community Paediatrician and all those at the meeting, including a hospital consultant paediatrician, appear to have accepted the judgment that there should be no further child protection investigation but that the social worker would carry out a Core Assessment. It was clear to all that police were to take no further action.

7.4.15 After the meeting it was incorrectly recorded by health professionals that a child protection investigation would be undertaken, but this was not recorded in the formal minutes of the meeting and no other agency has any such record. Those formal minutes were not distributed to agencies by CSC until nine months after the meeting, but no challenge was then made by health professionals on the issue of whether there was to be / should have been a child protection investigation. The lack of formal, sustained challenge to this inappropriate decision, by medical staff who had identified inflicted injuries, was unacceptable.

7.4.16 In April 2010 a school nurse was told by the Head Teacher that Child K had bruising to his head, which he said had been caused by his “father”. The school nurse made a record that the school was following this up but did not check that any action had been taken, In fact no child protection referral was made by the school and there is no record that the child received any medical

attention at the time. This echoes the incident when the FSW assumed that CSC would be aware of information and there was therefore no need for her to act. This recurring feature indicates both that relationships between agencies were not sufficiently close and that professionals were not alert to their individual professional responsibilities. This was a matter that should have been formally referred for a child protection investigation, not reported almost casually to the nurse.

7.4.17 In August 2010 the school nurse and the health visitor discussed the situation with a Specialist Safeguarding Nurse and decided that the family need no longer be regarded as raising particular concerns. It is difficult to understand the thinking behind this decision, especially when it was taken with the benefit of specialist advice. The IMR notes that there had been a number of changes of health visitor, which may have hindered them from taking a long-term view, so that the decision was largely based on the recent experience of the health visitor at the time. But this was a family with entrenched, long-term problems. There was no liaison with CSC and no clear reference to what these professionals expected other agencies might be doing, if anything. Even allowing for the benefit of hindsight it is hard to see any enduring, positive change in the family's circumstances which would have led the practitioners in this direction. It perhaps again points to both the plausibility of Ms L's presentation, and a lack of rigour in considering the facts.

7.4.18 One consequence of the decision to "downgrade" the concerns about the family was that there was no liaison with the health visiting service in the new locality when the family moved house a few months later. Had they still "officially" been seen as a cause for concern, systems would have prompted that liaison. As a result, when new issues were routinely notified to health visitors following police involvement with the family, the health visitors were not aware of the full background of previous concerns. The school nurse - the same school nurse because Child K was still at the same school - was also notified but did not liaise with the health visitors or GP.

7.4.19 Community health professionals became significantly involved again in March 2011 when the children were made subject to Child Protection Plans. The School Nurse, a very experienced practitioner, made a point of speaking to Child K before that meeting and was able forcefully to represent to the meeting the evidence of his enduring unhappiness and its links with persistent domestic abuse in the family.

7.4.20 However, when Child K was re-assessed by the School Nurse prior to the Review Conference three months later, as described at Paragraph 5.7.8, she noted that he had facial bruising, which he attributed to an accident on a trampoline. He also presented as tired and his weight was static. Despite the fact that he was subject to a Child Protection Plan these issues did not lead the nurse to liaise with CSC (or any other agency). She did speak to Ms L who dismissed any cause for concern. Again Ms L seems to have been able to present in a way that professionals, even experienced, specialist professionals, found credible.

7.4.21 We know now that this Child Protection Plan was effectively meaningless, principally because of the lack of leadership from CSC. But all the agencies contributing to the Plan had an equal responsibility to share information. Facial bruising to a child with this history and the other concerns about his presentation clearly should have prompted the nurse to liaise with other agencies. It seems that the focus of attention was drifting away from the immediate safety and welfare of the children, towards a greater preoccupation with the domestic abuse in the family.

7.4.22 The school nurse, in common with most of the other agencies involved, was in favour of terminating the Child Protection Plan at the first Review Conference. Only the Health Visitor felt that this was a premature decision. A Child in Need Plan was drawn up, with various actions allocated to the community health practitioners. They were followed up appropriately and there were no further significant incidents in which these services were involved before Child K's death.

7.4.23 Some well-worn themes emerge from an overview of this agency's involvement with Child K. The IMR comments on the lack of liaison between the GP and community health services:

"there was no recording of any direct liaison from the GP or to the GP during Child K's lifetime".

However the SCR panel heard that there have been significant improvements in the quality of liaison between these services, prompted, to some extent, by matters arising from a previous SCR in Southampton. GP practices are now required to hold formal meetings with their link health visitors (and midwives when appropriate) on a 6-12 weekly basis (depending on size of the practice). The GP and HV are asked to identify children who are flagged as vulnerable and agree joint actions.

7.4.24 It can be anticipated that a SCR will find failure to communicate and share information adequately. Such failures need to be put in context – they are easy to identify with hindsight, and hindsight also brings a clarity to the evaluation of how significant something might be. But some of these failures are not so easily explained. There must be serious concerns when health practitioners do not recognise the significance of what was admitted to be an injury caused by an adult biting a child's face, or of facial bruising to a child recently made subject to a Child Protection Plan.

7.4.25 The abiding concern arising from this IMR is that it reflects a degree of complacency. Practitioners who become involved in reviews like this need to be able to reflect on what has happened and learn from it. Yet the IMR variously reports that

"Having interviewed the (relevant officers) all practitioners felt (they had adequate) knowledge on the indicators of abuse and how to act on any concerns".

and

"(the officer) informed the author that her manager at this time was (too) overwhelmed with her own work load to have one to one managerial

supervision but she feels that this did not impact on how she managed the case”.

This should be the focus of further reflection for this agency.

7.5 University Hospital Southampton NHS Foundation Trust

7.5.1 The report from this agency deals with Ms L’s contact with maternity services, the contact between a number of family members and general medical services, and with A&E services. Hospital-based services had no professional contact with Mr X or Mr Y.

7.5.2 Ms L’s children were born at University Hospital Southampton. Her contact with maternity services, though sometimes disrupted by other circumstances, was generally satisfactory – certainly there was no lack of compliance that would suggest cause for concern. For the purposes of this report, no major learning points arise from the involvement of maternity services with this family.

7.5.3 The most significant contact with the hospital was the occasion when, in September 2008 at just over four years old, Child K was brought to A&E with Injuries to the penis and a

‘mild abrasion to right forehead, slight laceration, abrasion on right upper lip, some blood in left nostril and finger tip bruises to right thigh’.

He presented as very upset and staff found it difficult to engage with him. His mother behaved inappropriately towards him, shouting and handling him roughly, so that staff had to intervene to stop her. The child gave what appeared to be rehearsed responses when asked how the injuries were caused, saying for example that he had

“walked into a door”.

Staff had explicit concerns that he may have suffered inflicted injuries.

7.5.4 The report from the hospital adds to the concerns arising from the accounts of all the other agencies involved. The IMR notes that

“there were significant inconsistencies (in the accounts) provided to explain the bruising on his body and the cut and laceration to mouth and cheek. In addition, Ms L’s account for his facial injury differed again from Child K’s. . The potential significance of these inconsistencies...do not appear to have been fully recognised, nor responded to by practitioners”.

Also, these concerns were not fully recorded by hospital staff until the day after discharge so that an opportunity to present a better informed picture to the Strategy Meeting was lost.

7.5.5 There were other worrying factors. Accounts are again inconsistent or inadequately recorded but it is possible that Ms L had not brought Child K to hospital promptly, and that this was not recognised as a cause for concern in itself. Ms L had spoken of leaving Child K – a four year old – unsupervised in the bath, offering this as a possible explanation for injuries. Essentially the IMR identifies a lack of thoroughness in the way that hospital staff reacted throughout this incident.

7.5.6 In the context of the weaknesses already noted in the responses of all the other agencies involved, this presentation can now be seen as the most significant missed opportunity to identify physical abuse as a serious cause for concern. This is the only recorded occasion that a group of experienced professionals including paediatric nurses and doctors had unequivocal concerns, arising directly from observation of the mother's conduct and from medical evidence, about inflicted injuries and abusive treatment of Child K. Yet the dynamics of the inter-agency meeting at the hospital were such that these concerns became diluted and eventually were lost.

7.5.7 A year later in September 2011 Ms L herself was treated in hospital as a result of injuries caused, she said, in an assault on her by Mr X. She had been punched to the face, neck and body as a result of a dispute about a computer game. Hospital staff made appropriate referrals to police, CSC and to the IDVA who was already involved following previous domestic abuse.

7.5.8 The next significant contact with this hospital was in fact when Child K died. Hospital staff dealt appropriately with all the immediate aspects of this challenging situation but there are concerns arising from events after the death. These are considered separately below.

7.6 The General Practitioners

7.6.1 Because of the number of individuals involved – the children, their mother, her partners and their partners – information has been drawn together from eight GP practices in Southampton. The only evidence of GPs responding proactively to concerns about Child K is the referral to CAMHS in 2008. The outcomes of that referral were routinely reported back to the GP but did not lead to any further action, which is understandable – the GP could reasonably be expected to await further contact from Ms L who had sought help in the first place. After this the GPs received partial information from other agencies which had been more directly involved and were reporting back to the GPs.

7.6.2 The GPs were invited to the ICPC but did not respond. There are factors which make it difficult for GPs to attend such meetings.

“Most GPs book their surgeries more than 2 weeks in advance making attendance very problematic. As small businesses the financial implications of remunerating a locum to cover a session to attend is prohibitive and compounded by the current capacity issues and lack of availability of suitable locums”.

This does not excuse or explain a straightforward failure even to respond to the invitation. Arrangements have now been made, with partial success, to facilitate GPs' contributing reports to Child Protection conferences.

7.6.3 The GPs should be a lynch pin in the network of services that can be working with a family. Here there is little evidence of any of the GPs recognising the “social” aspects of the case – the multiple indicators of potential concern and drawing them together.

“There is no documentation pertaining to the home or social circumstances in any of the patient records ...Despite the significant amount of information shared in the minutes of the child protection conferences about home circumstances, past criminal activity (both mother and stepfather) and parental cannabis use there appears to have been no consideration of what the home conditions were like for the children and what effect these factors had on the parenting capacity of the adults charged with their care”.

7.6.4 There are structural factors which affect the ability of GPs to take the overview they might offer. Families have different surnames, different addresses and the adults may have a number of relationships. Since 1999 there have been mandatory arrangements for a standardised system of recording clinical information (READ codes), including a uniform set of READ codes relating to safeguarding and child protection. However there is still room for inconsistency and error in the use of those codes. Depending on how information is recorded and by whom, the overall process of drawing information together and understanding its potential significance can be hampered.

“There were a number of important factors which were not READ coded appropriately to highlight the vulnerabilities and risks to this family including that of domestic violence, maternal cannabis use, aggressive behavior with criminal convictions and concerns about poor living conditions. There is little evidence that any of these were considered as risks to the children”.

7.6.5 The final sentence of the previous paragraph is particularly significant for a review like this. A key message for GPs is to recognise that they can be the professionals best placed to link issues in the way adults present with the potential for those issues to affect parenting capacity. This leads to an important practical recommendation from the IMR:

“Assessment should be made with regard to parenting capacity during all engagements with individuals who present with mental health issues, emotional distress, learning disabilities, or drugs and alcohol misuse. Potential parental risk factors need to be READ coded in children’s notes to increase awareness of the potential risk”.

7.6.6 Those improvements in practice need to be supported by the structural arrangements for the delivery and quality of GP services. The IMR explains the limitations in current arrangements – in summary, a set of financially rewarded targets, which do not necessarily focus on outcomes and are not monitored thoroughly. The principal conclusion from this IMR is compelling: *“(without)... robust monitoring arrangements and an accountability / governance structure there is no incentive to change and we still focus on measurable disease processes and not holistic health and wellbeing outcomes or the factors which could highlight potential vulnerability and risk”.*

7.7 Cafcass

7.7.1 The involvement of Cafcass arose, in 2007, from the dispute in the courts between Ms L and Mr C about residence and contact with Child K . It came to an end at the conclusion of these proceedings in December 2008,

when Mr C did not attend the final hearing and no order was made by the courts. It is right to say at the outset that Cafcass is an organisation which had well recognised problems some years ago and has made major changes to its operational arrangements and overall culture since that time. There have also been local management changes which are significant. The report from Cafcass does describe weaknesses but it is accepted that they have introduced a raft of new systems and practices intended to address these problems.

7.7.2 The agency's initial contact with the family is described in their IMR as "poor". The adviser who saw them did not respond appropriately to significant and substantial information about domestic abuse. A recommendation could have been made to the court that there be a welfare report before making any directions as to contact and access. There was no such recommendation and staying contact with Mr C was agreed, despite the evidence of cause for concern. The report does identify that

"in 2007 there was a strong, implicit culture in the Southampton court, with some judges, that contact should take place between an absent father and child unless (there was) categorical proof evidenced risk".

Also, at that time the culture in the agency would have been led by Duty Officers seeing their role as primarily to assist the courts in managing cases, without necessarily prioritising the best interests of the child. That is now explicitly the service's fundamental consideration.

7.7.3 Concerns about Mr C and then Mr X were not fully recognised until the fourth contact with an adviser in June 2008 when a welfare report was recommended. During the course of the subsequent contact the allocated adviser was told that there had been an accident and Child K had been injured. Despite the recognised concerns in the case this did not lead that adviser to liaise with CSC.

7.7.4 Evidence of physical injury to Child K came to the attention of Cafcass officers twice, in August and October 2008, but there was no recognition of the possibility of physical abuse and the potential need for a child protection referral. The IMR then considers the incident in December 2008 at the Cafcass offices, when Mr X threatened to stab Mr C in the presence of Child K and his sibling. This was appropriately referred to police and CSC, and there is an identifiably more urgent approach in the work of the adviser at the time. However the reviewer notes that the arrangements for the meeting could have been better thought through, to avoid such a confrontation. Moreover Child K was not then seen at all for the purpose of the proceedings. The IMR also notes that

"the incident at the office may have distracted (the Cafcass officer) from assessment of the risk issues presented by Mr C and in his final report contact was promoted... without assessment of the risks identified at the outset".

7.7.5 The report stresses that the role of Cafcass in this case was limited but rightly acknowledges that the officers dealing were qualified social workers who should recognise evidence of child protection concerns and that the local

authority should be made aware of those concerns. The report is very thorough, detailing both the missed opportunities in the Cafcass response to events and the service improvements made since that time.

7.7.6 There is one issue that the report from Cafcass does not highlight as a cause for concern when it might do so. They made repeated unsuccessful requests to the local authority for access to the allocated social worker's Core Assessment and were eventually told that it could not be shared without a manager's permission. The matter was not resolved. In fact we know from CSC that the Core Assessment *"commenced on 16.09.08 and was concluded and signed off on 19.05.09"*.

7.7.7 So when Cafcass were pursuing this, in the period leading up to the final hearing in December 2008, the report was far from being completed, as it should have been, within 35 days, and it appears that the social worker was dissembling to conceal that. While that is principally a matter for the local authority the Cafcass officer could have escalated their unsuccessful requests to a more senior level.

7.7.8 Making good use of escalation arrangements should not be seen as a threat. Rather it should contribute to the development of constructive challenge across agency boundaries as a positive element of safeguarding practice. There is a recommendation from this report which raises the issue of escalation for all agencies.

7.8 Southampton City Council, Independent Domestic Violence Advisor Team

7.8.1 Broader issues about the relationship between domestic abuse and the safeguarding of children are discussed in section 8. This section of the report considers the extent to which this service was able to meet the requirements of its specialist role. The IMR explains that:
"The IDVA service has a specific function to provide intense one to one advice & support to victims of DV identified through robust risk assessment to be at the highest risk of serious physical harm or death. The IDVA service is ... based on nationally recognised best practice and has been accredited to national standards ... (and) aims to reduce the risk of harm to victims through safety planning, security measures and support through the criminal and civil justice system. IDVA intervention is usually intense and at a critical point in the safety of the victim and the support should be short term lasting around 4 months until the immediate dangers and risks are reduced and ideally the domestic violence ceases".

7.8.2 The IDVA service was first involved with Ms L between October 2007 and March 2008. She had been referred by police as a result of violence and threats from Mr C. An IDVA, who was also the service manager, was involved in supporting Ms L through the various legal processes arising from her separation from Mr C and negotiating arrangements for his contact with Child K. Ms L gradually withdrew from contact with the IDVA and the service

terminated its involvement after a number of attempts to contact her, to which she did not respond.

7.8.3 The service next became involved in March 2011, with the same IDVA, again as a result of a police referral, but now because of violence from Mr X. From an early point the IDVA identified that Ms L was minimising the nature and consequences of the abuse. When she resumed the relationship with Mr X she did not respond to most contacts from the IDVA and there was a period of months when, although the case remained allocated to the IDVA, there was no contact. Ms L then cancelled some appointments and had occasional telephone contact with the IDVA but generally appears to have avoided contact. The case was still technically open to the IDVA when Child K died.

7.8.4 The IMR explains that the service had been established early in 2007 and was significantly under-resourced until 2013, when staffing reached the level recommended by Coordinated Action Against Domestic Abuse¹⁸ (CAADA). During that period the IDVA service was also evolving and developing more effective and efficient working relationships.

7.8.5 The issues related to resources and the development of the service effectively mean that this case would not now be handled in the same way as it was then. The service manager would not be directly involved but would be providing supervision to staff. A Safeguarding Policy specific to the service has been implemented and electronic recording and case management systems introduced.

7.8.6 Overall the service, and partner agencies, recognised that in relation to domestic abuse this was a “high risk” case and generally responded in line with the resources and working arrangements at the time. There was actually relatively little direct contact between the IDVA service and Ms L, and a good deal of evidence, particularly in relation to Mr X, that Ms L avoided the service.

7.8.7 However there are indications of weaknesses across and between the agencies. It is clear that the IDVA was frustrated at times with a failure by CSC to follow up actions agreed, such as a decision to make a referral to a specialist NSPCC service. Yet the IMR does not pick up the point that this frustration should have led to escalation of concerns to more senior managers.

7.8.8 Equally, at the Child Protection Conference in April 2011, attended by the IDVA, it was agreed that there should be weekly contact between the IDVA and Ms L. That is an ambitious target, especially for a developing service, still trying to find its feet. Predictably the IDVA was unable to achieve and maintain this level of involvement. Ms L was also evasive and there is some evidence of controlling behaviour by Mr X – taking and keeping Ms L’s phone - to undermine the arrangements made.

¹⁸ This is the national charity commissioned by the Home Office to implement procedures for a risk based approach to dealing with domestic abuse.

7.8.9 The IMR acknowledges that the commitment made at the ICPC was not achieved but does not reflect on why that was the case, what it meant for the assessment of risk or whether other agencies were made aware that an unachievable target had been set. In fact the IMR comments, oddly, that *“It is very difficult to ensure that the Individual management Review does not become a critical analysis of the way in which the IDVA Service operates”*. That is exactly what the IMR should provide.

7.8.10 Overall, in the face of Ms L’s sustained avoidance, it seems improbable that anything the IDVA service might have done differently would have altered the course of events. It is also clear that this service has worked hard to attract and maintain the resources needed to support and develop the team. But, as with some other services contributing to this review, there may be a need for a greater openness to learning lessons across the agencies from these events.

7.8.11 A specialist service supporting those who have suffered domestic abuse needs to maintain a sensitivity to issues of child protection. These are very likely to arise in their work. Yet there is again a complacency in the IMR’s comment that

“The IDVA Service is adult focussed as it is believed that the best protection for the child is the protection offered to the mother”.

That comment avoids the issue that abused mothers (or fathers) may not protect their children and may indeed be both directly and indirectly involved in harming them.

7.9 Hampshire Probation Trust

7.9.1 This Trust (HPT) had no involvement with Ms L but had substantial contact with Mr X, Mr Y and, to a lesser extent, Mr C.

7.9.2 Mr C had contact with HPT before and after but not during the period under review in this report. He had convictions for offences of violence and was supervised by the probation service in 2004. During that supervision he was brought back before the courts twice for non-compliance. After the death of Child K he was supervised by the HPT for an offence of shoplifting. There are indications that the death of Child K, and the subsequent determination that he was not in fact the child’s father, have affected him and compounded problems such as misuse of alcohol. HPT’s involvement with him has been appropriate and no issues arise from it.

7.9.3 The service knew Mr X first when he was on license after a custodial sentence for a crime of violence. He was generally compliant and engaged satisfactorily with the supervision requirements. There was at that time nothing to suggest any issues of domestic abuse or child protection. The most recent contact with probation was in May 2008.

7.9.4 Mr Y was known to probation after failing to comply with the requirements of supervision by the Youth Offending Team, for offences

committed in his youth. He then became subject to probation supervision, with which he repeatedly failed to comply, leading to a custodial sentence. His most recent involvement with probation came to an end in October 2009.

7.9.5 During their involvement with probation it became known that both Mr X and Mr Y had been abused within their family as children. Mr Y was judged to have been particularly affected by this, and the probation officer reported difficulty in engaging him. Supervision addressed substance misuse, mental health and strategies for coping with stress, all of which were appropriate for his presenting problems.

7.9.6 The report from HPT does identify, with the benefit of hindsight, some learning points, but these are not matters likely to have altered the course of events. The report rightly identifies that there was no specific evidence of anything that should have raised child protection concerns for any children in contact with these brothers.

7.10 South Central Ambulance Service NHS Foundation Trust

7.10.1 This Trust was significantly involved in that it transported Child K to hospital after he suffered his fatal injuries. However no safeguarding referral was made by the ambulance staff involved.

7.10.2 This Trust did not comply with the request to submit an IMR. After repeated requests the Trust eventually provided answers to specific questions raised by the SCR Panel Chair. Most significantly the Trust confirmed that no safeguarding referral was made because the ambulance staff *“thought that as the child was being taken to hospital in cardiac arrest ... the investigation process would be started anyway”*. Even more worryingly the response confirms that the staff in attendance *“did have safeguarding concerns”* but assumed that other agencies would deal with this.

7.10.3 The strapline on the SLSCB website is the familiar assertion that *“Safeguarding is everybody’s business”*. It should not be necessary to remind ambulance staff, at the sharp end of responding to the abuse of children, of that responsibility. They should be aware of the important role they may need to play as evidence is drawn together, perhaps for legal proceedings. The fact that the Trust struggled to comply with the requirements of the SCR process, underlines that concern. There have been similar problems in other SCRs locally.

7.10.4 The Trust has acknowledged their failing in this case and has advised of a number of measures to address the issue, and monitor compliance. The Board will also wish to keep their performance under review.

7.11 Southampton City Council, Adult Services

7.11.1 This agency was involved only once, in September 2011, when Ms L was being treated in A&E at Southampton General Hospital for injuries said to

have been inflicted by Mr X. Ms L was treated during the day and was discharged in the early evening. The following morning adult social care services at the hospital received a safeguarding referral which had been completed on the ward during the afternoon of the previous day but not faxed through until that morning.

7.11.2 Adult Services did follow this up by contacting Ms L directly without delay, and satisfying themselves, as best they could from her responses, that she was receiving appropriate advice and support. However they make the point that their ability to respond most effectively to referrals like this depends on the referrals being made, ideally, while the alleged victim is still in the hospital. Otherwise they have *“no opportunity to formulate a risk assessment and subsequent protection plan”*.

7.11.3 We do not know if this is a frequent problem but it does highlight a potential weakness in working arrangements between agencies. This has been referred to the Southampton Adults Safeguarding Board for their consideration.

7.12 Dorset Healthcare University NHS Foundation Trust – report for information

7.12.1 This agency provided the mental health service which Mr X had contact with in September 2011 after the serious assault on Ms L. Their report explains that *“The Steps to Wellbeing Service is part of the National Improving Access to Psychological Therapies (IAPT) programme. The service provides a range of short-term psychological interventions to adults experiencing depression and/or anxiety disorders”*.

7.12.2 Mr X attended once for assessment, describing how, for most of his life, he had been *“depressed, stressed and angry”*.

He particularly wanted help with controlling his anger. The assessment indicated a moderate depression and he was offered high intensity cognitive behavioural therapy. He attended one session in mid-October, failed to attend two subsequent appointments offered, both in October, and was then discharged from the service.

7.12.3 This brief contact is the only evidence received by this review suggesting that Mr X had any degree of insight or awareness of his problems. However, even though the service responded promptly and efficiently, he withdrew and the contact proved minimal. It does not add to the lessons to be drawn from this review.

7.13 Southampton City Council, Housing Services – report for information

7.13.1 For most of the period under review Child K did not live in local authority housing. Ms L had been a council tenant, after a period of homelessness when Child K was born, but she left her tenancy nearly three years before her son's death. She did so to go to Staffordshire in 2009. When she returned to Southampton, with the assistance of the local authority, she moved into privately rented accommodation, where she remained until Child K died.

7.13.2 This report does identify some room for improved sharing of information across agencies, but these would not have affected the overall course of events. This agency's role in this case was minimal.

7.14 NSPCC - Report for information

7.14.1 The only significant involvement of the NSPCC was that they were the agency contacted in June 2008 by workmen who had been working near the family home and were concerned about Child K. The information recorded by the NSPCC is alarming:

“(The workmen) had seen the child (male aged no more than five years) on several occasions, assumed to be going to and from school. He was described as constantly having a lot of bruises...the day before he was seen to have two black eyes (as if he'd been “hit by a boxer all black underneath”) and a nasty cut on his forehead which was also badly bruised. There was bruising to his back (he had his shirt off) and legs and a bite mark (described as being like a love bite) on his leg. There were a couple of finger marks around the child's neck and a couple of finger marks under his jaw”.

The workmen had spoken directly to the child, who was hanging around the area, not indoors and not at school, and he had told them he had walked into a door. They had also noted that a woman they believed to be his mother had two black eyes.

7.14.2 The NSPCC passed this information to CSC without delay and had no further involvement. As described above the CSC response was slow and inadequate, as was that of the police. In fact the NSPCC did not refer the matter directly to police as well as CSC, which they should have done. It was also “signed off” for no further NSPCC action too swiftly and without the response being tracked. The report from the NSPCC explains procedural changes made which should now prevent this happening.

7.15 Staffordshire County Council - Report for information

7.15.1 Little is known about the episode in 2009 (from March for a few months) when Ms L and the children were living in Staffordshire. CSC in that area have no record of involvement but the school at which Child K was registered has reported that his attendance was poor at 46% and an Educational Welfare Officer was involved. It is known that Ms L continued to

attend some ante-natal services in Southampton, which may to some extent explain the poor school attendance, and suggests that she always intended to return to this area.

8. ISSUES ARISING FROM THIS OVERVIEW OF THE CASE

8.1 Introduction

8.1.1 As explained above a number of SCRs were initiated at the same time by the Board. Three SCRs have already been adopted and published. Most of the agencies contributing to those SCRs are, as one would expect, the same. The periods of time under consideration in each review overlap substantially. One of the reviews – Family A – is different in that the family in question were from a travelling community. Otherwise there are similarities in the circumstances of all the families.

8.1.2 This is a “stand alone” report. It describes and addresses the key issues emerging from this SCR. However there is a significant correspondence between the lessons learned from the reports already published and the matters arising from this review. This section of the report will highlight key issues specific to this review, and will also cross-reference and quote from the published reports, but will try not to repeat the detail of points already made. Inevitably, recommendations from this report echo those made from the reviews already completed.

8.2 The “voice of the child”

8.2.1 A failure to hear what has been termed “the voice of the child” is such a frequent finding in SCRs that Ofsted has examined this issue in depth in published research¹⁹. Ofsted found five key messages with regard to the voice of the child.

1. The child was not seen often enough by the professionals involved, or was not asked about their views and feelings – Child K was rarely seen alone by a social worker. The only professional who appears to have successfully engaged with him directly on one occasion was a school nurse.
2. Agencies did not listen to adults who tried to raise concerns – Child K’s MGM repeatedly tried to raise concerns, as did the workmen who saw an injured and neglected four year old child.
3. Practitioners focused too much on the needs of the parents, especially on vulnerable parents – the domestic abuse of Ms L became the focus of agencies’ attention, to the detriment of Child K, and to a lesser extent, his siblings.
4. Agencies did not interpret their findings well enough to protect the child – in this case agencies never formally identified the likelihood of physical abuse and appear to have been led by a false confidence, for example when they terminated Child Protection Plans at the earliest

¹⁹ The voice of the child: learning lessons from serious case reviews (Ofsted April 2011)

opportunity and without any firm evidence of improvement in the situation

5. Parents and carers prevented professionals from seeing and listening to the child – this may not apply in this case. Ms L often spoke about the child's injuries, giving at times improbable explanations – but may have been confident from her previous experience that this would not lead to a coherent response.

8.2.2 An even more fundamental concern, not directly included in Ofsted's list, is the situation where the child does directly disclose cause for concern but that disclosure does not lead the agencies to take any or any effective action. To some extent that is explained by the points listed above but it is also of course a cause for concern in its own right. There are at least three occasions when Child K spoke of being physically harmed by Mr X but no action was taken.

1. In April 2010 Child K was seen to have bruising to his head in school and told teachers that Mr X had done this by banging his head on a bed and a bicycle.
2. In October 2010 Child K hit another child in the face, saying that this was what "Daddy" did to him.
3. In June 2011 Child K spoke at school about "*getting bruises off my dad*"

8.2.3 A particularly tragic aspect of this case is that there are indications that, unlike some abused children, Child K might have been relatively easy to engage and further disclosures may have been facilitated. There is evidence suggesting that he was coached in what to say if questioned about injuries, but there is also an ingenuous quality to his conversations with staff, especially in school. That suggests that an experienced assessor might have found a way in, and heard the "voice of the child". As we know, principally as a consequence of both organisational disarray and individual error in CSC, there never was such an assessment.

8.3 The overall quality of child protection services

8.3.1 This review highlights very basic shortcomings in routine child protection arrangements. They are referenced throughout the consideration of the individual agencies above, and particularly in the evaluation of CSC, the agency with lead child protection responsibilities. The lack of any adequate assessment, the failure to follow up explicit referrals, including a referral from a relative (MGM), failures to make checks with other agencies, the ineffective use of formal child protection procedures and arrangements – these all have their roots in the problems in the local authority during the period under review. That is described above and the description has been accepted by the agency.

8.3.2 Yet all the other key agencies also failed Child K. The pre-school and the school failed more than once to make child protection referrals despite explicit evidence of injury. Indications of inappropriate sexualised behaviour were set aside by the school. Police were slow to respond to the first child

protection referral and too quick to terminate their involvement in two further incidents of physical injury. Hospital services lacked thoroughness so that inconsistent evidence was not identified. A Consultant Paediatrician and other medical / nursing staff accepted that a child protection investigation would not be pursued despite having found medical evidence of inflicted injuries. A school nurse was told that Child K had been hit by his father but took no further action. A health visitor saw injuries to the eye, soon after a child protection investigation, but did not follow this up. A child mental health professional was explicitly told of a non-accidental injury and did not report this. Cafcass failed to follow up allegations of non - accidental injury.

8.3.3 Child K demonstrated sexualised behaviour from an early age. It is known that he was allowed or made to watch pornographic films with his mother and Mr X. We cannot know the extent of any further sexual abuse but this in itself was harmful. It was repeatedly noted, especially at his school, but his mother was never challenged about it.

8.3.4 Some of those weaknesses can be attributed to poor professional practice by individuals and a failure to exercise an adequate managerial supervision and scrutiny of that practice. The SCR on Child I and Child K similarly found that

“One aspect of this case that cuts across all the themes... is the lack of effective management oversight and the fact that no one in a senior position challenged the poor practice... ”.

The same report suggests some of the key underlying reasons for this, which apply equally to this case:

“One factor possibly contributing to this situation was the absence of any effective supervision for the senior practitioners themselves, a lack of involvement of team managers in practice decisions and a culture within the department which encouraged senior practitioners to reduce demands on the service”.

8.3.5 Other underlying causes are also echoed in the findings of many SCRs. There may have been a view that “social problems” were inevitable for such a family from such an environment. Ms L had been a teenage mother whose adult life had been characterised by violence and disruption. Professionals may have had low expectations of the quality of life these children should expect, and may have wrongly accepted that a degree of adversity was inevitable. Child K was engaging and likeable and it was too easy for professionals to focus on those positive factors rather than the issues which might give cause for concern.

8.3.6 Some professionals over-identified with Ms L, regarding her only as a victim. In fact we know now that she was repeatedly dishonest, not just with professionals but even to the extent to which she concealed the truth about Child K’s paternity. There was a continuing failure to explore the extent to which she not only neglected and failed to protect Child K, but also may have been a perpetrator of the violence he suffered. The fact that she was a victim clouded professional judgment and obscured the need systematically to explore the relationships within the family.

8.3.7 There was a deep denial across the system of the real problems these children faced. Even when they became briefly subject to Child Protection Plans the category used was “emotional abuse” – which was not incorrect but was not adequate. It was selected because it was less specific and less likely to upset the adults than directly raising the issue of the physical maltreatment of Child K.

8.3.8 All the SCRs recently completed in Southampton have identified the lack of challenge within and between agencies. In this case there is some limited evidence of professional disagreement – the lack of consensus when Child K was in hospital, and one agency dissenting when the Child Protection Plans were removed. But on neither occasion did those involved seek to take the matter further.

8.3.9 The SCR on Child I and Child M suggests that *“the most likely explanations (for a lack of challenge) are:*

- 1. Lack of knowledge on the part of managers about what good practice looked like.*
- 2. Lack of scrutiny of the decision making of front line managers.*
- 3. Accommodating lower standards in recognition of the demands on the child protection services. It is known that children's social care was going through a very difficult period with high staff turnover including at senior management level... In such situations there can be reluctance to make yet more demands of over-stretched colleagues”*

8.3.10 Professionals may have been intimidated by Mr X. He was a violent man. His blunt refusal to engage with any professional, even when the children were subject to Child Protection Plans, was not identified as a concern or challenged in any way. SCRs have frequently found that practitioners failed to make a connection between the position they found themselves in – such as being intimidated by his brooding presence - and the probability that a child might feel similarly intimidated.

8.3.11 Ms L conspired with Mr X to conceal the abuse of her son, perhaps to some extent in fear for her own safety, or simply to prevent detection. Yet she herself was also seen to have directly mistreated the child, in the incident in the supermarket and when he was in hospital. There were times when she pre-empted enquiries by offering an explanation for injuries which might otherwise have aroused suspicion. She tolerated or was complicit in his exposure to inappropriate sexual material.

8.3.12 Little evidence emerges from this review of a parent who was loving and protective, and tried to prioritise the needs of her children in adverse, dangerous circumstances. At the same time there is no evidence that she was ever really challenged about the harm she was causing to those children, and especially to Child K.

8.4 Physical abuse

8.4.1 The earliest concerns about Child K suggest that he was being physically abused. Throughout his life Child K was repeatedly seen with evidence of physical injury, injuries for which his mother offered implausible and unevidenced explanations. There is no evidence that the likelihood that she was lying so as to conceal the physical abuse of her son was ever put to her, even when police were involved in the responses to his injuries.

8.4.2 Medical advice to the SCR emphasised that considerable force would have been necessary to inflict some of the injuries with which Child K was seen. Many of the injuries he visibly suffered were to his head which can be particularly traumatic for a small child. Many of the explanations offered seem entirely unconvincing.

8.4.3 Research²⁰ in 2010, the year before Child K died, identified *“an increase in numbers of individuals injured in violence of 20% among children aged 0 to 10 years”*.

The research recognises that their sample group is relatively small but adds that

“since a rising trend in violence against the 0 to 10 age group was also found in the 2009 survey (an 8% increase in 2009 compared to 2008) this finding is likely to represent a real upward trend”.

8.4.4 Apart from the occasion when he was admitted briefly to hospital (when physical maltreatment was confirmed), the causation of the injuries to Child K was never medically assessed. Often it was re-defined as “rough handling”, a more acceptable concept which masked the reality of the cruelty. There was an entirely unfounded rule of optimism – if there was not immediate evidence of abuse, there was no need to enquire more deeply. It must be a matter of concern for the Board that agencies were so ready repeatedly to set aside the indications of physical abuse. There is a recommendation that the Board should highlight this as a learning point in disseminating the outcomes of this review.

8.5 Assessment of risk

8.5.1 There is evidence throughout this review of assessments which are incomplete, misjudged or inaccurate, and little evidence of assessments which are thorough and well-informed. But there is a particular absence of any sense that the immediate risks for these children, and Child K in particular, needed to be evaluated and managed.

8.5.2 Professor Eileen Munro²¹ has defined the task in straightforward terms. There is a need to establish and describe

- What has been happening

²⁰ Violence in England and Wales in 2010: An Accident and Emergency Perspective (Sivarajasingam, Wells, Moore, Morgan, Shepherd)

²¹ Effective Child Protection (Munro 2008)

- What is happening now
- What might happen
- How likely it is to happen
- How serious it would be

The combination of seriousness and probability leads to an overall judgement of risk.

8.5.3 This is an ongoing process, not an event, and must consider both past and present in order to identify future risk. It is not a “tick box” exercise, although checklists and similar “tools” can be helpful. The outcome should be a coherent story about the child’s circumstances, in context, appreciating that there will be uncertainty about some matters.

8.5.4 There was an avoidance, across the agencies, of the evidence of the physical abuse of Child K, exemplified in the decision that the child protection plans should be based on “emotional abuse”. A systematic approach to assessment generally, and the assessment of risk in particular, should have served to correct that. There are many templates and models for assisting with this but the fundamental requirement is an alertness to the possibility of harm and a process of analysis and reflection which allows for that risk to be assessed and addressed.

8.5.5 That risk assessment then needs to be supported by supervision and review. The reality of repeated abuse was not recognised or was denied by the practitioners involved. Supervision arrangements needed to scrutinise that position but there is little evidence, across the agencies, of supervision which enabled a reluctance to challenge and to maintain that challenge.

8.6 Differential treatment of Child K - scapegoating

8.6.1 Because none of Child K’s many injuries ever led to a competent child protection investigation we cannot be certain that any of those injuries were inflicted. However it is probable that he was repeatedly deliberately harmed. The very fact that he had so many injuries raises concern. There was an unequivocal medical opinion of non-accidental injury when he was in hospital. The number and nature of the injuries seen by the workmen in 2008 is also strongly suggestive of physical abuse. Child K himself said on a number of occasions that he had been abused.

8.6.2 However no evidence has been submitted to the review to suggest that the other children of this family were similarly abused. Sibling 1 had some contact with medical services because of injury but the analysis of those events does not suggest a non-accidental causation.

8.6.3 We know now that Child K was not in fact the son of Mr C or Mr X. However Mr X believed that Mr C, whom he did not like and whom he had threatened to stab, was the father of Child K. Mr X was a violent man who may have developed a particular antagonism towards, or a rejection of, Child K, linked to his feelings towards Mr C.

8.6.4 Comparisons with Daniel Pelka arise again. Daniel was scapegoated in his family and the first SCR judged that *"It is relatively rare in cases of child abuse that one child is singled out and scapegoated in the way that Daniel was. The apparent good care of the other children appeared to give a false reassurance that Daniel's problems were not related to abuse"*.

The satisfactory health and development of the other children may have similarly served to deflect or ease concerns for Child K.

8.6.5 There are indications that Child K was directly and persistently abused in a way that was different to the maltreatment of the other children. His presentation and behaviour at school should have pointed up the need to understand the family dynamics and relationships. A sound assessment would have included some observation of Child K both alone and with all those caring for him. It would have been open to the possibility that his mother was abusing him or was failing to protect him from differential treatment in the family. The school nurse was able to get Child K to "open up" and talk about his life at home, and his feelings – suggesting again that he may have been more accessible than some children, but that opportunity was never explored.

8.7 Domestic abuse

8.7.1 The Home Office²² has defined domestic abuse as *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality"*. There is a pattern of incidents here which clearly meets that definition.

8.7.2 The domestic abuse of Ms L by both Mr C and Mr X is evidenced repeatedly throughout these events. Evidence in the care proceedings for Child K's siblings frankly and graphically describes serious, sustained abuse, admitted but still minimised by Mr X. It is clear, from accounts given by Child K himself, that Ms L was repeatedly seriously assaulted in the presence of her children.

8.7.3 Mr X was involved in boxing – which sometimes helps people to manage violence and aggression - but that was not the case here. There is only one glimpse of any evidence that Mr X felt that his behaviour needed to change – his brief involvement with mental health services towards the end of Child K's life. Even then it is not clear that this initiative was prompted by any concern for those affected by his violence.

8.7.4 Children who experience domestic abuse are likely to be at risk of other types of abuse. Research²³ tells us that domestic abuse is a central issue in child protection. It is a factor in two thirds of serious case reviews where a child has died. Yet the agencies involved with this family focused almost

²² Home Office September 2012

²³ Brandon 2008

entirely on the harm and risks for Ms L, without considering with the consequences and potential risks for children in these circumstances.

8.7.5 SCRs repeatedly locate the abuse of children in the context of what has come to be known as the “toxic trio” – where it is accompanied by either mental ill health or substance misuse or both. While domestic abuse is particularly clearly evidenced here we also know that cannabis was habitually used in the family home and that Ms L sporadically sought help for “depression”.

8.7.6 In her analysis of 184 serious case reviews for the period April 2009 – March 2011 Brandon²⁴ found that:

“At least one of these characteristics was evident in the lives of the families at the centre of serious case reviews in 86% of the cases. Almost two thirds of the cases featured domestic violence, and parental mental illness was identified in 60% of cases. Parental substance misuse was evident in 42% of cases. All three factors were present in just over a fifth of the cases [22% of the children in the study] and, as in our previous biennial reviews, we argue that it is the combination of these factors which is particularly toxic”.

8.7.7 We do not have a clear understanding of Ms L’s view of the abuse perpetrated against her, or its consequences for her. She may have become inured to harm after so many years of abuse. Repeated abuse can lead a mother to become preoccupied with protecting herself and weaken her ability to protect her children and be a good parent for them.

8.7.8 Child K was sensitive to the abuse of his mother. He spoke about it to professionals when given the opportunity to do so. It will have affected the way he thought about his mother and about the men she lived with. More generally there is evidence that children who witness repeated domestic abuse can internalise that as being somehow “their fault”. The younger the child, the higher can be the extent of emotional and psychological distress and disturbance. We know that Child K was increasingly failing to cope with the demands of being at school and socialising with adults and other children.

8.7.9 Not all children affected by domestic abuse are assisted by “services”. Family and friends are often better placed to provide support and help children to understand and cope. But, when sustained domestic abuse is so well evidenced as in this case, it is disappointing that there is little evidence of thought being given by professionals to its consequences for the children of the family.

8.7.10 Children in that situation need access, possibly separately from any parent, to advice and support in building resilience. As some specialist research²⁵ has concluded

²⁴ New learning from serious case reviews: a two year report for 2009-2011 (Brandon et al)

²⁵ Meeting the needs of children living with domestic violence in London (Refuge / NSPCC 2011)

“Ensuring sufficient and varied opportunities are available for children to talk to skilled adults in confidence about the domestic violence in their lives is a priority today and in the future”.

8.7.11 There is no evidence that the agencies gave priority to the needs of Child K and his siblings in this way. Instead professionals focused largely on Ms L, who was seen solely as a victim who was telling the truth about the dynamics of her relationships. This raises issues about the thoroughness of MARAC arrangements and there is a recommendation that this be considered further.

8.8 The deployment of social work students

8.8.1 In September 2011 a social work student was asked by SW3, the student’s supervisor, to manage this case. Just before that MGM had on several occasions raised concerns which had not been followed up by SW3. The decision by SW3 to allocate this case to the student was not shared with anyone else. It is not clear that SW3’s managers were even aware that MGM had raised the concerns but they certainly did not know that a student had been asked to deal with the case.

8.8.2 It can be difficult to identify cases which offer the best learning opportunities for students, yet are still appropriate for them to manage. CSC increasingly work only with cases where risk is high. Students need to be closely supported and supervised in dealing with tasks appropriate to their experience, and always taking account of the fact that they are still in training.

8.8.3 Here the first task given to the student was to follow up the concerns raised by a grandmother about the care and protection her daughter was providing to her children. It might have been appropriate for the student, with adequate support and preparation, to take a history from the grandmother. Instead the student was sent, unaccompanied, to interview the mother – an approach that was inappropriate to the situation and potentially unsafe for the children.

8.8.4 Ms L denied any cause for concern and said that she had now fallen out with her mother because of these these false allegations. The student did not report this back and was not immediately questioned about the visit by SW3. As the IMR remarks
“The increased risk in the situation is not picked up. The grandmother who is a support and a protective factor for the children is no longer in the confidence of Ms L”.

8.8.5 The student was supervised by SW3 twice in the coming weeks. On the first occasion the recording by SW3 is that the “parents” (ie Ms L and Mr X) have “engaged positively”. There is absolutely no evidence of this. Mr X continued to refuse any contact – there could not have been a less “positive engagement”. In so far as she co-operated at all we can see that Ms L feigned compliance. The recording by SW3 of the second supervision session is a copy, word for word, of the recording of the previous session.

8.8.6 It is worrying that a student should be placed in this position and that the local authority, the organisation which has accepted responsibility for contributing to the student's training, should be so unaware of what had happened. The Review learned that there had been 37 social work students in CSC during 2011 – too many to be catered for by a service of that size, let alone one with such problems in its management of staff and services. There must be serious concerns about the reliability and competence of SW3, but also about the broader arrangements in the local authority for the deployment and management of social work students. There are recommendations accordingly.

8.9 Professional responsibility and accountability

8.9.1 We have correctly been warned to be wary of hindsight bias, and it is of course right to try to avoid simple cause and effect explanations for failures to respond to apparently clear causes for concern.

“Remember at all times, what you are trying to do. In order to understand other people's assessments and actions, you must try to attain the perspective of the people who were there at the time. Their decisions were based on what they saw on the inside of the tunnel – not on what you happen to know today²⁶”.

8.9.2 Equally we should identify poor practice. When SCRs identify professional failings they should say so, not without explanation, but as well as trying to understand the complexities of causation. SCRs aim to identify what can be learned from an analysis of events and the relevant contextual factors, and the relationships between them. As part of that analysis it is right to recognise that individuals can make mistakes (which may then not have been identified / prevented by any organisational systems designed to do so).

8.9.3 This review has found more evidence of individual error than is sometimes the case. Those errors are detailed throughout this report in relation to many of the contributing agencies. One instance – the undisclosed delegation to an unsupported social work student of a difficult investigation – was dangerous.

8.9.4 The events under review took place some years ago, and local circumstances have changed. Nonetheless this report recommends that each agency should formally review their performance in the light of this overview of events. This exercise should determine whether any further action is necessary in order to support individuals, promote good practice and contribute as well as possible to the safeguarding of children in Southampton.

8.10 Post mortem and “Rapid Response” arrangements

8.10.1 The SCR Panel identified a number of issues- operational, procedural and resourcing - relating to the events after the death of Child K. The post

²⁶ Decker 2002

mortem examination was carried out by a forensic pathologist but this doctor was not accompanied by a paediatric pathologist. The Designated Doctor commented on the fact that no paediatric radiologist was involved in examinations carried out after the death, which she advised should be *“standard practice in the investigation of abuse in living children, and in the investigation of unexpected infant deaths”*.

8.10.2 Hampshire Constabulary have considered these aspects of their investigation in their Addendum Report. They have agreed that it would have been in line with national guidance to have ensured that a paediatric pathologist contributed directly to the post mortem and also that a paediatric radiologist should have been involved in the conduct of skeletal surveys. The failures to do so were significant weaknesses in the police investigations.

8.10.3 Since 2008 there has been a statutory requirement that a local authority, its LSCB partner agencies and other relevant persons should provide a co-ordinated response to the unexpected death of a child – generally referred to as “Rapid Response” arrangements – based around multi-agency meetings. The nature and level of the response should be determined by the circumstances of the death. There is also a statutory requirement that the deaths of all children under the age of 18 must be reviewed by a Child Death Overview Panel (CDOP) on behalf of the LSCB.

8.10.4 The SCR Panel heard that there was a history locally of a failure across agencies to prioritise and adequately resource the arrangements necessary to comply with these requirements in relation to child deaths. The Panel heard reports of similar issues arising in other localities. Here they have already been noted in one of the SCRs completed for the SLSCB during 2014. There was a recommendation from that review which is echoed in this report.

8.11 Serious Case Review process

8.11.1 As explained in the introduction to this report the previous Chair of the LSCB awaited a decision on whether there would be a prosecution, and then the Finding of Fact in care proceedings on the siblings of Child X, before deciding that there should be no SCR.

8.11.2 The SCR Panel was concerned about both that decision and the time taken to reach it. Whether or not Child K died as a result of inflicted injuries, there was a concern that he may have done and there had been substantial contact with key agencies. He had recently been subject to a Child Protection Plan. One would always want to avoid an unnecessary SCR, because of the distress this would usually cause a family, and because these are exercises which consume a lot of time and resources. However in these circumstances the Panel judged that there was clearly good cause to initiate a review.

8.11.3 The decision to conduct such a review does not require the evidence needed by the criminal courts or the courts dealing with family proceedings.

The decision not to conduct an SCR was taken over a year after the death. That delay meant that the opportunity to use the process of formal review rapidly to identify key learning points was lost. Practice in Southampton has now changed, as has the statutory context – Working Together 2013 states the expectation that SCRs or comparable reviews should be carried out more frequently. Nonetheless there is a recommendation from this report to endorse that locally.

8.11.4 Unfortunately, once this review was initiated in 2013, it did not proceed smoothly and it was necessary to introduce a new Lead Reviewer in May 2014. It was then necessary to await the outcome of the re-launched criminal investigation before certain matters could be concluded and the report could be presented to the SLSCB.

8.11.5 SCRs should always seek to identify good practice as well as cause for concern about what agencies may have done. In this case however the Panel concluded unanimously that the review had produced no evidence of good practice to be highlighted in this report.

8.12 Could the death of Child K have been prevented?

8.12.1 Hindsight brings a deceptive clarity to reviews like this and recent academic work correctly stresses the need to understand events and relationships as they were perceived at the relevant time. But that should not excuse a failure to take steps which would have given the best possible view at that relevant time.

8.12.2 There were many opportunities to intervene in this family. There was little evidence of the needs and safety of the children being prioritised by those caring for them. Evidence strongly indicating the physical abuse of Child K was repeatedly set aside.

8.12.3 Three months before his death Child K's maternal grandmother wrote to the local authority. She gave a graphic account of her concerns and the reasons for them. She reported at least one injury, what she thought was a cigarette burn to the child's throat, which had not been investigated (and her letter did not lead to any investigation).

8.12.4 MGM reported that Ms L was colluding with Mr X in breach of his bail conditions. Specifically she said that all the children had been taken to see Mr X (by his own mother)

“even though Child K cried and said he did not want to go...Ms L made him because that is what Mr X wanted”.

She concludes by saying that

“I just don't want to take that phone call to hear that something has happened to either my daughter or my grandchildren”.

She received no response to this letter and some months later did indeed receive that phone call.

8.12.5 MGM was not being alarmist in writing in those terms. She understood that fear and distress was an everyday reality for all these children and particularly Child K. She could see that all those responsible for protecting him – both those looking after him day to day and the professional agencies – were not offering that protection.

8.12.6 A judgment on whether his death could have been prevented does not rely on establishing exactly what happened when he received the injuries which led to his death. His safety could have been addressed long before that, if the agencies involved had taken the actions necessary to understand what his life was like and had met their statutory duty to protect him.

9. CONCLUSIONS – A SUMMARY OF KEY ISSUES AND LESSONS LEARNED

9.1 Child K was physically, emotionally and sexually abused, and he was neglected, physically and emotionally. From infancy he repeatedly witnessed the domestic abuse of his mother, in assaults which were increasingly frequent and violent. It is a mark of his resilience that he continued to present much of the time as lively and cheerful, but the failure to see that this presentation masked a lifetime of abuse is alarming. This was not a case which required particular investigative expertise or determination. Evidence of abuse and neglect was repeated and explicit.

9.2 The local authority, the lead child protection agency, did not protect Child K, despite compelling evidence of abuse. They made fundamental failures - not talking to the child, over-identifying with an abusive parent, failing to listen to a grandmother who had explicitly alerted them to the abuse of the child. Their work was not planned or reviewed, involvement drifted inconclusively and staff were not supervised.

9.3 Those failings need to be put in context. There had been a major, long-running industrial dispute after the council made reductions to staff terms and conditions of employment. This had led to acute shortages of staff and demoralisation. Management arrangements were unstable throughout the organisation. The local authority was taking on too many social work students and not adequately supervising what they were required to do.

9.4 It is now nearly three years since the death of Child K, and the review heard of many changes in the design and delivery of services in Southampton since then. Nonetheless there were serious systemic and also individual failings, which were found in many of the organisations contributing to this review. Staff at the pre-school and the school failed to make child protection referrals on a number of occasions despite explicit evidence of injury and inappropriate sexualised behaviour. A school nurse received a report that Child K had been hit by his “father” but took no further action. A health visitor saw possible injuries soon after a child protection investigation but did not follow this up. A child mental health professional and a Cafcass officer failed to follow up indications of non - accidental injury. The Serious Crime Review conducted by Hampshire Constabulary after the death of Child K found serious weaknesses in the management and resourcing of the police investigations carried out at the time of Child K’s death. Managerial oversight across all these organisations was inadequate.

9.5 There was a particularly significant missed opportunity when Child K was admitted to hospital. Police were too ready to conclude that no investigation was necessary. Medical and nursing staff then accepted too easily that no child protection investigation would be pursued. This was despite clear medical advice that injuries had been inflicted, compounded by concerns arising from the mother’s conduct.

9.6 The domestic abuse of Ms L lies at the heart of these events. It will have profoundly affected Child K and the other children but it also served to sidetrack the agencies. Not only did they lose sight of their principal responsibility for safeguarding children, they also lost alertness to the possibility that Ms L was both a victim and a perpetrator of abuse. The fact that she was a victim clouded professional judgment and obscured the need systematically to explore the relationships within the family. Although the scale of domestic abuse was at times recognised, its consequences for the family were not.

9.7 In common with all the SCRs recently completed in Southampton the failure, across the agencies, adequately to assess the situation or to challenge a lack of assessment was critical. There was never a thorough assessment and the processes in place to identify and challenge that omission were weak. Staff supervision, especially in the social work service, was absent or inadequate. The formal arrangements, when the children were subject to Child Protection Plans, were weak and failed to focus on the child. The decision to remove Child Protection Plans at the first opportunity is very difficult to understand, even with the benefit of hindsight and an understanding of the dynamics of the meeting.

9.8 Within that muddled approach the differential treatment of Child K was not identified. He was scapegoated and abused in a way that was different to the maltreatment of the other children of the family. However, in the absence of any rigorous, collaborative assessment of the situation, this aspect of the situation was not understood and addressed.

9.9 Professionals may have been intimidated by Mr X, a violent man. His refusal to engage with any professional was not challenged. SCRs have frequently found that practitioners fail to make a connection between being intimidated themselves and the probability that a child would feel similarly threatened.

9.10 Child K died in 2011 and this review was not commenced until the summer of 2013. There was a long delay in making a decision about the review. The initial decision not to undertake a review was inappropriate because the circumstances of the death indicated that it may have been caused deliberately and there had been a history of significant agency involvement with the family. SCRs need to be initiated without delay if lessons are to be learned and changes made. That can be done while other legal processes are taking their course.

10. THE RECOMMENDATIONS FROM THIS SERIOUS CASE REVIEW

10.1 Introduction

10.1.1 These recommendations to the Board reflect the key lessons to be learned from this review. They draw on the views of the SCR Panel and the author of this report. Some of them relate to fundamental weaknesses.

10.1.2 The review does not make a recommendation for every point of learning that has been identified. These recommendations are complemented by more detailed recommendations, specific to each agency, contained in the IMRs from those agencies.

10.1.3 It is nearly three years since the death of Child K. Agencies have not awaited the completion of this review in order to tackle issues arising from these events. Some of these recommendations, or aspects of them, have been identified and addressed already. As indicated above there is a substantial overlap with recommendations from other recent SCRs in Southampton.

10.2 Recommendations to the Southampton Safeguarding Children Board

10.2.1 The Board should require the key local statutory agencies with child protection responsibilities to demonstrate that, where a child may be at risk of significant harm, this is recognised and reported appropriately, investigations and assessments are conducted without delay and all procedural and good practice requirements are met.

10.2.2 The Board should evaluate the quality of strategy meetings and child protection conferences and audit the decisions being taken at those meetings.

10.2.3 The Board should review and strengthen as necessary arrangements across all agencies for recognising and responding to children who need to be protected as a result of domestic abuse.

10.2.4 The Board should use the findings of this review to raise public awareness locally of the links between domestic abuse and the safeguarding of children.

10.2.5 The Board should require all agencies to promote the use of escalation procedures when there is disagreement between professionals, and should audit the use and effectiveness of escalation arrangements.

10.2.6 The Board should require all agencies to demonstrate that there are safe and effective arrangements for the professional supervision of staff.

10.2.7 The Board should require the local authority to demonstrate that the deployment and supervision of social work students is appropriate and safe.

10.2.8 The Board should require schools and pre-school provision, where relevant, to demonstrate that there are reliable arrangements for the appointment, training, supervision and management of the Child Protection Lead Officer.

10.2.9 The Board should require the relevant agencies to review and improve as necessary their compliance with the statutory requirements arising from the death of a child.

10.2.10 The Board should ask the agencies contributing to this review to re-consider their performance, in the light of this overview of events, to determine whether any further action is necessary in respect of individuals, teams or safeguarding practice generally.

10.2.11 The Board should raise with the relevant NHS commissioning body the failure of the South Central Ambulance Service NHS Foundation Trust to provide a full report for this review.

10.2.12 The Board should ensure that there are reliable arrangements for making timely decisions as to whether a Serious Case Review should be carried out.

10.2.13 The Board should require local agencies with child protection responsibilities to confirm their arrangements for the quality assurance of submissions to any future Serious Case Review.

APPENDIX A: THE LEAD REVIEWERS

Moira Murray

Moira Murray is a qualified social worker and has worked in the area of child protection for local authorities and voluntary sector agencies for over thirty five years. She was seconded for 12 months in 2006 to the Department for Children Schools and Families (now Department for Education) to undertake an historic file review of referrals to List 99 (teachers barred list). She was a non-executive board member of the Independent Safeguarding Authority from 2007 – 2012, and in 2009 co-authored Safeguarding Disabled Children: Practice Guidance (HM Govt, DfE).

Ms Murray began working independently in 2010. Since then she has chaired and written a number of Serious Case Reviews, undertaken safeguarding audits for local authorities and the NHS and delivered safeguarding training. In 2012 she was appointed as Safeguarding Manager for the Olympic and Paralympic Games, and has more recently undertaken a review of Child Protection and Whistle Blowing Policies and Procedures for the BBC.

Kevin Harrington

Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has worked on more than 45 SCRs in respect of children and vulnerable adults. He has a particular interest in the requirement to write SCRs for publication and has been engaged by the Department for Education to re-draft high profile SCR reports so that they can be more effectively published.

Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council, and has undertaken investigations commissioned by the Local Government Ombudsman. He has served as a magistrate in the criminal courts in East London for 15 years.

APPENDIX B: THE SERIOUS CASE REVIEW PANEL

Name / Designation	Organisation	Role
Ms Moira Murray	Independent	Lead Reviewer (Panel Chair)
Head of Children's Services	Southampton City Council	Panel Member
Detective Chief Inspector	Hampshire Constabulary	Panel Member
Team Manager	NSPCC	Panel Member
Operations Manager	Probation Service	Panel Member
Designated Nurse	Southampton City Clinical Commissioning Group	Panel Member
Designated Doctor	Southampton City Clinical Commissioning Group	Panel Member
National Improvement Manager	CAFCASS	Panel Member
Mr Kevin Harrington	Independent	Lead Reviewer (Report author) In attendance
Legal Services Manager	Southampton City Council	Legal Advisor In attendance
Manager	SLSCB	In attendance
Senior Democratic Support Officer	Southampton City Council	In attendance (minutes)

APPENDIX C: TERMS OF REFERENCE

1. Circumstances leading to this SCR

Child K was taken to hospital in December 2011 with head injuries. He was unconscious and his condition deteriorated until his death two days later. Child K and his family were known to services as a result of repeated serious incidents of domestic abuse and concerns about the safety and welfare of the children.

2. Period Under Review

The period under review is from 01 November 2007, when the first allegations of ill-treatment of Child K were made until the conclusion of the initial police investigation in April 2012. Agencies are also asked to summarise relevant background/contextual information/key factors/significant events about the family at the start of the review period.

3. Agencies

The agencies contributing to this review are:

- Southampton City Council Children's Social Care Services
- Hampshire Constabulary
- Southampton City Council Prevention & Inclusion (including Education)
- Solent NHS Trust
- CAF/CASS
- University Hospital Southampton NHS Foundation Trust
- Southampton City Clinical Commissioning Group - the GPs
- Southampton City Council Independent Domestic Violence Advisor (IDVA) Service
- Hampshire Probation Trust
- South Central Ambulance Service NHS Foundation Trust
- Southampton City Council Adult Social Care Services
- Dorset Healthcare University NHS Foundation Trust
- Southampton City Council Housing Services
- NSPCC
- Staffordshire County Council

4. Analysis

Each agency was asked to address the following issues:

1. Were practitioners knowledgeable about potential indicators of abuse or neglect and what to do if they had concerns about a child's welfare?: e.g. neglect, domestic abuse, sexual abuse
2. Were assessments and investigations carried out and followed up appropriately? This includes the use or not of CAF, initial and core assessments, medical and health assessments, strategy discussions and criminal investigations and any other assessments that should be provided by each agency

3. Where relevant, were formal planning arrangements²⁷ in place and implemented appropriately?
4. Were communications, within and between agencies, effective?
5. Was practice sensitive to racial, cultural, linguistic and religious identity and any issues of disability?: include here also cultural issues relating to the family such as the where the family lived, their lifestyle, environmental and social factors
6. Was practice child focused e.g. were the child(ren)'s wishes and feelings ascertained and given appropriate priority? Was consideration given to what it was like to be a child living in the family?
7. Were managers appropriately involved in this case? In what way? If not, why was this?
8. Did any resourcing issues affect the way this case was dealt with? If so in what way and why was this?
9. Is there evidence of good practice in the way this case was handled? If so what was this and what factors contributed to enabling such good practice?
10. Was there a need for and evidence of professional challenge? If not why not?

The analysis should consistently address the 'why' questions, that lie behind good and poor practice. E.g. why assessments were and were not carried out, why the quality of such assessments was poor or excellent? Consider what factors facilitate good practice and what obstacles were there in achieving best outcomes.

5. Involvement of Staff

Agencies should identify and interview any staff that they feel can add value to the review.

6. Involvement of Family

Child K's adult family members have been notified that the review is happening. The lead reviewers will seek to engage family members in the review process when and where that is appropriate.

²⁷ These could include, for example, Common Assessment Framework, child protection or child in need plans, Care Programme Approach plans.

APPENDIX D: REFERENCES

Footnotes have been used to indicate specific quotations from or references to research, practice guidance and other documentation. This Overview Report has been generally informed by the following publications

- Working Together to Safeguard Children,(HM Government 2013)
- The Victoria Climbié Inquiry (Lord Laming 2003)
- The Protection of Children in England: A Progress Report (Lord Laming 2009)
- Improving safeguarding practice, Study of Serious Case Reviews, 2001-2003 Wendy Rose & Julia Barnes DCSF 2008
- Analysing child deaths and serious injury through abuse and neglect: what can we learn – A biennial analysis of serious case reviews 2003-2005
- Understanding Serious Case Reviews and their Impact - a Biennial Analysis of Serious Case Reviews 2005-07 DCSF 2009
- London Safeguarding Children Board – SCR Toolkit (2010)
- The Munro Review of Child Protection: Final Report (HMSO May 2011)
- The Munro Review of Child Protection: Interim Report (HMSO February 2011)
- Publication of Serious Case Review Overview Reports: Letter from Parliamentary Under Secretary of State for Children and Families 10th June 2010