
# SERIOUS CASE REVIEW

# Child L

# Overview Report

**Independent Lead Reviewers:**

**Brian Boxall (Chair of the SCR Panel)**
**Moira Murray (Report Author)**
**May 2014**

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# 1 INTRODUCTION

## 1.1. Background to the Review

1.1.1. This report will summarise the findings of the Serious Case Review which was conducted in respect of Child L for the period of 15 months between September 2011 and December 2012.

1.1.2. Child L, who was 6 years old, arrived at A&E, University Hospital Southampton in late December 2012 accompanied by her mother. A neighbour had called the emergency services concerned about bruising to her face and concerns for her welfare. On examination Child L was subsequently found to have 92 bruises of varying ages to her face and body, was confused and amphetamines were found in her urine. The explanation given by Child L and her mother, as to how the injuries had occurred, was assessed by the consultant paediatrician as being inconsistent with the injuries sustained by Child L.

1.1.3. Child L and her mother were known to health, education and children's social care (CSC) prior to the incident necessitating her admittance to hospital. There was particular concern about Child L's lack of school attendance and of some behaviours she exhibited at school, however, there was very limited success in engaging the mother in professional interventions.

1.1.4. Child L's older brother, (Sibling 1) who stayed at the mother's address from time to time, was known to police and Children's Social Care.

1.1.5. Child L's birth father had contact with his daughter for a limited period when she was approximately 2 ½ years old, which was curtailed by Mother. Efforts were subsequently made on Father's part, through the judicial process to gain access to her, but contact did not materialise until after Child L was removed from Mother's care.

1.1.6. At the time Child L sustained the injuries, her mother was involved in a relationship with a man, Mr A who had a long history of drug misuse, had five criminal convictions for violent behaviour, including domestic violence. His identity was not known to many of the professionals, and those that were aware of his identity did not know of his involvement with Child L and her mother.

1.1.7. On her discharge from hospital, Child L did not return to the care of her mother. Her mother and Mr A were subsequently convicted of criminal offences related to the injury and neglect of Child L.

1.1.8. The multi-agency response, post identification of injuries, will be subject to a practitioners learning event to fully explore the findings and learning arising, subsequent to this serious case review.

1.1.9. The case was referred to the Southampton Local Safeguarding Children Board Serious Case Review Committee (SCRC) in January 2013. There was insufficient information from agencies available at that time to decide whether the case warranted a serious case review. Agencies were required to access records and scope their agency's involvement and report back to the next meeting. In April 2013, when the SCRC

reconvened the then chair of the SCRC, who at the time was also the chair of Southampton LSCB, made the decision to conduct a Partnership Review, as the criteria for commissioning a serious case review were considered not met. There were, however, lessons to be learned for single and multi-agency working.

1.1.10 At the next meeting of the SCRC in May 2013 draft terms of reference for a Partnership Review were drawn up and relevant agencies were required to produce individual management reports. These reports were completed, as requested, by the end of July 2013.

1.1.11. During this period, the Southampton Safeguarding Children Board Chair left his post and the interim chair reviewed the case and decided that it did meet the criteria for a Serious Case Review, as set down in Working Together, March 2013.

1.1.12. Working Together, March 2013 states that a Serious Case Review should be undertaken "*where abuse or neglect is known or suspected and **either**:*

- *a child dies; or*
- *a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child"*[1]

1.1.13. The purpose of the serious case review is to "*Identify improvements which are needed and to consolidate good practice*."[2] Additionally, serious case reviews should be conducted in a way which:

- *"Recognises the complex circumstances in which professionals work together to safeguard children;*
- *Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;*
- *Is transparent about the way data is collected and analysed, and*
- *makes use of relevant research and case evidence to inform the findings".*[3]

1.1.14. Southampton Safeguarding Children Board chose to use a traditional model for serious case reviews when undertaking this review. Two independent lead reviewers were appointed and on 14 October 2013 revised Terms of Reference[4] were issued to participating agencies, with additional guidance for authors completing individual management reports. Each agency was asked to revisit and amend reports which had been submitted to the Partnership Review to take into account the revised terms of reference, but not to change the format or substantially re-write the reports.

1.1.15. The Southampton Safeguarding Children Board constituted a panel to oversee the conduct of the serious case review, whose membership included some of those

[1] Paragraph 8, Chapter 4, Working Together to Safeguard Children – A guide to interagency working to safeguard and promote the welfare of children. HM Government March 2013
[2] ibid Paragraph 7, Chapter 4
[3] ibid Paragraph 10, Chapter 4
[4] The Terms of Reference and full details of the lead reviewers can be found at Appendix X

professionals, namely the Designated Nurse, Designated Doctor and the Cafcass Service Manager who had been members of the Serious Case Review Committee.

1.1.16. During September 2013 arrangements were made to appoint two independent lead reviewers. Brian Boxall was appointed to Chair the serious case review and Moira Murray was appointed as the Overview Report Author. Further details can be found at Appendix A.

1.1.17. The membership of the serious case review Panel is set out below:

| Name/Designation | Organisation | Role |
|---|---|---|
| Brian Boxall | Independent | Lead Reviewer/Independent Chair |
| Moira Murray | Independent | Lead Reviewer/Overview Report Author |
| Interim Head of Service, Children's Social Care | Southampton City Council | Panel Member |
| T/Detective Superintendent | Hampshire Constabulary | Panel Member |
| Operations Manager | Hampshire Probation | Panel Member |
| Designated Doctor | NHS Southampton City CCG | Panel Member |
| Designated Nurse | NHS Southampton City CCG | Panel Member |
| Service Manager | NSPCC | Panel Member |
| Service Manager | Cafcass | Panel Member & IMR author |
| Service Manager | Housing Services | Panel Member |
| Legal Services | Southampton City Council | Legal Services Manager |
| Board Manager | Southampton Safeguarding Children Board | In attendance |
| Senior Democratic Support Officer | Southampton City Council | In attendance |

The following agencies contributed individual management reports to the review:

- Southampton City Council, Children's Social Care
- Southampton City Council, People Directorate, CYP Strategic Commissioning, Education and Inclusion Division
- Hampshire Constabulary
- Southern Health NHS Foundation Trust
- University Hospital Southampton NHS Foundation Trust
- Solent NHS Trust
- South Central Ambulance Service:

- NHS England
- Cafcass
- Southampton City Council Housing Services
- HM Prison Service
- Hampshire Probation Trust
- Letter from 'In Touch' service

## Methodology

1.1.18 This Overview Report is derived principally from the agency Individual Management Reviews (IMRs), which were based on an analysis of agency records and interviews with staff. Additional information was provided in letter form from agencies which had limited contact with the family. The report is also informed by Panel discussions, dialogue with IMR authors and relevant research. No IMR was received from the South Central Ambulance Service, despite several requests from the SCR Panel Chair.

1.1.19 Following the completion of criminal proceedings in respect of Mother and Mr A, both Mother and Father were interviewed and contributed to the review.

1.1.20 This report is structured as follows:

- A factual summary of key events based on information provided by agencies
- Views of Family Members
- The Child's Experience
- Key themes identified by the review process, incorporating an analysis of each agency's involvement and consideration of the Terms of Reference
- Conclusions and Lessons Learned from the Review
- Recommendations

# 2 FACTUAL SUMMARY OF THE CASE – KEY EVENTS

## 2.2 Family Background

2.2.1 The family is White British and English is their first language. At the time of Child L's birth in 2006 Mother was living in privately rented accommodation with Child L's older half-brother, (Sibling 1) then aged 14. Mother had been treated by her GP for physical and mental health issues including depression and agoraphobia. She had also disclosed 'nondependent' cannabis use.

2.2.2 At the time of her antenatal booking appointment, Mother made it very clear that the pregnancy was a result of a one off encounter and that the father would not be involved with Child L's upbringing.

2.2.3 The identity of Child L's birth father was not known to most professionals until 2010 when he made a court application for contact and Parental Responsibility. Prior to this date, Father did have limited contact with Child L. When Child L was 2 ½ years old the Child Support Agency became involved in the case, and a DNA test proved that he was Child L's father. Father is believed to have had regular contact with Child L until January 2010 when Mother refused to allow him to see his daughter. It was at then that Father commenced private law proceedings.

2.2.4 Mother engaged well with ante-natal services. She disclosed to the midwife that she had overdosed two years earlier, because of depression brought on by her father's death. Mother also said that she smoked 10 cigarettes a day, although in a letter to Mother's GP from the Obstetric Registrar letter refers to her smoking 10-20 cigarettes a day, 3-6 of which were cannabis. Mother had taken daily doses of amphetamine for 3 years, but had stopped on becoming pregnant (she said she had also stopped drinking alcohol) and had taken cocaine in the past. Mother explained that she was experiencing panic attacks as the GP had reduced her antidepressant medication because of her pregnancy. Mother was however being supported by the GP in reducing the dose.

2.2.5 Given her history Mother was referred to the perinatal mental health team with her consent, for further assessment concerning maternal mood and ongoing depression. No record however can be found confirming whether the perinatal mental health team were involved with Mother, and her GP continued to treat her for depression. She was also referred for consultant obstetrician-led care because of her recreational cannabis use, past history of amphetamine and drug use, depression and other potential medical risks in the contest of her age. Mother was discussed at hospital drug liaison meetings in March and April 2006. The meeting was attended by a Southampton Children's Social Care Social Worker, a drug advisory clinical practitioner, the Child Protection/Safeguarding Midwife and other obstetric and neonatal staff. It has not been possible to establish whether the social worker was from the hospital team or CSC. Electronic records have been checked and no reference can be found of a CSC social worker attending the meeting. It is therefore presumed that the Social Worker was hospital based. Mother was advised on the health implications for herself and her unborn baby, and was later referred to the NHS 'Quitters' service for smokers. Although Mother's smoking decreased she continued to smoke cannabis throughout her pregnancy, against medical advice.

2.2.6 No midwifery concern form was raised for the Safeguarding Midwife and Social Worker at the booking assessment in relation to the identified safeguarding risk factors. This was not compliant with the safeguarding procedures in place at the time.

2.2.7 In May 2006 Mother was admitted for an elective caesarean section due to placenta previa (low lying placenta). Child L was born at 39 weeks gestation. During the caesarean section Mother lost a significant amount of blood, but Child L's weight and head circumference was within the normal range. At the time of the birth Mother was still taking antidepressant medication. Because of the potential risk of developing withdrawal symptoms Child L was subject to monitoring throughout her period on the post natal ward. Mother took her own discharge at 23.00 hours the day after Child L's birth. Mother said she was anxious about being in hospital and it was with reluctance that she and Child L were discharged by medical staff. Child L was however assessed as medically fit to be discharged and Mother stated that she would receive support from Maternal Grandmother and friends. The discharge plan ensured that Mother received training on recognising withdrawal symptoms in Child L from anti-depressant medication and what action to take. The community midwives were alerted.

2.2.8 The community midwife visited Mother and Child L six times after their discharge from hospital. Mother was available for five of the six visits. However, once the health visitor took over from the midwife Mother proved less willing to engage.

2.2.9 Mother was available for the first home visit by the Health Visitor in May 2006, and was described as appearing 'lethargic and tired' and disclosed that she had been depressed and on anti-depressants for some time. The Health Visitor assessed the family as needing additional support because of Mother's mode of delivery and history of depression. Due to an emergency arising the Health Visitor had to miss the next planned home visit in early June and left a note saying that she would visit the following week. Unfortunately, this visit could not be kept due to an outstanding meeting which the health visitor needed to attend. This resulted in the Health Visitor being unable to visit Mother and Child L until July when a joint home visit was undertaken with EWO.

2.2.10 The EWO had been concerned about Sibling 1's poor school attendance and had also expressed concerns that Mother may have been dealing cannabis, although there was no evidence to substantiate this. Following this joint visit there was a long period of non-engagement between Mother and health visiting services. This non-engagement may have been influenced by the Health Visitor being unable to follow up planned appointments in the early months of Child L's life.

2.2.11 The reasons for this need to be put into the context of the resources available and the high level of need and degree of deprivation of families living in this area of Southampton. At the time Health Visitors had caseloads of 400 – 750 families. The pressures on Children's Social Care were similar, with Social Workers holding caseloads of 50, compared to a recommended average of 20. However, whilst recognising the demands on Health Visiting Services, it was unusual that in the early years of Child L's life of a possible 34 health appointments or contacts she was only taken to or available for 7 of these.

2.2.12 Child L was not taken for her six week assessment with the GP and her immunisations were delayed. Appointments for neonatal audiology were missed. Her 8 month developmental review was not attended and planned/unplanned visits by the health visitor often resulted in no contact with mother or child. Whilst health visiting services were under pressure such a lack of engagement by a mother, resulting in a baby not to being taken to developmental checks would have been considered unusual. There was regular liaison between the Health Visitor and the GP surgery about the lack of engagement and non-attendance for immunisations. The Health Visitor did discuss therapy sessions with Mother, who said that she had attended once, but had not gone subsequently. Given Mother's reluctance to participate in group activities, the health visitor had been able to offer only limited support.

2.2.13 Similar difficulties in gaining access to the family prevailed for the Education Welfare Service (EWS) when the school became concerned about Child L's poor attendance in 2011.

2.2.14 In August 2006, on an occasion when Mother was seen by the health visitor she had noticeable bruises to her face and arm, and when asked how these had occurred she explained that they were due to moving furniture. The issue of domestic abuse was

not pursued. At the time there was no evidence of a male living in the household, apart from Child L's brother, who was considered to be supportive in assisting Mother with the care of his baby sister.

2.2.15 Issues concerning domestic violence by Sibling 1 towards his partner were to later emerge and their child was made subject to a Child Protection plan in 2012.

2.2.16 From September 2007 until September 2008 Child L was assessed as a child of concern by the health visiting service due to non-engagement by Mother. Despite a failure to attend/keep appointments, prior to December 2012, Child L was considered fit and well with no chronic or ongoing diseases or conditions. She did attend the GP surgery for minor conditions but was not on any regular medications. Although Mother maintained that Child L suffered from ear infections, no evidence can be found that this was the case.

## Key Events 2010 – 2011

2.2.17 In January 2010, Child L started at Pre-School 1. She was well dressed and attended regularly. Mother was seen as anxious and agoraphobic, but no other concerns were noted. In April of the same year, Father made an application to the Court for 'Contact and Parental Responsibility'. Cafcass received notification of this application and a first hearing was set for early June 2010.

2.2.18 Cafcass ascertained that the family was not known to Children's Social Care (CSC), but police checks indicated that both parents had previous convictions including theft and possession of cannabis. Updated Police checks in respect to Father in June 2011 showed that he had a caution for battery, as well as a pending prosecution for criminal damage and battery in relation to his then partner.

2.2.19 In June 2010, Mother informed the Family Court Adviser (FCA) by telephone that she had not received notification of the proceedings from Father and had thus not attended the first court hearing. She further advised the FCA that she was concerned about Father having contact with Child L and would be worried for her daughter's safety if he did. Mother also stated that due to mental health problems she would be unable to attend further court hearings. In July 2010 Mother was required by the court to provide medical evidence in support of her inability to attend court.

2.2.20 In August CSC had their first contact concerning Child L when Mother's GP requested child minding services to enable Mother to attend a court hearing. The call ended before the GP could be advised that Mother would need to make her own child care arrangements. (but see paragraph 5.1.25)

2.2.21 A letter supporting Mother's inability to attend court was provided by her GP, whom she saw in June and August 2010 with symptoms of anxiety and agoraphobia. Cafcass have no record on their file as to whether the letter reached the court, as the letter would be on the court file.

2.2.22 Mother did not attend the Family Proceedings Court hearing in August 2010 when a contact order was made in respect of Father. In Mother's absence Father was

granted Parental Responsibility, and a schedule of contact with Child L was ordered for two hours each week after school, to be reviewed in October 2010.

2.2.23 This contact did not take place and Father had no contact with Child L during the period under review.

2.2.24 In July 2010, Mother had completed an 'Existing Applications for the Housing List' form, detailing that she now required a two bedroom property as her son (Sibling 1) had moved to live with friends. This change in circumstance led to Mother and Child L's needs being reassessed (Mother had registered with the council when Child L was born) and improved the family's prospects of being offered council accommodation. In September 2010, Mother and Child L moved into a two bed roomed council flat on a well maintained housing estate. Prior to this move, the family lived in privately rented accommodation. When Mother attended the Housing Office to sign the tenancy agreement she was interviewed by a Housing Officer who also completed a 'Personal Information Checklist'. It was noted from information freely offered by Mother that she was being supported by In Touch, a local support agency and that she had been referred to hospital for mental health issues. Later in September the same Housing Officer made a routine home visit to ascertain how Mother was managing the tenancy and identify whether she required any support. No issues were noted on the electronic Housing system.

2.2.25 In September 2010 Child L had begun to attend Infants School 1. Health Visiting records should have been sent when Child L started school, however they were not received by the School Nurse until January 2011[5]. The Head Teacher contacted CSC seeking advice and to ask whether Child L, was known, after Father had arrived at the school with a court order detailing contact arrangements. Because the Health Visiting records had not arrived and Child L had not been handed over to the School Nurse as a family of concern or a child in need, the Head Teacher had no knowledge of the family and Mother's lack of engagement. Mother had denied knowledge of the court order to the school and was refusing to allow Child L to attend school on the days that Father was due to have contact with her. The Head Teacher was advised by CSC to contact Education Legal Services for advice and to keep a copy of the Court Order on file to confirm that Father had Parental Responsibility. The CSC contact was then closed.

2.2.26 Father contacted Police in late October 2010 as he did not know Child L's whereabouts as Mother had moved address (to council accommodation). Police ascertained where Mother was living, visited her and Child L, and informed Father that Child L was well. Mother requested that Police did not disclose her address to Father, however, in December 2010 Police received a court order requiring that her address be disclosed. Police informed CSC of their involvement and letters were sent to Mother and Father by Children First (CSC) advising them of the need to seek conciliation and arrange contact in the best interests of Child L.

[5] This was an ongoing problem at that time in Southampton. Records for school aged children became electronic from October 2011, so enabling school nurses to have instant access to Health Visiting records

2.2.27 In July 2011 there was a reported assault by Sibling 1, who was living with Mother at that time, against his partner Miss C[6]. This was the first of several reported incidents of Domestic Violence between the couple during the period under review.

2.2.28 In August 2011 Cafcass prepared a Section 7[7] report for the court. Father was becoming frustrated about Mother's lack of engagement and non-compliance with the court order. Mother remained resolutely opposed to contact between Child L and Father, citing his non-involvement with Child L and his history of domestic violence. Father described Mother's general care of Child L as being adequate, but was concerned about poor school attendance and alleged that she had been a drug dealer in the past. He also maintained that Mother was dependent on medication for her mental health and agoraphobia.

2.2.29 The Family Court Adviser (FCA) visited Child L at home in the presence of her mother, who refused to allow any discussion of Child L's wishes and feelings. The home was described as stable, warm and welcoming, and Child L was assessed as being confident and sociable. The FCA was however, aware of Child L's poor school attendance and told Mother that she needed to ensure that Child L attended school. The FCA recommended that: an order was needed for the disclosure of Father's criminal history and pending criminal charges; and a Finding of Fact hearing be set in relation to alleged domestic violence between the parents before contact could be considered.

2.2.30 In September 2011 the court ordered the disclosure of police information and Mother was required to make Child L available for a meeting with the FCA to ascertain her wishes and feelings. Mother stated that she would not comply with any contact order made in favour of Father.

2.2.31 Father was convicted in June 2011 and sentenced in October 2011 for a criminal damage offence. He was sentenced to a twelve month community order with twelve months supervision and was required to undertake an Integrated Domestic Abuse Module (1-1 programme with domestic violence offenders). Father engaged well with the Probation Service during the following twelve months and by September 2012 when his supervision ended, was assessed as being of low risk in all categories.

2.2.32 Cafcass provided a report to the court in November 2011, following two home visits to Child L and additional inquiries. The report recommended that both parties were to undergo hair strand testing for drug use; Father to complete a Community Rehabilitation Order; Mother to provide evidence in respect of her mental health issues and that no order for contact be made until this information was provided.

2.2.33 The Court agreed with Cafcass recommendations, apart from the drug testing request. Cafcass was required to provide a position statement before the end of March 2012.

2.2.34 During November 2011 Infants School 1 became concerned about Child L's attendance, particularly the number of 'odd days off' she was having and requested that the Education Welfare Officer (EWO) visit the home. A further referral was made

[6] Referenced in the Solent NHS Trust IMR
[7] As required under Section 8, Children Act 1989 in private law proceedings

to the Education Welfare Service (EWS) in December 2011 as Child L's attendance had dropped to 78%. At this time lack of school attendance was an overall concern for Southampton City Education Authority.

2.2.35 In November 2011 Sibling 1, who now had a child with his partner Miss C, was given temporary custody of their child and returned to live with Mother and Child L. There had been a history of arguments between the couple, as well as reports of domestic violence.

## Key Events January – August 2012

2.2.36 By early January 2012, Sibling 1 and Miss C had been reunited and the couple were living with Mother. Their child was in the care of the maternal grandmother, an arrangement with which they were unhappy and were advised by Police and CSC to seek legal advice to regain care and control.

2.2.37 The EWO made a planned home visit in January 2012 to explore reasons for Child L's poor school attendance, but no one was at home. A follow up visit successfully took place five days later. Mother told the EWO that due to her own ill health she was unable to get Child L into school. Mother said she had difficulty walking because of a back complaint and asked if school transport could be provided. The EWO explained that it could not and suggested she asked a friend to help. Mother said she had no friends in the area.

2.2.38 By the beginning of February 2012 Child L's attendance had dropped to 74% and the school asked that the School Nurse liaise with the EWO to request that a Common Assessment Framework (CAF)[8] be completed. At this time school attendance levels were of general concern to Southampton City Education Authority. Attempts by the EWO during February and March to meet with Mother were unsuccessful due to Mother's lack of willingness to engage. The EWO wrote to Mother in mid March 2012, inviting her to attend a meeting at the school and offering to complete a CAF. Mother responded by refusing the invitation, stating that she did not need support and had no wish to engage in the CAF process.

2.2.39 During this period under review Sibling 1, his partner Miss C and their child were all living with Mother. There was animosity between both sets of grandparents and

[8] Common Assessment Framework The CAF is a four-step process whereby practitioners can identify a child's or young person's needs early, assess those needs holistically, deliver coordinated services and review progress. The CAF is designed to be used when:a practitioner is worried about how well a child or young person is progressing (e.g. concerns about their health, development, welfare, behaviour, progress in learning or any other aspect of their wellbeing); a child or young person, or their parent/carer, raises a concern with a practitioner; a child's or young person's needs are unclear, or broader than the practitioner's service can address. The process is entirely voluntary and informed consent is mandatory, so families do not have to engage and if they do they can choose what information they want to share. Children and families should not feel stigmatised by the CAF; indeed they can ask for a CAF to be initiated. The CAF process is not a 'referral' process but a 'request for services'. The CAF should be offered to children who have additional needs to those being met by universal services. Unless a child is presenting a need, it is unlikely the CAF will be offered. The practitioner assesses needs using the CAF. The CAF is not a risk assessment. If a child or young person reveals they are at risk, the practioner should follow the local safeguarding process immediately. HM Govt, DFE

Police were involved in several incidents concerning verbally abusive behaviour by both grandmothers.

2.2.40 In April 2012 there was a final court hearing in respect of Father's application for contact with Child L. Cafcass had recommended that after two initial supervised contacts Father should have unsupervised contact with his daughter as per the order of August 2011. However, no order was made as neither party attended the hearing and the case petered out. Cafcass closed the case in May 2012.

2.2.41 It was not until mid May 2012 that Mother agreed to attend a meeting at the school with the Head Teacher, the EWO and the School Nurse. Mother gave several reasons for Child L's poor punctuality and poor school attendance. She stated that Child L had problems with her ears and it was agreed that the School Nurse would review this. Mother had completed and returned a comprehensive health questionnaire to the School Nurse in May 2011, which identified no health concerns for Child L and stated that all her immunisations were up to date. At the time the questionnaire had been completed Mother had stated that Child L had had a hearing problem in the past. She gave consent for Child L to be seen by the School Nurse, but she herself did not wish to discuss any problems at an appointment with the School Nurse at the time. This questionnaire was taken as read and was a self reporting assessment by Mother of Child L's health needs.

2.2.42 During the meeting Mother said she was agoraphobic, had problems with her own physical health, could not bring Child L to school and had no one to help her do so. By this time Mother had applied for Disabled Living Allowance and was being prescribed medication for lower back pain. The EWO offered to support Mother, but the offer was declined. It was agreed that Child L would continued to be monitored at school and by the Education Welfare Service.

2.2.43 At the end of May 2012 Mother completed a leave of absence form to take Child L on holiday to Spain for two weeks. The school did not authorise the absence and a penalty notice was issued. It was noted that the holiday was for the same time period as the previous year. Mother would have known about the intended holiday when she attended the meeting at the school to discuss Child L's attendance.

2.2.44 Child L had a health assessment undertaken by the School Nurse at the end of June. Her growth was satisfactory, although her weight had slightly dropped since her assessment the previous year. Her hearing and vision tests were normal.

2.2.45 From June to August reports of domestic violence by Sibling 1 against Miss C were received by Police and CSC. During this period Mother was caring for her grandchild and this included a time when her grandchild was made subject to a Child Protection Plan. It was not suggested that Mother was abusing/had abused her grandchild. Child L was not subject to discussion at the initial child protection conference. Sibling 1 and his partner were also brought to the MARAC (Multi-agency Risk Assessment Conference).

2.2.46 During this period Mother's home was visited by the Health Visitor, because her grandchild was living with her. At this time the EWO was also trying to gain access to Mother to discuss Child L's poor school attendance. However, contact by the EWO

was unsuccessful as either there was no answer or Mother refused entry, stating that she was unwell. There was no liaison between the Health Visitor or the EWO, even though they were involved with the family during the same period, albeit for different reasons.

**Mr A:**

2.2.47 It is believed that Mr A became Mother's partner sometime after his release from a short prison sentence in September 2012. The exact date of when Mother became involved with him is not known as she refused to share information concerning this relationship with any agency. However, during an interview with the Overview Report Author in April 2014 Mother clarified that she had known Mr A for approximately twenty years. She had met him again in September 2012 when she and Child L visited a friend's house and Mr A was present.

2.2.48 It is known that Mr A had children from several relationships. He was known to CSC in relation to one of his children. He was not identified when checks were undertaken by CSC in respect of Child L in November 2012, due to the incorrect spelling of his surname. If the correct name had been entered and checks been made it would have shown referrals to CSC and information from March 2003 to August 2011. The referrals concerned domestic violence by Mr A towards his former partner, and threats to kill her and their baby. Mr A served a prison sentence for breach of conditions which triggered a suspended sentence and was released in August 2011.

2.2.49 Previously in 2008 his GP Surgery noted that Mr A's then girlfriend had had a still born child, and that in 2009 he was intending to be a 'house husband' for his partner's unborn child. Mr A had a well documented history of drug dependency, including amphetamine, cocaine and cannabis use. He was known to be violent, and although diagnosed with depression and anxiety, did not engage when referred with primary and mental health services, including the Drugs and Alcohol team. He had been removed from a GP list in 2011 because of aggressive behaviour. Mr A had also been subject to three MARACs, (as a perpetrator) two in 2009 and one in 2010.

2.2.50 He had an extensive criminal history of offending dating back 30 years (from the time he was an adolescent). By December 2012, when the assault on Child L took place he had 23 convictions for 48 offences, including drug related offences and offences against the police and against the person (Domestic Violence against former partners).

2.2.51 However, none of Mr A's convictions involved offences against children, until his conviction in respect of Child L in April 2014. Until the events of December 2012 Hampshire Police and CSC had no record of any links with Mr A and Child L's address. When released from prison in September 2012 he was regarded by police as being of "no fixed abode". In the past he had resided at numerous addresses, often sleeping on friends sofas.

2.2.52 At the time of the assault on Child L, Mr A was subject to three ongoing complex police investigations into suspected drug dealing, for which he was on unconditional bail (the criteria for conditional bail had not been met). From the time of his release from a short prison sentence in September 2012 until the events of December 2012,

he came to the attention of police on a weekly, if not daily basis. He was convicted of drug dealing offences in August 2013 for which he received a substantial prison sentence.

2.2.53 Whilst in prison in August 2011 Mr A displayed volatile and aggressive behaviour towards prison officers and fellow prisoners, which included smashing a television and deliberately flooding his cell. At that time he was referred to the prison mental health team as there was concern that he may have been a suicide risk. Following a mental health assessment he was classified as presenting low risk of self harm and suicide.

2.2.54 In August 2011 Mr A was released on licence from a twelve month prison sentence for drug offences and breach of a suspended sentence for violence against a former partner. The Public Protection Unit informed CSC that he posed a risk to children due to domestic violence. The risk related to his former partner and their children.

2.2.55 Mr A was under the supervision of the Probation Service, who visited his prison release address in September 2011, as part of supervision of his post custody licence. Due to time spent on remand he had been released on a 3 month licence, and was required to reside at this address and comply with drug treatment. Living at the address was an adult female, who was not seen during the Probation Officer's visit, and her 16 year old daughter, who was present. The Probation Officer assessed the 16 year old daughter to be mature. As the relationship between Mr A and her mother (who was not interviewed) was considered to be one of landlady and lodger, the Probation Service decided that the prison release address was suitable and did not present a risk.

2.2.56 Mr A failed to adhere to the conditions of his licence. Whilst he did on occasions report to his Probation Officer he was at times under the influence of drugs and failed to attend the Drug Intervention Programme as required. In November 2011, the Probation Service reviewed the case, but decided not to initiate a recall because of the limited time remaining for Mr A to be on licence.

2.2.57 Information has come to light during the course of this review, which was not known to the Probation Service at the time of their visit in September 2011 that the 16 year old daughter living at the address when the Probation Officer visited had been taken to A&E in August 2011. She had been admitted to hospital due to intoxication, as well as being under the influence of drugs, having snorted two lines of amphetamine.

2.2.58 A&E staff were appropriately concerned about this incident and the CSC Emergency Duty Team was contacted. It was recorded that the lodger, referred to only by his first name was 'meant to be looking after' the 16 year old in her mother's absence.

2.2.59 As a result of this contact an initial assessment was initiated by CSC due to concerns about the lodger, the home environment and a lack of engagement with CAMHS following the girl's admission to hospital.

2.2.60 Agency checks identified by CSC were dependent on cooperation from Mother and daughter. Although the girl's father was said by hospital staff 'to be furious' on learning of his daughter's admission to hospital, he was not contacted by CSC when the initial and core assessments were undertaken. As cooperation from mother and daughter

was not forthcoming, the full details of Mr A's identity were not ascertained and he was referred to by his first name throughout the notes recorded on the CSC electronic recording system. As a result no checks were made with the Police or the Probation Service.

2.2.61 The initial assessment progressed to a core assessment, which was not completed due to lack of engagement by the family. The 16 year old girl refused to speak with CSC and her mother assured CSC that she had ensured that the lodger had left her home and had spoken to her daughter about misusing alcohol and drugs. (NB In September 2012 Mr A gave this same address as where he was residing when was stopped by the police. See paragraph 2.2.64 below). This assurance was accepted by CSC and because of lack of engagement the case was closed. No consideration was given to calling a strategy meeting, no comprehensive checks were undertaken to ascertain the identity of Mr A and whether he posed a risk. Whether this was because the girl was 16 years old and mother seen to be a protective factor is not known.

2.2.62 In early 2012 Mr A served an 8 day custodial sentence. Whilst in prison he presented similar aggressive behaviours as he had done whilst serving prison sentences in 2011 and in early 2012. On Mr A's release from an earlier prison sentence in 2012 a letter was sent to CSC concerning the risk he posed to his former partner and children. During the period under review Mr A was not subject to MAPPA[9] arrangements.

## Key Events September – December 2012

2.2.63 In September 2012 Child L transferred into Year 2 at Infant School 1 and the EWO arranged a home visit to see Mother later that month. On the day of the visit Mother cancelled the appointment. On the same day Mr A was released from prison.

2.2.64 On his release from remand in September 2012, Mr A returned to the same prison release address where he had been previously lodging in August 2011. Police were aware of this address, but as indicated above had no knowledge of the incident in August 2011. As he was not subject to licence neither the Probation Service nor CSC were aware of where Mr A was residing. CSC had no involvement with him at this time.

2.2.65 Two days after Mr A's release from prison in September 2012 Mother was late collecting Child L from school. She explained that she was unwell and was noted to be wearing sunglasses, although the weather was not sunny. Child L had disclosed in school that her mother and her friend had fallen asleep on the sofa. Child L provided no further information and it is not known whether 'the friend' was Mr A.

2.2.66 Child L was absent from school the following day with a viral infection and the following week the EWO and the Prevention Social Worker (PSW) did an unannounced home visit. Mother and Child L were at home, but both professionals were refused entry and Mother spoke to them on the doorstep. Child L was present and chatted enthusiastically about being in school that day.

[9] Multi-agency Public Protection Arrangements

2.2.67 Towards the end of September Child L began to mention Mother's partner in school, stating that she "couldn't wait to see him". The school reported their concerns to the Education Welfare Service about the inappropriateness of the way in which Child L spoke about Mother's partner and requested that the PSW become involved. The school was unaware that the PSW had already visited the home with the EWO. The PSW made another home visit the day after the school made their request but Mother refused entry, saying she was "too busy".

2.2.68 The EWO attempted a further home visit at the beginning of October, but was again refused entry by Mother, who also refused any offer of support. The day after the EWO's visit Child L did not attend school and when the school telephoned to ask why, Mother said she herself was unwell and was unable to get Child L into school. The EWO had also contacted Mother who said she had been unwell with a bad back and asthma, and had been unable to get Child L to school. She stated that she had no family who could help.

2.2.69 Child L was absent from school for a day the following week. At this time it became known to school staff that Child L had the house keys to enable her to get into the flat unaccompanied (Child L aged 6 years 5 months). Child L was the subject of discussion at the School Attendance Safeguarding Audit meeting. Concerns about Child L's inappropriate behaviour had also been discussed with the School Nurse. Details of the inappropriate behaviour were not discussed verbally with CSC and neither was a written record sent to CSC. It has been clarified that the behaviour related to:

- Child L "putting her hands down the front of a dance instructor's costume." (The school had arranged for a belly dancer to give a demonstration at school).

- Child L "would come up very close to male workmen when they had come into school." (This was clarified to be positioning herself very close to the workmen but not touching them).

- Child L was considered to be very confident with adults.

2.2.70 A decision was made that Mother would be invited to attend a meeting in mid October with the school, the EWO and the PSW. The meeting was set for the end of the school day so that Mother could combine the meeting with collecting Child L. Further concerns had been raised by Child L's class teacher who reported that Child L had said in class that 'Florence Nightingale made love to the soldiers'.

2.2.71 Mother arrived very late at school on the day of the meeting, saying that she had fallen asleep. The meeting had decided in Mother's absence that the EWO would discuss the case with the EWS Senior Practitioner and that the EWO and PSW would see Child L in school to speak with her alone. Mother was in agreement for Child L to be seen.

2.2.72 The school, EWO and PSW passed their concerns about Child L by email to CSC. The EWO and the PSW eventually met with Child L towards the end of October. Child L talked about Sibling 1's child and his new baby. She spoke about other family members but made no mention of Mother's partner/Mr A.

2.2.73 It was at this time that Sibling 1 and Miss C's child was removed from a child protection plan.

2.2.74 On the same day as the EWO and PSW met with Child L, CSC, Children First Team received an anonymous telephone call expressing concerns that Mother was well known in the area for drug and alcohol use. The caller alleged that Child L was left unsupervised outside the flat until 9pm, with inadequate clothing in all weathers. She had no access to a toilet and was urinating and defecating in public. The caller went on to state that Child L was swearing and using 'adult language.' The caller expressed fears that a man in a flat opposite was watching Child L and that 'something bad would happen.'

2.2.75 The case was initially allocated to Senior Practitioner 1, Initial Response Team whilst awaiting allocation to a social worker for an initial assessment. It was planned that an unannounced home visit to Mother would take place; Child L would be seen in school and agency checks would be undertaken.

2.2.76 For three weeks Child L's case was allocated to Senior Practitioner 1 in the Initial Response Team, until it was allocated to NQSW 1 (Newly Qualified Social Worker) to undertake an Initial Assessment. The Initial Assessment did not meet the required 10 day working day time scale.

2.2.77 During the three week period whilst the case was awaiting allocation Child L had been brought to school late on one occasion when Mother had overslept. Mother was described by school staff as 'looking a bit shaky'.

2.2.78 In early November 2012 the EWO contacted Senior Practitioner 1 to discuss Child L's behaviour. Concerns included an occasion when the EWO had met with Child L in school during which Child L had cuddled her, stroked the EWO's hair, stood on a chair, pulled up her top and sang 'I'm sexy and I know it.' The EWO described Child L's behaviour as being overtly sexual. Other concerns discussed included Mother's lack of engagement with services and Child L disclosing that she was allowed to play outside unsupervised until late into the evening, until 9pm at times. The EWO also told Senior Practitioner 1 that the school had been contacted by a local authority in the Northeast of England as Mother had applied to be a foster carer. The school had shared with Mother their concerns about this application and Mother had become upset, saying she would not send Child L to school.

2.2.79 In mid November 2012 the case was allocated to NQSW 1. NQSW 1 made an unannounced home visit the day after the case was allocated to undertake an initial assessment. Mother was distressed on learning that a referral had been made to CSC and initially refused to co-operate. A visit was re-arranged for the following week.

2.2.80 During the initial assessment visit Mother presented as anxious and upset. Although keen to engage in discussion with the social worker Mother refused to disclose the name of her boyfriend saying that they had only been together for a couple of weeks. She acknowledged that there were difficulties with Child L's attendance and on occasions she was late, but this was due to her back complaint. Mother was working

with the school to improve Child L's attendance and punctuality. Mother said that Child L was allowed to play out until 9pm in summer and at weekends. But stated that she had to be in earlier in winter and had never been denied access to the flat.

2.2.81 NQSW 1 then met with Child L after school, on her own, in her bedroom for forty minutes. Child L said she was happy at home and got on well with Mother's boyfriend, Mr A. The Social Worker asked Child L to spell Mr A's surname, which she did. Subsequent events were to show that the surname was incorrectly spelt, but when asked at the time of the visit, Mother confirmed that the spelling was correct.

2.2.82 NQSW 1 found nothing of concern during the course of his visit, although Child L had said that she was allowed out, unsupervised until 8-9 pm. Child L was aged six and a half at this time. However, he considered it appropriate to interview Child L for a considerable time to ascertain further information and to hear the child's voice. He recorded that there were no signs of neglect or drug use, the flat was clean and tidy and there was food in the fridge/freezer. However, the incorrect spelling of Mr A's surname and Mother's lack of cooperation in supplying the correct information resulted in erroneous checks being undertaken to ascertain whether he was known to agencies. The review has clarified that it is possible to undertake checks on first and surnames where there is limited/erroneous information by use of asterisks instead of letters. If this had been done at the time NQSW 1 undertook a PARIS check on Mr A he would have been identified as being known to CSC with a history of domestic violence.

2.2.83 Senior Practitioner 1 requested that agency checks be undertaken to complete the Initial Assessment. These were undertaken by NQSW 2 in the Initial Response Team. The school reported that Child L's attendance and punctuality had improved since the involvement of the EWO and although the Prevention Social Worker (Tier 2 service) had become involved, Mother had refused to engage with her. Child L was described by the Head Teacher as well presented and interacting well with peers. Mother had told the school that Child L was not allowed to play outside late, but Child L had said she was allowed to do so until 8 pm. More recently Mother's friend Mr A had brought Child L to school, but Mother collected her. A Sharing Information (Section 17) request form was faxed to the GP Surgery. However, a response was not received until February 2013, when the forms were returned blank.

2.2.84 At the end of November 2012 the school business manager contacted CSC at the request of the Head Teacher to report that Child L had been brought to school by a neighbour. The neighbour had arrived at another neighbour's house to take her child to school and had found Child L there. Child L said Mother had a doctor's appointment and she had been waiting for Mother's boyfriend Mr A to take her to school, but he had not arrived. On receipt of this information, NQSW 1 contacted the school to request that the incident was recorded in writing and sent to CSC.

2.2.85 At the beginning of December 2012 the Initial Assessment was signed off by Senior Practitioner 2 Initial Response Team and the case was closed on the basis that there was no role for CSC. The Initial Assessment recorded that Child L was looked after by her mother and her older brother, Sibling 1, aged 20. No connection was made by CSC that Sibling 1's family was known and that his child had been subject to a child protection plan. Sibling 1 used different surnames.

2.2.86 In early December 2012 Mr A was arrested and found to be in possession of amphetamine and equipment which indicated that he was dealing drugs. Mr A told Police he was of no fixed abode at the time of his arrest. He was later charged with being concerned with the supply of Class A drugs.

2.2.87 At the time CSC closed the case, the school continued to report concerns about Child L to the EWO. The EWO discussed the case with Senior Practitioner 2 and stated that she did not believe the Initial Assessment addressed the concerns raised by the school and the EWS. Senior Practitioner 2 advised the school to keep a chronology of incidents/concerns and refer back to Children First (CSC).

2.2.88 Child L was considered at a School Attendance Safeguarding Audit meeting attended by the Head Teacher, the EWO, the EWS Senior Practitioner and the PSW at the beginning of December 2012. Two incidents of previous bruising were discussed. One concerned a small mark seen on Child L's throat said to be caused accidentally by another child. The second was a bruise seen on Child L's chest, which Mother said was probably caused by Child L catching herself on a broken bed. The school thought that the accounts given as to how the injuries occurred were untruthful. This information was not passed to CSC. Additionally, there were concerns that Mr A, about whom the school had little knowledge, was bringing Child L into school late and leaving her to wander around. His identity was not known as he signed himself by his first name only in the record book for parents/carers delivering a child to the school. This was not challenged by the school.

2.2.89 In mid December 2012 Child L had gone unaccompanied to a neighbour's flat one morning, as Mother was unwell and was unable to get her to school. The neighbour took Child L to school and informed the Head Teacher of what had happened. Later that day, Child L appeared anxious and disclosed that sometimes Mr A shouted and swore at her mother. The EWO visited to inform Mother of these concerns, however, Mother refused to let her into the flat, stating that everything was fine and she did not require support.

2.2.90 The school business manager subsequently telephoned CSC to inform them of these concerns and was advised to request that the EWO visited the home. Mother however refused to engage with the school or the EWO, and other agencies were having similar difficulty in gaining access to the home, for example there was no response when a Housing Department repair worker called at the flat in response to Mother asking for a repair to be undertaken.

2.2.91 In mid December Mr A was again arrested and charged with further offences involving Class A and Class B drugs. He told Police he was of no fixed abode.

2.2.92 The school continued to have concerns about Child L, which the school business manager reported to CSC. In early December 2012, CSC had requested that the school compile a log of safeguarding issues as there appeared to be a lack of evidence for the school's concerns. The school sent a log in mid December, which included details that:

- Increasingly it was Mr A (a man the school knew nothing about) or a neighbour who brought Child L to school**.**
- Child L had disclosed that she was having to get herself up and dressed and make her own breakfast, as Mother was asleep or unwell. At other times Child L had appeared at a neighbour's flat in her pyjamas requesting that she be taken to school.
- On occasions Child L had the house keys and Mother's mobile phone.
- Mother's refused to engage with the school, the EWO or the PSW

2.2.93 On receipt of the incident log, Senior Practitioner 1 requested that a student social worker draft a letter to Mother indicating that further concerns might invoke child protection enquiries. However, this letter was not sent. On checking with the school prior to sending the letter, CSC was informed that the school had noticed a marked improvement in Child L's attendance and punctuality.

2.2.94 A meeting was arranged in late December, prior to the Christmas holidays, for Child L to be seen in school by the EWO and the PSW. The purpose was to explore any issues of concern that Child L might have, but Child L disclosed nothing, saying that she was looking forward to Christmas. The school, however, continued to have concerns that the end of term was approaching and that Child L would not be seen for 2 weeks over the Christmas holidays.

2.2.95 In late December 2012, Police were called to Child L's address by a neighbour whose child had called at the flat and found Child L sitting outside with bruising to her face. The child had been so concerned at Child L's appearance that a photograph of her had been taken on the child's mobile phone. When Police arrived at the flat, Mother initially refused to allow entry, however the police officers insisted that Child L was seen.

2.2.96 On entering the flat cannabis plants were found in the sitting room. Child L was found to have multiple bruising to her face and body, a very high temperature and was delusional. Mother explained Child L's injuries as having been caused by her daughter falling onto a rocking horse in the early hours of the morning when reaching for a drink from the windowsill. No medical treatment had been sought for Child L from the time of her fall, which had allegedly occurred 13 hours before Police arrived.

2.2.97 Child L was taken by ambulance to hospital. On admittance to the Resuscitation Unit Child L was found to have 92 bruises, old and new to her face and body, and amphetamine was found in her urine. Child L said that she had fallen when trying to get a drink of water in the early hours of the morning and that Mother and Mr A had put her back to bed. Child L did not state how she got the other marks on her body, and denied that either Mother or Mr A had hurt her. Child L did disclose that "Mr A sometimes came into her room to keep her safe' whilst Mother was asleep".

2.2.98 This was the first time that Police were aware of Mr A's involvement with Mother and Child L, and it was the only occasion that his correct identity became known to agencies, other than the police.

2.2.99 The Consultant Paediatrician attending Child L considered that the explanation offered as to how the injuries occurred was not consistent with her injuries. Child L was

admitted to hospital. Mother and Mr A were subsequently convicted of offences related to the harm caused to Child L.

# 3 INTERVIEWS WITH FAMILY MEMBERS

3.1.1 Following completion of criminal proceedings Mother was interviewed by the Overview Report Author in April 2014. Father wished to contribute to the review and he was also interviewed in April 2014. The SCR Panel considered it inappropriate to interview Mr A as part of the review process.

3.1.2 Information provided to the Overview Report Author from Child L's allocated social worker indicates that she has made a full recovery from the injuries she sustained in December 2012. She initially settled well with foster carers and recently moved foster placements. It was not considered appropriate to contact Child L directly to seek her views.

3.1.3 The following is an account of the interviews with Child L's parents. As is evident Mother and Father gave differing accounts of their relationship and held differing views as to their daughter's experience of their parenting.

- **Interview with Mother**

3.1.4 Mother explained that she was from the Southampton/Winchester area, but had lived for sometime in the North East of England during which time her son was born. She had then returned to live in Southampton to be closer to her extended family. Mother said she had a back complaint and was agoraphobic.

3.1.5 Mother said that she had met Father through mutual friends and they had known each other for four or five years before Child L was born. Child L's pregnancy was unplanned and came as a complete surprise. Mother said that when she informed Father she was pregnant he said she should have a termination and subsequently broke off all contact.

3.1.6 At the time of Child L's birth Mother did not wish to have contact with Father, as she felt that he had no commitment to her or their child. Mother explained that although Child L's birth had been difficult she had taken her own discharge from hospital as she just wanted to go home and care for her new baby. Once she got home everything was fine. Mother stated that Child L and Sibling 1 got on well together and that her son adored Child L.

3.1.7 It was not until Child L was 2 ½ years old that Mother contacted the Child Support Agency (CSA). Following a DNA test it was confirmed that Child L was his child and Father once again became involved in their lives. According to Mother, Father saw Child L once a week for approximately six weeks before they argued, which resulted in Father assaulting Mother and saying he was going to seek a court order to remove Child L from her care.

3.1.8 Following this argument Mother said that there was no way that she was going to allow Father to remove Child L and although she initially did not engage in the private law proceedings she did attend court and cooperated with the assessment process.

The case eventually petered out and Father's application for contact remained unresolved.

3.1.9 Mother conceded that Child L's school attendance had been 'up and down' once she started to attend Infants School, but explained that this was because Sibling 1, Miss C and their child was living with them. The family home was cramped, but Mother wished to ensure that Sibling 1 had accommodation for his family. She gave them her bedroom and slept on the sofa. Child L remained in her own bedroom. CSC was happy with the arrangement, but Mother recognised that Child L's school attendance had deteriorated as a result.

3.1.10 Mother explained that often she could not get up to take Child L to school because of her back complaint, but denied that neighbours took her to school on several occasions. Mother said that this had only happened on one occasion. Mother was clear that Child L was not required to look after her when she was unwell. She also denied that Child L stayed out to play until late in the evening. Mother said that she had allowed the EWO into her home, but this was not always convenient as on occasions she needed to collect Child L from school.

3.1.11 When asked about Sibling 1's poor school attendance, Mother explained that he was bullied at school and it was for this reason that he did not attend.

3.1.12 Mother said that she had met Mr A at the home of a mutual friend during the six week school summer holidays of 2012. She and Mr A had known each other for approximately twenty years as they used to frequent the same pub. On the evening they met Mr A had walked Mother and Child L home and he started to come round for tea. Their relationship then started to develop.

3.1.13 Mother had no concerns about Mr A's behaviour towards her or Child L. She was happy for him to take Child L to school on the days she felt too unwell to do so.

3.1.14 When asked about the injuries to Child L Mother maintained that these were caused by Child L falling out of bed whilst reaching for a drink of water and hitting her face on the rocking horse. She admitted that although Child L had suffered a nose bleed and had a large lump on her head she did not think that Child L required medical attention. She explained that the other bruises on Child L's body were caused by normal childhood falls. Mother could not explain how Child L had come to have amphetamine in her system. She said that Child L often had high fevers, so she thought the high temperature following her fall was nothing unusual. Mother said that she had only admitted in court to neglecting Child L because she had not contacted a doctor quickly enough following Child L's injuries. She maintained that Child L had asked to go out to play following the injuries and it was then that the Police had been called. Mother admitted to having a couple of cannabis plants in the front room of her flat, but said these belonged to Mr A.

3.1.15 Mother repeated that Mr A had never been violent towards her or Child L and that Child L had never said that Mr A had hurt her. Child L had continued to like Mr A and Mother did not believe that the situation had deteriorated when he became involved.

3.1.16 During the interview Mother became upset and was frequently in tears. She now has contact with Child L on a limited basis and was desperate to have her child back home. Everything had been perfect until Mr A came into their lives. Mr A had been the first man with whom she had had a relationship since Child L's father. It was Mother's view that Mr A had ruined their lives.

- **Interview with Father**

3.1.17 Father explained that he knew Mother because she was his cannabis dealer. They had known each since 2005 and she was a well known cannabis dealer in the area. Father also knew that Mother used amphetamine and cocaine, but stated that he did not use these drugs.

3.1.18 Father regularly visited Mother at her flat and was aware that Sibling 1 was not attending school. On learning that Mother was pregnant he did not believe that he was the father, as he was aware that a lot of men visited Mother's home. It was two and a half years after Child L's birth that the CSA contacted him and a DNA test proved that he was her father. It was at this point that Father began to have contact with Child L. He maintained that he saw Child L for approximately six months, for once or twice a week. He said he made cash maintenance payments to Mother during this time.

3.1.19 Contact ended in 2010 after Father had refused to take Child L out when Mother said she was too unwell to attend pre-school. An argument had ensued and Father admitted to grabbing Mother by the arms to prevent her from hitting him.

3.1.20 Father maintained that the pre-school knew that he was her father as he used to collect her on occasions. After Father had been given Parental Responsibility and contact he had visited the Infant School 1 to show them the court order. On learning of this Mother had said she would remove Child L from school and move house. It was at that point Mother determined that she would not allow Father to have contact with Child L.

3.1.21 The court proceedings which Father had instigated were frustrated because of Mother's refusal to engage and Father could not financially afford to continue with the case.

3.1.22 Father admitted to having a conviction for domestic violence against a former partner but had benefited from attending an offenders programme organised by the Probation Service. He had turned his life around, he had a permanent well paid job and drug tests instigated by CSC to enable him to have contact with Child L had been negative.

3.1.23 Father expressed concern about the number of drugs that Mother had in her home. He was worried that Child L had been exposed to these drugs when she was a small child as they were frequently left lying around in the sitting room. He stated that Mother kept amphetamine in the freezer. Despite these concerns Father conceded that he did not report Mother to the Police or CSC at the time.

3.1.24 He said that Mother did care for Child L, and she was clean and fed. However, Father did not agree with the way in which Mother allowed so many people into the home and was concerned that Child L's school attendance would begin to deteriorate, as had

Sibling 1's. Father maintained that Mother had encouraged Sibling 1 not to attend school and he did not want this to happen to Child L. He also felt that Mother's drug use had increased after his contact had ceased with Child L in 2010. This had accelerated when Mr A came on the scene, although Father conceded that he did not know of Mr A prior to the criminal trial.

3.1.25 Father was unaware that Child L had been removed from Mother's care and that she and Mr A were being prosecuted until he was served with papers in respect of the care proceedings concerning Child L in February 2013. He had undergone a parental assessment as part of the care proceedings. The court had decided, however that he was not in a position to care for Child L and that Child L should be placed with foster carers.

3.1.26 Father disagreed with this decision and expressed his concern and love for this daughter several times during the interview. Father has the same contact arrangements with Child L as Mother. He stated that he is building a positive relationship with Child L. Child L regularly speaks of what happened and has told Father that she never wanted to see Mr A again.

# 4 THE CHILD'S EXPERIENCE

4.1.1 The purpose of this section of the report is to provide some understanding of the day to day home environment in which Child L lived from her perspective. Information is taken from the IMRs provided to the review, based on case records and interviews with staff. The aim is that knowledge will be gained of the impact and effect of the parenting Child L received, the importance of school and the involvement of professionals in her life.

4.1.2 Little is known of Child L's early childhood experiences. Apart from the time when Mother was pregnant with Child L and after her birth there was very limited engagement with professionals by Mother. Appointments for developmental health checks were not attended and Child L's immunisations were delayed. She did not attend Sure Start provision, although Mother registered for this service. Child L was almost an 'invisible child' until she started to attend Pre-School 1 in January 2010.

4.1.3 There were no recorded concerns about Child L whilst she was at Pre-School 1. She was well dressed and attended regularly. Mother was seen as anxious and agoraphobic. Special arrangements were made so that she could drop off and collect Child L 10 minutes early, so that Mother would not have to engage with other parents. Staff believed that Mother's anxiety may have been related to issues of domestic abuse, as Mother was insistent that no one but she should collect Child L.

4.1.4 Child L had no contact with Father until she was 2 ½ years old. Father has informed the review that he regularly saw Child L until January 2010 when Mother refused to allow contact to continue. Father then issued court proceedings to obtain parental responsibility and contact with his daughter.

4.1.5 During the court proceedings the Family Court Adviser (FCA) visited Mother to complete an assessment. The home was described as stable, warm and welcoming, and Child L was assessed as being confident and sociable. Mother, however was

reluctant to allow Child L to express her wishes and feelings about seeing Father, and it was only when the court ordered that her views should be ascertained that Mother agreed to Child L seeing the FCA on her own. The FCA who saw Child L completed various work sheets to gauge Child L's views – e.g. "about me", "things that make me feel safe", "things that have happened to me". The FCA's assessment was that Child L was "a delightful little girl" who appeared to have a positive attachment to her Mother and older brother. The FCA was however aware that Child L's school attendance was poor and made it clear to Mother that it was her responsibility to take Child L to school.

4.1.6 Child L, having had no recent contact with Father, did not refer to him during the assessment. However, the importance of a father figure to Child L is illustrated by several comments she made to professionals during the period under review. When NQSW 1 interviewed Child L, whilst undertaking the Initial Assessment, she repeatedly told him that "she wished he was her Dad". Similarly, when Mr A first appeared in her life, Child L was very excited and talked enthusiastically in school that "she couldn't wait to see him again".

4.1.7 From information available to this review it would appear that it was when Mother began her relationship with Mr A that Child L had any regular significant involvement with an adult male, since contact had ceased with Father in 2010. Whilst Sibling 1, Miss C and their child lived with them from time to time, the family unit was essentially Mother and Child L. Sibling 1 was known to be violent towards Miss C and Child L could have been exposed to the volatility of her older brother's behaviour. Mother's propensity for abusive behaviour also began to emerge, as she became known to the police because of her involvement in escalating disputes with members of Miss C's family.

4.1.8 Child L went on to attend Infants School 1, a small school which served a local community of mixed private and rented housing, with a significant amount of council housing. During Reception Year at Infants School 1 there were no concerns about Child L. She was described by the Head Teacher as an immaculate, bright, articulate child who enjoyed learning. Whilst Mother did not engage with the school Child L was considered to be doing well.

4.1.9 This situation changed however when Child L went into Year 1 (September 2011 – July 2012). Her attendance became a significant concern at 76.86%[10], as did her punctuality. Mother admitted she had difficulty in getting Child L to school, but gave different reasons for this, varying from her own ill health to Child L having problems with her ears. Child L was having odd days off and there was an increase in her arriving late for school and being picked up.

4.1.10 From 2011 onwards, prior to Mr A's arrival in Child L's life, a picture began to emerge of a child who lived largely in isolation with her mother. A mother who refused to engage with professionals, who was in physical ill health, who was agoraphobic, had

[10] Pupils whose school attendance falls below 95% are of concern, as this impacts on their learning and achievement, below 80% is a significant concern. Prevention and Inclusion IMR page 6

suffered from depression in the past and was using prescription pain killers. Mother also admitted regularly using cannabis, and on occasions amphetamine.

4.1.11 Given the limited information available as to the extent of Mother's drug use, it is not possible to quantify the effect this had on the quality of care Child L received. Father has however provided information to the review that Mother was a regular drug user and well known drug dealer It was apparent that despite an improvement in her attendance in Year 2 to 94.52% significant concerns about Child L's care began to emerge from September 2012 onwards.

4.1.12 During this period the school requested that the EWO (with Mother's permission) meet with Child L in an attempt to ascertain what life was like at home. Child L was described by the EWO as chatty and enthusiastic. She was a child who enjoyed school. Child L did not freeze or appear to be concealing information when chatting about her home and family. Child L did present as a child with a vivid imagination, with professionals having difficulty in establishing what was fantasy or reality in some of their discussions with her. Child L was described by her teachers as a child who appeared older than her years.

4.1.13 There were continued concerns about Child L's punctuality and behaviours in class, which escalated when it was apparent that Mr A was involved in a relationship with Mother. It also coincided with school staff noticing bruising to Child L. Child L was in turn being brought to school by neighbours and Mr A. Mother was increasingly evasive, refusing to engage with the school, the EWO or the PSW. An anonymous referral had been made to CSC initiating an Initial Assessment in November 2012, and the school was keeping a log of concerns which was passed to CSC.

4.1.14 Having been described as immaculate, bright and eager to learn, Child L was arriving at the homes of various neighbours, sometimes in pyjamas asking to be taken to school and given breakfast. The neighbours, parents of other children at the school, were also informing the school of their anxieties about Mother's care of Child. The anonymous referral to CSC expressed concerns that Child L was allowed out to play unsupervised possibly until 9pm, with no access to toilet facilities. Just before the Christmas holidays, Child L expressed her own anxieties about Mr A shouting and swearing at her mother.

4.1.15 Having been an anxious parent who insisted on delivering and collecting her child, Mother was being seen less frequently, and was relying on others, especially Mr A to take Child L to school. Child L at age six and a half was being increasingly left to care for herself, She had keys to the flat, which she brought to school and on occasions Mother's mobile phone. On one occasion Mother had contacted Child L at school to ask where her keys were, and at other times had sounded confused and tired when the school had spoken to her. Given Mother's emerging inability to offer appropriate care to Child L, her ability to care for herself was becoming a concern. Child L was having to care for herself and was increasingly taking on the role of carer for Mother.

4.1.16 It is apparent from considering Child L's experience as a child living in her home environment that:

- Mother refused to engage with professionals and the family appeared isolated;

- Mother had physical and mental health problems and misused substances;
- Although Child L was rarely seen by professionals in her early childhood, she did not have significant health concerns and on arrival at Pre-School 1 was considered to be well dressed, with a caring, if anxious mother;
- Her home was considered warm and welcoming, by some professionals who gained access (namely the FCA and NQSW 1) with no evidence of neglect or drug misuse by Mother;
- No significant concerns continued until Child L entered Year 1 at Infants School 1. It was then that her attendance dramatically deteriorated. Mother became even less willing to engage with professionals, and additionally was unable to comply with the requirement to ensure that Child L attended school;
- Child L was increasingly having to care not only for herself but also for Mother;
- Although there was no evidence, there were rumours that Mother was dealing drugs and when police gained entry to the home at the time of the incident involving injuries to Child L in December 2012 cannabis plants were found;
- Little is known about the men (with the exception of her older brother) who featured in Child L's life until after the incident which necessitated this serious case review. This was due in the main to Mother's total unwillingness to disclose any information about her relationships. This is manifest in Mother's refusal to allow Child L's father contact, her refusal to provide correct information concerning Mr A's surname and her denial of when her relationship began with Mr A. Had Mother provided this information, agency checks would have identified Mr A as a dangerous and violent offender, and early intervention processes to safeguard Child L may have ensued.

# 5 THEMES FOR ANALYSIS

- **Working with resistant and uncooperative parents**

5.1.1 It is striking from information available to this review how little was known about Mother's background, her own childhood or her extended family. It is known that Child L's maternal grandmother collected her from school occasionally, but little is known as to the level of contact she had with her daughter and granddaughter. Child L's grandmother is said to have supported Mother at the time of Child L's birth and was present when Child L was admitted to hospital in December 2012. Similarly there is limited information about Sibling 1's childhood experiences. It is known that he was born in the Northeast; Mother said the relationship with his father was abusive and his school attendance began to seriously deteriorate when he entered Year 7 of secondary school.

5.1.2 Lack of knowledge about the family history is due in part to safeguarding concerns not coming to the significant attention of statutory services until Child L began attending infant school. It is however also a reflection of Mother's unwillingness to engage with services. It is apparent that the limited engagement which did take place with agencies was on Mother's terms. Appointments were frequently not kept, and although she was referred to the Community Mental Health Team, Mother did not attend any appointments offered. Professionals were often denied access or spoken to on the doorstep. The exception was the hospital ante-natal team and the midwifery service following Child L's birth, and on one occasion the EWO and NQSW 1. The GP Surgery did feature when Mother required medication, documentation for civil court

proceedings or support for her claim for disabled living allowance. Child L was also taken to the GP surgery on four occasions for minor illnesses.

5.1.3 Mother's unwillingness to engage with agencies perhaps needs to be seen in the context of her cannabis use, as well as her misuse of amphetamine. Given that cannabis plants were found when Police visited her flat after Child L sustained non accidental injuries in December 2012, may in part explain Mother's reluctance to allow professionals access to her home, unless a visit had been pre-arranged. This is evident in her limited contact with the EWO and the PWS. When NQSW 1 made an unannounced visit to undertake an Initial Assessment he was refused access and told to return at a later date.

5.1.4 When Child L's school attendance became an issue in November 2011, having dropped to 78% she was referred to the EWS. Mother rebuffed offers of support and when Child L's attendance had dropped to 74% in February 2012, the school requested that the school nurse ask the EWO to complete a CAF. Mother refused to engage, maintaining that she did not require any support. This reaction reflected Mother's earlier refusal to engage in the CAF process following Child L's birth.

5.1.5 Concerns continued about Child L's poor attendance and issues about Mother's mental and physical ill health were given as the reason for Child L's poor punctuality or for not attending school.

5.1.6 Although efforts continued to be made until May 2012 to engage Mother in completing a CAF, she resolutely refused. Little else was offered to Child L. No assessment was undertaken of Mother's parenting capacity apart from staff monitoring Child L when she was in school, and passing on concerns to CSC.

5.1.7 As Lord Laming points out, the CAF is "*in danger, like other tools, of becoming process-focused or, even worse, a barrier to services for children where access to services depends on a completed CAF form*"[11]

5.1.8 Mother's refusal to engage with services was typical of her attitude towards agency involvement with her and her children. This was evident in her earlier refusal to engage with the EWS over her son's lack of school attendance, and was manifest in her refusal to engage with the health visitor, the EWO and the PSW concerning Child L. Mother kept agencies at 'arms length' as much as possible, even to the extent of initially denying Police access to her property at the time of the incident in December 2012. Knowing that Child L had suffered significant harm, Mother did not put the welfare and interests of her child first but instead sought to thwart statutory agencies from discovering the extent to which Child L had been ill treated, and continued to protect the identity of Mr A.

5.1.9 Although known to police Mr A ensured that his full identity was kept from other agencies. He was known simply by his first name at the time of the incident involving the 16 year old daughter of the woman with whom he was lodging in August 2011 and signed only his first name in the school record book on the occasions he delivered Child L to school.

[11] The Protection of Children in England, Lord Laming 2009:42.

5.1.10 In his 2003 report into the death of Victoria Climbié, Lord Laming stated:

> *"I recognise that those who take on the work of protecting children at risk of deliberate harm face a tough and challenging task…Adults who deliberately exploit the vulnerability of children can behave in devious and menacing ways. They will often go to great lengths to hide their activities from those concerned for the well being of a child."*[12]

5.1.11 This message was reinforced by Lord Laming in his progress report into the protection of children in 2009[13], following the death of Baby P. Whilst Mother was not 'menacing' towards professionals, she had come to the attention of the police because of her threatening behaviour towards her grandchild's family. She was devious in her refusal to allow access to her home and to Child L. It took time to get Mother's cooperation, and it was with reluctance (and a court ruling) that she agreed to allow Child L to be interviewed by the Cafcass FCA, and latterly the EWO, the PSW and NQSW 1. Her refusal to disclose details of her relationship with Mr A is evidenced in this review. It has emerged since Child L has been in her foster care placement that Mother coached her in how much and what type of information she should reveal whilst at school and to other professionals.

5.1.12 Whilst not wishing to minimise the difficulty faced by professionals attempting to gain access to Child L, as Lord Laming points out: "*staff have to balance the rights of a parent with that of the protection of the child"*[14]

- **Toxic Trio of Domestic Violence, Mental illness and Substance/alcohol Misuse**

5.1.13 Research[15] has shown that domestic violence, adult mental ill health and substance/alcohol misuse continue to be major factors in families where children are killed or seriously hurt. In her analysis of 184 serious case reviews for the period April 2009 – March 2011 Marion Brandon 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"*[16]

5.1.14 Brandon et al goes on to assert that it is more common for these factors to exist in combination than singly and it is this that *"poses a particular risk to the child's safety."*[17]

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[12] The Victoria Climbié Inquiry, the Lord Laming Report, 2003:3
[13] The Protection of Children in England, Lord Laming 2009:51-52
[14] The Victoria Climbié Inquiry, the Lord Laming Report, 2003:3
[15] New Learning from serious case reviews, Brandon et al, July 2012
[16] ibid page 30
[17] ibid page 37

5.1.15 It is known that Mother had relationships with men who had convictions for domestic violence. Father had convictions for battery and criminal damage, was subject to MARAC (as a perpetrator) and had completed a programme for domestic violence offenders. Although there is no direct evidence of Father's violence to her, Mother maintained throughout the civil court proceedings that Father was violent and gave this as her reason for not allowing him contact with Child L. She was also said to be fearful that Father would not return Child L to her care. Mr A had served several periods of imprisonment for domestic violence and threats of violence against women and children. He was considered to be a risk to his former partners and his children. On his release from prison in 2011 and 2012 CSC and the Probation Service were duly informed of the degree of risk he posed.

5.1.16 There was a significant history of domestic violence by Child L's older brother, Sibling 1, to Miss C and mother of his children (second child born after the period under review). The first reported assault was in July 2011 at Child L's address as Sibling 1 was living there at the time. Further incidents resulted in the case being discussed at MARAC in July 2012, and their child subsequently being placed on a child protection plan. At this time Sibling 1 was living with Mother who was caring for her grandchild and Child L. No consideration appears to have been given by CSC as to where Sibling 1 and his child were living at the time the MARAC was held, as there was no cross referencing with Mother's address. The Police were the only agency to cross reference the two families.

5.1.17 There were several occasions when professionals expressed concern as to whether Mother had been subject to domestic violence. In August 2006, when Child L was a young baby Mother was seen to have noticeable bruises to her face and arms by the Health Visitor. The Health Visitor recorded that they 'looked like finger marks'. However, when asked how the injuries occurred Mother said they had happened when she was moving furniture. The possibility of domestic violence was not pursued by the Health Visitor. At the time there were no known adult males living in the household, although Sibling 1 was living at home with Mother. However, professionals need to acknowledge that domestic violence is not confined to people involved in intimate relationships.

5.1.18 The Health Visitor had been sufficiently concerned to note the injuries in her records, and intended to record any future concerns when she visited Mother at home. As previously referenced the Health Visiting service at the time was under significant pressure due to lack of resources. Caseloads were between 450-750 families. As part of a three year national programme, to be achieved by the end of March 2015, it is recommended that caseloads for each full time equivalent Health Visitor will be 250. The Health Visiting base where the Health Visitor worked had staffing shortages due to retirements and corporate caseloads were introduced. This had challenges for the staff in ensuring that all documentation for their families of concern (of which Child L was one) was seen by the Named Health Visitor.

5.1.19 Mother's injuries noted by the Health Visitor should have been followed up given a lack of willingness by Mother to engage with agencies was already beginning to emerge. If this had happened early intervention services could have been provided to Child L and other agencies made aware of concerns. This does, however, need to be

seen in the light of Mother's unwillingness to be involved with professionals, which has featured throughout this review.

5.1.20 Since 2010 Health Visitors are required to use The Family Health Needs Assessment Tool which has a question about domestic violence and allows for its exploration. Similarly, *Professional Guidance on Domestic Violence and Abuse* since issued by the Department of Health in June 2013 to Health Visitors and School Nurses aims to help professionals to recognise factors that may indicate domestic violence and describes steps to ensure appropriate support and referral where necessary. The guidance acknowledges that because of the role of midwives, health visitors and school nurses they are often one of the first to become aware of domestic violence and abuse issues within families, and have a significant part to play.

5.1.21 The school also expressed concerns that Mother may have been subject to domestic violence, as illustrated when they noted on one occasion she was wearing sunglasses when it was not sunny (although this incident may have also been concern about drug use). Subsequently, when Mr A became involved with Mother, Child L was to express her anxieties that he shouted and swore at Mother.

5.1.22 On his release from prison in August 2011 the degree of risk Mr A presented to women was assessed as high and as medium to children by the Probation Service. The assessment was however made in the context of the risk he posed to his previous partner and their child. The risk he presented to the public in general did not meet the requirement for Mr A to be registered under Multi-agency Public Protection Arrangements (MAPPA). The HM Prison IMR author raises the question of whether Mr A should have been referred to MAPPA. Whilst the Probation Service assessment considered the possibility of his registration under MAPPA, it did not recommend it. Because of the nature of his index offence (a drug offence and breach of a suspended sentence for violence committed against a former partner) Mr A would have only qualified under MAPPA category 3. The Probation Service has clarified that to register under this category the responsible authority must:

- Establish that the person has committed an offence which indicates that he or she is capable of causing serious harm to the public, and
- Reasonably consider that the offender may cause serious harm to the public which requires a multi agency approach at level 2 or 3 to manage the risks.

5.1.23 The Probation Service considered that the first of these criteria was met but the second was not and registration was discounted. It is important to note that additional concerns raised by Prison Officers regarding Mr A's aggressive, rude and volatile nature during his period in prison were not communicated by the prison staff to the Offender Manager responsible for his licence supervision.

5.1.24 When Probation Officers undertook a risk assessment of Mr A in September 2011 at his prison release address, it was done on the basis that he was not involved in an intimate relationship with the woman with whom he was staying. She was said to be his landlady and was not present at the time of the visit. Her 16 year old daughter was present, and she was assessed by the Probation Officers as being 'mature'. It was on this basis that the address was seen as suitable and the woman and her daughter were assessed as not being at risk from Mr A. The Probation Service has clarified

that the Probation Officers were unaware that the 16 year old daughter had been admitted to hospital in August 2011, when Mr A was lodging with the family. This was as a result of excessive drinking and amphetamine use whilst in Mr A's care.

5.1.25 Whilst the Probation Officers who visited had undertaken safeguarding children training, there was a lack of holistic assessment of the risks posed to the 16 year old young person residing at the address. Consideration was not given to the possibility that the 'landlady' may have been at risk of domestic violence, despite her not being seen, because Mr A was said not to be involved in an intimate relationship with her. Her 16 year old daughter was assessed as being confident and mature, and was therefore not thought to be at risk or vulnerable. Given, Mr A's history of offending it is difficult to understand on what evidence this assessment was made. The Probation Service was not informed by CSC of the incident involving the 16 year old girl in the misuse of drugs and alcohol. CSC supervision records show that the Senior Practitioner responsible for the case at the time asked for clarification as to who the lodger was, but there is no indication that this was undertaken. However, the Probation Officer whilst recording the presence of a child in the household undertook no agency checks with CSC to ascertain whether the family was known. In the past, the Probation Service had assessed Mr A as a high risk to previous partners and a medium risk to children. This episode and his involvement with Child L indicate that he presented a high risk to both women and children.

5.1.26 The child safeguarding policy operated by the Probation Service at the time did not require contact with CSC in all cases but indicated that there should be contact where there were concerns. The policy highlighted drug abuse as a stress factor which required a check with CSC. Mr A was a violent serial drug offender, who did not adhere to the terms of his licence and was living in a household where there was a child present. Had a holistic approach to safeguarding been adopted, then the Probation Officers would have discovered the risk Mr A posed to children and young people.

5.1.27 The safeguarding children policy issued by the Probation Service in 2012 now states that Probation Officers are required to contact CSC to see if children with whom any offender is in significant contact are known to be at risk or in need.

5.1.28 Mother had a long term diagnosis of physical illness, and was treated for depression, anxiety and agoraphobia. She was prescribed antidepressants and analgesics by her GP. Prior to Child L's birth Mother had been signed off work because of back pain and agoraphobia. Her symptoms had been exacerbated due to stressful life events, including several bereavements in 2001 for which she was prescribed Diazepam and following a related overdose she was referred to the Community Mental Health Team (CMHT). Mother did not attend appointments offered. She was re-referred to the CMHT in 2005 after Sibling 1 asked to live with his father and she was being prosecuted for his non-school attendance. Mother did not attend. At the time of Child L's birth Mother continued to be depressed and was taking antidepressant medication which had been reduced because of her pregnancy.

5.1.29 In 2010 following the death of two close relatives Mother experienced thoughts of self harm and an exacerbation of symptoms such that she did not attend a civil court appearance. The GP contacted CSC requesting support for Mother with child minding

for Child L whilst she attended the civil court hearing. The call ended before a social worker could explain that the family did not meet the threshold for support.

5.1.30 Given the above it is apparent that Mother had a significant history of mental illness, manifest in depression and agoraphobia, which was essentially treated with medication. This was seemingly because of her refusal to engage with mental health services. Mother was known to use cannabis and amphetamine on a regular basis, information which she disclosed to her GP, and to midwifery services when pregnant with Child L. It was also known that Mother was misusing alcohol prior to Child L's birth. In addition, the GP surgery was aware that Mother had experienced domestic violence as she had disclosed that her relationship with Sibling 1's father had been abusive.

5.1.31 No consideration was made of Mother's parenting capacity during her engagement with the GP surgery, as required under the *Joint Working Protocol 2008; Safeguarding children whose parents/carers use drugs/alcohol or have mental health needs*. There is no evidence that a formal mental health assessment was done or if any risk assessment was undertaken to review the potential impact of her parenting capacity.

5.1.32 Significant parental mental health issues should trigger an assessment of parenting capacity. Depression is a common diagnosis in Primary Care and whilst the International Classification of Diseases (ICD) recognises mood disorders as a significant mental health problem the Quality and Outcomes Framework (QoF Mental Health Indicators) does not. These individuals are not highlighted as requiring regular monitoring and annual reviews. Many Practitioners follow the QoF guidelines rather than clinical need especially as workload increases and budgets are target driven. Neither Mother nor Mr A would be required under QoF to be reviewed.

5.1.33 Additionally, there is no evidence that a review was undertaken of Mother (or Mr A's) repeat prescription requests for strong analgesics, where the potential for misuse is evident.

5.1.34 There appears to have been no overall assessment undertaken of the impact of Mother's mental illness, her substance and alcohol misuse and her experience of domestic violence. No referral was made to CSC by the GP Surgery detailing Mother's history and the risk her mental illness and substance misuse posed to Child L. The GP practice did receive a Section 17 form request for information from CSC following the anonymous referral concerning Child L in November 2012. The form was scanned uncompleted into Child L's notes. The form may have been scanned into the patient records on receipt (part of handling communications regarding patient's process). It may have been completed by hand and faxed back after this. No one is sure what happened in this case.

5.1.35 No information concerning Mother's physical and mental ill health and the risks presented to Child L was communicated to CSC by the GP practice. This resulted in a missed opportunity for CSC to fully assess Child L's vulnerability to significant harm.

- **Early Intervention: Quality of Assessments**

5.1.36 It is evident that when Mother was pregnant with Child L concerns became known about her mental health, cigarette smoking, significant daily use of cannabis and previous consumption of alcohol, amphetamine and cocaine. This information was provided by the GP in his referral letter to the hospital and by Mother at her booking assessment with the hospital midwife. The risks posed to Mother and her unborn baby were explored and well documented by the booking midwife. However, no concern form was raised for the Safeguarding Midwife and Social Worker in relation to the identified safeguarding risk factors. This was significant information which should have been passed as a referral to the Safeguarding Midwife and the Hospital Social Work Team. This did not happen and is a reflection of poor practice.

5.1.37 Given Mother's history appropriate tests were carried out by midwifery staff at the antenatal clinic throughout Mother's pregnancy to ascertain whether she was drinking alcohol and/or using drugs other than cannabis. The test results proved negative.

5.1.38 Efforts were made to assist Mother to stop smoking and she did briefly attend the 'Quitters' service. Mother was unable to stop cigarette smoking, (information varies as to whether she was smoking 10 cigarettes a day or 10 -20 day, 3-6 were cannabis)[18] and whilst she said she did not increase her use of cannabis, she could not reduce it. The hospital communicated concerns to the GP about the antidepressant medication Mother was taking and its affect on the unborn baby. This resulted in the dosage being reduced and Child L being monitored for withdrawal symptoms following her birth.

5.1.39 Information from research findings provided to the serious case review[19] indicates that the use of cannabis in pregnancy does not seem to have any specific effect on the developing baby in terms of congenital malformations. Neither does growth or survival appear to be effected, once the use of alcohol and tobacco are taken into consideration. Following birth there is no apparent effect on birth weight and no increased risk of sudden infant death syndrome. However, cannabis is usually smoked with tobacco, for which the risks presented and the effects on the unborn baby is well documented.

5.1.40 These concerns, including her age, led to Mother having obstetrician led care by the specialist obstetrician managing drug-using women.

5.1.41 Mother's case was discussed at the April 2006 drug liaison meeting at the hospital. A Southampton CSC Social Worker and the Child Protection/Safeguarding Midwife were amongst the professionals attending the meeting. Apart from monitoring Mother during the antenatal period and Child L post-natally for anti-depression medication withdrawal symptoms, there was no early intervention by agencies. There was no multi-agency discussion in early pregnancy, which could have led to a pre-birth planning assessment being undertaken by a social worker. Whilst Mother was monitored for substance misuse and was appropriately assessed from a medical perspective as high risk throughout her pregnancy, there was no consideration given to completing a

[18] Registrar's letter in appendix UHS IMR
[19] Research findings considered by the Designated Doctor and SCR Panel member: UHS information to mothers 2011; BAAF, 2004

CAF[20] in respect of her unborn child or making a Child Protection referral to CSC. There was no liaison between the midwifery and health visiting services prior to Child L's birth.

5.1.42 Mother required a caesarean section and lost a significant amount of blood following Child L's birth. The baby required close monitoring for possible withdrawal symptoms from Mother's antidepressant medication. The day after Child L's birth Mother became anxious and took her own discharge against medical advice. She left the hospital at 23.00 hours having received 'training' on how to recognise withdrawal symptoms in Child L. Monitoring of mother and baby was then undertaken by the community midwife and later the health visitor. Given Mother's history of mental ill health, drug misuse and lack of support at home, as well as the trauma associated with Child L's birth, it would have been appropriate to have held a pre-discharge multi-agency meeting in order to fully assess the risk to Child L before allowing Mother to take her own discharge. This did not happen. No referral was made to Early Intervention Services or to CSC.

5.1.43 The community midwife observed good interaction between mother and baby, with Child L gaining weight. However, given the traumatic time Mother had experienced when giving birth, together with her history, close monitoring of the relationship between Mother and Child L was essential. Once the midwife withdrew it was for the Health Visitor to undertake this role. The Health Visitor was aware from the joint visit undertaken with the EWO in 2006 that she had concerns that Mother may have been dealing drugs. The Health Visitor never asked Mother directly about her drug use. She did frequently liaise with the GP surgery about Mother not keeping appointments. The surgery was fully aware of Mother's substance misuse, but this information appeared not to have been shared with the Health Visitor. Not withstanding resource issues for Health Visiting services at that time, it was in the main because of Mother's unwillingness to engage with the Health Visitor that close monitoring of Child L did not happen. Appointments and visits were not kept, which resulted in Child L being considered as a 'child of concern' by the health visiting service.

5.1.44 One agency with whom Mother did have contact was the GP Surgery. The GP had important information concerning Mother's physical and mental health, her alcohol and substance misuse. The GP made an appropriate and detailed referral to the hospital when Mother was pregnant with Child L, and requested help with child minding services from CSC when Mother needed to attend civil court proceedings in 2010. There was however no discussion with Mother of the need for early intervention services, or given Mother's lifestyle, recognition that there were safeguarding concerns for Child L.

5.1.45 Once Child L started at Infant School 1, the Health Visiting records which should have been sent to the School Nurse[21] in September 2010 were not received until January 2011. Concerns about Child L's attendance did not become apparent until she entered Year 1 in September 2011. She had however been considered a 'child of concern' by the Health Visiting service for several years prior to her arrival at the school. Mother had completed a comprehensive health questionnaire sent out by the School Nurse in

[20] The Common Assessment Framework was implemented at this time
[21] The School Nurse was employed by Solent NHS

June 2011, which identified no health concerns by Mother. Child L's immunisations were recorded by Mother as being up to date, and she ticked 'no' to wanting to discuss any concerns about her child in an appointment with the School Nurse. The questionnaire was taken as read and was a self reporting assessment by Mother.

5.1.46 As concerns about Child L's behaviour and her poor attendance increased the School Nurse, the EWO and the Head Teacher met with Mother in May 2012 to discuss Child L's attendance and lateness. The school had made several attempts to meet with Mother, with whom they found it difficult to build a relationship as she was often on the outskirts of the classroom or the playground. At the meeting Mother was offered support from either a Family Support Worker or a Nursery Nurse, both of which she refused. The plan arising from the meeting was to monitor the situation, and Mother was given the contact details of the School Nurse, should she change her mind about accepting support. There was also discussion with Mother of completing a CAF.

5.1.47 There was no indication as to what was being monitored, by whom and when a CAF would be considered appropriate. When interviewed during the process of this review, the School Nurse clarified that the plan was for the school to monitor Child L's attendance and if there was no improvement then a CAF would be completed. Given that a CAF requires the consent of the parent and in light of Mother's stated refusal to engage in the CAF process, it is difficult to see how this plan would have resulted in 'a good outcome' for Child L[22].

5.1.48 The School Nurse made an assessment of Child L's health needs in July 2012 with Mother's consent. No health concerns were identified. Child L was described by the School Nurse as presenting in clean clothes, being confident and happy to talk. Child L's experience of life at home was not explored, as there was nothing of concern evident. The School Nurse Safeguarding Lead has clarified to the review that the health assessment completed by the School Nurse was more of a screening rather than an assessment session. School Nurses will only record something if there is something of concern to report. In the case of Child L there was nothing abnormal to note in the records.

5.1.49 The School Nurse was aware that the school was concerned about Mother being anxious and about her general demeanour. Although drug use may have been suspected it was never discussed. By mid October 2012 the school informed the School Nurse that Child L was behaving inappropriately towards adults and that the PSW (who was employed as a Tier 2 social worker by Southampton City Council, but line managed by the school) had made a home visit at the request of the school had been refused entry by Mother. The school had arranged a meeting with Mother to discuss these concerns, and would involve the School Nurse if they considered intervention by School Health was appropriate. The School Nurse was not contacted again in relation to Child L and had no further involvement in the case.

5.1.50 During her involvement with Child L the School Nurse did not assess her as being a child in need and she was never discussed in safeguarding supervision. This is perhaps not unsurprising given Child L's general good health, presentation and demeanour, as perceived by the School Nurse. The main concern of the school was

[22] Working Together 2013 makes reference to the need for clear plans if good outcomes are to be achieved for children

her lack of attendance and poor punctuality, which was reported to the EWO and the PSW. That the School Nurse was unaware of wider concerns about Mother and her parenting capacity was due in part to a lack of information being shared from other agencies. This was especially so of the Health Visitor who was visiting Child L's home in July 2012 because Sibling 1's child was living with Mother and was subject to a child protection plan. The GP surgery also had significant knowledge about Mother's depression and substance misuse but this was never shared with the School Nurse. This issue is discussed in detail in the Effective Communication and Information Sharing section below.

5.1.51 Early on the school identified concerns about Child L's attendance, punctuality and Mother not always collecting her at the end of the school day. These were appropriately referred to the Education Welfare Service (EWS), whose remit was to ensure that Child L's school attendance and punctuality improved. When additional concerns emerged about Child L's inappropriate behaviour and Mother's lack of willingness to engage with the school to discuss these issues, the PSW was asked to become involved. The case was co-worked by the EWO and the Prevention Social Worker, who were each attached to two secondary schools and eight primary schools. Their aim was to work in partnership with the school and other services.

5.1.52 As is apparent throughout this review Mother was only prepared to engage with the EWO on her terms. Apart from meeting Mother at two meetings convened at the school by the Head Teacher, the EWO gained entry to Child L's home on one occasion, in January 2012. Mother refused to allow the Prevention Social Worker (PSW) entry on the two occasions she attempted to visit. Although the school kept the EWO and the PSW informed of their concerns about Child L, apart from monitoring her in school and logging her absence, there was little proactive intervention. This was largely due to Mother's resistance to the involvement of agencies in her life and that of Child L. When the school raised concerns with CSC they initially were referred back to the EWS, whose recourse was to monitor and suggest a CAF.

5.1.53 It was only after an anonymous referral to CSC in late October 2012 that an Initial Assessment was undertaken. The school had made verbal referrals to CSC in October, and there had been liaison between the EWO and the CSC Senior Practitioner following CSC receipt of the anonymous referral. Further written referrals of the school's ongoing concerns were made to CSC following the outcome of the Initial Assessment, which the school considered did not appropriately address the risk to Child L. However, although CSC requested that the school kept a log of incidents, it is evident that the school was sending somewhat contradictory messages to CSC.

5.1.54 In November 2012 after the Initial Assessment visit and again in late December 2012 the school reported that Child L's situation had improved because her attendance had improved. Yet, also in early December and prior to the end of term they expressed concern that Child L was going to be unmonitored during the Christmas Holidays. It is evident that not all the information about Child L's concerning behaviour was passed on to CSC. CSC had no record of the detail of the school's concerns about Child L's inappropriate behaviour towards adults, which has only been made available through this review process. Given the paucity of agency checks undertaken by CSC prior to and after the Initial Assessment, on the information available to CSC, it was

considered that there was a lack of evidence to support the school's concerns. Thus, Child L was considered not to have met the threshold for CSC intervention. The school was becoming increasingly frustrated that they were not being taken seriously by CSC but did nothing to escalate their concerns within agreed escalation of concerns procedures.

5.1.55 Up to the point of the anonymous referral being made to CSC involvement with Mother had in the main been limited to information from Cafcass, the Police and the School concerning Father's application for contact. The GP had enquired about the possibility of child minding for Child L to enable Mother to attend a court hearing, but there had been no disclosure of concerns about Mother's care of Child L, neglect issues or Mother's drug use until the anonymous referral was received in October 2012.

5.1.56 Outside of the review period there had been concerns about Sibling 1's school attendance, with a suggestion that Mother was keeping him at home to keep her company. However, it was not until domestic violence between Sibling 1 and Miss C became a concern that CSC became involved in child protection procedures in relation to their child. No link was made between Sibling 1 and Child L by the Social Worker allocated to the case when his child became subject to a Child Protection Plan. Mother was visited at home by the Health Visitor and the allocated Social Worker as she was caring for her grandchild when child protection concerns became apparent. There appears to have been a lack of necessary information gathering during the Section 47 inquiries. If a robust assessment and identity checks had been undertaken by CSC during these procedures the link between Mother, Sibling 1 and Child L would have been established. This did not happen. Unless information was inputted into the electronic system, there was no process for linking two families together. If appropriate checks had been undertaken concerns about Mother's parenting capacity, given her medical history and substance misuse, as well as increasing concerns about Child L's non school attendance would have come to light. In turn this would have then informed the Initial Assessment undertaken following the anonymous referral concerning Child L.

5.1.57 Given this lack of knowledge about Mother and Child L the actions of CSC prior to October 2012 can be seen as appropriate. There was no basis for intervention by CSC. The issues raised all concerned Father's application for contact with his daughter, in which Cafcass, the appropriate agency was involved. The concerns of the school, up until a few days before the anonymous referral was received, had not been referred to CSC as they related to attendance and poor punctuality, which were being dealt with by the EWO. Additional concerns about Mother's unwillingness to engage and Child L's behaviour at school had been referred to the Prevention Social Worker for her intervention with offers of support to Mother.

5.1.58 However there was considerable delay in allocating the case for an Initial Assessment to be undertaken. It took three weeks from the referral being received and the case being allocated to NSW 1. The reason for the delay may have been due to the structure of the Children First at that time. In February 2012 a former CSC Principal Officer had set out the terms and remit for Children First. Their role was to undertake the necessary information gathering and risk analysis at the point of first contact in, to enable a recommendation to be made regarding whether a contact should become a referral to the Integrated Assessment Team for Initial Assessment.

5.1.59 The anonymous referral made to Children First was appropriately passed to the Initial Response Team for Initial Assessment. The Initial Response Team was then a small part of the Integrated Assessment Team and comprised of three social workers, overseen by a Senior Practitioner. The Initial Response Team was developed as a way of responding to a back log of 70 cases awaiting Initial Assessment. The term 'maybe cases' was introduced, meaning that further consideration was necessary of whether the case required an Initial Assessment or signposting elsewhere. However, this function ran the risk of being less focus on the child and more on assessing the threshold.

5.1.60 Initially, when cases were passed from Children First to the Initial Response Team, they were allocated to the Senior Practitioner until subsequent allocation was made to a social worker to undertake the Initial Assessment. On PARIS (CSC electronic recording system) there was one Outstanding Referrals box for the Initial Assessment Team and the then Initial Response Team. Any referral that was not already allocated would show in the Outstanding Referrals box. This enabled the duty Senior Practitioner to see immediately what work was outstanding. At the time of the referral concerning Child L in October 2012 the Initial Response Team retrieved the referral from the Outstanding Referrals box. It was standard practice for a PARIS notification to also be sent to duty Senior Practitioner for the Initial Response Team to alert him/her to the referral from Children First and common practice would have been for that Children First to have had verbal communication directly with the duty Senior Practitioner to reiterate the referral.

5.1.61 At the time the referral was received in October 2012 the arrangements in place for the assessment and allocation of cases was set up to deal with the problem of a large backlog of referrals. The referral was also being assessed as a 'maybe' case. It was for this reason that the referral concerning Child L remained unallocated for three weeks.

5.1.62 In early November the EWO had telephoned Senior Practitioner 1 to discuss her concerns about Child L. She relayed concerns about Mother's lack of engagement, inconsistent information from Child L about the time in the evening she was allowed to stay out unsupervised and Child L's 'overtly sexual' behaviour in a meeting. The information was entered on PARIS as a communication by Senior Practitioner 1, before the case was allocated to NQSW 1.

5.1.63 Under PARIS there was no automatic notification on the system for information received after initial referral. Notification is reliant on a specific action being selected on PARIS by the user after the most recent information has been entered onto PARIS case records.

5.1.64 The Initial Assessment was allocated to NQSW 1 who had been in his permanent social work post, based within the Initial Response Team for approximately one month. He was supervised by Senior Practitioner 1 and later by Senior Practitioner 2, who was new to her position in the Initial Response Team. NQSW 1 undertook his Initial Assessment visit three weeks after the anonymous referral had been received by CSC. If the assessment had been completed within the required ten day timescale it may not have provided additional evidence of concerns at that time, given Mother

told NQSW 1 that her relationship with Mr A was only a couple of weeks old. Crucially if the case had been allocated sooner all new information received after the initial referral would have been passed directly to NSW 1 to be incorporated into the Initial Assessment visit and subsequent analysis. This did not happen.

5.1.65 When NQSW 1 undertook the Initial Assessment visit he was unaware of the concerns which the EWO had raised with Senior Practitioner 1. He did a detailed assessment on the information he had available but this was limited to the information contained in the anonymous referral, not subsequent information. He found no evidence of neglect or drug use at Child L's home, and Mother denied that Child L was allowed to stay out late into the evening unsupervised. He explained, when interviewed by the CSC IMR author, for this review that "*he had stayed longer than usual as felt there may have been something else, however he was satisfied on leaving that there were no significant issues and that he had not missed anything during the assessment*"[23].

5.1.66 During the visit NQSW 1 spoke with Mother and Child L separately. Mother agreed for him to interview Child L alone in her bedroom. In retrospect this was not the most appropriate arrangement, as any such interview should be conducted in a neutral setting if at all possible to ensure that neither the child nor the professional is placed in a vulnerable situation. NQSW 1 found Child L keen to engage and presented as 'confident and bubbly'.[24] There was no evidence of sexualised behaviour and NQSW 1 did not specifically address this area as it was not part of the original referral. NQSW 1 told the CSC IMR author that he had no recall of this concern subsequently being raised with him by Senior Practitioner 1. There is no evidence on PARIS to indicate that this area was to be considered as part of the case work plan. Thus, although information which would have informed the Initial Assessment had been appropriately referred to CSC and recorded on the system, it was not known to NQSW 1 when he did the visit. Senior Practitioner 1 who had originally entered the information on PARIS did not make NQSW 1 aware of these concerns prior to his visit. Senior Practitioner 2 who was new to the Team and was the Senior Practitioner responsible for signing off the completed Initial Assessment, was seemingly unaware of the additional information from the EWO.

5.1.67 The Initial Assessment was signed off on the basis that although the school had some difficulties in engaging with Mother, Child L's school attendance was not ideal and she was often late, Child L was generally well presented. Mother stated that Child L was looked after by her or Sibling 1. Some outreach work had been undertaken by the EWO and the PSW/Tier 2 Social Worker and on this basis a role for CSC could not be identified at that time. Within days of the case being closed Infants School 1 raised further concerns about Child L being neglected and of her disclosing that she was frightened when Mother's partner was swearing and shouting at Mother.

5.1.68 The Initial Assessment was the appropriate means to identify Child L's needs. Its findings based on the limited information of the anonymous referral and the home visit led NQSW 1 to recommend that there was no identified role for CSC, which was subsequently sanctioned by Senior Practitioner 2. It is to the credit of NQSW 1 that he spent some time with the family and insisted on speaking with Child L for forty minutes

[23] CSC IMR page 22
[24] ibid

without Mother being present. He was able to recognise that perhaps something was not quite right in the home and wanted to ensure that he had explored any possible concerns with Child L. She in turn was able to engage with him and appreciated his child centred approach, indicated by telling him she '*wished he could be her Dad*'[25] Whether Child L had been coached by Mother to answer questions posed by professionals needs to be considered in the light of Child L disclosing further information about her life at home whilst in foster care.

5.1.69 At the time the Initial Assessment was undertaken in November 2012, there was a policy in place in CSC where only one agency check was required. The check was made with the most appropriate agency to assist the assessment, unless the need for further checks had been identified. In Child L's case Senior Practitioner 2 entered a Management Decision on PARIS for checks to be undertaken with the school as well as with the School Nurse, in case of previous information from Health Visitors. The check was not made with the School Nurse and although a form requesting information was faxed to the GP there was no response until a blank form was returned in February 2013. No follow up was undertaken by CSC.

5.1.70 An agency check was undertaken with the Head Teacher in December 2012, after the school had made two further referrals of concerns and had submitted an incident log as requested by CSC. The school check was made by NQSW 2 based in the Initial Response Team. But there was no continuity of social work involvement in the case, and no continuity of management oversight. Agencies which could have provided important information to inform the Initial Assessment were not contacted.

5.1.71 Full agency checks would have identified further information about Mother's history and that of her son, Sibling 1. Similarly, if Mr A's name as supplied by Child L and confirmed by Mother, had been entered into PARIS with the use of asterisks to ascertain possible variations of the spelling, Mr A would have appeared as being known to CSC. Whilst it is commendable that NQSW1 did undertake a check on the name supplied after his visit, it is unfortunate that he was unaware of this function on PARIS to check the correct spelling of a name.

5.1.72 Because of the backlog of cases requiring assessment by the Initial Response Team, in addition to the limit on the number of agency checks being undertaken, an interim measure had been agreed sometime prior to the incident involving Child L that only the analysis section of the Initial Assessment would be completed. This practice was passed from Senior Practitioner 1 who was initially involved and responsible for the supervision of NQSW 1 to Senior Practitioner 2. Following the incident concerning the injury of Child L it was discovered by the Integrated Assessment Team Manager that partial recording had been continuing and as a consequence of this, full recording of Initial Assessments was reinstated.

5.1.73 Early intervention and assessments undertaken by the Prison and Probation Services in respect of the risk posed by Mr A and Father (by the Probation Service) have already been addressed in this report.

[25] ibid

5.1.74 The involvement of UHS in assessing the risk to Child L both prior to and after her birth has also been documented. The involvement of UHS in the assessment of Child L when she was admitted to hospital following the incident in December 2012 will be dealt with after outcome of the trial of Mother and Mr A. This also applies to the Police.

5.1.75 Whilst Mr A was well known as a serial and violent drug user and dealer by Police, they in common with the other agencies involved in this review had no knowledge of his relationship with Mother until after the incident in December 2012.

5.1.76 The Housing Department acted appropriately in its involvement in assessing the housing needs of Mother and Child L. This was especially so when Mother stated she was depressed in her application for social housing in 2006, and a housing officer visited her. It was also good practice to undertake a 'settling in visit' after Mother had been offered a council tenancy in 2010.

5.1.77 The role of Cafcass in assessing the appropriateness of Father's application for contact with Child L and whether this would be in her best interests was in keeping with policy and practice. Given Mother's refusal to allow Child L to be seen on her own to ascertain her wishes and feelings in relation to Father's application for contact, it was good practice on the part of the FCA in seeking an order from the judge requiring Mother to comply with the FCA's request. Similarly, the issue of Mother and Father's criminal records and their drug use was also identified as requiring further assessment as to their parenting capabilities. The requirement that Child L should attend school was also brought to Mother's attention by the FCA.

- **Effective Communication and Information Sharing**

5.1.78 There was a lack of effective communication and information sharing by the GP practice with other professionals. Mother's medical history contained important information concerning her capabilities as a parent. However, the GP who saw her, whilst communicating concerns to the hospital at the time of Mother's pregnancy failed to consider the ongoing safeguarding risks presented by Mother's behaviour to Child L after her birth. There was no communication with CSC or with the School Nurse about Mother's agoraphobia, depression and substance misuse.

5.1.79 There was no documentation on the school nursing records concerning Mother's mental health as there was no liaison with the School Nurse and the GP practice. There were concerns about Mother being anxious and her general demeanour, but the School Nurse had no awareness that Mother was on anti-depressants. The School Nurse reported in interview with the Solent NHS Trust IMR author that GPs will not disclose information about parents, only about the children with whom the School Nurse is working. This view was confirmed by the School Nurse Lead and explained that GPs will not share information about adults as School Nurses do not have consent for adult information to be disclosed. If liaison had taken place with the GP it would have informed the School Nurse of further risk factors and provided information for a more informed assessment of Child L's needs by the school, the EWO and the PSW. These concerns could then have been referred on to CSC.

5.1.80 Whilst the GP was kept informed by the court and Cafcass about Father's application for contact, the documentation was noted and filed. The outcome of the court proceedings was shared with the GP and the letter from the court highlighted a number of potential risks to Child L. There is no indication that any action was taken. There is no evidence that the impact of such a case and the circumstances of the reasons for Father's rehabilitation order following his conviction for offences related to domestic violence or Mother's mental health issues were documented or considered as potential risk factors for Child L.

5.1.81 A Section 17 form was sent to the GP Practice from CSC in November 2012 following the anonymous referral concerning Child L. The form detailed the concerns about alleged neglect of Child L and that Mother was a well known drug and alcohol abuser. CSC requested that the GP complete the form and return. An incomplete form was scanned into Child L's records and no information was shared with CSC by the GP practice. No follow up was made by CSC, and a blank form was returned by the GP in February 2013.

5.1.82 Whilst there was telephone communication between the Health Visitor responsible for Sibling 1 and Miss C's child when they were living with Mother in March 2012 and the allocated Social Worker for the case, there was no direct reference to Child L. This was despite Child L being present when the Health Visitor saw Miss C at Mother's address. It was not possible for the Health Visitor to explore issues with Miss C concerning the animosity between both sets of grandparents because of Child L and Mother's presence. Yet there was no liaison with the School Nurse to ascertain information about Child L being in the home nor was there professional curiosity as to Mother's history, given she had shared care of her grandchild. There was no liaison with Mother's GP as to her suitability to care for her grandchild. If this had occurred, and the GP had recognised the need to share patient information on child protection grounds, then the connection between the two families i.e. Sibling 1 and Mother and Child L would have been known to CSC.

5.1.83 The Health Visitor when interviewed by the Solent NHS Trust IMR author explained that she had observed no concerns about Child L and did not liaise with the School Nurse or CSC. If there had been safeguarding concerns she would have liaised with the School Nurse, however she was focussed on Sibling 1's family and did not consider wider safeguarding issues which might impact on Child L in the home environment. Later, in July 2012 when domestic violence between Sibling 1 and Miss C was subject to MARAC, the Health Visitor was unaware of the MARAC meeting occurring. The serious case review has been informed that this was possibly due to corporate case loading when a Health Visitor colleague may have read the report that had been printed out, and due to poor staffing levels this information may not have been communicated to the Health Visitor concerned.

5.1.84 In July 2012 when the Health Visitor became aware of the level of domestic violence by Sibling 1 towards Miss C, she discussed the effect of domestic abuse on his child with him whilst at Mother's home. This was good practice. The Health Visitor was aware of the frequency Sibling 1 and his family stayed with Mother and Child L, and of the extent of the domestic violence between Sibling 1 and Miss C. She did not however take into account the impact this may have had on Child L.

5.1.85 Infant School 1 was persistent in communicating concerns about Child L to the EWO, the Prevention Social Worker and then to CSC. However, there was not always consistency in the information which was conveyed.

5.1.86 This is manifest by the way in which the School raised concerns with CSC. Agreed procedures for making interagency referrals were not followed. Information was conveyed by email or telephone, until the School was asked by CSC to send a log of their concerns in December 2012. At times the School Business Manager was tasked with contacting CSC by telephone to refer concerns about Child L. Whilst recognising that the Business Manager was aware of concerns about Child L, had had direct contact with Mr A and viewed him and his presentation with concern, it was not for her to share such information with CSC. It was for the School Designated Child Protection Officer to pass on such information. Delegating this responsibility to the Business Manager resulted in CSC requesting that the Head Teacher contact them. Whilst safeguarding is 'everyone's responsibility', CSC rightly viewed it as inappropriate for child protection concerns to be communicated by the School's Business Manager, rather than the Designated Child Protection Officer. It raises questions about the School recognising the need for confidentiality when referring child protection concerns, and whether the School's Child Protection Policy and Procedures were being adhered to.

5.1.87 Although the School notified CSC of their concerns about Child L's sexualised behaviour, the detail of that behaviour, as described in paragraph 2.2.69, was not shared. Thus, the seriousness of the risk of possible sexual abuse posed to Child L was not fully assessed. Similarly, there was a lack of consistency in the messages the School was conveying to CSC in December 2012. Concerns for Child L's welfare and non school attendance were being raised at the beginning of December. Just before the end of term however, the School was reporting that the situation had much improved. CSC thus questioned what role they could play in the case, given the inconsistency of the information being conveyed.

5.1.88 This conclusion by CSC was based in part on the perceived involvement of the EWO and the Prevention Social Worker. The EWO had been in contact Senior Practitioner 1 in early November 2012 to share information about the family. She had also made contact again in December 2012, after completion of the Initial Assessment, to inform CSC that she and the School disagreed with the conclusions of the assessment. CSC was however aware that the EWO had met with Mother and had undertaken individual work, (together with the PSW), with Child L.

5.1.89 Given that CSC was informed that Education Welfare and Tier 2 Social Work (PSW) Services were involved, it could be presumed from the perspective of CSC, that the case was being held and actively worked with by the EWO and the PSW. The involvement by the EWO and the limited involvement on the part of the PSW may have led to a false sense of security on the part of CSC that social work intervention with the family was taking place. This together with the concept of 'maybe cases' being held by the Initial Response Team reinforced the view of CSC (after the Initial Assessment was completed) that no further action was required.

5.1.90 The lack of clarity of the role of the Tier 2 social worker service is one which has led to confusion in this case. The Tier 2 social worker, also referred to as the Prevention

Social Worker, was employed by Southampton City Council, but worked directly with the School. Thus, the possibility for effective communication and sharing of information between CSC and the Tier 2 Social Work Service was limited. Information was essentially shared and communicated within and between the School, the EWO and the PSW. It was not however, communicated appropriately with CSC. In the event the PSW made no contact with CSC concerning Child L. This was left to the School and the EWO.

5.1.91 The function of Tier 2 Social Work, its involvement in this case and implications for effective practice are discussed in the Lessons Learnt section.

5.1.92 In addition to the above considerations, the conclusion reached by CSC that there was no requirement for CSC intervention was based on incomplete information gathering prior to the Initial Assessment being undertaken. This has been discussed at length in the section concerning Quality of Assessments above.

5.1.93 There was an absence of comprehensive assessment when Sibling 1, his partner and their child were living with Mother and Child L, and concerns had been raised about the level of domestic violence. Although a Section 47 investigation had been undertaken, leading ultimately to Sibling 1's child being placed on a child protection plan, no information appears to have been gathered or shared about Child L. At that time in July 2012 concerns were emerging about Child L's attendance and Mother's lack of engagement. None of this seems to have been taken into account, as none of the agencies involved with Child L have any records indicating that CSC requested such information as part of their assessment.

5.1.94 Similarly, the Probation Service failed to seek information from CSC following their visit to Mr A's prison release address in September 2011. If they had done so, information would have come to light of Mr A's involvement in the incident concerning the 16 year old daughter of his landlady the previous month. Had the Probation Service taken a less complacent approach to assessing the suitability of this accommodation arrangement, information concerning the risks posed to women and children from Mr A would have been shared and recorded.

5.1.95 In turn, CSC would have had Mr A's full identity details. Information could have been collated from agencies involved with him, including the GP, who had considerable knowledge of Mr A's substance misuse, mental health and history of domestic violence.

5.1.96 When the 16 year old girl was taken to hospital in August 2011 information should have been shared with Police, either by the hospital or CSC. The Police were not informed of this incident by either agency. If they had been, it is possible that the disclosure of this information would have led to a Police investigation.

- **Escalation of Concerns: including the need for and evidence of professional challenge**

5.1.97 The lack of robust information gathering and welfare checks prior to and at the time the Initial Assessment was signed off were not challenged by managers in the Initial Response Team. Neither was there continuity of social workers involved in the case.

Whilst recognising that limitations on information gathering for Initial Assessments was agreed policy by CSC at that time, this does not excuse the lack of professional challenge, and more especially management oversight of the two NQSWs involved in the Initial Assessment process.

5.1.98 Similarly, there was no professional challenge of the probation officers who assessed the prison release address of Mr A to be appropriate. It would appear that this assessment was made on the basis that the 16 year old was 'mature,' and Mr A's propensity for domestic violence and abuse only concerned those women with whom he engaged in intimate relationships.

5.1.99 Although outside the review period the lack of engagement by Mother after Child L's birth should have been escalated by the Health Visitor. There was sufficient concerns about Child L to designate her as a 'child of concern' by health professionals, however there appears to have been no discussion at a management level of the need for early intervention services or referral to CSC.

5.1.100 The School should have provided a detailed and robust chronology of their concerns about Child L's sexualised behaviour, Mother's refusal to engage with agencies, the increasing neglect Child L was experiencing and the concern about Mother's new partner. If concerns had been documented in this way, they could have been brought to the attention of senior managers in the EWS and CSC. Whilst the School and the EWO expressed their frustrations to CSC about decisions taken in the case, these were not brought to the attention of managers using Southampton LSCB agreed escalation protocol.

5.1.101 The lack of escalation of concerns is a regular and frequent finding of serious case reviews. Whilst agencies may be reluctant to initiate escalation procedures, perhaps because of concern about maintaining positive inter-agency relationships, the need to ensure that child protection issues are appropriately investigated and decisions challenged is a pre-requisite to good safeguarding children practice.

- **Absence of Fathers**

5.1.102 Like so many other serious case reviews, this review concerns a child who had limited contact with her father. This resulted in Father not featuring in most of the agency IMRs, with the exception of Cafcass and the Police. In Child L's case, as has been explained, Father was unaware that he had fathered a child with Mother until Child L was approximately 2 ½ years old. It was only when he was contacted by the CSA and underwent DNA testing that Father became aware that Child L was his daughter.

5.1.103 Father explained in interview with the Overview Report Author that he did have regular and frequent contact with Child L for almost six months during her early childhood. This was curtailed by Mother and it is to Father's credit that he made application to the court for parental responsibility and contact with Child L.

5.1.104 When undertaking the Initial Assessment CSC had details on the social care records of Father's identity provided by the School and Cafcass. No attempt was made to involve him in the assessment, and as this review has illustrated Father had

considerable knowledge of Mother's history, which would have informed that Assessment. This was a missed opportunity to explore the risks presented to Child L by Mother's drug use and involvement with those using and dealing drugs.

5.1.105 Whilst not underestimating Father's previous convictions for domestic violence and his cannabis use, he did comply with the requirements of his probation order and there is no reason to suggest that he would not have engaged with a CSC Initial Assessment.

5.1.106 Research findings[26] have shown when considering men and fathers in the context of serious case reviews that:

"*A number of issues emerged including the dearth of information about men in most serious case reviews; failure to take fathers and other men connected to the families into account in assessments"*

5.1.107 It was certainly the case in this review that there was little known information concerning Child L's father and no account was taken of him in the Initial Assessment. If Father had been contacted by CSC, given that he had been awarded Parental Responsibility by the Court, not only would he have been able to provide important information to the assessment, consideration could have been given as to whether Father offered additional protection to Child L when he was in contact with her from the age of 2 ½ - 3 years. Albeit this was for a relatively short period, but during this time Child L was described by her pre-school teachers as immaculate and well cared for. Once Father was no longer in contact, Mother's care of Child L can be seen to change, her school attendance began to deteriorate, which culminated in a rapid downward spiral of neglect once Mr A entered their lives. Given that Father was not contacted this aspect of the assessment was not explored.

5.1.108 The fundamental importance of fathers in the emotional and psychological development of children is recognised. It is apparent that having a father was very important to Child L as illustrated by her comment to the NQSW that she 'wished he could be her dad,' and in her initial excitement when Mr A first came into her life. When interviewed for this review, Father described how pleased Child L was that she was seeing him again, but how she also questioned why previous contact when she was much younger had not continued.

5.1.109 The lack of awareness by most agencies of Mr A's identity, coupled with Mother's attempts to conceal his identity has been illustrated throughout this review. Apart from the Police and the Probation Service, no professionals knew the extent of Mr A's criminal history and his propensity for violence. One agency which did come into contact with him whilst it was known he was staying at Mother's address was the School. Unfortunately, Mr A was not challenged by the school when he simply signed his first name in the school record book.

[26] Understanding Serious Case Reviews and their Impact, A biennial Analysis of SCRs 2005-2007, HM Govt, 2009, page 3, HM Govt 2009. Ofsted reports have also highlighted the lack of attention to the role of fathers or male members of the family.

5.1.110 The other agency which had significant contact with Mr A during this time was the Police. However they did not have the intelligence/information to be able to link him with the family or Mother's address. Mother's complicity in not disclosing his identity to professionals enabled Mr A to remain in her home and perpetrate significant harm against Child L.

- **Organisational and contextual factors**

5.1.111 The *Indices of Multiple Deprivation* Report, May 2011, ranked Southampton City as 81 out of 326 local authorities. Most recent data shows that the incidence of domestic violence and abuse is high, with domestic violence making up around 20% of violent crime during the period 2012 -2013. Domestic violence cases referred to MARAC[27] during this period showed that Southampton had twice the national average highest risk cases identified and going to MARAC. Domestic violence has been a feature of this case, as all Mother's known partners had convictions for domestic violence, as did her son.

5.1.112 Given this context, it is important to recognise that during the period under review the local authority was facing severe challenges in its ability to provide services to children. There had been a long running industrial dispute across the council, which had resulted in staff and managers resigning. This led to acute staff shortages, a lack of management oversight, a large number of referrals awaiting assessment and unallocated cases. As has been previously described the arrangements put in place for the assessment of referrals to First Response Team resulted in detailed information not being gathered and agency checks not being undertaken. 'Corners were cut' which resulted in inadequate assessments and children left at risk of harm.

5.1.113 It was under these circumstances that concerns about Child L were initially assessed. Vital information was either not recorded or was not accessed, both before and after the Initial Assessment, which enabled Mr A to remain in Child L's household, leaving her at risk. Additionally, the involvement of the EWO and the PSW led to a misplaced assumption that there was social work intervention with the family.

5.1.114 The lack of robust, appropriate assessment of children in need/in need of protection was endemic in CSC both before and during the period under review. This is manifest given the number of serious case reviews which have been recently commissioned.

5.1.115 There has been fundamental change within CSC and Southampton Local Safeguarding Children Board in the past 12 months. This has led to the restructuring of services to children and the appointment of a new independent chair to the LSCB. The framework for the assessment of referrals has radically changed. The Tier 2 and hospital social work services have been amalgamated into Children's Social Care and a new well resourced Multi-agency Safeguarding Hub (MASH) has been established. Given the commitment of agencies to the success of the MASH, it is to be hoped that cases such as that of Child L would now be appropriately assessed and managed.

[27] Highest risk cases are assessed and presented to multi-agency risk assessment conferences MARAC)

## 6 Consideration of a previous serious case review in Southampton

6.1.1 There are a number of serious case reviews currently being undertaken by Southampton Local Safeguarding Children's Board, of which this is one. The findings of those reviews are not yet known, however, it is to be anticipated that there are likely to be similar themes emerging from each review.

6.1.2 A review concluded by Southampton Safeguarding Children Board in April 2012 concerned Child G, a three month old baby. Whilst the circumstances of that review were different, there are some findings which resonate with this review, including information sharing between the Probation Services, the GP and children's Social Care.

6.1.3 Most specifically the need for accurate information gathering to inform an assessment was a finding of the Child G serious case review, which is particularly relevant to social work practice in respect of Child L. As the Child G review author appropriately points out:

*"The purpose of assessment is not simply to collect information, but to collate and analyse the material and then if necessary to probe further in respect of any possible areas of concern, so as the process can inform and help to direct future practice. If assessment tools are used effectively and completed fully, then they can significantly aid the understanding of any risk factors and the sorts of interventions that may be required to address them"*[28].

6.1.4 This finding is one that could be easily transposed to the Initial Assessment undertaken in respect of Child L.

6.1.5 Agencies are already involved in delivering comprehensive action plans in response to that review that may well have implications for the way in which the findings of this review and others currently being undertaken are followed up. The recommendations of this review have not however been restricted as a result of the recommendations from the former review.

## 7 CONCLUSIONS AND LESSONS LEARNED

7.1.1 The review has identified the importance of the need for a comprehensive approach to information gathering when assessments are being undertaken. This was a failure on the part of the Probation Service and CSC. The Probation Service did not fully assess the risk posed by Mr A when they visited his prison release address in 2011. Their assessment that the daughter of the 'landlady' was safe because she was a 'mature' 16 year old, demonstrated a lack of awareness of safeguarding children on the part of those undertaking the visit. Sadly, this assessment was ill judged as this young person had already suffered harm from the misuse of alcohol and amphetamine whilst in the care of Mr A.

[28] Child G Executive Summary paragraphs 5.5 - 5.6

7.1.2 If the Probation Officers who made that assessment visit in September 2011 had taken the time to check with CSC as to whether the family offering lodgings to Mr A was known, information would have been provided of the incident in August 2011 which necessitated a 16 year old girl's admission to hospital. The safeguarding children policy issued by the Probation Service in 2012 now states that Probation Officers are required to contact CSC to see if children with whom any offender is in significant contact are known to be at risk or in need.

7.1.3 At the time however, the Probation Service failed to take into account the risk presented to the landlady (and her daughter) who was providing lodgings to Mr A because it was stated that he was not involved in an 'intimate' relationship with her. The assessment of the risk Mr A posed to women and children was based on his violence towards previous partners and their children, as set down in the risk assessment tool used by the Probation Service. An assessment system which has such a narrow focus on the risk posed by those who perpetrate domestic violence, poses risks to other women and children. The Probation Service has revised and updated their Domestic Violence Policy since the period under review, and is a lesson learned.

7.1.4 The lack of robust information gathering to inform assessments undertaken by CSC during the period of the review was endemic. This was in part due to a high number of referrals and the acute staff shortages of social workers and managers in the Rat that time. A situation which was considered resolved by a decision made that only certain agencies should be contacted for information when an Initial Assessment was undertaken. In addition, the use of the term 'maybe' cases sought to focus on the process of whether a case warranted intervention and not on the safeguarding needs of children. Cases remained unallocated for weeks from the time of initial referral, as was the case for Child L. Once allocated there was no consistency of social workers involved in the case nor was there consistency of management oversight. This led to a failure to undertake a holistic assessment of risk.

7.1.5 There were aspects of the practice of NQSW 1, which warrant commendation. Once he gained access to the family, NQSW 1 spent considerable time with Mother and Child L. He spoke to Child L alone for forty minutes and whilst it may not have been appropriate for him to conduct the meeting in her bedroom, he adopted a child centred approach and was trying to ascertain information in a child friendly environment. Despite Mother's reluctance to provide information he attempted to discover Mr A's identity and although an incorrect spelling of the surname was provided, he did carry out checks on his return to the office. It was unfortunate that NQSW1 was unfamiliar with the process available on the system to ascertain the possible different spelling of surnames. The review has been assured that CSC staff, especially those dealing with referrals, have been made aware of the means to undertake this task.

7.1.6 The failure to gather relevant information was accompanied by a failure on the part of agencies to share information. The GP had substantial knowledge of Mother's mental health, drug and alcohol misuse and incidents of domestic violence. The GP Surgery had been informed that Sibling 1's child was subject to a child protection plan. None of this important information was shared with CSC or the School Nurse. A blank Section 17 form was returned to CSC three months after the request had

been made of the GP surgery, by which time Child L had been removed from her mother's care. This was a serious failing and is an indication of a lack of willingness on the part of the GP to engage in the process of safeguarding children.

7.1.7 Information was appropriately shared within and between the School, the EWO and the PSW, but not all the information known to the School was shared with CSC. Information about Child L conveyed to CSC by the School lacked consistency and the way in which it was referred was not compliant with the inter-agency referral process. The School are to be commended for their persistence in contacting CSC to inform them of their concerns for Child L. However, when the School felt that these concerns were not taken seriously the School did not invoke the agreed 4 LSCB procedures to escalate such concerns.[29] The failure to utilise escalation procedure is a common finding from serious case reviews.

7.1.8 That agencies did not share information that Sibling 1 and Child L were siblings is seemingly because professionals did not link the two families together, due to different surnames. Given that Sibling 1's child was made subject to a child protection plan and had only just been removed from that plan when the anonymous referral concerning neglect of Child L was received, again reflects a failure of information gathering and professional curiosity. Mother had been visited by the social worker and the health visitor allocated to Sibling 1's child, on at least one occasion when Child L was present, yet no connection was made between the two. A lesson learned from this review is for professionals to scrupulously gather as much information as possible concerning family members and those living in households when undertaking Section 47 inquiries, and to cross reference surnames on social care records.

7.1.9 Although outside the period under review, the historical information held by the GP and the Health Visiting Service concerning Mother's refusal to engage with services after Child L's birth was not shared with agencies. This information has been made available to this review, and has proved to be extremely informative as to Mother's past behaviours. It provides an indication of her long standing refusal to engage with professionals and of her parenting capabilities.

7.1.10 The difficulties faced by professionals when working with parents who refuse to engage cannot be underestimated, as has been exemplified by this review. Mother's attitude was one of consistent refusal to allow access to her, her child or her home, except on her terms. Mother protected Mr A's identity from CSC and the School, which ultimately resulted in her failure to protect Child L from neglect and significant harm. The need for professionals to focus on the welfare of the child as being the paramount concern over the demands of difficult parents is a finding of this and many other serious case reviews.

[29] 4 LSCB Procedures for Resolving Professional Disagreements

## 8 RECOMMENDATIONS

8.1.1 These recommendations arise from the Overview Report and reflect decisions made by the Serious Case Review Panel. They are endorsed by Southampton Safeguarding Children Board.

8.1.2 The recommendations arising from Individual Management Reviews have been formulated into a combined action plan, which is being implemented.

8.1.3 The following recommendations are for the Southampton Safeguarding Children Board to consider:

1. The Board should require that lead professionals are made aware of the involvement of any new adults having significant contact with a family where there are children in need or in need of protection.

2. The Board should ensure that where concerns require escalation all agencies are aware and make use of the *Resolving Professional Disagreements Procedure* as agreed and implemented by Hampshire, Isle of Wight, Portsmouth and Southampton LSCBs.

3. The Board to ensure that the findings of this review are used to enhance the engagement and compliance of agencies participating in the MASH to share and provide information when required to safeguard children.

# APPENDIX A

## Lead Reviewers:

### Independent Chair

**Brian Boxall** is a retired Detective Superintendent who served with Surrey Police for thirty years. During this time he was responsible for public protection, including child protection. He is currently the Chair of a Children and Adult Safeguarding Board. Since 2007 he has acted as a Chair and author for a number of Serious Case Review Panels. Brian has completed the accredited Government Office London/Tavistock training for chairs of Serious Case Review panels and Overview Report Authors and the 2013 NSPCC Department of Education improving the quality serious case review training.

### Independent Overview Report Author

**Moira Murray** is a qualified social worker and has worked in the area of child protection for local authorities and the voluntary sector 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).

Since 2010 Moira began working independently. Since then she has chaired and authored 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.

## APPENDIX B

**Glossary of Terms:**

| | |
|---|---|
| CAF | Common Assessment Framework |
| Cafcass | The Children & Family Court Advisory & Support Service |
| CMHT | Community Mental Health Team |
| CSC | Children's Social Care |
| EWO | Education Welfare Officer |
| EWS | Education Welfare Service |
| FCA | Family Court Adviser |
| ICPC | Initial Child Protection Conference |
| ICD | International Classification of Diseases |
| MAPPA | Multi-Agency Public Protection Arrangements |
| MARAC | Multi-Agency Risk Assessment Conference |
| MASH | Multi-agency Safeguarding Hub |
| NSQW | Newly Qualified Social Worker |
| PSW | Prevention Social Worker |
| QoF | Quality and Outcomes Framework |

## APPENDIX C

## References:


Working Together to Safeguard Children, 2013

Children Act 1989

The Protection of Children in England, Lord Laming 2009:42

The Victoria Climbié Inquiry, the Lord Laming Report,

New Learning from serious case reviews, Brandon et al, July 2012

Joint Working Protocol 2008: Safeguarding children whose parents/carers use drugs/alcohol or have mental health needs

Research findings considered by the Designated Doctor and SCR Panel member: UHS information to mothers 2011; BAAF, 2004

Understanding Serious Case Reviews and their Impact, A biennial Analysis of SCRs 2005-2007, HM Govt, 2009, page 3, HM Govt 2009.

The Indices of Multiple Deprivation Report, May 2011

Southampton Safeguarding Children Board in April 2012 concerned Child G, a

4 LSCB Procedures for Resolving Professional Disagreements

# APPENDIX D

## TERMS OF REFERENCE

a) 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*

b) 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*

c) Where relevant, were formal planning arrangements in place and implemented appropriately?

d) Were communications, within and between agencies, effective?

e) 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 where the family lived, their lifestyle, environmental and social factors*

f) 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?

g) Were managers appropriately involved in this case? In what way? If not, why was this?

h) Did any resourcing issues affect the way this case was dealt with? If so in what way and why was this?

i) 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?

j) Was there a need for and evidence of professional challenge? If not why not?

**Family Background (**Family Composition as known to the agency, and family history prior to 23rd December 2012)

The details of the subjects of this review are listed in the below table. The details are as recorded within police records on 23rd December 2012.

| Name | Date of Birth | Relationship | Address |
|---|---|---|---|
| Child L | Born 2006 | Subject | Looked After Child |
| Mother | Born 1970 | | Southampton |

| | | | |
|---|---|---|---|
| Father | Born 1976 | | Hampshire |
| Mr A | Born 1969 | Mother's Partner | HM Prison |
| Sibling 1 | Born 1992 | Half Brother | Southampton |