Leicester Safeguarding Children Board

SERIOUS CASE REVIEW
Relating to CHILD R

Date of birth: 2010
Date of death: 2011, aged 10 months

Ethnic Origin: Dual Heritage

OVERVIEW REPORT

Prepared by

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Independent Author

Date of Report: January 2012

Please note: The report has been anonymised and subject to redaction to protect the identities and privacy of family members and professionals involved.

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1. INTRODUCTION

1.1 Summary of the circumstances leading to the Serious Case Review.

1.1.1 Child R, aged ten months, was living with Mother and Sibling, who at the time was just over two years old. They lived in a two bed roomed end terrace house, which was described as 'without carpets, dirty and untidy and with limited food in the house'.

1.1.2 Living with Child R and Mother was Mother's partner, who had joined the household within the previous 5 weeks. Mother's partner was not the natural father of the two children and described himself as 'step father'. Mother had resumed a friendship with Mother's partner in February 2011 but he had only moved in to the house shortly before the event.

1.1.3 Mother has stated that she left the home on a Friday morning at 10.15am having fed, changed and dressed Child R and set off for college. Mother was attending a course studying literacy and numeracy. Both children were left in the care of Mother's partner as had previously been the case. Mother was expected to return at midday.

1.1.4 At 12.16pm Mother has stated that she phoned to explain that she was going to meet a male friend for lunch and would return later. Mother has subsequently confirmed that she could hear Child R 'giggling' in the background having just woken up according to Mother's partner.

1.1.5 At 12.51pm a 999 call was received by the East Midlands Ambulance Service (EMAS) for a 10 month old baby who was reported to have 'gone limp and had difficulty in breathing'. The caller was a male, who identified himself as the step father of Child R. A Community Paramedic and a Double Crew Ambulance were immediately dispatched to the address.

1.1.6 Mother's partner continued to speak to the Call handler, who gave instructions about giving CPR to Child R. The emergency staff arrived within four minutes and assessed the condition of Child R and provided appropriate treatment.

1.1.7 As the EMAS personnel were attending to Child R in the home Mother returned. Mother accompanied Child R in the ambulance to the hospital Emergency Department. Mother's partner stayed with Sibling

and other relatives, who had arrived in the meantime, and came to the hospital later.

1.1.8 Child R was reported on examination to have multiple injuries as follows:

- Fractured left clavicle
- Bruising to head, neck and ear
- Multiple Intra Retinal haemorrhages to both eyes
- 2 head injuries resulting in brain bleed
- Cardiac arrest

1.1.9. Child R was pronounced dead in the afternoon the following day.

1.1.10 The Police and Children's Services were informed by the local emergency Hospital Safeguarding team of the circumstances shortly after the emergency admission and action was taken to safeguard Sibling, who was being cared for initially by members of the maternal extended family. A Section 47 Enquiry was started in relation to Sibling including a child protection medical assessment. Sibling was placed in a foster placement under Section 20 of the Children Act 1989 with Mother's agreement and was then moved to be cared for by MGF and his partner at the end of August 2011.

1.1.11 Two days after the death of Child R an Interim Care Order was granted to the Local Authority in respect of Sibling and an Initial Child Protection Conference was held within fifteen working days. Although Sibling was not made the subject of a Child Protection Plan as the Care proceedings process offered protection, the Child Protection Conference made recommendations for further assessments and in particular a comprehensive assessment of Mother's parenting capacity.

1.1.12 Mother's partner was initially arrested on suspicion of GBH and after Child R's death was further arrested on suspicion of murder. Conditional Police Bail was set. A criminal investigation is in progress.

1.1.13 There has been correspondence between the Coroners Office and the Leicester City, Head of Service, Children's Safeguarding, Social Care and Safeguarding to share information about Child R and to seek agreement to invite the family members to participate in the Serious Case Review.

1.1.14 At the time of the events leading to the death of Child R, the two children were receiving universal services from the Health Visiting service and the GP service. They were not subjects of Child Protection

Plans or Care proceedings and had never been prior to the death of Child R.

1.1.15 The Children's Services Duty and Assessment Service (DAS) had closed an Initial Assessment four days earlier following two referrals during the previous two months by EMAS. The referrals had arisen after Sibling had been taken to the Accident and Emergency department by ambulance in connection with injuries and the Paramedic staff had reported serious concerns about the conditions in the home. The referrals were made through the EMAS Safeguarding Referral Line, who referred to Children's Services.

1.2 Terms of Reference of the Serious Case Review

1.2.1 The Notification of a Serious Childcare Incident from was sent to Ofsted on the 4th July 2011. The Serious Case Review Subgroup recommended on the 5th July 2011 that the criteria were met for a Serious Case Review and the Independent Chair of Leicester Safeguarding Children Board accepted the recommendation by the Subgroup and notified Ofsted thereof on the 11th July 2011. The purpose of the Serious Case Review is as outlined in Chapter 8 (8.5) of Working Together to Safeguard Children 2010, namely to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result; and
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children.

1.2.2 In the scoping of this Review the Serious Case Review Subgroup recommended that the criteria were met and determined that the timeframe for concluding the Review was the 10th January 2012. The criteria apply to all children, including those with a disability and are set out in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006:

(1) The functions of a LSCB in relation to its objective (as defined in section 14(1) of the Act) are as follows –

(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a Serious Case Review is one where –

(a) abuse or neglect of a child is known or suspected; and

(b) either –

(i) The child has died; or

(ii) The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the Child.

When a child dies and abuse or neglect is known or suspected to be a factor in the death, the LSCB should always conduct a SCR into the involvement of organisations and professionals in the lives of the child and family. This is irrespective of whether local authority Children's Social Care is, or has been, involved with the child or family. These SCRs should include situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse. LSCBs should consider whether to conduct a SCR whenever a child has been seriously harmed in the following situations:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect; or

- a child has been seriously harmed as a result of being subjected to sexual abuse; or

- a child has been seriously harmed following a violent assault perpetrated by another child or an adult; and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.

1.2.3 The scope of the Review included consideration of the Leicester Safeguarding Children Board Interagency Child Protection Procedures and covered information about Child R, Sibling and the significant adults in the children's lives e.g Mother, Birth Father and Mother's Partner. Information about the extended family is included where relevant to the Review and in order to understand the historical context of the children's family.

1.2.4 The timeframe of the Review covers information between the dates of January 2008 and August 2011 specifically. Historical information has been included if the SCR Panel determined that it was relevant to the Review.

1.2.5 The Terms of Reference for the Review were set out by the Serious Case Review Subgroup as follows:

1. In relation to the care of the children:

   a) What strengths did the agency/organisation identify?

   b) How well were these strengths recorded, expressed and reviewed?

   c) What concerns did the agency/organisation identify?

   d) How well were these concerns recorded, expressed and reviewed?

   e) How did the agency/organisation respond to these concerns?

   f) How effective was the response of the agency/organisation?

2. In relation to "hearing the voice of the child":

   a) How often were the children seen by the professionals involved?

   b) Was this frequently enough?

   c) In view of the ages of the children, was it possible to ascertain their views and feelings? If so, how were the children's views and feelings ascertained? How were their views and wishes recorded?

   d) Identify the adults who tried to speak on behalf of the children and who had important information to contribute. What evidence is there that these individuals were listened to?

   e) Provide detail on any instances where parents and carers prevented professionals from seeing and listening to the children

   f) To what extent did practitioners focus on the needs of the parents? Might this focus on the parents have resulted in the implications for the children becoming overlooked?

3. In relation to Thresholds and Signposting:

   a) To what extent were the assessment(s) that were completed in relation to the family 'fit for purpose'? How did the assessment(s) accurately identify need and risk?

b) How did the agency/organisation give consideration to undertake a Common Assessment Framework?

c) Provide detail on the needs and risks that were identified and detail whether these were reviewed and managed properly

d) Provide detail on referrals that were made (or should have been made) to relevant agencies/organisations on the basis of information known to your agency/organisation.

e) Did the agency/organisation have knowledge of Domestic Violence in relation to any of the family members? If so, what was the response to this?

4. Provide detail on the ways in which the families' cultural, linguistic, ethnic, religious and disability needs were taken into account by the agency/organisation

5. Provide detail on the extent to which inter and intra-agencies' policies and procedures, and Government guidance was followed in this case

6. Provide detail on the agency/organisations' management oversight and supervision (of the family and of the worker[s]) in this case. Was the oversight and supervision adequate?

7. To what extent were the decisions, assessments and plans made by the agency/organisation in relation to members of the household, visitors and family robust enough to meet the family's needs?

8. To what extent was the exchange of information appropriate, sufficient and effective:

   a) within the agency/organisation?

   b) between the agency/organisation and other partner agencies/organisations?

9. To what extent was the standard of recording appropriate, sufficient and effective:

   a) within the agency/organisation

   b) between the agency/organisation and other partner agencies/organisations?

10. What recommendations can the agency/organisation make in the light of the facts and the outcome(s) in this case, in order to improve practice?

11. Give examples of good practice that indicate sound intra and inter-agency working.

1.3 Members of the Serious Case Review Panel

1.3.1 The membership of the Serious Case Review Panel was agreed by the Serious Case Review Subgroup in August 2011 and consisted of senior managers and/or designated professionals from the key statutory agencies, who had had no direct contact or management involvement with the family of Child R and were not the authors of the Individual Management Review reports.

1.3.2 The SCR Panel members were:

Anne Binney - Independent Chair

Policy Officer - Leicester Safeguarding Children Board

Detective Chief Inspector for Safeguarding - Leicestershire Constabulary

Lead for Safeguarding Children - East Midlands Ambulance Service EMAS

Head of Hostels - Leicester City Council Housing

Head of Service - Children's Safeguarding, Leicester City Council

Associate Director of Quality - NHS Leicester City

Head of Children's Safeguarding - NHS Leicester City

Designated Lead Safeguarding - NHS Leicestershire County and Rutland

Note: Three Health representatives on the SCR Panel attended different panel meetings to ensure representation within the timescale set, thus covering for any absences.

1.3.3 The Independent Overview Author, Birgitta Lundberg, was in attendance at all the SCR Panel meetings.

1.3.4 The Health Overview Author attended the SCR Panel on two occasions and is the Nurse Consultant, Designated Nurse for Safeguarding Children, NHS Leicester City.

1.4 Independent Chair and Independent Overview Author

1.4.1 The Independent Chair of the SCR Panel in respect of Child R is Anne Binney, who has over 40 years' experience in children's social care, 13 of

these at senior management level which included management of front line safeguarding services. She retired from a position as Assistant Director responsible for Children's Social Care services in 2010. As well as her social work qualification and registration, she holds an Advanced Certificate in Child Protection Studies and previously chaired an ACPC and LSCB. In addition, Anne holds a Diploma in Management Studies and a Masters degree in Manager and Organisation Development. Since retirement from her full time post, she has worked as an independent consultant, primarily chairing and authoring Serious Case Reviews. Anne Binney is not employed by any of the agencies of the Leicester Safeguarding Children Board.

1.4.2 The Independent Overview Author is Birgitta Lundberg, who has compiled the Overview Report, the Executive Summary and contributed to the Action Plan to be produced by the Leicester Safeguarding Children Board. She is a qualified and GSCC registered social worker and has 30 years experience of social work practice and management in local authority social care services including 12 years as the manager of child protection/safeguarding and reviewing services. In the past 5 years she has been working as an Independent Social Work Consultant producing Overview Reports and undertaking multi agency Audits. She also writes Safeguarding and Children's Services Procedures as commissioned by tri.x proceduresonline. Birgitta Lundberg is not employed by any of the agencies of the Leicester Safeguarding Children Board.

1.5 Individual Management Review Reports and Health Overview Report

1.5.1 The authors of the Individual Management Review reports and the Information Report were senior managers and/or senior practitioners, who had not had direct contact or management involvement with the family of Child R. Similarly the Health Overview Report Author had not had any direct contact or management involvement with the family or Child R.

1.5.2 Report Authors:

Regional Children's Services Lead - NHS Direct East Midlands

Named Doctor for Safeguarding, ASCP - NHS Leicester City and LCCHS(LPT)

Named Nurse Child Protection - Families ,Young People and Children' Services Division ,Leicestershire Partnership Trust

Senior Specialist Nurse - Safeguarding Children, Acute Trust

Clinical Quality Manager - East Midlands Ambulance Service NHS Trust

Service Manager, Child Protection - Children's Social Care and Safeguarding

Serious Case Review Officer - Leicestershire Constabulary

Senior Probation Officer, PP - Leicestershire and Rutland Probation Trust

Service Manager - Leicester City Council Housing

Operations Manager - Social Housing Provider

1.5.3 The Information Report was provided by the Principal Education Welfare Officer in relation to the education history of Mother's partner by the 1st November 2011.

1.5.4 The Individual Management Reviews (IMR) reports were provided in several draft versions and the Final reports were submitted as follows:

East Midlands Ambulance Service Trust - by the 31st October 2011

NHS Leicester City and LCCHS (LPT) - by the 2nd November 2011

Families, Young People and Children's Services Division, Leicestershire Partnership - by the 1st November 2011

Leicester City Council Housing - by the 31st October 2011

NHS Direct – by the 28th October 2011

Leicestershire Constabulary - by the 1st November 2011

Leicestershire and Rutland Probation Trust - by the 28th October 2011

Social Housing Provider - by the 31st October 2011

Children's Services - by the 2nd November 2011

1.5.5 The Health Overview Report was submitted in a number of draft versions with the Final report being concluded by the 5th December 2011.

1.6 Agencies with nil returns

1.6.1 A letter was sent out to all agencies to request a search of records in relation to Child R ,Sibling, Mother ,Birth Father and Mother's partner on the 6th July 2011 .The following agencies responded that there were no records of any contacts with their agency:

The NSPCC	No previous contact; responded by 7th July 2011
The Youth Offending Service	No previous contact; responded by 7th July 2011
The Connexions service	No relevant information; responded by 8th July 2011

1.7 The Serious Case Review process

1.7.1 Three days after Child R's death the Serious Case Review Subgroup recommended that the Review should take place. The Terms of Reference were agreed and the Panel membership was confirmed. A timeline was agreed for the review process. The Leicester City, Leicestershire and Rutland Local Safeguarding Children Board procedures for Serious Case Reviews were followed.

1.7.2 The first SCR Panel meeting took place on the 10th August 2011 and the Panel made some amendments to the Terms of Reference, the IMR template and the timeframe of the scope of the Review.

1.7.3 A half day IMR Authors briefing took place on the 15th August 2011, which set the expectation that IMR reports in first draft should be returned by 23rd September 2011. The meeting was well attended and provided an opportunity to discuss the process, the report template and the information available at the time. The briefing was attended by the Independent Chair and the Independent Overview Author.

1.7.4 A series of SCR Panel meetings took place to review the information and the IMR reports, some meetings were half days and some full days: 5th October 2011; 12th October 2011; 7th November 2011; 28th November 2011 and 12th December 2011.

1.7.5 The IMR Authors were invited individually to attend the Panel meetings in October and the Health Overview Author attended Panel meetings in November.

1.7.6 The purpose of meeting with the Authors was to allow for any questions and queries about the information in the reports and to undertake the quality assurance role, which is a part of the Panel's function. Additional information was requested where the Integrated Chronology demonstrated gaps in information. Some of the additional information requests related to professional and organisational practice which needed to be expanded on or explained more clearly.

1.7.7 Updated versions of the IMRs were subsequently submitted to the Panel within a set timeframe. The IMRs from health agencies were

required so that the Health Overview Report could be produced prior to the Overview Report being written. The timescales were tight and there was some pressure on all authors in order to remain within the overall timeline of the SCR.

1.7.8 As a criminal process is taking place, there was discussion with the Police in the Panel about the opportunity to involve the family members in the Review process to ensure that they could contribute to the Review if they wished to. It was agreed that meetings could take place with Mother and maternal family members as long as a Police Family Liaison Officer was present and the questions and discussion with the family members related to matters connected to the Review process rather than the criminal investigation. The Coroner's Office was kept informed.

1.7.9 As a result letters and a leaflet were sent by the Independent Chair of the Panel to Mother and maternal family members, as well as Birth Father, explaining the Review process and offering opportunities to meet with the Overview Author.

1.7.10 Several dates were offered for the meetings and the Overview Author met with Mother and maternal Step Grandmother. The other family members did not respond or attend. For details of the information from the meetings see section 2.4 of this report. The Police Family Liaison Officer was present at both meetings and Sibling was present with maternal Step Grandmother.

1.7.11 Correspondence by the Independent Chair with Legal Services took place in order to seek legal advice about the sharing of Birth Father's information. Advice was provided in a written reply, which is on record, and Birth Father's information relevant to the Review was provided to the Panel. Birth Father was invited to meet with the Overview Author but no response was received to the invitation.

1.7.12 The Overview Report was presented to the Serious Case Review Subgroup along with the Health Overview Report, IMRs, the Integrated Chronology, the Integrated Action Plan and the Executive Summary on 4th January 2012 prior to submission to Ofsted.

2. THE FAMILY

2.1 Family composition and ethnicity.

2.1.1 The family all live in the area of Leicester except Birth Father's family, who live in the London area. Birth Father also has links in the West Country. The maternal family members are in contact with one another

on a regular basis and the information in records and from the family describes relationships as supportive but sometimes 'volatile' when disagreements occur. Mother reported that MGF and his family, which includes two step siblings, were in regular contact at weekends often caring for Sibling and Child R. See **Genogram** in Appendix 2.

2.1.2

Relationship/Code	Age at the time of Child R's death	Relationship to Child R	Ethnic Origin
Child R	10 months	Subject child	Dual Heritage
Sibling	2 years and 2 months	Older sibling	Dual Heritage
Mother	23 years	Mother of children	White British
Birth Father	22 years	Father of children	Black Caribbean
Mother's partner	21 years	Recent new partner, not related to children	White British
MGF	Not known	Maternal Grandfather	White British
SMGM	36 years	Step Maternal Grandmother	White British
MGM	44 years	Maternal Grandmother	White British
MA1	26 years	Maternal Aunt	White British
MA2	25 years	Maternal Aunt	White British
MA3	22 years	Maternal Aunt	White British

2.1.3 The ethnicity of Child R and Sibling was recorded as 'dual heritage' and Birth Father is recorded as Black Caribbean. In the 2001 census the recorded category of 'Mixed: White and Black Caribbean' in the area where the family lived was 1.1% (compared with 1.01% for Leicester City as a whole). In 2008 the Office for National Statistics estimated the mixed community with Leicester City was 2.6% (compared to 1.7% for England as a whole).

2.1.4 Leicester is a unique city in England because of its high proportion of people with different ethnic and faith backgrounds, its large numbers of young people and the levels of deprivation in the city. 43% of Leicester's population has an ethnic minority background and the city was projected to have a majority non-white population sometime after 2011 (Annual Population Survey 2008). Leicester has a resident population of approximately 79,569 children and young people aged 0

to 18, representing 27% of the total population of the area. In 2011 59.8% of the school population was classified as belonging to an ethnic group other than White British compared to 22.5% in England overall.

2.1.5 There were no records indicating a religious affiliation for the family members.

2.2 Community Context

2.2.1 Mother and the children lived in a two bedroom house in a Social Housing Scheme tenancy in a predominantly white working class area of the city. There were accessible community resources, such as shops and libraries. Children's Centres were located in the area as well as Community Centres.

2.2.2 Leicester is the 20th most deprived of the 354 Local Authority districts in England. It has 13 city wards which are in the 28 most deprived wards in England with almost half the population of the city being highly disadvantaged. The Leicester Ward Health Profile for 2011 for the electoral ward in which the family lived has deprivation levels higher than the average for Leicester City as a whole, with an estimated 1287 children living in poverty. (Health Overview Report)

2.2.3 In March 2010 nearly one third of Leicester's households claimed either housing benefit or council tax benefit. Housing benefit claimants have increased over the last two years. Leicester's unemployment rate is higher than the rest of the country and the gap is increasing. Compared to other cities in the region, there is a high proportion of people in Leicester with no qualifications and a high proportion with both low literacy and low numeracy skills. (Children's Services IMR)

2.2.4 The area, where the family lived, is recorded as having a high crime rate, which is influenced by the large retail outlets located there. There is a strong partnership between the Neighbourhood police team, local Housing providers and the City Anti Social Behaviour Unit in the area. The Domestic Violence incidents are not higher than elsewhere in the city, which has in excess of 8,576 domestic violence reports to the police per year. (Leicestershire Constabulary IMR)

2.2.5 Child R and Sibling were not recorded as attending any community resources other than the Health Visiting clinic at a Children's Centre.

2.3 Family history and Child R.

2.3.1 Child R was the second child born to Mother and Birth Father. During the pregnancy, and subsequently, Mother maintained that she was not sure if Birth Father was the father of Child R as Mother had had another relationship with someone not named, who might have been the father. DNA tests in the criminal investigation process have determined that Birth Father was the natural father of Child R.

2.3.2 Child R was described in records and by Mother and SMGM as 'a contented baby, who was developing well'. The birth was normal and at the first homevisit after discharge the Health Visitor noted that Mother 'handled the baby with care and confidence'. Child R was breastfed on demand. In a follow up home visit the record noted that Mother was observed 'handling baby with confidence a little heavy handed but loving and good eye contact towards the child.' When questioned about the meaning of 'heavy handed' the Health visitor explained that Mother was a bit too casual in her handling of the baby, which was pointed out to her at the time.

2.3.3 At a home visit at 32 weeks Child R was described as 'appearing well, clean and appropriately dressed and was reported to be eating a good variety of family food.' Child R's development age was reported as 'appropriate'.

2.3.4 Child R and Sibling stayed overnight with relatives at times including with MGF and SMGM. When Child R stayed overnight Mother did not bring a 'sensor mat' for Child R to sleep on. This sensor mat was used at home by Mother as a part of the baby alarm monitor system, which Mother had been given by one of the Maternal Aunts to use with Sibling. At the meeting with the Overview Author Mother explained that the sensor mat can be bought in most high street retailers with baby alarms. SMGM was not aware of the sensor mat being used nor were the Health Visitors.

2.3.5 The Overview Author was able to see photographs of Child R, which were on display in maternal grandfathers home.

2.3.6 Sibling was also present when the Overview Author visited the home of SMGM and MGF. Sibling is a lively and friendly two year old, happy to sit and draw and talk about the activity. Sibling has settled well with MGF's family and is subject to Care Plans and Looked After Review processes.

2.3.7 As a part of the Care Plan and Care proceedings Sibling has regular supervised contact with Mother. Contact arrangements are also in

place for Birth Father and both parents are subject of separate Parenting Assessments.

2.3.8 Mother has experienced an unsettled childhood with many changes of carers and schools. Mother was not at any point a Looked After Child. The various carers were all members of the extended family in the area in and around Leicester.

2.3.9 Mother's parents were young parents with four children and struggling financially. They separated prior to 1990 and MGM and the children were from 1990 to 2006 subjects of referrals about a range of concerns from neglect, alcohol and drug misuse, domestic violence and non school attendance. At one point Mother was reported to have been struck by MGM but the complaint was withdrawn.

2.3.10 Mother stated at the meeting with the Overview Author that the person she would turn to first if she needed advice was MGM.

2.3.11 The records noted that Mother commented in the calls to NHS direct that she had been advised by MGM to make the calls.

2.3.12 Mother did not attend school regularly and achieved no qualifications. Mother was employed in different jobs after school had finished, holding a waitressing job for three years. She explained to the Overview Author that she lost this job after meeting Birth Father and failing to attend work regularly.

2.3.13 Mother can recount her memories from her childhood and teenage years quite clearly. The records show little if any traces of intervention by the agencies such as the Police or Children's Services. The culture that Mother's family had in the two previous generations, and Mother still has, is one of suspicion and avoidance of public agencies. Mother will not seek support other than financial from "social services" although she was ready to call the police for assistance in dealing with Birth Father and to make reports of others when there were disputes such as family fall outs. Mother was clearly proud of the fact that she had not been "in care".

2.3.14 Birth Father lived in London with four siblings and left school at 15 years of age. He is recorded as having self reported using cannabis from the age of 9 years old.

2.3.15 Birth Father had no known record of offending prior to the Court appearance for a serious assault against his ex partner in 2007 and other related offences. Full Court reports were submitted and, it was noted that, there had been no previous domestic violence reports. The

mental health assessment concluded that there was no evidence to suggest a psychiatric illness but any confused behaviors were related to heavy cannabis use. Birth father was assessed as presenting Low Risk of Harm to children and Medium Risk of Harm to a known adult and the public. There were no identified Child Protection issues at that time as the couple (Birth father and ex-partner) did not have any children.

2.3.16 Birth Father and Mother had a relationship that fluctuated but in reality he lived with Mother for the period from the pregnancy and birth of Sibling in 2008/09 to December 2010. During 2008 he spent some weeks in a Youth Offending Institute following a breach of the Suspended Sentence of 14 weeks custody, which he had received in relation to the domestic violence offences. The breach was due to his lack of attendance and engagement with his sentence. Birth Father was subsequently on license with an Offender Manager from the Probation service till January 2009.

2.3.17 Birth Father was not referred to in depth in any records, except the Probation IMR, although he is noted as being present with Mother and Sibling on several occasions in other agency records. The few descriptions there were report that he interacted well with Sibling and Child R. Mother reported to the Overview Author that he was a 'good father' when Sibling was a baby but as Sibling became older treated Sibling more as a 'friend rather than a child.'

2.3.18 Mother's partner was not noted in records except as a 'friend' who was present in the house when the social worker visited following the first referral of Sibling by EMAS. Mother was asked for details and about the relationship but declined to answer.

2.3.19 A brief background history has emerged from the Police IMR and the Information Report from Education Services. Mother's partner lived with his mother and brothers and often with his grandmother .

2.4 Overview of the Integrated Chronology of events and agency involvement

2.4.1 This section has been divided up in two parts as the intention in this section is not to reproduce the full Integrated Chronology but to draw out significant points in time and provide a story of what is known in agency records about the children's lives. Some comments will be made to highlight specific issues. The following extracts from the Integrated Chronology are the Independent Overview Author's view of significant information and events which occurred prior to the death of Child R. The extracts have been divided into two separate time periods

2008 – 2010 and 2010 -2011, which cover the overall period set out in the Terms of Reference. The full Integrated Chronology can be accessed in Appendix 4.

2.4.2 **2008 to 2010**

In October 2008 Probation made a referral to Children's Services requesting that an Initial Assessment be undertaken as Birth Father, who had a history of convictions in relation to Domestic Violence and possessing a weapon, was moving in with his current partner, Mother. They were expecting a baby in five months time. Birth Father had not been fully cooperative with the original requirements of his sentence and a breach of the Suspended Sentence had led to a short period in custody. The risk assessment by the Offender Manager was stated as" low risk to children, primarily because no children had been part of the previous relationship, and medium risk towards adults when Birth Father had been using cannabis and/or drinking alcohol".

2.4.3 A pre-birth assessment request led to the referral being opened to the Children and Maternity Hospital Social Work Team which was in place at the time. Two appointments were set and missed until Mother and Birth Father came to the office requesting assistance with accommodation.

2.4.4 Birth Father engaged with the Offender Manager to undertake work on 'anger management' at the same time as applications were made for housing for the couple. The license for the Probation involvement expired in January 2009 and the case was therefore closed.

2.4.5 During this period Children's Services allocated a social worker mid January 2009, who contacted the Community Midwife, who reported that there were no concerns about the pregnancy and that Birth Father was 'very polite' when present.

Author's Comment:

This was a missed opportunity as a Pre birth assessment multi agency meeting involving Midwifery, Health Visiting, Children's Services, Probation and the Police should have addressed the risks of domestic violence and the misuse of drugs (cannabis had been reported in relation to both parents).

A pre birth assessment at this point should have addressed Mother's background history of 'being parented' and an assessment of her parenting capacity to meet the needs of Sibling.

A child focussed assessment would have laid the ground for any services provided to children connected to Mother in the future and would therefore have improved the chances of better outcomes for the children. The Reports by Laming in 2003 and 2009 stressed the need for 'early intervention with a child focussed, holistic assessment and services in partnership with parents and carers.' The Final Munro Review report made similar recommendations to develop and use' early help services' to prevent future escalation to child protection action.

2.4.6 The social worker had further discussions with the Probation service, where the feedback was of an improvement in Birth Father's cooperation and engagement. Birth Father was reported to have said that he had reduced his cannabis use.

2.4.7 The social worker visited the flat that Mother was in and concluded that it was not suitable for a baby. The focus of the social work involvement was to contact Housing and secure new accommodation for the family. Mother was moved to a hostel shortly before the birth in March 2009 and at this point the social worker left and the case was managed via the Duty system.

2.4.8 Sibling was born at the end of March 2009 and Mother and baby were discharged home to the hostel. In April the case was allocated to a Student Social Worker, who visited the home, both at the hostel and subsequently at the house that they were moved to mid April 2009, and observed Mother interacting with Sibling. Financial assistance was provided following requests from Mother.

2.4.9 The Student Social Worker contacted the Health Visitor at the end of April 2009 to consult about Sibling's progress and was informed that the Health Visitor had not been aware of the domestic violence history of Birth Father. A joint home visit was undertaken following the conversation and the conclusion was that Sibling was progressing well and the Health Visitor was satisfied with Sibling's weight and presentation.

2.4.10 In early May 2009 Mother reported a domestic violence incident to the police, who attended at ten o'clock at night. The police established that there was a new born child in the household but Birth Father had left when they arrived. The risk was recorded as 'standard' although the supervising sergeant requested a referral to the Child Abuse Investigation Unit about the child .The referral was not made. There was no contact with any other agencies.

2.4.11 As the Student Social Worker's placement ended the case was transferred back to the Duty System and at the end of May 2009 Mother requested some further financial assistance for help with carpets and furnishings. Mother was advised to speak to the Support service linked to the Housing Provider. The Housing Provider Support Service undertook an assessment during June 2009 and offered advice about debts and services available.

2.4.12 Four attempts were made to contact Mother in June 2009 by the Duty social workers and a home visit took place at the beginning of July 2009. At this point it was decided to close the case.

2.4.13 The main reason for the closure decision was that Mother reported that the relationship with Birth Father had ended, although at the same time Mother referred to Birth Father coming to the house drunk late at night demanding to be let in. The advice was given by the Duty Social Worker to contact the police, if Birth Father turned up and harassed Mother. The Duty worker agreed to write to the Housing Provider about removing Birth Father's name from the tenancy. During the same home visit Mother explained that she was suffering from post natal depression and she was advised by the Duty Social Worker to see her GP if she felt worse. Mother saw the GP on the same day according to records and was prescribed anti depressants. The GP did not inform the Health Visitor of Mother's circumstances. The Health Visitor and the Housing Provider Support service were informed of the decision by Children's Services to close the case.

2.4.14

Author's Comment:

The decision to close the case at the point when the relationship had just been reported to have ended and Birth Father had a history of serious domestic violence leading to convictions in the context of a relationship ending was a professionally risky decision. There was no evidence in the records that the risks to Sibling and Mother had been reassessed. Leaving a young Mother, who was reporting feeling depressed, to take action to deal with Birth Father's behaviour without any agency support was questionable.

The Student Social Worker's Transfer summary had raised a number of concerns about the original lack of assessment of Birth Father's domestic violence offences and there was no evidence that these concerns had been addressed before the case was closed.

The decision to close the case was over optimistic about the support provided by the extended family and Mother's capacity to protect Sibling.

See section 3.2 of this Report: Analysis by Theme, for further exploration of this decision and pre birth assessments.
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2.4.15 By late August 2009 there were some complaints about noise nuisance to the Social Housing Provider, who contacted Mother. Mother was warned that such behaviour could put the tenancy at risk .The contact confirmed that Birth Father had returned to the household.

2.4.16 In September 2009 Mother had a further period of treatment with anti depressants and was also advised to have a review of asthma medication. There was no notification of the depression or consultation with the Health Visitor by the GP practice.

2.4.17 The treatment for depression was repeated in November 2009 as Mother reported 'arguing with her partner, poor sleep and poor appetite.' At the same time when approached by the Housing Provider Support service to clarify if any further support was needed , Mother responded by stating that she was fine and as a result the case was closed.

2.4.18 At the end of November 2009 Mother called the police on two separate occasions reporting a dispute with Birth Father, who was refusing to leave as she was ending the relationship and wanted him to move out. Mother reported that he was harassing her and had threatened to 'take her son off her'. The police assessed the risk as 'standard' and issued a Harassment Warning which was administered to Birth Father at the end of December 2009. The police did not contact any other agencies in relation to the reports although Mother made it clear that there was a young child present and she was pregnant.

2.4.19 **2010 to 2011**

During the early part of 2010 Mother continued to raise issues with the Housing Provider and the Police about the dispute with Birth Father about whose name was on the tenancy..At the end of January 2010 the Housing Provider recorded a Police visit where Police gave Birth Father a warning to stay away from Mother.

Author's Comments:

There were missed opportunities to refer Sibling and the fact that Mother was pregnant to the Child Abuse Investigation Unit and Children's Services as the police officers dealing with the contacts from Mother did not define all the

contacts as 'domestic violence'. They did not check their information systems, in line with procedures, for past history or share information.

Most research around Domestic violence identifies the time of pregnancy as a high risk period and in this case Mother reported that there was conflict between her and Birth Father about who the father of the child was. The past history of Birth Father's convictions was particularly relevant to a relationship break up again.

2.4.20 During March 2010 Mother became unwell with Bells Palsy and was found to be anaemic. Treatments were provided and the pregnancy progressed satisfactorily. Sibling was seen and observed at the Health Visiting clinic and developmentally all was recorded as satisfactory. There were no references in Health Visiting clinic records to Mother's health or the pregnancy. There was a considerable gap in time for Sibling to have been seen as the last developmental check was with the GP aged 10 weeks. There should have been a contact as a part of the universal services at 4 months, usually a maternal and child health check undertaken by a Health Visiting Nursery nurse. Sibling was seen by the GP in January 2010 with a cold and was immunised against swine flu.

2.4.21 During April and May 2010 the Housing Provider records demonstrated that Birth Father had returned to stay at the address as complaints were made about noise and disturbances in the tenancy. Mother and Birth Father denied that Birth Father had been knocking on other tenants doors and gave an undertaking to the staff at the Housing providers office that they would be careful in future. Birth Father was still a registered tenant at the address.

2.4.22 Child R was born in August 2010 .There had been no consultation with other agencies or any pre birth assessment undertaken, yet the information had been shared in April 2009 with the Health Visiting service about Birth Father's history in relation to domestic violence in connection with Sibling and was therefore a part of Sibling's records. It was noted at the time of Child R's birth that Mother had had social work input according to the Euroking information system and the Safeguarding Midwife was notified. Children's Services were contacted and reported that 'the case was closed'. As a consequence no further action was taken and Mother and Child R were discharged home. No consideration was recorded as having been given to undertake a review of the children's circumstances such as checking the past records of Sibling and updating the background information.

2.4 23 The next home visit by the Health Visiting service, who were the main agency in contact with the children, took place in August 2010.Both

children's weights were recorded and their health and development was checked. Mother expressed concerns about Sibling's hearing and vision, which were noted to be reviewed. The Health Visitor noted that there were no carpets and the floor was uneven with baby equipment cluttering up one side, which was identified as a 'potential hazard'. Mother requested a referral to a charity for carpets and household items. The previous post natal depression after Sibling's birth was noted. The case load priority was updated to high and a visit was planned within another two weeks. No checks were undertaken with other agencies or any information sharing with the GP.

2.4.24 The next visit took place in September 2010 and Child R was examined and noted to be satisfactory. A further visit for the 6-8 week screening took place at the end of September 2010 and Child R was recorded as 'healthy, alert and active'. The home was still described as 'cluttered 'and a renewed request for carpets and other equipment was made by Mother. Mother explained to the Health Visitor that she was applying to move out as she did not want to live with Birth Father anymore. He was not aware of this. Following this visit a clerical amendment was made to change the case load priority from high to medium.

2.4.25

Author's Comment:

There was no evidence that the Health Visitor explored the reasons for the plan to move out or considered whether there was a need to reassess the risks or needs of the children if their circumstances changed. In view of the past history of domestic violence with Birth Father, which the Health Visiting service was aware of, a review of information and checks with other health professionals such as the GP would have been appropriate. A review of Mother's parenting capacity to manage the new situation as a single parent would also have been good practice and could have been managed as a CAF.

2.4.26 During October and November 2010 Child R had the regular immunisations and developmental checks with the GP. Mother attended the GP service in relation to her own health.

2.4.27 In December 2010 Mother contacted the police on two consecutive days as there was a dispute about the home and Mother declared that the relationship had ended and Birth Father was refusing to leave. The Police attended on both occasions, although it was different officers, and on the second call out Birth Father was taken to the train station at his own request. The risk assessment was determined as 'standard'

and no referrals to Children's Services were made subsequently. The Police officer who saw the home did not record any information about the home but recalled when interviewed for the IMR that the home had been 'untidy but the officer had seen worse'.

Author's Comment:

This was a missed opportunity. These two incidents should have been linked and past information should have been located. A referral should have been made to Children's Services in view of the range of risk factors present:

Birth Fathers past DV convictions
The current relationship break up
Birth Fathers wish to have contact with Sibling
Mother's history of ambivalence
The dispute about paternity of Child R
Mother's depression
The dispute about the tenancy

An Initial Assessment should have been undertaken with full agency checks.

2.4.28 In January 2011 a Nursery Nurse from the Health Visiting service undertook a home visit and a number of issues caused the Nursery Nurse concerns:

- Child R's weight had fallen below the 25th centile and Child R was being given solids earlier than advised.
- The home was chaotic, cluttered and dirty with food that had been on the floor for more than a day.
- Sibling appeared bored and clingy and followed the Nurse out in to the road without Mother intervening.
- Mother appeared disengaged and spent the time texting; she informed the Nurse that Birth Father had now left for good.
- When asked about the impact of the separation Mother said that she was fine and the children did not miss him.
- Child R's immunisations were overdue

The overall situation caused the Nursery Nurse serious concern and a phonecall was made to the Health Visitor immediately from the car to report the matter. As a result the two Health Visitors involved had a discussion but the main focus was on the charity application and the physical conditions of the home rather than the impact on the children and Mother's capacity to care for them. The fact that the circumstances had deteriorated since Birth Father left and were indicators of neglect was not recognised by the Health Visitors.

2.4.29

Author's Comment:

The Health Visiting service should have considered an assessment, such as a CAF, at this point in view of the signs of neglect. If Mother had declined Support services, they should have consulted with other agencies and made a referral to Children's Services for an Initial Assessment.

Both children were Children in Need of additional services in view of the family history and Mother's parenting capacity needed to be assessed to ensure that they were not exposed to risk of significant harm. Mother had not been caring for them on her own prior to Birth Father leaving and although her family was supposed to be supportive there was no evidence of any support in place given the state of the home.

2.4.30 At the end of March 2011 there was a homevisit by the Health Visitor to see Child R, who was recorded as appearing 'well, clean and appropriately dressed.' The home was still described as 'floor littered with all sorts of things' and Child R was noted to be crawling. Mother commented that she was happier since the separation from Birth Father and stated that she had a new partner, who visits the home. There was no evidence that the Health Visitor tried to access more details about this person. It is not known if this was Mother's partner as Mother makes reference to a range of male friends. The Charity application was finally completed given that it was first mentioned just after the birth of Child R. In the event the Charity turned the application down in April 2011 suggesting other charities.

2.4.31 In early May 2011 Sibling was reported by Mother to NHS Direct following a fall the previous day at the home of one of the Maternal Aunts. MGM had advised Mother to call as Sibling had a head injury, which was described as having happened "being pulled by a cousin and hitting the head against a metal stair gate". Sibling was described as 'confused and having a big lump on the head.' NHS Direct called an ambulance as Mother stated that she was unable to get to the hospital herself and could not leave Child R.

2.4.32 The Paramedic was dispatched immediately and arrived at the home within three minutes .While undertaking the assessment of Sibling and waiting for the ambulance to arrive the Paramedic noted that the conditions of the home ' were not an environment fit for children to be living and playing in.' The Paramedic recorded the conditions in detail such as: dirty crockery ,food and wrappers all over the floor and the

children eating from the floor, and noted Child R in a baby walker appearing happy and cheerful. As a result of the concerns the conditions caused the Paramedic, a referral was made to the EMAS Safeguarding Referral Line .Mother was not informed of the concerns. The Paramedic followed the ambulance to the hospital and took responsibility for handing over the referral at the hospital. A Patient Report Form was completed and a copy was provided to the receiving Nurse in the Children's Emergency Department.

2.4.33 The PRF form stated that: Sibling had '*banged the head on a metal stair gate approximately 24 hours earlier resulting in a large haematoma at the time but which had now reduced*.' It also stated that: '*a bruise*'*was forming and a smaller haematoma now present. The patient was very active but had a short attention span although Mother stated that Sibling had a reluctance to eat and drink and had been a bit more vacant and quieter than usual* '. A note had been added to the PRF form according to the EMAS IMR to say that '*a Safeguarding Referral was made due to the 'conditions of the house''*.

2.4.34 On examination a large bruise to the forehead was seen. No other injuries or bruises were seen on the rest of the body. The implication was a minor head injury and the examining Doctor sought a senior review for the head injury and 'safeguarding issues'. A senior Doctor reviewed Sibling and confirmed that it was 'a minor head injury' and discharged Sibling home with verbal head injury advice and requested a Health Visitor Referral form to be completed. The reference to 'safeguarding issues' was explained by the Doctor on interview for the IMR as a 'general term' used to indicate that Sibling had not been in the care of parents at the time of the incident and had not been taken in for medical attention until more than 20 hours later.

2.4.35 The EMAS safeguarding referral was passed to the Children's Services the following day first by a phone conversation and then by fax. The notification of the visit to the hospital was received by the GP the following day.

2.4.36 Sibling was seen 7 days later for a routine 28th month assessment at the Children's Centre by a Nursery Nurse, who provided accident prevention information in line with the Healthy Child Programme. The bruising and black eye were noted. A number of aspects of the developmental assessment were noted as concerns, for example speech and a squint. These required a referral for follow up with the specialism and the Nursery Nurse recorded the need to liaise with the Health Visitor and to discuss current involvement. This contact was recorded on the system in early July and the documents had not been scanned on to the electronic system prior to this Review commencing.

2.4 37 The Police record a 'family disagreement' 9 days later reported by Mother, who was being threatened by her sisters, much of it via texting, and stated that she was frightened. The argument centred on 'parenting skills and reporting each other to social care'. No offence was noted but an appointment was made for an officer to visit Mother two days later. Mother informed the police that Birth Father had left the county, which was logged as 'intelligence information'. This incident was recorded as a 'domestic incident' with a 'standard 'risk assessment. The follow up visit was undertaken three days later but there was no direct liaison with Children's Services although the Officer recalled that the conditions in the home had 'not been of a very high standard in respect of cleanliness and upkeep'. There was no record of the Police Officer questioning why there had been threats to make reports to Children's Services. This visit was recorded as having taken place on the same day as Children's Services carried out their follow up visit to the recent attendance by Sibling at the hospital.

2.4.38 Children's Services undertook a homevisit 12 days later and this was the first time that Children's Services became aware of Child R although the EMAS referral mentioned a 'sibling'. The Social Worker asked if the children were siblings and was told that Mother was not sure about the paternity of Child R. The Social Worker noted that the home was very cluttered and messy with items on the floor in the hall, kitchen and living room. There was clothing, lollipop sticks, computer games and rubbish. There were lots of toys but they were grubby. The children were in nappies but were not too soiled and had no visible marks. A male came in during the visit but Mother declined to clarify who this was and said that it was not her partner. There was discussion with Mother about the need to keep the environment clean and safe for the children including safety equipment .Mother was advised to discuss this with the Health Visitor. The Social Worker undertook to check the referral for Family Support services with the Health Visitor. The notes from this visit were given to the Team Manager as this was the last working day for the Social Worker in this post and the notes were placed on the record system after the death of Child R.

2.4.39 Sibling's case was reallocated and a few days later the new Social Worker made phone calls to check if Health Visiting had made the referral for Family Support services. As the Health Visitor was on leave a call was made to the Family Support Manager, who did not know of Sibling but confirmed who the Health Visitor was. The Social Worker left a message for the Health Visitor to make contact to discuss the progress of the referral to Family Support.

2.4.40 By mid June 2011 Mother had enrolled to undertake an Adult Numeracy course through Learn Direct at a college. The first Learning appointment took place on the 16th June, when Mother would have left the children to attend the course. It was not clarified in any records who looked after the children that day. Mother stated at the meeting with the Overview Author that she had felt able to leave Mother's partner to look after the children while she attended college.

2.4.41 Late afternoon the day after Mother contacted EMAS about a fall that was described as Sibling 'smacking the head on a toy car' during the day. Mother had attended the Learning Session at college that day and Mother's partner had looked after the children. Mother told the Emergency call handler that she had taken Sibling to the chemist, who has advised Mother to go to the GP surgery or the hospital. Mother had gone to the GP surgery, who had advised that Sibling should be taken to the hospital. As they had no means of getting to the hospital Mother had returned home and called for an ambulance to take Sibling to the hospital. Sibling was reported to have had a previous head injury and the previous Safeguarding referral was noted. A Paramedic was dispatched and coincidentally it was the same person as in early May, who attended the home. A double crew ambulance delivered Sibling to the hospital by 6pm.

2.4.42 Sibling was examined thoroughly by the Doctor who noted: 'Tripped while on the last stair. Sustained a small superficial laceration above right eye. Sibling was with mother's partner at the time of incident. Community liaison form completed to notify Health Visitor. Wound cleaned and closed with glue.' The examining Doctor did consult with an ED Consultant given that two head injuries had occurred within a month and on each occasion Sibling had not been in the care of Mother. The advice was that as Mother had taken action to call the ambulance to deal with the injuries there should be no concern at home for the safety of Sibling; however the Doctor decided that it would be advisable to refer the matter for follow up by the community Health Visitor and a liaison form was completed.

2.4.43 EMAS made a Safeguarding referral to Children's Services Duty team the following morning by a phone call followed by a fax of the written referral. The concerns were reported as a hazardous environment and the fact that there had been no change since the previous attendance at the home for an incident with the same child.

2.4.44 The EMAS referral was received by the Children's Services Emergency Duty team, who passed it to the Duty Assessment team, where the Team Manager noted that Sibling had an allocated Social

Worker and an email of the referral was sent to the Team Manager of the allocated Social Worker.

2.4.45 Three days later the allocated Social Worker received a phone call from the Health Visitor in response to an earlier message for contact to be made. The Health Visitor had been on leave. The Social Worker informed the Health Visitor of the fall downstairs by Sibling and the hospital attendance on the 17th June 2011. The social work records noted that the Health Visitor said she had visited the home and there were health and safety concerns.

2.4.46 The Family Support Manager received a referral form from the Health Visitor on the same day, June 21st 2011. The records were unclear about Mother's consent to the referral. The Referral Form set out the following information:

"Single mother with 2 children; Mother reports that she obtains support from her family. However family home does not reflect this. The family home does not appear to be equipped with the basic essentials and in some respects likely to cause an accident. Both children need to be integrated within a playful learning environment"

Areas of work to be focussed on:
"To liaise with charitable organisations in order to obtain household items and floor covering.
To assess benefits and assist finances.
Encourage and assist with day care/groups for both children"

Desired outcomes:
"For family home to be equipped with household basic essentials.
For children to access day care/groups
For Mother to understand and prioritise children's needs".

2.4.47 The Family Support Manager and Supporting Children In Need managers held an allocation meeting and agreed that a Neighbourhood Nursery Officer would be allocated to support the family to access Stay and Play sessions and to look at funding for basic equipment.

2.4.48 Five days later, on the 26th June 2011, the Children's Services closed the case as it was recorded that the Health Visitor had made a referral to the Family Support services to provide support with the 'cluttered and dirty home conditions.'

Author's Comments:

The decision to close the case without undertaking a homevisit to check and update information about the children since the last referral about the second visit to hospital by Sibling was not good practice and with hindsight was a missed opportunity.

As a result the case was closed without the Social Worker being aware that Mother was attending a course and that Mother's partner had moved in to live at the address and was caring for the children when Mother was at college. Similarly, the fact that Sibling had been in the care of Mother's partner at the time of the 'fall on the stairs' was missed.

2.4.49 During the end of June 2011 Mother continued to attend Learning sessions at college on a daily basis.

2.4.50 The Health Visitor phoned Mother to discuss the two hospital attendances by Sibling and safety in the home. The phone call was noted as taking place at 17.20 on the 30th June 2011. The Family support referral was discussed and the importance of help and support was stressed. Mother stated that she had not been contacted following the referral and the Health visitor undertook to contact the Family Support team for an update. It was not recorded if the Health Visitor was aware of Mother attending the Learning sessions.

2.4.51 The following day at 10.15 Mother has stated that she left the home having fed, changed and dressed Child R and set off for college, where Mother attended a course studying literacy and numeracy. Both children were left in the care of Mother's partner as had previously been the case. Mother was expected to return at midday.

2.4.52 At 12.16 Mother phoned to explain that she was going to meet a friend for lunch and would return later. Mother has subsequently confirmed that she could hear Child R 'giggling' in the background having just woken up according to Mother's partner.

2.4.53 At 12.51 a 999 call was received by the East Midlands Ambulance Service (EMAS) for a 10 month old baby who was reported to have 'gone limp and had difficulty in breathing'. The caller was a male, who identified himself as the step father of Child R. A Community Paramedic and a Double Crew Ambulance were immediately dispatched to the address.

2.4.54 Mother's partner continued to speak to the Call handler, who gave instructions about giving CPR to Child R. The emergency staff arrived

within four minutes and assessed the condition of Child R and provided appropriate treatment.

2.4.55 As the EMAS staffs were attending to Child R in the home Mother returned. Mother accompanied Child R in the ambulance to the hospital Emergency Department. Mother's partner stayed with Sibling and came to the hospital later.

2.4.56 Child R was reported on examination to have multiple injuries as follows:

- Fractured left clavicle
- Bruising to head, neck and ear
- Multiple Intra Retinal haemorrhages to both eyes
- 2 head injuries resulting in brain bleed
- Cardiac arrest

Child R was pronounced dead in the afternoon the following day.

2.4.57 The Police and Children's Services were informed by the local emergency Hospital Safeguarding team of the circumstances shortly after the emergency admission and action was taken to safeguard Sibling, who was being cared for initially by members of the maternal extended family. A Section 47 Enquiry was started in relation to Sibling including a child protection medical assessment. Sibling was placed in a foster placement under Section 20 of the Children Act 1989 with Mother's agreement and was then moved to be cared for by MGF and his partner at the end of August 2011.

2.4.58 Two days after the death of Child R an Interim Care Order was granted to the Local Authority in respect of Sibling and an Initial Child Protection Conference was held within fifteen working days. Although Sibling was not made the subject of a Child Protection Plan as the Care proceedings process offered protection, the Child Protection Conference made recommendations for further assessments and in particular a comprehensive assessment of Mother's parenting capacity.

2.4.59 Mother's partner was initially arrested on suspicion of GBH and after Child R's death was further arrested on suspicion of murder. Conditional Police Bail was set. Mother was interviewed formally as a witness.

2.5 Summary and Conclusion of the Integrated Chronology

2.5.1 By merging all the known contacts provided in the IMRs into the Integrated Chronology, it has been possible to get an overview of the involvement of the different agencies with the children and the significant adults. A picture emerges of a vulnerable young Mother, who is struggling to meet the needs of the children in relation to basic routines and safe caring. The environment when Birth Father was present appears to have been more settled for the children in terms of basic routines and care. However, the reports of 'domestic incidents or noise disturbances' and Mother's own account of the relationship indicate that there were many arguments and fights involving physical violence between Mother and Birth Father. There were repeated references in the records of requests for financial assistance with furnishings such as carpets and at the same time all the agencies noted the deteriorating conditions of the home but no one considered the impact on the children of the signs of neglect.

2.5.2 It becomes apparent that there were a number of missed opportunities for the agencies to share information and work collaboratively to assess the needs of the children and promote their welfare through consultation, referral and/or Assessments:

- The referral in 2008 from Probation in relation to risks of domestic violence by Birth Father should have led to a pre Birth Assessment meeting between the relevant agencies to draw up a Care Plan for the birth of Sibling.
- The Initial Assessment by Children's Services and the involvement by Health Visiting were focussed on the accommodation issues rather than Sibling.
- The joint homevisit late April 2009 by the Student Social Worker and the Health Visitor should have led to a review of the risks in relation to the domestic violence information about Birth Father, which would have led to sharing information with the police.
- The police should have referred the domestic violence report in early May by Mother and checked with Children's Services. Information sharing between the agencies at this point would have led to a better informed assessment of the impact on Sibling of the care by Mother and Birth Father.
- At the point of closing the case of Sibling in early July 2009 when Sibling was 4 months old Children's Services should have updated all agency checks and reviewed the case. The Student Social Worker transfer summary concerns about the domestic violence assessment should have been addressed.
- Mother presented on three occasions at the GP surgery to be treated for 'post natal depression'. The Patient Health Questionnaire scale to measure depression was used and

treatment prescribed. There was no consultation or information sharing across the health agencies about the impact on Mother's capacity to care for Sibling.

- There were two domestic violence call outs to the Police in November 2009 leading to a Harassment Warning being administered to Birth Father in late December 2009. There was no information sharing with other agencies although, at this time, Mother was reported to be pregnant again.
- Child R was born in August 2010 and no pre Birth Assessment was undertaken although Birth Father was still present in the household, the paternity was uncertain and the domestic violence risks had not been addressed. Children's Services were not aware of the birth as no referral had been made by the GP or Midwifery/Maternity services.
- In August and September 2010 the Health Visiting Service noted the 'lack of carpets and uneven floor' as a concern and did not consult about the information from Mother about 'leaving Birth Father 'or consider the impact on Sibling and the newborn Child R.
- In December 2010 there were call outs by Mother to the police on two consecutive days in relation to the relationship with Birth Father ending. As previously noted this was the risk factor in relation to the domestic violence behaviour by Birth Father in the past. A referral should have been made to Children's Services and agency checks should have been undertaken.
- The homevisit in January 2011 by the Health Visiting Nursery Nurse was a point at which a referral should have been made to Children's Services as there were signs of neglect including a drop in the weight of Child R. This was a missed opportunity to assess Mother's parenting capacity either through a CAF or a Core Assessment.
- During May and June 2011 there were increasing concerns about the state of the home and the impact on the children. The neglect described in records was not recognised as such and agencies failed to work together to pool information to promote the welfare of the children.
- The two presentations in the A and E department of Sibling with head injuries were dealt with without considering the wider implications about the care being provided to two very young children by Mother except by EMAS, who made safeguarding referrals appropriately. It was a missed opportunity by Children's Services that the assessment that followed the first referral was not followed up fully and the second referral was lost.
- If the agencies had been more probing and proactive in their assessment of Mother at this point the presence of Mother's partner would have become known. The fact that Mother was attending a

course leaving the children in his care would have been considered.

2.5.3 Collectively the agencies failed to focus on the children's needs as the main issues which were addressed related to accommodation and the state of the home. The impact on the children's lives was missed. The significance of Mother's own background history and its impact on her capacity to safeguard the children was never addressed as the assessments that took place focussed on accommodation and the relationship with Birth Father, although the threat of domestic violence by him was never fully explored. As information was not shared collaboratively in the weeks prior to Child R's death the presence of Mother's partner was not recognised or the fact that he was left to care for the children while Mother attended the Learning course.

2.6. Information from the Family.

2.6.1 Two meetings took place with family members following the letters sent out by the Independent Chair of the SCR Panel offering an opportunity to contribute to the Review process. The letters were sent to Mother, Father, both sets of maternal grandparents and maternal aunts.

2.6.2 Maternal Grandfather and Step Grandmother responded and requested a meeting at their home. At the time MGF was unable to be there but maternal Step Grandmother and Sibling were at home. The Police Family Liaison Officer was also present. MGF was spoken to on the phone as he apologised for being unable to be there but he was comfortable with SMGM to speak on behalf of both of them and was offered the opportunity for another meeting, if he wanted to.

2.6.3 It was a good opportunity for the Overview Author to observe and interact with Sibling, who presented as very well settled in the home. Sibling was open and friendly displaying curiosity about the visitors, yet happy to play with toys as the adults were talking. Step Grandmother reported that Sibling has 'come on in leaps and bounds' since being placed with them with noticeable improvements in speech and behaviour.

2.6.4 The family was reported to be devastated by the death of Child R and subsequent events .There had been no warning signs according to SMGM that had alerted them to any risks posed by Mother's partner. They had viewed Mother's partner as 'a bit immature' and had been surprised that he moved in to the home so quickly and that Mother was leaving the children in his care although they had observed that he 'seemed to be good with the children and handling their behaviour'. They had been surprised on Father's day in June 2011 as Mother had

bought Father's day's presents for him from the children such as a T-shirt with a Father's day logo. The family felt that it was an early stage to allow Mother's partner to become so involved with the children so quickly.

2.6.5 The family had been concerned over time about the condition of the home when visiting Mother and the children and had often had the children, Sibling in particular, to stay with them over weekends. The family had made comments to Mother about tidying up but felt that they had to be careful. They felt that if they pressed Mother too much about the care of the children she might stop them from seeing the children, which they felt would place the children in a worse position.

2.6.6 When asked about what services they thought might have been helpful to Mother and might have prevented the tragic outcome for Child R, the response was that they could not think of anything that might have made a difference. They had not felt able to consider making a referral themselves to Children's Services and had not considered other agencies such as Health Visiting.

2.6.7 The meeting with Mother took place in her new flat which she had only recently moved in to so many items were still in boxes. Mother was on her own although she reported that one of her sisters was staying with her for the time being. The Family Liaison Officer was present during the meeting. Mother appeared to have a good relationship with the Family Liaison Officer and was using the support that was offered. Mother had started attending bereavement counselling. Mother spoke briefly about the Care proceedings and meetings in relation to Sibling and expressed her hope to be able to care for Sibling in the future. She showed the Overview Author around the flat and explained her plans for decorating it and planning a room for Sibling.

2.6.8 Mother could not think of any services that might have made a difference to what happened. She reiterated that she would not have been able to attend the Children' Centre regularly as it would have been too difficult with going on two buses with the children. Mother did not seem to think that she had needed support services.

2.6.9 Mother expressed serious anxiety about what had happened to Sibling at the second incident when he was taken to hospital having had an accident while in the care of Mother's partner in June. She had believed the account given by Mother's partner of what had happened at the time but she now wished that she had been more suspicious. Mother did not demonstrate much emotion throughout the meeting but this issue clearly bothered her.

2.6.10 Mother recounted having accidentally met Mother's partner in town recently and stated that 'he had laughed at her about what happened' and she had become very distressed. Mother was advised to contact the Family Liaison Officer straight away if she was in any way approached by Mother's partner.

2.6.11 Mother was asked about any domestic violence issues that might have arisen with Mother's partner and she was clear that she did not think there had been any issues. Mother also stated that there had been no domestic violence issues with Birth Father either although they had argued. In exploring what Mother understood by the term domestic violence, it was noticeable that she had answered that there had been none in her relationship with Birth Father but then proceeded to give examples of violent incidents between them.

Author's Comment:

As agencies routinely ask women about domestic violence issues in assessments such as presentations in Accident and Emergency departments, bookings for pregnancies, Initial Assessments and CAFs for example ,there is an issue about how women interpret the expression ' domestic violence or abuse' in relation to their own situation and therefore how they answer the question. Mother had consistently denied any domestic violence issues yet the examples given by her would have been interpreted by others as such. Mother's own background history had been one of witnessing violence particularly in relation to MGM, which would have influenced her views of the definition of domestic violence. There is a lesson for professionals to probe a bit more rather than routinely ask the question and record the answer.

2.6.12 Mother was advised that if she wanted to add anything at a later stage she could contact the Family Liaison Officer, who would pass the information on for a response.

2.6.13 Both Mother and SMGM were told that they would be informed prior to the publication of the Review and would be offered a meeting to talk through the reports and the findings. They were reassured about the anonymisation and the timescales in view of the criminal process and submission to Ofsted was explained.

3. ANALYSIS

3.1 Analysis by Agency including the Health Overview Report

3.1.1 *"Working Together sets out how organisations and individuals should work together to safeguard and promote the welfare of children and*

young people in accordance with the Children Act 1989 and the Children Act 2004. It is important that all practitioners working to safeguard children and young people understand fully their responsibilities and duties as set out in primary legislation and associated regulations and guidance."
- Introduction to Working Together to Safeguard Children March 2010

3.1.2 All agencies providing services to children and families are expected to work within the framework of the legislation, statutory guidance and practice guidance issued by government. All Local Safeguarding Children Boards are required to have in place Inter Agency Safeguarding procedures easily accessible to all staff and service users. The Leicester Safeguarding Children Board have online open access to their inter agency child protection procedures and all member agencies are expected to have internal agency systems and procedures in place to underpin the Leicester Safeguarding Children Board's procedures.

3.1.3 Safeguarding procedures should be reviewed and updated on a regular basis and all staff should be made aware of how to access and use them through induction, training and supervision.

3.1.4 The IMRs and the Health Overview report in this SCR were required to consider the services delivered within the framework of the current legislation and guidance and in relation to the Leicester Safeguarding Children Board inter agency procedures.

3.1.5 The IMRs and the Health Overview report produced for this Serious Case Review have all addressed the Terms of Reference and set out the history and background of the children where there was information in records about them. Some interviews with staff and professionals have helpfully added to and clarified the information provided in records. The IMRs and the Health Overview Report have drawn the information together and provided some good and some excellent analysis of the services provided to the children and their Mother. The IMRs have aimed to assess what the outcomes were of the services provided for the children. Robust questioning about compliance with basic standards and available procedures at the different times is evidenced in the IMRs. Most IMRs have made very useful references to research in order to aid learning. Some specific issues have emerged for individual agencies and some themes have developed as common across agencies. The sections below will address the agencies separately and then consider the common themes before concluding with an analysis of the review process.

3.1.6 All the IMRs used the template provided by the Safeguarding Business unit. The template is set out in a way which allows for a comprehensive report. The Education Information report used the same template and modified it appropriately. The template allows for quite a bit of interesting and helpful contextual information being presented about the agency in question .This information is located at the beginning of the reports. The template might benefit from a brief section in Part 1 after the Family composition which briefly explains the event leading to the Review in relation the subject child and whether the agency was involved at the time. The current template leaves the reader to go through several pages of information about the agency prior to the direct information about the child.

3.1.7 Children's Social Care and Safeguarding IMR

3.1.8 The IMR set out useful information about Children's Services and about the city in which the services are provided. It is interesting to note that there were organisational changes in 2010 and 2011 and that, at the same time, there was an increase in referrals to January 2010 as they rose by some 45% (1,950 per quarter up from 1,270). This inevitably impacted on other social care activity such as child protection enquiries and initial assessments. The increase in referrals was sustained throughout 2010 to 2011 and created some difficulties with dealing with unallocated cases.

3.1.9 Over the same period the numbers of children subject to a child protection plan also increased, with a peak of 429 in September 2009, to 395 in January 2010. At the end of June 2011 the number of children subject to Child Protection Plans was 419.

3.1.10 The IMR concluded that staff turnover or sickness absence did not affect the provision of services to the children in this case. However, the response to the birth of Sibling might have been impacted on by organisational change at the time that the referral from Probation was dealt with, as the hospital based service changed.

3.1.11 The staff involved with Sibling and Child R had all received a range of single and multi agency training including a 4 day Safeguarding Children Investigations course. The IMR does not state if there had been specific courses about recognising neglect and/or domestic violence, which they had attended.

3.1.12 The IMR concluded that there were two significant episodes of contact with the children and Mother prior to the death of Child R. The first episode is set out as starting from the referral by the Probation Service

in October 2008 prior to the birth of Sibling and concluding when the case was closed in early July 2009 when Sibling was 4 months old.

3.1.13 During that time period the case was allocated to a social worker between October and March 2009, at which point the worker left. The case was then managed by different Duty workers with a period of allocation to a Student Social Worker in April and May 2009. During this period Sibling was seen by the different social workers 8 times, 2 of which were in the office.

3.1.14 The IMR identified a number of Learning Points in relation to the first period and in particular comments on the need to undertake assessments that include a good understanding of the past history of each parent and its impact on the parents' capacity to meet the needs of their child ,emotionally, practically and safely.

3.1.15 In my opinion a pre Birth assessment should have taken place prior to the birth of Sibling when the referral from the Probation service was received. The past experiences of Mother should have been explored and there was enough background information in records at the time about Mother to raise concerns about her parenting capacity. Children's Services also had information about Mother's own experience of 'being parented' by MGM which should have raised concerns about Sibling and subsequently Child R being left to be cared for by MGM:

"In fact there is a long history of concerns about MGM's violent behaviour and substance misuse; records indicate that Sibling was left in her care at least on one occasion when Social Care was involved. When the Social Worker discusses with Mother MGM having contact with Sibling, following Child R's death, Mother's response is "make sure she isn't drunk"." (Children's Services IMR)

A good pre birth assessment should have addressed the background histories of both parents and any other potential carers for the child. An understanding not only of the day to day skills of parenting but the impact on the care of Sibling of poverty, the family culture and attitudes to working with support services should have been fully explored.

3.1.16 A Pre Birth assessment should also have addressed the risks posed by Birth Father in view of the history of domestic violence offences. Although the offences had not involved children, the risks were not explored in relation to the relationship with Mother and the changing dynamics when Sibling and subsequently Child R were born. There

was evidence throughout of the relationship between Mother and Birth Father being volatile in view of the number of times Mother requested help to remove his name from the tenancy and there were contacts with the police and the Housing Provider about disturbances. The fact was that Birth Father was present in the household until December 2010.

3.1.17 The IMR concluded that the management oversight of the case "could have been more robust". In my view this is an example of the need for 'reflective supervision' as recommended by Professor Munro. The preoccupation with the accommodation issue moved the focus away from the children and their needs and safety being addressed robustly. The management decisions to sign off the closure of the case without ensuring that all aspects had been addressed and concluded was poor practice. Sibling's circumstances should have been fully updated and reviewed.

3.1.18 The second period of involvement from May 2011 to the end of June 2011 related to the referral from EMAS, when Sibling was taken to the A and E department having been injured at the home of one of the Maternal Aunts. The referral was taken and checks for previous records identified the original assessments and records. The case was noted as needing a home visit during an exercise to reduce unallocated cases in the team.

3.1.19 A home visit was undertaken 16 days after the referral was received and Sibling was seen and Child R was present. The records note that Children's Services had not been aware of Child R's birth. At this point Child R was 9 months old. Having discussed a number of issues with Mother and queried who the male present was, the Social worker explained that another Social worker would do a follow up visit to check that the house had been cleaned. In my view, this homevisit in response to the referral from EMAS did not demonstrate a prompt response to the referral as 16 days from the referral to the Initial Assessment visit had elapsed. The IMR identified 'high demand' in referrals and workload at the time but the age of Sibling and background history that was available in records should have led to a more rapid response. If the Duty team, prior to allocation, or, once allocated to, the Duty Social Worker had undertaken full agency checks they would have gathered more information about Mother, Sibling and they would have found out about Child R.

3.1.20 The Social worker reported back to the Team manager leaving hand written notes as the worker was leaving. This was not good practice and as a result the notes did not enter the information system. A joint follow up visit with the Health Visitor was recommended; the referral by

Health Visitor for Family support was noted as was the unknown male and the new addition to the household, Child R. Mother's statement that 'she was not in a relationship 'was accepted and Birth Father's absence was noted. The case notes were not added to the case record system but the case was allocated for follow up by the end of May 2011.

3.1.21 The second presentation of Sibling in the A and E department mid June following injuries whilst in the care of Mother's partner was referred by EMAS and the referral was passed by the Emergency Duty Team to the Duty Assessment Service who emailed it to the Team manager of the allocated Social worker.

3.1.22 The second EMAS referral was not connected to the first referral because, as noted above, the information from the first referral and subsequent visit had not been entered on the information system. The allocated Social Worker ,aware of only the first referral, liaised with the Health Visitor and without a further visit to the home recommend that the case could be closed as the Health Visitor had made a referral to the Family Support Service and they had accepted it. The issues were identified as 'conditions in the home which need addressing'. The Social worker had not realised the presence of Mother's partner in the home or the fact that Mother was attending a course leaving him to care for the children. Similarly, the fact that Sibling's second injury had taken place and was whilst in Mother's partner's care was not discovered.

3.1.23 The response to the referrals from EMAS was a serious, missed opportunity as the Social worker, who undertook the home visit after the first referral raised a number of issues that needed to be followed up. The IMR comments that there were issues about the notes made by the Social worker not being 'added to the system' as they were mislaid. In my view there was confusion and poor practice in the management of the case. The recording and information systems were not used appropriately and important information was missed.

3.1.24 This failure to follow up to assess the conditions in the home and clarify the information about Child R and the male who had been present led to a closure of the case, which should not have happened. If the records had been managed according to expected standards the information would have been available when the second EMAS referral was received. A home visit should have followed for an assessment to be concluded before any further action was determined. The EMAS referral was quite clear that the conditions had not improved in the time elapsed between the two incidents. The management sign off to this case closure should not have been made.

3.1.25 There was some evidence that Social work staff were aware of the needs of the children in relation to their ethnicity as the IMR noted that the records demonstrated that the Social worker had queried during the Initial Assessment in 2008 with the parents, if they had given any thought to Sibling's specific needs in relation to identity, personal care and feeding. There was discussion about whether they had considered that it would be helpful to Sibling to have contact with Birth Father's family in London as well.

There was no record of similar considerations in relation to Child R, who was not known to Children's Services until the first visit in relation to Sibling when Child R was 9 months old.

Additionally the IMR noted that the Social worker involved in working with Sibling after Child R's death had recorded that Mother made comments to Sibling which the worker felt were very negative to Sibling and 'racist'. The Social worker discussed the comments with Mother.

3.1.26 The contact after Child R's death and the actions taken to safeguard Sibling are well documented and followed the procedures and guidance within the agency as well as the relevant legislation and inter agency procedures.

3.1.27 The IMR expressed concerns about the common understanding between agencies of the 'thresholds 'for referrals to Children's Services and for a CAF to be undertaken. This concern related to the actions by the Heath Visiting service at points when they should have made a referral but did not. In my view there appears to be uncertainty in agencies about the point at which a referral should be made and how it should be received which raises questions about a 'common understanding' among agencies. In order for a common understanding between agencies about referrals to operate there needs to be some elements of trust and respect for the different professional roles and responsibilities and permission to question and discuss each other's decisions and the reasons for them.

3.1.28 Although the Learning points and recommendations reflect the findings of the IMR, it could have addressed the issues of the understanding in Children's Services itself about the threshold criteria and how to respond to referrals more robustly. Particularly the response to referrals involving very young children and issues of neglect and domestic violence should have been addressed to improve the practice in relation to checking and sharing information effectively.

3.1.29 Leicestershire Police IMR

3.1.30 The IMR provides information about the way the agency is organised at a local level, with references to the locality where the family lived, as well explanations about how it works in partnership with other agencies such as Housing providers. The Neighbourhood Policing Team who covered the relevant area had experienced little change in staffing over the past few years so they were well aware of the issues relating to the area.

3.1.31 The Domestic Abuse policy and document which was in force during the time frame of this case is updated regularly and states that:
'The Leicestershire Constabulary will take positive action to protect the victim and any children present from further harm when domestic abuse occurs. The possibility that an initial complaint will not be subsequently pursued is irrelevant, and should not affect the action taken or the manner in which the victim is dealt with. The Leicestershire Constabulary will work with partner agencies to help victims of domestic abuse make safe and informed choices'.

3.1.32 Risk assessments were undertaken using the SPECSS model as a tool until the end of September 2011, when it was replaced by the DASH risk assessment model. Where high risk is identified the CAADA risk assessment tool is used. This process assists in the decision making about making referrals to a Multi Agency Risk Assessment Conference. (MARAC)

3.1.33 An Adult Referral and Coordination Team was introduced in April 2010 and this became the Comprehensive Referral Desk (CRD) in February 2011 with the aim to: "protect the lives of the vulnerable and those exposed to domestic and child abuse by the effective co-ordination of multi-agency resources to risk'. More than 1,500 referrals are processed by the CRD each month.

3.1.34 The Child Abuse Investigation Unit (CAIU) and the Domestic Abuse Investigation Units (DAIU) operate to support the Basic Command Units. The DAIU reviewed all domestic incidents assessed as 'standard' risk for compliance and risk assessment until August 31st 2011 at which point the DASH model became operational.

3.1.35 The CAIU is responsible for responding to all familial child protection matters. Referrals to the CAIU are assessed by staff in the CRD. They are responsible for referring matters to the Social Care Services.

3.1.36 The IMR noted that Mother had been known to the agency since 2004 as a victim of an Indecent Assault and separately an alleged non

accidental injury by MGM. Mother's partner had also been known to the police since 2004 primarily as a victim of assault and theft.

3.1.37 During the period May 2008 and January 2011 there were three recorded domestic incidents involving Mother and Birth Father and three occasions when Mother contacted the police for assistance with Birth Father, which were not recorded as domestic incidents. These three occasions were not recorded on the Computer Intelligence System (CIS).

3.1.38 In the three domestic incidents a risk assessment was completed as 'standard'. These were all reviewed by the DAIU and no further action was taken.

3.1.39 The recording by the attending officers did not identify that the children had been seen by the officers. The interviews for the IMR have clarified that they did see the children and had not had any concerns about them. The fact that the recording did not contain the full information and was at times not accurate according to the set standards meant that the full picture was not taken into account when the risk assessments and the decisions about further action were made. Additionally, as three incidents had not been recognised as domestic abuse and had not been recorded as such, any interrogation of the information systems would have identified them as 'incidents' not crimes. The findings of the IMR were that officers did not fully comply with the expectations to check all information systems. The accumulated effect was that the risk assessments, that were undertaken, were unsafe and the decisions about follow up referral action were ill informed.

3.1.40 The IMR concluded that the risk assessment in 2009 which had been set as 'standard' should, if all the information had been taken into account such as the age of Sibling, the pregnancy, the Harassment Warning and previous history, have raised the risk to 'medium'. In my opinion the LSCB Interagency procedures for Domestic Abuse /Violence (Chapter 5.12 Section 6 Referral to Children's Social Care) should have been considered as there were children present and there had been several contacts. A referral should have been made by the Police to Children's Services. The Interagency Safeguarding procedures state:

"Whenever a professional becomes concerned that a child is, or may be, at risk of significant harm, a referral must be made to Children's Social Care Services in accordance with the Referrals Procedure.
Normally, one serious or several lesser incidents of domestic violence where there is a child in the household means that Children's Services

should carry out an Initial Assessment of the child and family, including consulting existing records."

3.1.41 In relation to recording the ethnic origin of the children the DASH Forms CR 12/12A do not allow for this information to be entered which means that the information would not be available to be placed in the CIS system. Children are not defined as victims in relation to domestic abuse in the information system. The standard Risk assessment forms do not have a space for these details either but it could be entered in to the Working sheets, which is optional. Although the Officers attending the call outs were aware of the dual heritage of the children it was not in any record.

3.1.42 In my view no checks could have been made by any other agency with the police about any members of the family; or any contact for consultation or referral prior to Child R's death. The initial referral to Children's Services from Probation in 2008 in relation to the domestic violence convictions of Birth Father and the subsequent assessment can therefore not have included any checks with the police as they should have done according to the Assessment Framework 2000 and Working Together 2006 (applicable at the time) and 2010 as well as the LSCB Interagency Child protection Procedures.

3.1.43 There was evidence of incorrect recording according to the IMR such as names spelt wrong, which not only means that information might not be found but also that it is a breach of the Data Protection Act 1998 and the Management of Police Information Code of Practice. Where a person is known by several names, for example Mother had been known by different surnames, the importance of recording correctly must be emphasised.

3.1.44 The Learning points and recommendations in the IMR reflect the findings of the IMR. It was noted that the issue of police systems checks and correct recording had been raised in two previous Serious Case Reviews, which covered the same time period as this Review and recommendations have been implemented since then. Audits have been planned to monitor the working practices in future.

3.1.45 Leicestershire and Rutland Probation Trust IMR

3.1.46 The IMR sets out the agency context, the underpinning legislation and regulations and addresses organisational change and capacity in a clear way. Protecting the Public is a central tenet of the National Probation Service and informs all risk assessments. The Probation Service works with adult offenders and does not have the facility to

offer services directly to partners and families. The service has the responsibility to refer to Children's Services when there are concerns about safeguarding issues or risks to children and young people have been identified.

3.1.47 Supervision of staff, audits and training in safeguarding are in place. City and County Probation Trust is implementing the Leicester Safeguarding Children Board's training strategy which includes level 2 internal and level 3 multi-agency training, which requires reviewing every three years. Managers are required to check whether staff within their teams have attended this.

3.1.48 The IMR explains the full details of the offences and convictions in relation to Birth Father and the background for the breach of the Suspended sentence. The risk assessment at the time is outlined and the details of the Supervision of Birth Father.

3.1.49 The IMR explores the involvement with Birth Father and Mother as the negotiations about accommodation on release from custody were addressed by the Offender Manager. It was made clear to Mother and Birth Father that a referral to Children's Services had to be made in view of the offences. Mother was reported to have been very concerned that the baby would be 'taken by social services'.

3.1.50 The Offender Manager agreed to include Mother in some of the meetings and agreed to a visit by Birth Father to his father in London over the Christmas period. There was some discussion about the couple moving to London.

3.1.51 The final meeting was in January 2009 and the City and County Probation Trust has not had any further involvement with Birth Father since then. The final Risk of Harm assessment viewed Birth Father as being a Medium Risk to known adults and the public and a Low Risk to children.

3.1.52 All policies and procedures were followed and recorded and information was shared with partner agencies including the Social Housing providers.

3.1.53 The IMR concludes that it would have been good practice for the Offender Manager to have contacted the Police Domestic Violence Unit to inform them and to request call out information, when it became clear that Birth Father was living with Mother. Information about any call outs would have been important to the Children's Services undertaking the Initial assessment. This was taking place in 2008 and since then an Information Sharing Protocol has been implemented

(February 2011) including guidance for Offender managers to request call out information from the Police. The guidance agrees that information will be provided at the Pre-Sentence Report Stage, Order Commencement (which would include Licence supervision) or when Domestic Violence Issues come to the attention of the Offender Manager.

3.1.54 The Domestic Violence call out guidance including report writing at Court, with clear contact numbers and criteria for referral, is now on the City and County Probation Trust Intranet System and Offender Manager's have been made aware of this and can easily access the relevant referral forms or telephone the Police DV Unit.

3.1.55 The IMR comments that the risk factor in relation to pregnancy and domestic violence should be recognised and notes that the City and County Probation Trust is currently revising their domestic violence policies and guidance. The only recommendation made relates to reviewing the guidance regularly.

The IMR has in my view addressed the issues which related to interagency working, particularly with the police, and has highlighted the role of the Offender Manager in overseeing and regularly reviewing the actions of the Domestic Violence Offender by checking call outs to the police. For example, if the checks had been undertaken in conjunction with making the referral to Children's Services it would have been discovered that Birth Father was alleged by Mother to have made threatening phone calls to her while in custody .Mother called the police, who visited her about the matter.

3.1.56 City Council Housing IMR and Housing Provider IMR

3.1.57 Two separate IMRs were produced by two different agencies which both provided housing services to Mother and the children at different points. The City Council Housing IMR covers hostel accommodation and a Family Support Service and the Housing Provider IMR is a housing association providing properties for social rent.

3.1.58 The Hostel, Family Support Services and STAR (Supporting Tenants and Residents) team follow a joint working protocol that prioritises people staying in the Hostel ensuring an effective and timely handover of cases. The Hostel is for homeless families and provides accommodation and housing related support for up to two years. The Family Support Services team play a crucial role in preparing carers and parents to develop and build on their parenting skills and ensure key development stages are picked up with children relating to their

educational, emotional and cognitive development. The service is delivered through a mixture of one to one sessions', group work and play activities which are all monitored and reviewed with key partner agencies. The Service also provides a fast track screening system for reporting concerns to the Duty Assessment Team in Children's Services about children in the hostel who may be at risk of harm or neglect.

3.1.59 Mother had a tenancy from 2007 and had an Anti Social Behaviour warning prior to Birth Father moving in to the property with her in 2008. In December 2008 they requested a move due to harassment and reported that Mother was pregnant. At the time of the birth of Sibling in March 2009 Mother moved in to the hostel and was then rehoused from there in to a two bed roomed house with the Housing Provider in April 2009. Birth Father was named as a joint tenant.

3.1.60 The STAR support service worked with Mother from April 2009 to offer various support around utilities, TV licence and benefits. The team noted that Birth Father was living in the home. The support service ended in November 2009 as Mother no longer wanted any service.

3.1.61 The Housing Provider remit did not include any support element and contacts only took place if a tenant contacted them or a complaint was made about noise or nuisance. The IMR makes a point to note that the agency had not been aware of Child R joining the household or Mother's partner having moved in. The IMR also clarifies that there was no regulatory requirement for the agency to expect tenants to keep them informed of changes to the household or to undertake visits to check.

3.1.62 During the time that Mother stayed in the Hostel after the birth of Sibling the Family Support staff saw Sibling every day for daily health checks and support was offered to assist Mother if she wanted it.

3.1.63 There were no recorded concerns of domestic abuse while Mother and baby stayed in the Hostel.

3.1.64 Birth Father was admitted to the same Hostel at Christmas 2009 after a break up with Mother admitting drug and alcohol misuse and having had a pellet gun. The police visited at the end of January 2010 to warn Birth Father to stay away from Mother. By March 2010 Birth Father was no longer using his bed space and following a warning was evicted from the hostel. From the Integrated Chronology it is clear that he had returned to stay with Mother.

3.1.65 The City Council Housing IMR has noted learning points and made recommendations which reflect learning from the IMR process. Although the stress on consent in the recommendation is useful, it does not draw out the need to consider that some times the needs of the child to be safeguarded means that consent can and must be overridden in order to protect a child.

3.1.66 The Social Housing Provider IMR recommends that a policy used by the same agency elsewhere in the country should be applied locally. The recommendation does not make it clear if the policy will be suitable locally and makes no mention of how it will be disseminated or maintained with staff.

It would have been more appropriate to recommend the development of a Child Protection Policy statement applicable to the Housing Provider in partnership with the LSCB in the local area and with procedures clearly stating that referrals should be made to Children's Services.

A greater awareness of the roles of other agencies and basic aspects of safeguarding would be of help to the staff group, which would be best addressed by accessing the Leicester Safeguarding Children Board multi agency training programme.

3.1.67 Health Agencies IMRs and the Health Overview Report.

3.1.68 The purpose of the Health Overview report is to collate and draw together the information from the IMRs which have been undertaken by different health agencies and provide an overview of the issues and lesson to be learnt for the Health community. In this case five IMRs were produced by University Hospitals of Leicester; Leicestershire Partnership NHS Trust; Leicestershire Partnership NHS Trust/NHS Leicestershire and Rutland PCT Cluster; East Midlands Ambulance Service NHS Trust (EMAS) and NHS Direct.

3.1.69 The different health IMRs represent a diverse range of staff who have had involvement with Child R and Sibling as well as Mother and other significant adults; such as Health Visitors, ambulance staff., GP, hospital staff. From the information in the IMRs the Health Overview report explores the context in which the organisation works in Leicester and gives useful information about the health needs of the local population.

3.1.70 The Health Overview report provides a thorough account of the contents of the IMRs and comments on the individual issues for each

IMR as well as the themes which are shared across the health agencies involved. The report comments on the learning points in the IMRs and the recommendations and adds four recommendations to address areas that needed to be strengthened or where there were gaps identified.

3.1.71 In my opinion the Health IMRs provided good contextual information as well as information about the services that had been provided. The IMRs were robust in their scrutiny of the records and in pursuing their enquiries in staff interviews .The Health Overview Author followed up where matters needed further clarification with the IMR Authors, who checked the information with staff.

3.1.72 The IMRs and the Health Overview report all provide useful references to research and explore the impact of the services on the children and consider what could have been done to improve the outcomes for the children.

3.1.73 The themes which are identified in the IMRs and the Health Overview report can be summed up as:

- The holistic perspective of the family considering their background and the family and community context was missing
- A curiosity about and an assessment of Mother's parenting capacity was missing
- The focus on the needs of the children and the impact on the children of their circumstances was missing for example the growing signs of neglect
- There was a lack of awareness of the possible risks of domestic violence in relation to Birth Father
- There was a lack of curiosity about males in the household or around the children
- There was a low level of communication between the different health professionals for example the GP and the Health Visitors / the Health Visitors and Designated or Named Safeguarding staff
- Issues about recording practices were noted
- There was a lack of awareness of signs of neglect

3.1.74 The Health Visitors, who were dealing with Sibling and then Child R, failed to take action at some crucial points which might have led to different outcomes for the children. The Health Overview Report and the relevant IMR concluded that the two Health Visitors assigned to Sibling and Child R were unclear about their roles and failed to take responsibility for the case. The primary issue was the visit in January 2011 by the Nursery Nurse, who became so concerned that a telephone call was made straight away after the home visit to one of

the Health Visitors. This Health Visitor subsequently spoke to the other Health Visitor but no immediate action was taken. They should have followed up with a home visit to see the children. A referral should have been made to Children's Services and checks with other health colleagues should have been undertaken.

3.1.75 The IMRs and the Health Overview report examined the process and systems in place for the handover of the EMAS safeguarding referrals in the A and E department. Consideration was also given to how they could be followed up for feedback about the outcome of the referral. The same process was discussed at the SCR Panel at length.

It was noted that the EMAS staff had acted in the interest of the children and had been in the unique position to have the same person observe the household without forewarning on two occasions.

The current system allows for a referral to be made by EMAS on the Patient Referral Form (PRF) although the form does not leave much room for making any notes other than that a referral has been made. It is the system within the A and E department to receive the information effectively and to capture it so that it becomes a part of the assessment that the doctors and nurses are making about the child that needs to be reviewed. There needs to be a clear system to handover the concerns and to record the information in a place where it can be accessed and used. There remains some difference of view as to the contents of the EMAS referral forms handed to the hospital staff at the time of the two presentations of Sibling at the hospital.

3.1.76 The Health Visiting staff should have responded to the information about Sibling attending the hospital following the reported falls with a home visit to discuss safety issues and the conditions of the home. The notifications of the attendances had reached the GP but did not reach the Health Visitors, who were informed of one of the hospital attendances during a telephone call to Children's Services.

3.1.77 There was lack of communication between the GP and Health Visiting services and the other way around as the Health visitors should be able to approach a GP if there are concerns. The reports by Mother of post natal depression on three occasions, where treatment was prescribed, should have been considered by the GP in the context of a young mother with young children. Mother was talking about stress and relationship problems and the GP should have informed the Health Visitor of Mother's state of mind. Similarly the Health Visitors should have consulted with the GP about their concerns about the conditions in the home particularly following any accidents.

3.1.78 The role of supervision and the access to consult with Named or Designated Safeguarding staff was noted as an issue with one member of staff but it is not clear from the reports if the use of safeguarding support is easily accessed or if this was only an individual problem. The Health Overview report comments that "most supervisory practice relates to cases where children are subject to child protection plans. However at all times specialist safeguarding supervision and/or advice is available through each organisation's dedicated safeguarding specialists (Named Nurses and Doctors, specialist nurses etc.), or clinical supervision can also be sought, for any case which gives rise to professional concern."

The question that has not quite been answered is 'who or how the Nursery Nurse, who was concerned in January 2011 after the homevisit, could have turned to for advice as the Health Visitors did not respond with a homevisit?

The Health Visiting Service IMR report considered research in relation to staff feeling overwhelmed (Brandon et al 55:2010) where" the chaos, confusion and low expectations encountered in many families were frequently mirrored in the organisational response. The families disarray was often reflected in professionals' thinking and actions so that both families and workers were overwhelmed and failed to see or take account of the needs of the child". As Mother seemed reluctant to accept support services the Health Visitors focussed on practical issues such as the application for funding for carpets from the start of their involvement. They continued to respond in the same way without any review of the impact on the children of this new information.

3.1.79 The recommendations in the Health IMRs and the Health Overview report reflect the findings of the IMRs. The recommendations in the Health Overview Report are primarily aimed at adding to the Child Protection training program in Health agencies.

3.1.80 The Health Overview Author expresses some frustration with the lack of progress in learning from previous Serious Case Reviews such as Child W. Similar findings had been reported about communications within health agencies for example between the GP and the Health Visiting service or between the various professionals in the A and E department. The need to view the family as a whole in line with the 'Think Child, Think Parent, Think Family' model and to ask questions about other adults in a household is pointed out by the Author. Rather than make further recommendations to add to training programs only, it would be useful to consider a mechanism to embed the learning in daily practice. This could be achieved by undertaking some time limited targeted research within the local services identified to ask the

staff groups how they think the lessons can be disseminated and maintained to best effect. The process of involving staff in developing effective learning and good practice could in itself improve standards when staff understand the context of the learning e.g. Child R.

3.1.81 The Education Information Report.

3.1.82 A brief report was provided about Mother's partner and it provided some background information. There was no information which could be said to have given any direct warning about any risks to children by Mother's partner. There was an incident which might have indicated a temper control issue but that was in the context of a teenager at school. There were no repeated incidents. There were no other remarkable events except non school attendance leading to a successful prosecution of Mother's partner's mother.

3.1.83 The records for Mother's schooling were extensively searched for both in the city and the county and with a number of surnames in mind. No records of any significance could be located, which confirms the view from the background history that Mother was moved around to different carers and addresses during her childhood and did not attend school in any meaningful way.

3.2 Analysis by Theme

3.2.1 In the recent report 'Learning Lessons from Serious Case Reviews' 2007-2011 (Ofsted October 2011), the number of babies under a year old in 471 Serious Case Reviews ,which involved 602 children and young people, was 210 which is 35%.

The report comments on the vulnerability of young infants and notes that the lessons are particularly important for the professionals, who work directly with this age group. The most common services to infants are the universal services of Health Visiting and GP services.

3.2.2 The report identifies the common findings in the SCRs of infants as follows:

- there were shortcomings in the timeliness and quality of pre-birth assessments
- the risks resulting from the parents' own needs were underestimated, particularly given the vulnerability of babies
- there had been insufficient support for young parents
- the role of the fathers had been marginalised

- there was a need for improved assessment of, and support for, parenting capacity
- there were particular lessons for health agencies, whose practitioners are often the main, or the only, agencies involved with the family in the early months
- practitioners underestimated the fragility of the baby.

In view of the themes which have emerged in this Serious Case Review of Child R as outlined in the IMRs, the Health Overview Report and this report so far the similarity with the themes from the Ofsted report are striking.

3.2.3 Additional themes and messages from the Ofsted report include the "importance of not closing cases too quickly after the baby's birth". This is also an issue in this case not so much in relation to the births but there were two points at which Children's Services closed the cases of Sibling too quickly. They did not consult with other agencies and update their information about Sibling and Child R before closure .They failed to check their own recording to make sure that they had met all the tasks set out in the Child in Need Plan or in one instance in a transfer summary. As managers are required to sign off any closure decisions they should not do so unless they are satisfied that the recording is up to date and the child/ren have been seen and reviewed before closure. The case closure lesson applied to the Health Visiting service as well as the case priority given determined the service provided to the child in question. The Health Visitors should reassess and review the case priority when new information is presented whether from observation or direct communication. In relation to Sibling and Child R there were additional needs and the priority should not have been set as 'medium' in September 2010 or 'universal' in March 2011. The rationale for the decisions was not recorded and in view of the information that was known at the time about the children the decisions do not meet the established criteria.

3.2.4 The significant part of the assessment of this family, which was missing across all the agencies, was an understanding of the importance of considering Mother's past experiences. Her capacity to form attachments to her children, to be able to meet their emotional needs and to provide them with a safe parenting experience had been impacted on by her own experiences of being cared for as a child. Moving around between carers and witnessing violent and aggressive behaviour, which included MGM's behaviour, has impacted on Mother's perception of how to parent her children. Her own mother MGM was referred to as the person Mother would turn to for support first which indicates that Mother models her parenting style on MGM. The outcome was that Child R and Sibling were both vulnerable to a

range of risks including being left with a number of unknown carers to be looked after while Mother went out to meet up with other friends and relatives.

3.2.5 The IMRs bring out that there was a slow response in the agencies to come to the recognition that the children were being neglected. There were a range of indicators being noted such as the conditions of the home over time, the children's weight in the first part of 2011 ,the children being left with different carers while Mother was meeting her own needs by going out not only to the course but to meet friends . The finding in the Ofsted report about 'practitioners underestimating the fragility of young babies' is applicable in relation to Child R and Sibling .The responses by agencies to concerns about the conditions of the home and two presentations to the A and E department did not demonstrate any urgency by the Health Visitors, the GP or Children's Services about the impact on the children.

"While definitions of neglect have become increasingly comprehensive and sophisticated, applying the concept of neglect to practice remains challenging. Research shows that practitioners frequently have different understandings of what constitutes neglect and find it difficult to decide at what point a referral should be made (Howarth 2005). Neglect is a notoriously complex and depressing issue to deal with, which can leave practitioners feeling overwhelmed by the enormity and plurality of the needs of neglectful families. Because these needs are often varied and interconnected, an effective inter-agency response is crucial. Nspcc Research Briefing –Child Neglect 2007.

The professionals were dealing with the conditions of the home by looking for practical solutions and Family support to Mother, who was not showing any signs of wanting to be supported. The impact on the children was being missed.

3.2.6 The early referral from Probation was an opportunity to have undertaken a Pre Birth assessment in relation to Sibling. A good assessment at this point would have laid a foundation for the information sharing for the future. It was not only the assessment of Mother that was missing but the assessment of Birth Father was very limited as it relied entirely on the Probation risk assessment which readily acknowledged that it was a low risk in relation to children because there had not been any children involved previously. Both parents should have had a clear chronology outlining background history and should have been assessed in relation to all the dimensions of the Assessment Framework (2000) to determine their capacity to parent Sibling and meet Sibling's needs and to address any safeguarding issues.

3.2.7 There was no evidence in the original assessment, which was not undertaken as pre birth assessment, that checks were undertaken with other significant agencies such as the GP. The assessment therefore was not a multi agency collaborative exercise as it should have been in line with all national and local interagency procedures and guidance:

Working Together (2010) is clear that "to achieve good outcomes for children all professionals with responsibility for provision of services and assessment must work together according to an agreed plan of action".

The evidence in all the IMRs and the Health Overview report was that the front line staff did not follow through checks, referrals and contacts between agencies. Forms and emails were sent in some instances and phone calls were made but the overall impression was of each agency addressing their own agenda, which is often described as "silo working" (Brandon et al 2008).

3.2.8 There should have been a much more detailed exploration of Birth Father's and Mother's understanding of domestic violence and the impact on children. Their relationship judging by the records and reports by Mother can be described as volatile and it is unclear where Sibling was at these times, for example when Mother broke a bottle over Birth Father's head because he had pinned her to the wall. All the available literature about domestic violence stresses pressure points as 'pregnancy',' relationship break up' and 'dispute about paternity' as high risk. These factors were in evidence in this case but were not addressed by any agency.

The findings from research in relation to domestic violence have consistently been that the number of recorded call outs and referrals do not reflect the reality of incidents taking place. It is probable that the environment for Sibling and Child R was more unsettled and involved more aggressive behaviour than had been understood from the records as Mother regarded 'arguments' and fall outs involving threats of violence as a part of everyday life. When asked about domestic violence in relation to Birth Father Mother repeatedly answered that there was none, yet we know from the records that there were frequent arguments and falls outs with Birth Father and other family members. Her own family refrained from taking any firm action about the conditions of the home as they were anxious that Mother would become angry and stop their access to the children. The Overview Authors meeting with Mother confirmed that Mother's view of domestic violence did not apply to her own circumstances for example when she

described her interactions with Birth Father or fall outs with her sisters and MGM.

3.3. Analysis of the Review process

3.3.1 The review process has been managed within the time frame expected by Working Together 2010 and the Panel meetings have been well attended. The administration of the Review by the Safeguarding Business unit has been excellent with a dedicated Policy Officer working closely with the Independent Chair to chase up authors and distribute the documentation. Templates were in place and were used by all agencies.

3.3.2 The time frame was tight as the process required the briefing of IMR Authors at an early stage so that they could start their work on the individual management reviews. The Health IMRs were needed by the Health Overview Author before work could begin on the Health Overview Report. As there were some delays in delivering the final IMRs and a full final integrated chronology the time left towards the end of the process for concluding the Overview report became tight. The discussions in the Panel meetings were helpful in order to clarify issues and request additional information.

3.3.3 The agreement by the Police and the Corners Office to give the go ahead to speak to the family was helpful and has added to the learning of the Serious Case Review. Mother was able to clarify her position about the use of support services e.g. that she would not have cooperated as she did not think that she or the children were in need of support. Mother's response to the standard question about domestic violence illustrated a learning point about how the question should be approached, not as a yes or no tick box question, but a more probing and exploring question about how the woman defines domestic violence and abuse and how they see it in relation to their own circumstances.

4. CONCLUSIONS

4.1 Conclusions and summary

4.1.1 In light of all the evidence available to this Review the SCR Panel and Overview Author agreed that the death of Child R could not have been predicted or prevented. There were no signs of danger in relation to Mother's partner; there was no record of previous convictions; no soft intelligence and no reports by other women about any domestic violence. The family members according to SMGF had not picked up

any warning signs. In short, there were no warning signs and Mother's partner had only been in the household for 5 weeks prior to the event.

4.1.2 Having considered the information available to this Review it was, however, predictable that Child R and Sibling would need additional services as Children in Need during their childhood. Mother's capacity to meet their needs, socially, emotionally and developmentally without extensive support was doubtful .It is unclear if Mother would have been able to put the children's needs before those of her own to cooperate with such services. The children would have remained vulnerable to persons posing a risk to children as Mother was willing to allow a range of people to look after them. In many ways, in view of her own background history and pattern of casual relationships Mother remains vulnerable to risky adults herself.

4.1.3 There would have been services in place for the children and the family, if referrals been made and acted on when they should have been, for example, in January 2011 or following the presentations to the A and E department of Sibling. We can only speculate whether the presence of regular services input and contacts by professionals would have served as a deterrent to Mother's partner. Even in such circumstances it is not certain that the death of Child R could have been prevented.

4.1.4 The Review of the tragic death of Child R was asked to consider a range of questions in the Terms of Reference about the services provided to Child R and Sibling. The Individual Management Reviews, the Health Overview Report and the Independent Overview Report examined the information and assessed it with reference to national legislation and guidance and to the local Leicester City, Leicestershire and Rutland Safeguarding Children Board Interagency Child Protection Procedures.

4.1.5 The Overview Author concluded that there were a number of missed opportunities to provide services to Child R and Sibling and to assess their needs in a multi agency format. Services could have been provided to promote the welfare of both children on a number of occasions. For example, pre Birth assessments to plan and prepare for their births and subsequent care might have safeguarded them from the impact of neglect, such as Sibling's delayed speech development. If services had been provided to support the family it could have made the children less vulnerable to being left with unsafe carers.

Although a pre birth assessment would not necessarily have led to services over a long period of time, a good assessment would have provided the base for future interventions by providing background

information and assessing the parenting capacity of Mother and Birth Father thus setting the scene for addressing the children's needs in the future.

4.1.6 In order to undertake good assessments agencies must share information and work together as stated:

"Effective information sharing is key to delivering better, more efficient services co-ordinated around the needs of children, young people and families. Building understanding and confidence in information sharing is essential to support early intervention and preventative work as well as for safeguarding children and promoting their welfare. Most decisions to share information require professional judgement .Practitioners must feel confident about when and how information can be shared legally and professionally, and that they will have the support of their managers and organisations."

- The Governments Response to Lord Laming: The protection of children in England; an action plan, May 2009 (62, page 7)

4.1.7 Information sharing had not been effective in this case and it was noticeable that all agencies had been remiss in undertaking checks with other agencies or in undertaking checks within their own agency. The purpose of undertaking 'agency checks 'is to establish which agencies are involved with a child, to confirm and share information and to proceed to plan any services and interventions jointly.

It should be standard practice to check any record / information systems in all agencies for background history of a child and relevant adults to ensure that needs are assessed and services are provided based on full and accurate information.

4.1.8 The evidence in the IMRs of a child centred service is weak. The Health Visitors, who provided services to both the children, had noted all the routine developmental checks and services to the children. They had recorded some comments about the conditions in the home and had focussed on exploring practical solutions with Mother. The aspect that was missing was an assessment, with conclusions, about the impact on the children of the environment they were living in. A child focussed service should regularly review and assess the meaning, the impact, for the child's welfare of the circumstances surrounding the child.

4.1.9 In fact the children were seen by various agencies, although this was not always recorded as it should have been, for example, by the police when called out to domestic incidents. Children's Services visited a month before the death of Child R and met Child R for the first time.

Concerns about the home environment were recorded and should have been followed up as recommended. The concerns, that were expressed, focussed on the need for practical Family support services to improve the physical surroundings rather than the impact on the children of the care provided by Mother.

4.1.10 There was no evidence that services had systematically addressed the needs of Child R and Sibling in relation to their dual heritage. Matters of personal care such as skin care and hair care should have been discussed with Mother. There were anecdotal references to Birth Father preparing food for Sibling and talking about his own family but there were no records of any contact with the extended paternal family once Sibling was born.

4.1.11 There were similarly anecdotal references to Mother and one of Mother's friends making remarks, which were viewed by professionals as racist about the children. There would have been serious concerns about the children's welfare if this had been a part of their life experience. It is not possible to comment further other than to raise the issue that when professionals undertake assessments of children of dual heritage, they must include culture and attitudes by parents and adults connected to the children in their assessment not only in relation to children's needs but in terms of any risks to them.

4.1.12 Policies and procedures were in place in relation to sharing information, making referrals and undertaking assessments. Policies and procedures were not universally complied with particularly in relation to information checks as noted above.

The IMRs do not offer explanations about why staff were not complying with undertaking checks but recommendations, for example by the Police to undertake a gap analysis with a view to identify the reasons for the lack of compliance, are being implemented. The IMRs concluded that the staff were not experiencing heavy workloads at the time, similarly the information systems were not too complicated or time consuming. The question about the lack of basic good standards with checking records and information systems for staff and managers may be more about a cultural commitment to the importance of including full and accurate information in decision making and assessments. Professionals need to understand the importance of keeping accurate, up to date records as a matter of being accountable to the service users e.g. the children and families as well.

4.1.13 The issue of a shared understanding by agencies of making referrals to Children's Services has been raised in the Review although there were procedures in place in the LSCB Interagency Child Protection

Procedures with a chapter setting out how to refer to Children's Services and how the referral should be received. Whether the referral procedures were not understood for example by the Health Visitors, who should have made a referral in January 2011, or whether the procedures were not being used in general was unclear. Based on the available information in the IMR it was more likely that the Health Visiting staff did not consider making any referrals as they did not recognise the circumstances described by the Nursery Nurse as Neglect, which should have been acted on.

4.1.14 There are chapters in the LSCB procedures about Neglect and Domestic Abuse / Violence which provide Practice Guidance and set out how to make referrals and what to consider in any assessments. In relation to both subjects the professionals in this case do not appear to have been familiar with undertaking full assessments in relation to either subject.

For example, Birth Father's domestic violence offences were never fully assessed for possible risks to Child R, Sibling or Mother. This was pointed out in the Transfer summary by a Student Social Worker on placement in 2009 but the recommendations were not followed up. Both at the birth of Sibling and at the birth of Child R a pre Birth assessment should have been undertaken. Birth Father was living with Mother at the time of Sibling's birth and was still in the household at the time of Child R's birth. The uncertainty about paternity would have increased the risks to Child R.

4.1.15 The only example of good practice that can be identified as having gone beyond expected good standards of work related to the EMAS staff member. The EMAS paramedic attended the home on two occasions and followed up by making safeguarding referrals in accordance with the agency procedures. As it was realised that there had been no changes in the home between the two visits the staff member made a point of querying what had happened to the first referral and made a second referral.

4.2 Lessons to be learnt

4.2.1 Pre Birth assessments should be undertaken as child focussed multi agency assessments of the members of the family and any existing support systems. The assessment of the parenting capacity of the adults caring for the child should include good background histories. The outcome of the assessments should be that Care plans and Child in Need plans are agreed and reviewed regularly, whether the services are to be provided as Family support, Child in Need or Child subject of a Child Protection Plan.

4.2.2. The decision making by staff and managers in relation to transfer summaries, recommendations for case closures, decisions about levels of risk or case priority and making referrals should be undertaken based on up to date information. The child's circumstances should always be reassessed and reviewed to take account of any new information. The impact on the child's well being of the proposed decision –whether to close a case or to refer it for example – should always be stated along with the reasons for the decision taken.

4.2.3 The Review identified the need to improve some information sharing systems such as the EMAS referral form, its contents, and how it is passed to staff in the A and E department. The other part of the system that needs to be clarified and improved is how the referral information is received and used in the A and E department by doctors and nursing staff to inform the medical assessment of the child.

4.2.4 How information was shared within agencies, such as between the GP and the Health Visiting Service, and between agencies has highlighted the need for all professionals to consider not only how they pass information on but how it is also received. Information sharing should be a participative process with an exchange of views and information with room for questions to be asked.

4.2.5 The Review has identified that there was practice guidance in place about Domestic Abuse and Neglect during the time frame of this Review. The front line staff and managers did not recognise the need to assess the children's welfare, and their possible needs to be safeguarded, in the context of the information that was available about domestic violence. Similarly they did not recognise the signs of neglect and consider the impact therefore on the children's welfare. The lessons to be learnt are that supervision and training of both front line staff and managers must incorporate the principles of multi agency working in assessments of all kinds in order to identify when there are signs of abuse and neglect.

5. RECOMMENDATIONS

5.1 An Integrated Action Plan has been produced and is attached to this Overview Report .A number of the actions have been implemented while the Serious Case Review has been in progress and the Integrated Action Plan has been monitored regularly by the LSCB.

5.2 The recommendations from the Individual Management Reviews and Health Overview Report are set out in the Appendices below. The recommendations address the main findings of this report.

Recommendation 1.

Any current Pre Birth Assessment protocol should be reviewed and an up to date interagency Protocol should be developed which reflects the learning from this Review .The Protocol should be made available on the LSCB website and should be included in the Interagency Child Protection procedures.

Recommendation 2.

Current single agency and interagency training programs in relation to Neglect and Domestic Abuse / Violence should be reviewed to incorporate the learning from this Review.

Recommendation 3.

The uptake and attendance of Safeguarding training courses, whether single agency or interagency, should be reviewed to ensure that the training 'Recognising the signs and symptoms of neglect and abuse' is targeted to front line staff , front line managers and supervisors in all agencies .

Recommendation 4.

An interagency review exercise should take place to examine the understanding across agencies of the 'threshold criteria 'for making a referral to Children's Services to determine whether there is a shared view of the criteria and the referral process. The Review exercise should aim to highlight good practice examples as well as any gaps or problems to be addressed.

Recommendation 5.

The systems for sharing information about safeguarding concerns between EMAS staff and A and E department doctors and nursing staff should be reviewed. A protocol should be developed between the services to ensure that information is recorded and shared effectively so that the relevant information is taken into account when assessing a child.

5.3 Each agency is required to provide feedback from the IMR and the Serious Case Review process to the personnel specifically involved in the case. The dissemination of the key learning will be targeted to the staff and managers in all the member agencies of the Leicester Safeguarding Children Board. Reports will be published on the LSCB website.

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