SERIOUS CASE REVIEW

(under Chapter 8, Working Together to Safeguard Children 2010)

In respect of deaths of the

children known as Child 1 and Child 2

Case "A"

Report by: Anne Binney, Independent Author

Accepted by Independent Chair of Leicester Safeguarding Children Board on 9 September 2011

Contents for Serious Case Review (SCR)

1. Introduction

1.1 In the early part of 2011, police broke into a flat in Leicester and discovered the bodies of two pre-school aged children and their mother. The deaths were treated as suspicious. The day prior to this, a body was found hanging in a local park and a note with the body led the police to enter the mother's flat. It was later established that the man, believed to have committed suicide, was the father of the two children. No other suspect is being sought in relation to the deaths.

1.2 The two children who died are the subjects of this Serious Case Review (SCR). They attended local pre-school provision and were described as cheerful, lively and vocal children. The youngest child was described as "always smiling". Their deaths caused great shock and upset to the local community and to all professionals who knew the family.

1.3 The mother of the children was White British and the father had claimed asylum in this country but was originally from the Middle East. The note found with the body had been written in his first language and it was only on translation the following day that police became aware of concern for the children and their mother. The two young children were of dual heritage and of Islamic faith. The mother was believed to have converted to Islam.

1.4 The cause of death of the children and their mother has not yet been ascertained but they are believed to have died some days prior to the discovery of the bodies. Police and Coroner enquiries are ongoing. The Coroner opened and adjourned the Inquests on 2 March 2011.

1.5 On 17 March 2011, David Jones, Independent Chair of Leicester Safeguarding Children Board decided to hold a Serious Case Review in respect of these two children, following a recommendation from a meeting of the Serious Case Review Sub-Group held on 1 March 2011. This was agreed at a full Board meeting on 17 March 2011. Criteria for holding a Serious Case Review are outlined in the statutory guidance for agencies entitled Working Together to Safeguard Children (2010). The guidance stipulates (Chapter 8, paragraph 8.9) that where a child dies and abuse or neglect is known or suspected to be a factor in the death, a Local Safeguarding Children Board should always conduct a Serious Case

Review into the involvement of organisations and professionals into the lives of the children and the family.

1.6 In this instance, the family were known to many local agencies and both of these children had been subject to child protection plans in the past and were still being supported by agencies under a family support plan at the time of their deaths. Although the cause of death is not currently ascertained, it was known that domestic abuse and harassment was a feature within this family and the Independent Chair of the LSCB concluded that a Serious Case Review should be undertaken so that any learning from these tragic circumstances could be quickly identified and acted upon.

1.7 Paragraph 8.5 of Working Together to Safeguard Children (2010) outlines the purposes of a Serious Case Review which are 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
- Improve intra- and inter-agency working and better safeguard and promote the welfare of children.

1.8 Serious Case Reviews are not inquiries into how a child died or was seriously harmed, or into who is culpable. These are matters for Coroners and criminal courts. Panels undertaking Serious Case Reviews are expected to liaise with Coroners and police.

1.9 On 13th April 2011, the Home Office put into place statutory Domestic Homicide Reviews and although the deaths of these children and their mother occurred prior to this coming into force, the Serious Case Review will also give consideration to the requirements of that guidance in completing this review.

1.10 Once the decision had been taken to conduct a Serious Case Review, local agencies were required to locate and secure their case files and agencies were asked to compile a chronology of agency involvement with the children and/or their parents. This was later extended to include an older half-sibling of the children and the father of this child, previously married to the mother. Written permission was sought from the father for their inclusion. At the time of the deaths of the subject

children, the older half-sibling resided with his birth father under a Residence Order. This child had lived with both parents then the mother in the early years of life and had also been subject to a child protection plan for a period, as a result of injuries caused by his mother. The Panel undertaking the Serious Case Review therefore sought permission for information about this child to be included in the review, to aid learning about involvement with the family over a period of time.

1.11 The two children who are subjects of this Serious Case Review will be known in this Report as Subject Child 1(older child) and Subject Child 2 (younger child). The oldest child who was not resident in their household at the time of the deaths of the subject children will be known as the half-sibling. The father of the older half-sibling will be known as Birth Father 1 and the father of the two subject children will be known as Birth Father 2. This is to ensure that confidentiality is maintained for the subjects of the Serious Case Review and other relatives. This published Serious Case Review only contains information pertaining to the half-sibling that is directly relevant to the two subject children. All other information has been redacted in order to preserve confidentiality.

2. Terms of Reference for the Serious Case Review

2.1 Once the decision had been taken to conduct a Serious Case Review, the Serious Case Review Sub-Group of Leicester Safeguarding Children Board drew up Terms of Reference for all agencies to address in their review of the case. These terms of Reference were considered by the Serious Case Review Panel in their first two meetings and amendments were proposed where further information had become available. Final Terms of Reference were available to authors of agency Individual Management Reviews at their briefing session held on 13 May 2011.

2.2 The Terms of Reference for this Serious Case Review are as follows:

1. What concerns did your agency have about the care of the children and how well were these concerns recorded, expressed and reviewed?

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) How often were the children's views and feelings obtained? How were the children's views and feelings obtained? 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 Domestic Violence:

   a) Provide detail on any instances where it was reported to your agency/organisation
   b) Provide detail on the occasions it recognised as an issue by your agency/organisation
   c) To what extent was your agency's assessment of Domestic Violence "fit for purpose"?
   d) Provide detail on the extent to which that assessment accurately identified needs and risks
   e) Provide detail on your agency's response to those needs and risks

f) Did your agency's assessment trigger a review of risk?
g) Provide detail on whether a referral to MARAC was considered by your agency?

4. Provide detail on the consideration by your agency/organisation to re-assess the risk as a consequence of the range of contacts between the parents (following their reported separation)

5. 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) Provide detail on the needs and risks that were identified and detail whether these were reviewed and managed properly
c) 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.
d) What evidence was there to conclude that a child protection plan was no longer required for the children on the occasion where a plan ceased? Was this decision correct?

6. In relation to Father's immigration status:

a) What did your agency/organisation know about the immigration status of Father? From what source(s) had this knowledge been gained?
b) To what extent did your agency/organisation knowledge about the immigration status of Father impact on your:
    I. Risk Assessment?
    II. Decision Making?
    III. Information Sharing?
c) Provide detail on the extent to which Father's immigration status was managed in accordance with the law and established procedures?

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

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

9. 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?

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

11. To what extent was the exchange of information appropriate, sufficient and effective:
    a) within your agency/organisation?
    b) Between your agency/organisation and other partner agencies/organisations?

12. To what extent was the standard of recording appropriate, sufficient and effective:
    a) within your agency/organisation
    b) between your agency/organisation and other partner agencies/organisations?

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

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

3. Process of the Serious Case Review

3.1 An Independent Chair and Independent Overview Author were appointed by Leicester Safeguarding Children Board in April 2011 to work with the Panel in conducting the review.

3.2 The Serious Case Review sub-group met on 5 April 2011 to scope the review and determined the timeline as from around the birth of the half-sibling in 2003 until the deaths of the children in 2011. Additional information was to be included in Individual Management Reviews (IMRs) as deemed relevant and appropriate by agencies.

3.3 A briefing session for the identified authors of Individual Management Reviews was held on 13 May 2011 and this was chaired by the Independent Chair of the SCR Review Panel. The independent author also attended. Initial IMRs were requested to be submitted by 13 June 2011.

3.4 The following outlines the process and relevant dates for this SCR:

14.2.2011	The LSCB was notified of the deaths of the subject children and their mother and father.
14.2.2011	Letter to agencies to secure records and to request chronologies. Agencies were asked to identify potential IMR authors.
15.2.2011	Ofsted and the Department for Education were notified.
1.3.2011	SCR Sub Group considered a Serious Incident Report and recommended to the Chair of the LSCB that a Serious Case Review was appropriate.
17.3.2011	Chair of the LSCB and Board decided to conduct a Serious Case Review and notified Ofsted and Department for Education.
13.5.2011	Briefing session for IMR authors.
23.5.2011	Further family members added to scope of review after consent
6.9.2011	Consideration of Overview Report by Serious Case Review Sub-Committee
9.9.2011	Acceptance of the Overview Report and Action Plan by LSCB Independent Chair
16.9.2011	Consideration of Overview Report by Executive Group of LSCB

3.5 The SCR Panel met on 7 occasions and membership was as follows:

Independent Chair – Chris Nerini, Head of Safeguarding for Leicestershire County Council

Detective Chief Inspector, Leicestershire Constabulary

Director, Safer and Stronger Communities, Leicester City Council

Head of Service, Children's Social Care and Safeguarding, Leicester City Council

Head of Service, Early Prevention, Leicester City Council

Associate Director of Quality, NHS Leicester City

Director of Performance and Business Development, Leicestershire and Rutland Probation Trust

Assistant Director, UK Border Agency

Head of Safeguarding, Action for Children

LSCB Manager

A City Council Legal Services representative was invited to meetings but gave apologies.

The Health Overview Author attended some panel meetings, as did the LSCB Policy Officer.

The Independent Author, Anne Binney, attended all Panel Meetings except for the initial meeting on 5 April 2011.

3.6 Dates of the SCR Panel Meetings were as follows:

5 April 2011, 15 April 2011, 22 June 2011, 6 July 2011, 13 July 2011, 24 August and 31 August 2011.

3.7 On 5 April 2011, the Panel invited the police officer responsible for liaison with the Coroner to provide a confidential briefing on inquiries post-deaths.

3.8 On 24 August 2011, the Panel invited an experienced practitioner in the field of domestic violence services to inform discussions on this aspect of the SCR.

3.9 The LSCB produced a helpful role definition paper outlining expectations for members of the SCR Panel. In addition, all panel members and the overview author signed a confidentiality agreement. All panel members formally

confirmed their independence of the case and any line management. The arrangement of commissioning an independent chair from a neighbouring local authority was seen by this author as extremely helpful as this person had knowledge and understanding of local issues and agencies, but was completely independent of the case and agencies involved. The composition of the SCR Panel was also deemed by this author as comprehensive and appropriate for this particular SCR. The involvement of the LSCB Policy Officer was of benefit in enabling panel members and IMR authors to be signposted to relevant local research and guidance.

3.10 The SCR Panel also considered and agreed a Communication Plan for this SCR.

3.11 The Serious Case Review Sub-Group received the draft Overview Report, the Action Plan and Executive Summary at its meeting on 6 September 2011.

3.12 The Executive Group of the Leicester Safeguarding Children Board received the draft Overview Report, the Action Plan and Executive Summary at its meeting on 16 September 2011.

3.13 The Independent Chair of Leicester Safeguarding Children Board received the reports on 6 September 2011. Reports were presented to the full Board at the meeting on14 October 2011.

3.14 Submission of the Serious Case Review was made to Ofsted and the Department for Education on 16 September 2011.

4. Contributors to the Serious Case Review

4.1 All Individual Management Review (IMR) authors were confirmed as independent of the case, as were their senior officers who signed off the IMR and accepted the recommendations and accountability to ensure that they were implemented.

4.2 The following lists the agency contributions, dates of submission of IMRs and methodology of review. Eleven IMRs were submitted, accompanied by chronologies. Two information reports in the form of brief chronologies were also received and one brief information report. In addition, the Health Overview Report was submitted following receipt of IMRs from health agencies and provided a comprehensive review and analysis which was considered by the SCR Panel at its meeting on 13 July 2011.

4.2.1 **UK Border Agency**

Date of Initial Submission: 13.6.2011

Date of Final Submission: 30.8.2011

Method of Review: Case files and databases. No interviews

4.2.2 **Leicestershire and Rutland Probation Trust**

Date of Initial Submission: 13.6.2011

Date of Final Submission: 7.7.2011

Method of Review: Case records, policy documents, training records, two staff interviews, 3 discussion meetings, 3 telephone discussion and 5 meetings with Director.

4.2.3 **Leicester City Council Housing Services**

Date of Initial Submission: 13.6.2011

Date of Final Submission: 29.6.2011

Method of Review: case records and policy documents, 5 interviews with staff, one telephone call and one email correspondence.

4.2.4 **University Hospitals of Leicester**

Date of Initial Submission: 13.6.2011

Date of Final Submission: 22.7.2011

Method of Review: Case records, one meeting, one telephone call and one telephone interview. Post natal birth records for 2008 were unable to be located.

4.2.5 **Leicester City Council, Children's Social Care Department**

Date of Initial Submission: 17.6.2011

Date of Final Submission: 31.8.2011

Method of Review: Case records, policy and research documents and 5 staff interviews.

4.2.6 **Leicestershire Partnership NHS Trust (health visiting)**

Date of Initial Submission: 14.6.2011

Date of Final Submission: 30.6.2011

Method of Review: Case records, policy and research documents, one interview with staff and four meetings with specialist staff.

4.2.7 **Leicestershire Partnership NHS Trust (GP and Community Paediatrician involvement)**

Date of Initial Submission: 14.6.2011

Date of Final Submission: 26.8.2011

Method of Review: GP records for all family members, LCCHS records for half-sibling, seven meetings with staff, 6 telephone calls, 6 emails, one letter. Further meetings were planned after the initial submission.

4.2.8 **Action for Children (Children's Centre)**

Date of initial Submission: 20.6.2011

Date of Final Submission: 21.7.2011

Method of Review: family case file, procedural documents, 4 staff interviews and one telephone call.

4.2.9 **Leicester City Council, Access, Inclusion and Participation**

Date of Initial Submission: 13.6.2011

Date of Final Submission: 11.8.2011

Method of Review: Case files, case notes, Pre-School register, 7 staff interviews and one telephone call.

4.2.10 **Education Service, Leicester City Council**

Date of Initial Submission: 16.6.2011

Date of Final Submission: 22.8.2011

Method of Review: Pupil databases, school files, pupil attendance register, 3 meetings and one telephone call.

4.2.11 **Leicestershire Constabulary**

Date of Initial Submission: 1.7.2011

Date of Final Submission: 22.7.2011

Method of Review: 5 meetings, 3 telephone conversations and 2 emails. Because of the IPCC investigation, accounts from officers involved were not sought directly.

4.2.12 Information reports in the form of chronologies were received from:

East Midlands Ambulance Service

CAFCASS

4.2.13 NHS Direct provided a brief report of their involvement accompanied by a chronology.

4.2.14 A Nil return was received from Leicestershire Partnership NHS Trust - Assist, received on 3 May 2011.

4.2.15 **Health Overview Report**

Date of Initial Submission: 8.7.2011

Date of Final Submission: 1.9.2011

Method of Review: Review of the three health IMRs and consultations with each of the IMR authors.

4.2.16 Quality and timeliness of IMRs was robustly reviewed by the SCR Panel. Each IMR author was invited to discuss their report and findings individually with the Panel. Some authors attended on 22 June 2011 and others on 6 and 13 July 2011. This provided a good opportunity for dialogue and clarification where required. Amendments and additions were sought by the Panel where required. This process assisted also in involving managers in the process and embedding learning. The Panel was mindful of the biennial overview report of SCRs published in 2010 (Brandon et al) which noted the lack of involvement and support for practitioners and managers involved in

Serious Case Reviews and the Panel wished to enhance participation without detracting from robust review.

Direct correspondence occurred with the one author who was unable to attend the panel because of annual leave and other work commitments.

While initial IMR submissions were made in good time, this was not the case for some of the subsequent submissions and the SCR panel appropriately chased some agencies for final versions and their Action Plans.

5. Other investigation and reviews

5.1 The Independent Police Complaints Commission is undertaking a review of police involvement with the family. The purpose of that review differs from that of the Serious Case Review which focuses on learning lessons.

5.2 The Coroner opened and adjourned an inquest into the deaths of the two subject children and of both parents and on 2 March 2011. This was to allow further investigation into the causes of death and circumstances surrounding them.

5.3 While police and Coroner enquiries were ongoing, this initially limited the planned family contact for the SCR Process. However, the Serious Case Review Sub-Group liaised with the Coroner and police to ensure that both processes could proceed without adverse effect. Leicester Safeguarding Children Board formed in September 2009, having previously been part of the Leicestershire, Rutland and Leicester Safeguarding Children Board. It was therefore important to establish these local processes for the relatively new Board which was carrying out its first Serious Case Review.

5.4 Information was shared with H.M. Coroner, Leicester City and South Leicestershire, about the Serious Case Review and on 29 June 2011 the Coroner indicated there was no objection to family members being contacted as part of the Serious Case Review.

5.5 The Leicestershire and Rutland Probation Trust submitted a report for a Serious Further Offence Review. This was graded as “good” by the National Offender Management Service.

6. About the Author and Independent SCR Panel Chair

6.1 Anne Binney, Independent Social Work Consultant, was commissioned on 12 April 2011 by Leicester Safeguarding Children Board to write the overview report into the deaths of the two subject children.

6.2 Anne 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 her full time post in April 2010 as Assistant Director responsible for children's social care services within a county council. In addition to her social work qualification, she holds an Advanced Certificate in Child Protection Studies and has previously chaired an ACPC and LSCB. Since retirement from full time work Anne has chaired SCRs and written overview reports as well as carrying out a review of front line social care services. The author holds a Diploma in Management Studies and a Masters Degree in Manager and Organisation Development.

6.3 Chris Nerini, Independent SCR Panel Chair, is employed as Head of Safeguarding at Leicestershire County Council. There was agreement by her employer to Chris being provided with time to chair this SCR, noting the benefit of a potential reciprocal arrangement.

6.4 Chris has 30 years' experience of working in the children's social care sector. She holds an MA in Social Work and an MBA. Chris has held senior management roles in a number of East Midland Authorities mainly focusing on child protection services and has previous experience of chairing serious case reviews, panel arrangements and LSCB sub groups.

7. Family Involvement

7.1 As noted in paragraph 5.3 above, the ongoing investigations of police and the Coroner initially delayed direct contact with family members as part of this SCR. Police had been in contact with family members as part of their enquiries. Liaison with police and the Coroner resulted in agreement that direct contact could be made. In April 2011, the Home Office published a guide to carrying out SCRs where there are concurrent criminal investigations. This is a helpful addition to current guidance clarifying the distinct but complementary processes.

7.2 On 23 May 2011, the LSCB Manager visited Birth Father 1 and gained his written permission for inclusion of his records for the identified timescale and those of his child, the half-sibling.

7.3 In July 2011, letters were sent to the maternal grandmother, a cousin of Birth Father 2 and to the former foster carers of Mother as they were believed to have had an ongoing relationship with her. The letters provided them with information about the Serious Case Review process and invited them to share comments about the support they perceived to have been provided to the family. There was no response received from any of these individuals. It was discovered that the address held for the former foster carers was not their current address but unfortunately attempts to identify the new address were unsuccessful.

7.4 The SCR Panel had hoped to write also to the paternal grandparents but it was not possible to make contact with them within the time constraints of this Serious Case Review.

7.5 Letters were sent to the maternal grandfather and to Birth Father 1 providing information about the Serious Case Review but also requesting a direct meeting, if they were willing.

7.6 In July 2011, the Independent Chair of the SCR Panel and the Overview Author visited Birth Father 1 by prior arrangement. However, he indicated that he did not want a discussion as his son was present and he did not wish for him to be reminded of events. A letter was sent the following day to acknowledge that he may not wish to have a direct conversation but offering to meet on a different date and venue without his son present, if he would prefer that. The option of a meeting to feed back the findings of the SCR was also offered. It had been the intention to consider a request to meet with the half-sibling but clearly his father's views would preclude that. It was confirmed that a local health visitor had been supporting the half-sibling and he was said to be "doing well".

7.7 A Panel Member and the Overview Author also arranged to visit the maternal grandfather in the north of England. This meeting took place at his home in August 2011. The maternal grandfather found out about the deaths of his two grandchildren and his daughter via a T.V. news bulletin. He was still extremely shocked by events, made more difficult as he had had to move home because of media intrusion. In addition, he had had to cancel the arranged funeral for his daughter and two grandchildren because of differing views in the extended family which are as yet unresolved.

The maternal grandfather stated that contact with his children had not been easy when he separated from his wife when Mother was about 7 years old and although he had made efforts to maintain it, obstacles were put in his way. Mother also has two full siblings, one older and one younger. Contact resumed with Mother when she was in care from the age of 13 and he made regular visits to the foster home and Mother to his home, supported by the social worker. The maternal grandfather states that Mother was a quiet, thoughtful person who never missed birthdays or Christmas and she included his children from a subsequent relationship in this. He described her as "*wanting to be loved, wanted affection".* She saw her full siblings when she was "*out and about*".

At the age of 17 Mother wanted to live with Birth Father 1 but her father advised against it. The maternal grandfather stated she became a Muslim to facilitate it and she was married in Leicester. Two weeks before the half-sibling was born in 2003, the maternal grandfather received a telephone call from Birth Father 1 to say that Mother was now in a Muslim family and did not want further contact with him. The maternal grandfather has never met his first grandson. He began to have contact again with Mother when she was divorced and when the half-sibling moved to the care of his father.

Contact increased when Mother set up home with Birth Father 2 whom the maternal grandfather met on about 5 or 6 occasions. Birth Father 2 was welcoming and invited the maternal grandfather to stay but he said he felt his daughter was "*treated like wallpaper, she couldn't speak and had to get drinks and meals".* The maternal grandfather stated that his daughter was not attending Mosques and not adhering to a Muslim diet. He was very shocked at the deaths of the children as he had seen Birth Father 2 as close to them and certainly had not imagined he would harm them. The maternal grandfather described how Birth Father 2 would collect Subject Child 2 from the bedroom if she was crying but also described Birth Father 2 as always having crazy ideas and "*bouncing off the walls".* The maternal grandfather commented on Birth Father 2's strong attachment to his home country which he talked about a great deal.

In 2010 the maternal grandfather was advised by his daughter that she was being beaten by Birth Father 2 and the maternal grandfather was aware that there were escalating concerns. He believed the response was for Mother to become even more protective of the two children and stated she was happy being a mother. The maternal grandfather did not believe she was experiencing any difficulties with the two children although he knew she was on tranquilisers. They kept in touch by telephone, Facebook and meetings in Leicester and his home area. He did not see Birth Father 2 after they had separated but was aware there was ongoing contact as he believed Birth Father 2 was forcing his way into the property. In about November/December 2010 he saw his daughter with bruising to her face and was aware that Birth Father 2 visited with a toy helicopter for Subject Child 1 at Christmas 2010. The maternal grandfather did not believe that Mother wanted these contacts and had advised her to move away. He believed she was pursuing a tenancy near him and he had helped her make an application. She had been left with debts when Birth Father 2 left and the maternal grandfather assisted where he could, working with her to get a payment plan with housing for example.

The maternal grandfather did not believe that Mother got sufficient help to ensure Birth Father 2 stayed away. He stated Mother had no confidence in police or social workers and took his advice to get her own solicitor. He strongly believed she would put the children first. The maternal grandfather had tried to contact social workers in 2009 and 2010 but was advised that there could be no discussion because of confidentiality.

The maternal grandfather had seen some meeting notes so was aware of some of the domestic violence incidents that had occurred. He believed these were sufficient to set alarm bells ringing and that people should be accountable for not intervening. He considers that Birth Father 2 was treated with kid gloves because of his race and that Birth Father 2 should have been arrested and removed from the country. The maternal grandfather does not think the couple reunited as some neighbours have suggested in the media and instead suggested cash payments may be encouraging speculation.

It was extremely difficult for the maternal grandfather to go over this ground, but he is keen that lessons are learnt to prevent anything similar happening. He stated he would welcome feedback from the SCR process and it was agreed that he would be contacted again prior to publication.

8. Family Composition

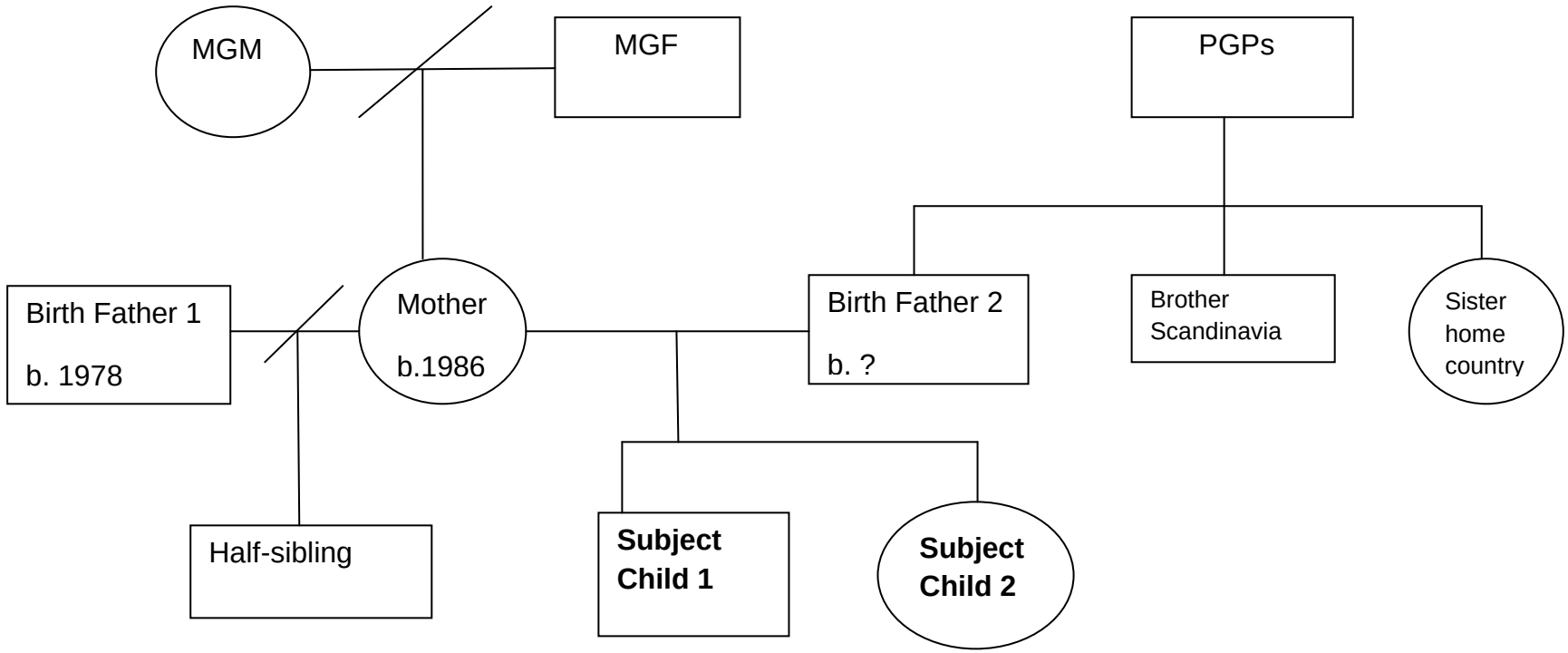
Identification Key

Ages given, where known, are those at the time of death of the subject children.

Descriptor	**Relationship to subject children**	**Age**	**Male or Female**
Subject Child		**3**	**Male**
Subject Child		**2**	**Female**
Mother	Mother	24	Female
Birth Father 2	Father	Not known – different dates of birth provided	Male
Half-sibling	Half-sibling	7	
Birth Father 1	None	32	Male
Maternal grandmother	Maternal Grandmother	Not known	Female
Maternal Grandfather	Maternal Grandfather	Not known	Male
Paternal Grandfather	Paternal Grandfather	Not known	Male
Paternal Grandmother	Paternal Grandmother	Not known	Female
Brother of Birth Father 2	Uncle	Not known	Male
Sister of Birth Father 2	Aunt	Not known	Female
Cousin of Birth Father 2	2nd cousin	Not known	Male

9. Genogram

N.B. Mother had 2 full siblings and 10 half-siblings with whom she had little contact



10. The Subject Children

10.1 Pen picture of Subject Child 1:

This little boy was described as lively and vocal, a “lovely little boy” who liked Thomas the Tank engine, climbing and was adventurous. His physical appearance was in keeping with his dual heritage and he celebrated significant Islamic festivals with his family. He was always noted by pre-school staff to be clean and tidy. Subject Child 1 attended a wide range of pre-school provision from “Stay and Play” sessions with his mother, to playgroup, pre-school and a crèche when mother attended a Freedom Programme for survivors of domestic violence. A number of agencies noted an appropriate warm attachment between the child and his mother. Warm attachments were also noted with Birth Father 2 on the few occasions they were seen together by professionals. The child was named after the village in which one of birth father’s parents was born. Subject Child 1 was meeting appropriate milestones. The home environment was clean and there was a range of toys. He had some reported problems in sharing toys, and could have temper tantrums, neither of which was unusual for his age. Some tension was noted between him and his mother around toilet training which was difficult for him, potentially related to a health issue. Mother sought help for this and with feeding and behavioural issues.

Prior to his birth there was a noted potential kidney problem which was followed up following birth. Although there were a number of appointments missed at the specialist clinic, surgery did take place to alleviate the problem. Prior to this, the child had suffered some recurring urinary tract infections and there was health concern about weight loss.

The child was taken to hospital by the parents aged 3 months for a check up when they reported that the child had been pulled from a chair by the older half-sibling. There was no injury noted on that occasion.

The child was subsequently taken to hospital by parents on the advice of the GP in March 2009 when a spiral fracture had been sustained, reportedly caused by a leg having become stuck while playing on a slide. The explanation was accepted as reasonable. In May 2009 the GP referred Subject Child 1 to hospital as a result of recurrent infections and weight loss. He was found to be anaemic.

The child was taken again to hospital by his parents in March 2010 when complaining of problems weight bearing on his left leg after another incident on a slide. After observation, the child was discharged home with no injury apparent.

10.2 Pen picture of Subject Child 2:

This little girl was described by a range of agencies as “always smiling” and a gentle, tactile little girl, interested in people who visited her home. Her physical appearance again reflected her dual heritage, although she had her mother’s hair colouring. Like her brother, she celebrated major Islamic festivals with her family. Subject Child 2 also attended a range of pre-school provision including playgroup and “Stay and Play” with her mother. This little girl also attended a crèche along with her brother when mother attended a Freedom Programme for survivors of domestic violence. When she first attended playgroup, she had difficulty mixing with other children, but this soon abated. She carried a comfort blanket if she was upset but soon forgot it when involved in activities. She particularly liked singing “Twinkle, twinkle, little star”. She was also named after a village in which the other paternal grandparent was born.

Both parents were seen by a range of agencies to respond warmly and with care to Subject Child 2. This little girl was meeting appropriate milestones. She was late in receiving her immunisations with a number of missed appointments and there were also missed appointments with the G.P. and eye clinic. When she did attend she was diagnosed with a possible squint and a degree of long-sightedness. The child was reported by a range of agencies to be clean and appropriately dressed but did not often wear her prescribed glasses. There were toys available to her in her home.

11. About the Family

11.1 Birth Father 2

11.1.1 Birth Father 2's country of origin was in the Middle East. He was Asian (Other) by ethnicity and of Islamic faith

11.1.2 Birth Father 2 initially sought asylum in the UK in April 2005 although it became known that he had previously sought asylum in a third country. His application in the U.K. failed and it was intended that he would be returned to the third country. He absconded twice from accommodation provided for asylum seekers which prevented his removal to a third country and in May 2006, he applied for asylum under a different name and with a different history. The UK Border Agency recognised this as a multiple application but he continued to use both names at various times in the U.K. The timescale for return to the third country ran out and he was provided with asylum accommodation support in Leicester in May 2006. His asylum application was rejected in December 2008, but he was granted 3 years' discretionary leave to remain on the basis that he had family ties in the U.K. with a partner and children. There was then no further requirement to report to the UK Border Agency.

11.1.3 Birth Father 2 had some contact with a cousin who resided in the UK and kept in contact with his parents and sister who remained in his country of origin. He is believed to have had a brother who lived and worked in Scandinavia but it is not known how much contact there was. He reported that his parents were unhappy that he had formed a relationship outside of his culture but his partner, the mother of the children, reported that she received text messages from his mother and partner when there were problems with his contact with his children in 2010. It is believed that he and the mother of the children were married but this was not confirmed. No agency knew whether he held parental responsibility for the two subject children.

11.1.4 Birth Father 2 reported to his G.P. that he had problems with anger management. He later referred to a difficult period in his home country when he was in the army. He had previously wanted to become a doctor or teacher. He also described guilty feelings about a road traffic accident in which he had been involved in that country. A professional in the G.P. practice provided leaflets about post traumatic stress but it is not believed that this was formally diagnosed. The G.P. also suggested an anger management course and advised contact with Assist, a health organisation set up to support individuals seeking asylum. Birth father 2 had no recollection of attending an anger management course and Assist provided a Nil return for this SCR. There are reports of Birth Father 2 working as a car mechanic in the U.K. but he was also recorded as owning a tyre company, working in a

factory and as a butcher. While there were times when he was uncooperative with social care services, Birth Father 2 was initially described as a pleasant and polite young man when professionals visited the home. He was present at the births of his children and also attended some medical appointments with them. The maternal grandfather noted that Birth Father 2 actively responded to the children's needs.

11.2 Mother

11.2.1 Mother moved to Leicester to join Birth Father 1 when she was aged 17. She married Birth Father 1 and gave birth to her first child the following year. She was initially from the North East of England and was in foster care from the age of 14 and later supported in that authority as a care leaver. Information was obtained from that local authority to assist in providing background to this Serious Case Review. Mother was a member of a large family. Her parents separated when she was aged 7 and she has two full siblings. Her mother formed a new relationship and a further seven children were born who are half-siblings to Mother. Her father also formed a new relationship and three children were born who are also half-siblings to Mother.

11.2.2 Mother made allegations that she was sexually abused by her step-father which were investigated in 2000 but were not substantiated. She claimed she was in fact the mother of the youngest child in the family at that time, not the half-sibling, but no evidence was found to support this. In that year there was an incident in which Mother said that maternal grandmother had threatened her with a knife and tried to force her to take aspirin in order to induce an overdose. Maternal grandmother gave a different account, stating she was holding a knife and threw the aspirin on the bed, suggesting Mother should take them if she was so unhappy. This occurred after Mother had told people in the local community that she was being abused at home. A Section 47 (child protection) investigation involving police and social care ensued and Mother remained in foster care (Section 20, Children Act 1989) although no charges were brought. Mother ran away from home in August 2000 after the incident described above and went to the address of a person posing a risk to children (at that stage known as a Schedule 1 Offender). She acknowledged visiting this address previously. Mother subsequently retracted her allegations of sexual abuse by her step-father, stating it was his friend who had abused her.

11.2.3 When first in foster care, Mother was a reported heavy user of solvents and was found unconscious on one occasion. She moved foster homes as the initial carers were unable to manage this. Mother then appeared to thrive in her new placement where she received a great deal of support and encouragement. Her good relationship with these carers continued until her death. She moved schools where improvement was noted, settled down and

obtained a part time job. At some point it became known that she had an older boyfriend and this was mentioned in her looked after children reviews. It is believed they met at College. It is not known how old she was when she began seeing this person who was described as 23 years old. It is assumed that this was Birth Father 1 as shortly afterwards, just after her 17th birthday, Mother moved to Leicester to join him and gave birth later that year to her first child.

11.2.4 Reports in Leicester refer to Mother's history of "neglect" although it is clear from the social care Individual Management Review that detailed information was collected on Mother's background for the initial child protection conference in relation to the half-sibling. This was not subsequently referred to in assessments. Prior to the incident in 2000 when Mother was living with her mother and step-father, there was no recorded concern about her family. Subsequently, and following Mother's move to foster care, there were referrals about potential neglect and on one occasion in 2006 an unannounced visit found very unhygienic home conditions with 27 dogs in evidence and dog excrement on the youngest child (aged 5). A further referral in 2007 suggested the home was "filthy" but this was not found to be the case on a home visit.

11.3 Birth Father 1

11.3.1 Birth Father 1 is also Asian by ethnicity and of Islamic faith, although from a different country of origin to Birth Father 2. He claimed asylum in this country in 2001 and was granted 4 years' Exceptional Leave to Remain on the basis that it was unsafe to return to his home country. He was later granted Indefinite Leave to Remain and became a naturalised British citizen. He and Mother separated in 2005 and later divorced. He obtained a Residence Order to care for his child, the half-sibling, in 2008.

11.4 The social context of this family is that they resided in Leicester which has one of the most ethnically diverse populations in the U.K., outside of London. It is the 20th most deprived area in the U.K. and the area in which the two subject children were living was noted as having poor outcomes for children in educational terms and where there was high level of teenage pregnancy, obesity, smoking and alcohol usage. The residents of the area were 97% White British. There was limited access to Mosques and cultural support which is one reason Mother gave for wishing to move.

12. The facts of this case – significant events between 2003 and 2011 as related to the timescale defined for this SCR.

12.1 The following extracts from the Integrated Chronology are the Independent Overview Author`s view of the significant events which relate to this Serious Case Review. The extracts have been divided into separate time periods of 2003 – 2005, 2006 - 2007 and 2008 - 2011.

12.2 **2003 – 2005:**

12.3 In 2003 Mother, aged 17, moved to Leicester to join Birth Father 1 whom she had met while in care to another local authority. She was in receipt of leaving care services from that local authority. Birth Father 1 had previously claimed asylum in 2001. He was initially given 4 years exceptional leave to remain because his home country was deemed unsafe for him to return.

12.4 Mother and Birth Father 1 made a joint housing application in 2003 and in that year the half-sibling was born. Mother was appropriately referred to the Teenage Pregnancy Team for additional support.

12.5 Mother attended all ante-natal appointments and was treated for anaemia in pregnancy. The birth was an emergency caesarean section following which Mother required a blood transfusion.

12.6 Appropriate community midwifery and health visitor visits took place and there was seen to be good initial progress with the child's immunisations being given on time. Mother's vulnerability as a result of her history was recognised by the health visiting service and she was offered increased support.

12.7 Early in 2004, Mother was reporting lack of support from Birth Father 1 and was tearful and low in mood. Verbal arguments were reported by Mother. The family had moved into a new home and mother was reported as isolated. The GP informed Health Visitor 1 of Mother's post-natal depression and prescribed anti-depressants.

12.8 On 6.12.04 Mother failed to attend an appointment with the practice therapist. (It is not clear from the chronology who had made this referral).

12.9 In April 2005, Birth Father 2 claimed asylum in the U.K. This was refused the following month as it was determined that he had already claimed asylum in a third country.

12.10 In June 2005, mother took up a housing tenancy. Birth Father 1 could not be named on the tenancy as he was claiming asylum.

12.11 In June 2005 Health Visitor 2 made an unannounced visit. Mother told her of her earlier depression but stated she was feeling better. She announced her separation from her husband.

12.12 In September 2005, Birth Father 1 applied for indefinite leave to remain in this country.

12.13 **In conclusion, for the period 2003 - 2005:**

This period saw Mother as a teenager in a new relationship in a new area with her first child born and tenancy of a flat obtained. Her partner was from a different culture. She suffered from post natal depression and complained of lack of support from her partner, later separating. Police were called three times to domestic violence incidents but no criminal charges ensured as they were deemed verbal arguments. Police referred to social care after the third such incident. While Mother was provided with support in recognition that she was vulnerable, there is no indication of a full assessment which would take account of the impact of her earlier experiences on her capacity to parent. However, there were no reported concerns about the child and Mother was seen to engage well with agencies.

12.14 **2006 – 2007:**

12.15 In early 2006, Birth Father 2 made a second application for asylum in this country using a different name and different details. This was recognised as a second application and he was to be removed to the third country where asylum had initially been sought.

12.16 In January 2006, the half-sibling was noted by the childminder to have sustained injuries and he was placed in foster care under Section 20, Children Act 1989 while a child protection investigation (S. 47) took place. A full skeletal survey was sought on 14.1.06.

12.17 In January 2006, Mother consulted the midwife as she was pregnant. On 19.1.06 she consulted her G.P. and spoke of depression. Her husband had left in November 2005 and she was not sleeping. Health Visitor 3 liaised with the G.P. who advised he had prescribed anti-depressants for Mother and referred for counselling. The G.P. advised “no concerns re the child since registering in June 2005”.

12.18 On 26.1.06 Children’s Social Care were chasing up the skeletal survey which had not been carried out.

12.19 On 31.1.06 the half-sibling’s name was placed on the Child Protection Register under the category of physical abuse. He was to remain in foster care under Section 20 of the 1989 Children Act while assessments were

undertaken. The plan was for parents to undergo parenting assessments and Mother to undergo psychological assessment.

12.20 In February 2006, Birth Father 2 failed to arrive at accommodation provided by the asylum service. He was twice treated as an absconder.

12.21 Mother requested a termination of pregnancy on the grounds that her child was in care and she could not cope. This was carried out in March 2006.

12.22 In March 2006 Mother's parenting assessment commenced.

12.23 In April 2006, Birth Father 2 was planning a voluntary return to his country of origin which was agreed by the UK Border Agency.

12.24 At the Review Child Protection Conference on 19.4.06, the child's name was to remain on the Child Protection Register. Police and social care services again chased up the skeletal survey which had not been carried out.

12.25 On 28.4.06, Mother failed to attend for the second time an appointment with the practice therapist.

12.26 In May 2006, Birth Father 2 was placed in accommodation for asylum claimants in Leicester. It was no longer possible for him to be returned to the third country where he had initially claimed asylum as the time period had elapsed.

12.27 On 17.5.06 the Community Paediatrician requested the skeletal survey which was carried out on 23.5.06.

> *Author's comment: there is no explanation in the records as to why a skeletal survey sought in January 2006 was only carried out 4 months later.*

12.28 In May and June 2006, police and children's social care continue to try to contact the community paediatrician to obtain the results of the skeletal survey. There is no recorded response to either call. Information received showed no abnormality. Children's social care service complained about the poor liaison.

12.29 At a Core Group on 19.6.06, Mother was reported to be employing sound management strategies. Plans to return the child to mother's care were made. Nursery support was sought via a Family Support Worker attached to Sure Start.

12.30 At a home visit on 30.6.06, Health Visitor 3 notes that the half-sibling is now back at home and that Mother's new partner **of 4 months** appears to have a

good relationship with him. Birth Father 1 was said to be providing respite. Social care records show the child as returning home on 1.7.06.

12.31 On 5.7.06 police provide Birth Father 2 with a formal warning for possession of cannabis. This is under the original name he provided for his asylum claim. On 5.7.06 police are asked for a search of the Police National Computer in respect of Birth Father 2 under the second name. This revealed no concerns.

12.32 A Review Child Protection Conference on 14.7.06 decided that the half-sibling should remain on the Child Protection Register. Nursery support is set up.

12.33 The Probation Service becomes involved as Mother is charged with 4 counts of Actual Bodily Harm. She is sentenced to 34 weeks' custody, suspended for 24 months, with 24 months' supervision and a curfew of 17 weeks.

12.34 In August 2006, Senior Practitioner 1 (social care) reports that they have spoken to the new partner and there are "no concerns". Health Visitor 3 liaises frequently with the nursery and tries to make contact with the G.P. On 28.8.06 Mother informs Health Visitor 3 she is pregnant. Mother is advised to inform Senior Practitioner 1.

12.35 On 30.8.06 Mother attends a booking appointment with the midwife as she is pregnant. The midwife has no access to earlier records and no concerns are identified.

> *Author's comment: the midwife is reliant on Mother's self-reporting to identify any health or social problems.*

12.36 On 7.9.06 Senior Practitioner 1 advised the midwife of their involvement and records show that the Minutes of the last Child Protection Conference were sent.

12.37 Police were called by neighbours to Mother's address on 13.9.06 as there was a reported argument between Mother and her partner over money with a child present. No further action was taken as the noise was deemed potentially to be from a "loud T.V.".

12.38 On 14.9.06, Mother was noticed at nursery to have bruising to her eye which she reported as from a fight the previous day with her partner. The nursery informed children's social care who informed Health Visitor 3 of the incident on 21.9.06. Police had noted no injuries to Mother the previous evening and it is possible that any injury was sustained after they had left the premises.

12.39 Mother was attending weekly appointments with the probation service. She advised Offender Manager 1 that she was getting counselling via the G.P.

> *Author's comment: there is in fact no record of mother being in receipt of counselling. She had failed to attend previous appointments.*

12.40 On 22.9.06 Birth Father 2's application to return to his country of origin was withdrawn.

12.41 At a Core Group on 25.9.06 there was report of difficulty in contacting Mother and that the half-sibling had been upset at pre-school. Mother stated that she and her partner were "working through their issues" and that she would ask him to leave if there were further disputes in front of the child.

> *Author's comment: there is no mention in the chronology that mother's pregnancy was discussed at this Core Group. It would have been very relevant to her situation and the recent domestic violence incident.*

12.42 On 9.10.06, Health Visitor 3 phoned the G.P. to discuss the situation. The G.P. advised that Mother would need to self-refer to the practice therapist because of previous non-attendance.

12.43 On 13.11.06 a potential problem with the kidneys of the new baby (Subject Child 1) was identified pre-birth.

12.44 On 14.11.06 there was a 3 year developmental assessment on the half-sibling. He was described as "happy and sociable".

12.45 On 30.11.06, there is recorded liaison between Health Visitor 3 and the midwife. It is not recorded whether the midwife was made aware of the child protection plan for the older child or the domestic violence incident.

12.46 On 6.12.06 the half-sibling ceased to be subject to a child protection plan and this was replaced by a family support plan. All agencies were reported to be positive about progress.

> *Author`s comment: there is no reference to any assessment of Birth Father 2. It is noted that the GP did not receive the minutes of this Conference.*

12.47 On 9.1.07, a month later, Mother rang the family support worker to ask for help in managing the half-sibling's behaviour.

12.48 On 15.1.07 the half-sibling's behaviour was described by the nursery officer providing family support as disturbed. Mother requested foster care for him which was agreed.

12.49 Health Visitor 3 makes contact with Senior Practitioner 1 on 25.1.07 and the social worker expresses concerns about the relationship between Mother and Birth Father 2. Health Visitor 3 advises inviting the midwife to the planned family support meeting on 30.1.07.

12.50 Mother and Birth Father 2 attend the family support meeting on 30.1.07 although Birth Father 2 is unsettled and angry until an interpreter arrives who is able to help him express his concerns. Mother and Birth Father 2 agree that "cultural" and language issues impact on their relationship. They agree to work on their relationship and it was agreed that the half-sibling would remain in foster care at that time although by 6.2.07 a rehabilitation plan is developed, to be carried out near to the planned caesarean section for the birth of Subject Child 1. By 14.2.07, Senior Practitioner 1 records that Mother and Birth Father 2 have "sorted out" their communication issues.

12.51 Mother required two blood transfusions after giving birth to Subject Child 1. Birth father 2 was present at the birth although this is not recorded on the chronology. The hospital was unaware of any child protection concerns but when a midwife overhears a conversation between Mother and Senior Practitioner 1 she realises that there is social work involvement with the family and liaison is set up. The hospital later complained about lack of liaison although there had been liaison between Senior Practitioner 1 and the community midwife in September 2006 and Health Visitor 3 and the community midwife in November 2006.

Author`s comment: the hospital did not have access to previous birth records for health matters and there had been no direct liaison with the hospital pre-birth even though a family support plan was in place and an older child had only recently been subject to a child protection plan and was again in foster care. The health visitor's suggestion that a midwife should be invited to the family support meeting does not appear to have happened. There is no explanation as to why a full pre-birth assessment had not been carried out in respect of this new baby, given the history.

12.52 Health Visitor 3 wrote and telephoned the GP expressing concerns about Mother in February 2007. Health Visitor 3 suggested a mental health assessment may prove beneficial but there is no further mention of this.

12.53 The half-sibling is returned to Mother's full time care just over a week following the birth of Subject Child 1. Social care services are said by Mother to be visiting daily.

12.54 Mother cancelled a planned home visit by Offender Manager 1 on 2.3.07 but failed to attend the office instead. This was the only missed appointment in 2 years and was just after the birth of Subject Child 1. .

12.55 In March 2007, Health Visitor 3 noted Mother to be "interacting warmly" with Subject Child 1 and that there were no reported difficulties with the half-sibling. Mother described Birth Father 2 as "very supportive".

12.56 Birth Father 2 attended the probation appointment with Mother on 7.3.07 and complained at the number of appointments they were expected to keep. Offender Manager 1, in supervision, is concerned at the potential controlling relationship of Birth Father 2 with Mother although this is not entered onto the risk assessment system.

12.57 Health Visitor 3 again liaises with the G.P. and again requests referral to the Practice Counsellor but says that Mother is not currently depressed.

12.58 In April 2007, Mother is considering asking Birth Father 1 to care for the half-sibling. She describes positive bonding with her new baby.

Author's comment: this is just over one month after the half-sibling was returned to mother's care. No report indicates any formal assessment of her attachment to that child.

12.59 In April 2007, Health Visitor 3 carries out an assessment for post natal depression (Edinburgh Post Natal Depression Score) and Mother scores 12. A score of 12 or above is meant to be referred to the G.P. but there is no record of this occurring. A home visit by Health Visitor 3 later that month found Mother to be still waiting to see the Practice Therapist.

12.60 Both parents attend a clinic appointment in April 2007 in respect of potential kidney problems for Subject Child 1. The child is to be seen by the Consultant but there is no attendance at the next appointment in May 2007.

12.61 On 1 May 2007, the half-sibling is taken to nursery by Birth Father 2 demanding that he is placed immediately in the care of Birth Father 1. This is said to be because of an incident in which the half-sibling pulled Subject Child 1 (aged 3 months) from his chair. They had taken Subject Child 1 to hospital but no injuries were found. Mother reported to Offender Manager 1 that she was "shocked" at the actions of Birth Father 2. She reported that he had threatened to throw Social Worker 1 through the window if she visited as he saw no reason for continued contact now that the half-sibling had moved.

12.62 Birth Father 1 was provided with support by agencies in caring for his son (nursery and child minder) and help in obtaining appropriate accommodation was provided. The half-sibling was said to settle well and Mother had weekly contact. The Family Support Meeting records of 24.5.07 focus on the care of the half-sibling and case closure is discussed.

> *Author's comment: this reflects the belief that the problems centred on Mother's relationship with the half-sibling. This is further confirmed when the planned Family Support Meeting for August is cancelled as there is seen to be good care provided by Birth Father 1. There is no apparent assessment of mother's need for support with her new child in a new relationship which has not been assessed in spite of the known history.*

12.63 In June 2007, Mother contacts the UK Border Agency in support of her partner. She sends a further 13 letters of this nature from this date until June 2008, plus telephone contact and contact on their behalf by a local M.P. Mother also discusses her concerns with Offender Manager 1 as she is worried at financial pressures and Birth Father 2's inability to work because of his status.

12.64 In July 2007 Mother sees the Practice Therapist and further appointments are planned which Mother fails to attend.

12.65 On 22.9.07 there was a second domestic violence incident between Birth Father 2 and Mother. Birth Father 2 was said to have punched and kicked Mother who called the police. Birth Father 2 said that he had reacted to the Mother shouting at the baby (Subject Child 1, aged 7 months). Both parents ran out of the house during the incident, leaving the baby alone. There was injury to Mother's neck and forehead. Birth Father 2 was arrested, remanded in custody and charged with battery. He was sentenced to a Conditional Discharge but the Probation Trust was not advised that the victim was Mother. This incident was assessed as medium risk by the police but no referral or

notification was made to children's social care or to the police Child Abuse Investigation Unit although the police did check with the UK Border agency but were advised that no removal could be made from this country while an application was pending.

12.66 On 28.9.07 Mother revealed that she was pregnant. She would again have been pregnant at the time of a domestic violence incident.

12.67 In October 2007, Birth Father 2 tells his G.P. of his concerns at "feeling angry all the time". He reports being frustrated at not being able to work. The G.P. records that the child is "safe" but there is no explanation for this judgment. In a second visit to the G.P. practice later that month Birth Father 2 reveals that he suffered trauma in his own country when serving in the Army and afterwards. He states his family are angry at his relationship. He had wanted to be a doctor or teacher prior to joining the army and he is feeling guilty about his involvement in a road traffic accident. He stated he felt very low and told of the domestic violence incident. A professional in the G.P. practice provided advice about Domestic Violence and Post-traumatic Stress Disorder and referrals were made for counselling and anger management. Birth Father 2 was prescribed tranquilisers. He failed his next appointment with the G.P. but was sent information in the post about Assist, a health agency specifically set up to provide support for asylum seekers.

> *Author's comment: No other professional is informed about Birth Father 2's concerns although there is an 8 month old baby in the household and Mother is again pregnant. There is no record of Birth Father 2 attending counselling or anger management and Assist provided a Nil return for this SCR.*

12.68 In December 2007 Mother seeks UK Border Agency approval to marry Birth Father 2.

12.69 **In conclusion for the period 2006 - 2007:**

This period saw Mother convicted of physical abuse of her first child and two failed rehabilitations of that child (the half-sibling) to her care. The second rehabilitation occurred just following the birth of her second child to a new partner who had not been formally assessed. There was evidence of closer bonding between Mother and this second child (Subject Child 1) and Mother reported good support from her new partner, who was also an asylum seeker. However, this belied the two domestic violence incidents that occurred, both when she was pregnant. Birth Father 2 was convicted on the second occasion but both parents minimised the events and the relationship continued. There was some agency concern about Birth Father 2's "controlling" approach to Mother. There was evidence of stress in the

relationship, with Birth Father 2 acknowledging his anger management problems and Mother seeking regularly to resolve his immigration status. It was also reported that cultural differences were impacting negatively on the relationship. Mother was seen to be responsive and to engage well with probation intervention and the health visitor provided very regular support. The police dealt with the domestic violence incidents as a single agency, as did the G.P. in responding to Birth Father 2. There was no formal pre-birth assessment of Subject Child 1 in spite of Mother's history. There was some evidence of missed health appointments for Subject Child 1 as well as his parents.

12.70 **2008 – 2011:**

12.71 In January 2008, a Residence Order was made to Birth Father 1 in respect of the half-sibling. CAFCASS were only involved on the day of the hearing but checked that children's social care were supportive of the application. Children's social care services closed the case at the end of January.

12.72 Birth Father 2 was removed from a UK Border Agency reporting centre in January 2008 for shouting and rudeness.

12.73 Offender Manager 4 recorded that Mother was very good with Subject Child 1 who was described as "bright and cheerful and trying to walk". The positive comments about Mother's care of the children and the warm bond were replicated throughout involvement of the Probation Trust.

12.74 The M.P. wrote to housing about the family's "multiple debts" and the problems arising from the immigration status of Birth Father 2. Between January and April 2008, Mother wrote numerous letters to the UK Border Agency as she was worried Birth Father 2 may be deported.

12.75 On 23.3.08 there was a report to police that Birth Father 2 had been assaulted by biting caused by Mother. She claimed this was in response to his pulling her hair. Birth Father 2 did not wish to pursue a complaint but the police officer returned to the premised, having noted the history. He noted that Mother was pregnant and made a referral to the Child Abuse Investigation Unit who in turn referred to Children's Social Care. A Domestic Violence Pack was also sent to Mother. Mother did not report this incident to Offender Manager 4 on 26.3.08.

12.76 Mother was suffering from anaemia in the new pregnancy but attended nearly all ante natal appointments.

12.77 Subject Child 2 was born in April 2008 after a normal delivery. Birth Father 2 was present at the birth.

12.78 In May 2008, Health Visitor 3 commented positively on the good progress of both children and on the good relationship with the half-sibling with whom they had regular contact. Mother reported "good support from her partner" but there is no detail as to what this entailed.

12.79 Birth Father 2 reported to UK Border Agency in June 2008 that he had lived with Mother since 14.4.06. This pre-dated his move to Leicester. He was granted permission to work in July 2008 although his second asylum application was rejected by the multiple applications unit.

12.80 On 4.8.08 Birth Father 2 attended his G.P. and reported that anger management was still an issue for him and that he could not recall having attended an anger management course. He reported feeling stressed. He was advised to see the Practice Therapist but there is no indication whether this was to be a self referral or a referral from the G.P.

12.81 In August 2008, Mother completed her supervision by Probation with only one missed appointment in 2 years.

12.82 In August 2008, there were 2 missed appointments for immunisations for Subject Child 2. It was eventually carried out in October 2008, although in that month the GP was advised of missed appointments by Subject Child 1 to the renal clinic.

12.83 Mother attended G.P. in November 2008 stating she was depressed and could not cope. She had financial worries and stated that her partner was not supportive and she was worried her children would be removed. She was advised to see the Practice Therapist and anti-depressants were prescribed and the dosage increased on a return visit some 2 weeks later. There is no evidence of this information being passed to Health Visitor 3.

12.84 In December 2008, Birth Father 2 was granted 3 years' discretionary leave to remain in the U.K. because of his right to family life.

12.85 Mother failed to attend further G.P. appointments in December 2008 and February 2009.

12.86 On 15.3.09 Subject Child 1 (aged 2 years 1 month) was taken to A&E with a spiral fracture to his leg. This was reportedly caused by his leg getting stuck in a slide.

> *Author's comment: Although this was deemed an accident this is the second fracture to a child aged less than 5 years in this family. Fractures for a child of this age are relatively unusual.*

12.87 There was a 2 year assessment by Health Visitor 3 of Subject Child 1 in April 2009. Both parents and all three children were present, including the older half-sibling. Both parents were seen to engage warmly with all the children and there were no concerns although it was reported that Subject Child 1's weight was now on 9th centile. It had gradually dropped over time from 75th centile.

12.88 In May 2009, the G.P. was advised of a number of failed appointments for Subject Child 1 at the renal clinic. He had not been seen since August 2007.

12.89 In May 2009, mother consulted NHS Direct as Subject Child 1 had oral thrush, mouth ulcers and was not eating. She was advised to take him to the G.P. which she did the next day and the G.P. referred him to hospital because of recurrent urinary tract infections and weight loss. He was admitted and observed and diagnosed with anaemia.

12.90 On 25.7.09, police were called as there was an argument between Mother and Birth Father 2. The children were present. No further action was taken by police but the incident was reported on 28.7.09 to children's social care services as there were "constant verbal arguments in front of the children" and Mother was depressed and struggling to cope. Children's social care tried to make contact with Mother on three occasions but as there was no response and they checked that Health Visitor 3 had no concerns, the case was closed.

> *Author's comment: there was no Initial Assessment carried out in spite of previous history of child abuse. This was a missed opportunity to assess the full situation of this family and mounting pressures.*

12.91 On 12.8.09, Subject Child 2 again was not taken for her immunisations.

12.92 On 31.8.09, there was a further domestic violence incident. Birth Father 2 had left the property by the time the police had arrived and Mother did not wish to pursue a complaint. It was stated that Birth Father 2 had poured lighter fuel on Mother. In some reports, it states that he had threatened to set light to her, but this is not reported in the police IMR. Mother tried to leave the flat with the children, but Birth Father 2 is reported as having smashed a mirror near to them and broken Mother's mobile phone.

12.93 The Police assessed this incident as "standard" risk but an enhanced risk assessment was requested. There is no explanation for either of these assessments. The Domestic Abuse Investigation Officer upgraded the risk

assessment to “medium” and children’s social care was subsequently informed.

12.94 On 17.9.09, over 2 weeks later, police reported this incident to children’s social care. As it was the third reported domestic violence incident, an Initial Assessment was agreed and the case was allocated on 25.9.09.

12.95 On 23.9.09, there was a further missed appointment for immunisations for Subject Child 2. Both parents hung up on the practice nurse who phoned to arrange a new appointment.

12.96 Mother initially minimised the incident of 31.8.09 to Social Worker 1 carrying out the Initial Assessment but later added that she had been punched and kicked in addition to what was reported to the police. She also advised of the incident in which Birth Father 2 had been charged in September 2007 when her head had been smashed against the headboard as her partner had thought she was going out and leaving him with a teething child. Mother did not want Children’s Services’ involvement and stated Birth Father 2 was living away from the flat.

12.97 Mother advised Social Worker 1 that Birth Father 2 had been arrested on 4.10.09 after making sexual comments to a 14 year old girl. Mother confirmed she was in telephone contact with Birth Father 2 but he had not seen the children.

12.98 Birth Father 2 was aggressive when phone contact was made by Social Worker 1 on 15.10.09 and refused to meet.

12.99 Liaison between the community development worker and Health Visitor 3 on 15.10.09 showed Mother had only attended 1 session of the behaviour management course.

12.100 Mother became upset and angry during the social work visit on 19.10.09 when it was mentioned that Subject Child 1 had been upset the previous week at pre-school. Mother refused further co-operation, stating her partner had left. Birth Father 2 also telephoned Social Worker 1 and was abusive.

On 19.10.09 Mother saw Health Visitor 3 briefly and said she did not intend to go to the Child Protection Conference and saw no need for concern as Birth Father 2 had left the home and she was accessing local services.

12.101 At the Initial child Protection Conference on 20.10.09, both children were made subject to child protection plans, under the category of risk of physical abuse. The parents were given 6 weeks to engage with children’s social care services or further legal advice would be sought. Assessment and work in relation to domestic violence and safe parenting was to be undertaken in a fortnightly visiting pattern. There was to be an assessment of Birth Father 2’s

use of cannabis. Both parents confirmed the next day that they would not co-operate. Police officers who knew mother well visited on 23.10.09 and encouraged her to co-operate with the plan.

12.102 The Core Group held on 28.10.09 was not attended by either parent.

12.103 Subject Child 2 was referred in respect of a possible squint in her eye on 2.11.09.

12.104 The case was transferred to the long term team in social care on 4.11.09 although Senior Practitioner 2 advised her manager on 16.11.09 that she did not have the capacity to visit. On 25.11.09 the duty social worker was asked to visit instead but resources did not permit this.

12.105 At the Core Group on 14.12.09, Mother was said to be willing now to co-operate. The children were seen by Senior Practitioner 2 for the first time. They had not been seen by a social worker since 19 October 2009 although police had been asked to undertake a safe and well check. There is no further record of social work contact with the family until the Review Child Protection Conference of 14.1.10.

12.106 Health Visitor 3 undertook a home visit on 12.1.10 and there was warm interaction between Mother and the children, no concerns were evident and Mother had enrolled on a positive parenting course. Birth Father 2 had visited on 10.1.10 to see the children. Mother was uncertain what contact arrangements were permitted.

12.107 At the Review Child Protection Conference on 14.1.10, the children remained subject to child protection plans

12.108 In January 2010 Birth Father 2 was arrested but released without charge for a road rage incident.

12.109 On 21.1.10 Mother told Senior Practitioner 2 she was considering a move to the north of England to be near her birth father.

12.110 At a Core Group on 5.3.10, Mother reported feeling low and tearful and was advised to see her G.P. She was feeling isolated and lonely. A new social worker was to be appointed and it was confirmed the referral to the Freedom Programme was outstanding.

12.111 On 15.3.10, Subject Child 1 started attending pre-school for 5 sessions per week. He had previously attended playgroup.

12.112 On 19 March 2010, the community development worker advised Health Visitor 3 that Mother had been receiving numerous text messages from Birth Father 2 in which he was threatening to kill himself. Health Visitor 3 advised the Duty social worker.

12.113 A new social worker (Social Worker 2) was allocated on 29 March 2010.

12.114 Mother wrote to the housing department on 14.4.10 asking for the names of the half-sibling and Birth Father 2 to be removed from the tenancy. She stated she had no contact with the half-sibling.

12.115 Birth Father 2 was charged with burglary of a shop premises and was later reported for intimidating a shop-keeper. This latter incident was dealt with by restorative justice but he was sentenced to an unpaid work requirement for the first offence in November 2010.

12.116 At a Core Group on 16.4.10, Social Worker 2 recognised that work was outstanding from the child protection plan and was planning to recommend a further period subject to child protection plans to complete this.

12.117 Mother attended G.P. on 16.4.10 stating she felt weepy, lonely and low. She stated she had split up with her partner 7 months previously. She was prescribed anti-depressants but failed a further appointment on 28.4.10.

12.118 Social Worker 2 undertook a home visit on 4.5.10 and reported good progress with Mother accessing local provision at the Children's Centre. There is no recorded discussion about Birth Father 2.

12.119 At the Review Child Protection Conference on 12 May 2010, Mother gave account of how she would deal with any attempt at contact by Birth Father 2. Positive reports were given of her accessing parenting courses at the Children's Centre. No concerns were raised about the children and the decision was taken to cease the plan. The risk factors were seen to no longer exist and further work could be completed under a family support plan. Although this was recommended by the independent chair of the Child Protection Conference, it was supported by agencies.

Author's comment: this decision was made although there had been no engagement with the children's father and no assessment of the impact of his recent text contacts. Social Worker 2 had had only brief involvement in which to assess the family and there was no record of the recent G.P. involvement. Attendance at the Freedom Programme was outstanding.

12.120 The police attended Mother's flat on 23.5.10 as she had reported Birth Father 2 to be outside wanting his possessions. No offences were disclosed so no further action was taken although both parties were spoken to. Mother informed the officers that she had been taking the children to see Birth Father 2 at his request.

Author's comment: it would seem that Birth Father 2 was seeking his possessions, some 7 months after reportedly separating. The Child Protection Conference Minutes had no mention of the children's ongoing contact with Birth Father 2. This incident was not reported to children's social care.

12.121 On 8.6.10 there was a call to police by Mother reporting that Birth Father 2 was constantly texting her and wanting her to resume the relationship. She stated he said he was outside the flat and she had found gifts from him. The call taker assessed mother as vulnerable and a response should have been made within 60 minutes. Resources did not allow this immediately. No response was received when officers called in the early hours of the morning and an appointment was instead made for 11.6.10 which did not in fact take place. On 25 June 2010 a welfare check was requested and it was revealed that a burglary had been reported on 24 June 2010.

12.122 On 15.6.10 Mother advised Social Worker 2 that she had "accidentally" met Birth Father in town and had gone with him and the children for a meal. His mother and sister were also reportedly texting her

12.123 On 22.6.10, Mother reported to police that Birth Father 2 had threatened to take the children back to his home country "within the hour". Police attended but father did not arrive. History markers were placed on the address and the pre-school. The incident was reported to the Domestic Abuse Investigation Unit and to children's social care. Mother was reported as wanting Birth Father 2 to have contact with his children. The incident was not recorded as a crime and was assessed as "medium" risk.

12.124 On 24.6.10, Mother contacted the police to report Birth Father 2 for harassment. She believed he had attempted a burglary at her home. The incident was assessed as "high" risk and Birth Father 2 was given a harassment warning although forensic evidence led to him being eliminated as a suspect in the burglary. The harassment warning was given as his behaviour was seen as a one-off event and not a "course of conduct" which would have led to arrest. Children's social care services had also contacted the police that day as Mother had contacted them in tears, thinking Birth Father 2 was watching the flat. Social Worker 2 made a home visit that evening.

12.125 The Domestic Abuse Investigation Unit sergeant reviewed the case in recognition of the high risk assessment and requested an enhanced risk assessment. This was not completed at that time as an alarm was being fitted during the visit and for reasons of confidentiality the assessment was discontinued. Mother told officers that Birth Father 2 had threatened in the

past to kill her if he saw her with another man and threatened to kill himself several times.

12.126 Birth Father 2 attended an arranged appointment with Social Worker 2 on 25.6.10, having refused an interpreter. The meeting only lasted 15 minutes as Birth Father 2 was late in arrival. He stated Mother was a "rubbish" mother and that they had separated 7 weeks previously. He had not seen the children for a month. He stated he would kill himself if he could not see the children. He was advised a risk assessment was required.

12.127 Birth Father 2 reported an aggravated burglary on 12 July 2010 at a different address. Arrests were made but charges were withdrawn when it became clear that accounts by Birth Father 2 and his associates were not entirely truthful. The incident apparently related to drug dealing issues. Birth Father 2 attended hospital with a head injury. Officers concentrated on the burglary and did not consider potential child protection matters and no information was passed at that time to children's social care.

12.128 On 14.7.10 Social Worker 2 visited Mother who stated she had had over 64 texts from Birth Father 2 who had admitted watching the flat. She was worried he had passports for the children and did not feel safe.

12.129 Subject Child 2 attended the eye clinic on 21.7.10, having missed a number of previous appointments.

12.130 The planned Family Support Meeting arranged for 28.7.10 was cancelled by Social Worker 2. Action for Children was starting Family Support work with Mother and the children at her own request.

12.131 Birth Father 2 had a second appointment with Social Worker 2 on 26.7.10 He stated he was depressed and was on anti-depressants and "welled up" when talking of the children. He described strong negative feelings about Britain and British women. Birth Father 2 was advised he should contact a solicitor if he wished for contact with the children.

12.132 In August 2010 Mother sought emergency contraception and then further contraceptive advice but stated she was not in a regular relationship.

12.133 The social work assessment concluded that Mother was offering a warm home environment and was integrated into her community. It was stated that Birth Father 2 had difficulty in engaging and used strategies to divert from assessment. Social Worker 2 intended to chase up the referral to the Freedom Programme for Mother.

12.134 As no further incidents were reported to the police, a local police officer arranged for the alarm to be removed on 9 September 2010. There is no record of re-assessment of risk or contact with children's social care services.

12.135 A Family Support Meeting was held on 13.10.10, attended by Mother. Birth Father 2 was not invited. Children's Social Care services were to remain involved for some months as Birth Father 2 was seen to be a significant risk. Alarms were said to be fitted at the flat, although they had actually been removed. There were many positive reports about Mother's parenting and involvement with local services

12.136 On 25 October 2010, Subject Child 1 had surgery to correct the obstruction in the ureter. He was discharged home the following day. The stent was removed on 20 December 2010.

12.137 A new social worker was appointed in November 2010 (Social Worker 3) who pursued referral to Freedom Programme and arranged for child care. Some information contained in Family Support Minutes was shared with the programme lead. Mother began attending the Programme on 19 January 2011.

12.138 Mother applied for a housing move in January 2011 citing harassment and domestic violence. She stated she had applied to a housing department in the north of England also. She wished to move to a different area where there were more links with the Muslim faith and community. It was reported that she had recently converted to Islam.

12.139 Subject Child 2 did not attend eye clinic appointment on 12 January 2011. Subject Child 2 did not attend a hospital appointment on 1 February 2011.

12.140 Birth Father 2 completed some of his unpaid work requirements between January and February 2011. Some were missed and breach proceedings were being started when his body was discovered. He was noted to be rude to staff on 17 January 2011.

12.141 During a social work visit on 18 January 2011, Mother stated she had not seen Birth Father 2 since the previous summer and that he had a new girlfriend. The housing support letter provided by Social Worker 3 and containing details of the history and risks was not forwarded to the local housing office by the central housing options unit. Mother was described as "happy and relaxed" at a Stay and Play Session in January 2011.

12.142 Mother attended 3 sessions of the Freedom Programme prior to her death and she participated fully, describing her experiences. She was seen as a role model for survivors of domestic violence by some other women. She spoke of continuing fear for herself and the children.

12.143 Children's social care records show that consideration was being given to case closure if no further issues were identified. This was discussed between Social Worker 3 and Health Visitor 3 on 9 February 2011.

12.144 On 2 February 2011, Mother attended the Freedom Programme and Subject Child 2 attended the local playgroup. Neither of the Subject Children or Mother was seen by agencies after this date and agencies were later notified of the discovery of their bodies, after the body of Birth Father 2 had been found.

12.145 **In conclusion, for the period 2008 – 2011:**

12.146 This period was characterised by increasing family pressures of debt and concern about the immigration status of Birth Father 2. His leave to remain was due to expire in 2011. He volunteered to his G.P. his concerns about his anger management and effects of past history but this information was not shared with any other professional. There was increasing evidence of strain on the relationship and more missed health appointments for Subject Child 1 and later for Subject Child 2 who was born in this period. Conversely Mother kept nearly all midwifery appointments, virtually all probation appointments and voluntarily engaged in local children's centre and community centre activity, regularly attending "Stay and Play" sessions. Mother ensured her children regularly attended pre-school provision but she failed to continue with practice therapy sessions.

12.147 All agencies reported warm relationships between both parents and these two children. There was a period of 7 months when the children were subject to child protection plans because of domestic abuse, and the emphasis was in ensuring that Birth Father 2 was prevented from returning to the home and from having contact with the children in spite of Mother's reported ambivalence about contact. The child protection plans were never fully implemented, with non-cooperation from both parents initially and the impact of domestic violence on the children does not appear to have been assessed or at least not recorded. Mother persuaded the Child Protection Conference in May 2010 that she was able to protect the children even though she had only recently been to the G.P. stating she was lonely and low.

12.148 The child protection plan was replaced by a family support plan and there was evidence of much local activity to support mother via the Children's Centre and the Community Centre as well as ongoing social work and health visitor support.

12.149 The police responded to each domestic violence incident although did not always share information fully with other agencies. They did risk assess each incident although the reported harassment was seen as a one-off and responded to accordingly. There was no evidence that the threat of abduction of the children was ever assessed thoroughly by any agency. The prevailing view was that Birth Father 2 remained a risk and that Mother was frightened but taking appropriate action. Agencies believed that the parents

had separated and that Mother was able to protect the children, despite several reports of her loneliness and depression and differing accounts provided by Mother and Birth Father 2 as to when they had separated. Agencies appeared to work on the premise that separation reduced risk when research and another local SCR would indicate increased risk at the point of separation and subsequent to this.

13 Information about post death inquiries presented to Serious Case Review Panel

13.1 On 5 April 2011, the initial meeting of the Serious Case Review Panel received a confidential briefing from the Senior Investigating Officer. This confirmed that the death of Birth Father 2 was potentially a suicide and the deaths of the two subject children and their Mother were treated as suspicious.

13.2 A forced entry was made to the Mother's flat following translation of a note found with the body of Birth Father 2 who had been found hanging in a local park the previous day. The bodies of the children and their Mother were recovered although cause of death could not be immediately determined.

13.3 There was evidence in the flat that Birth Father 2 had attempted to harm himself there and there were various notes left which indicated his concern at his children growing up in the kind of society he perceived to be found in this country. He was particularly concerned that they may become gay or lesbian.

13.4 Information was provided by some of Mother's friends that the couple had resumed their relationship and that Birth Father 2 had been residing at the property for the last 3 months. This was a covert relationship as the couple understood that agencies would be concerned at a resumption of their relationship.

14. Quality of Individual Management Reviews (IMRs)

14.1 There were eleven IMRs submitted for this SCR. All initial submissions were received in good time, although some revised versions were late. The Initial Briefing for IMR authors was well attended and all but one IMR author was able to attend Panel to discuss their IMRs. There was noticeably good support for IMR authors from the Panel members representing individual agencies. All but one of the IMR authors held interviews with relevant staff. This was good practice alongside reading of records. The exception was UK Border agency but it was accepted that an interview would not have been relevant for that agency. Each IMR author addressed the Terms of Reference for the SCR. The following notes the views of the Overview Author in relation to the IMRs.

14.2 The IMR for the **UK Border Agency** (UKBA) was helpful in explaining the process and context of the relevant asylum claims. The report noted that procedures were followed appropriately and that due attention was provided to language issues with interpreters used. Ethnicity, language and religion were recorded. The IMR raised concern at the lack of liaison between two sections of UKBA which led to Birth Father 2 receiving asylum support in Leicester when he was already being sought for removal to a third country and it is noted that action was swiftly taken to improve information sharing arrangements to minimise such risks. There is no reference to referral in relation to the request for voluntary return to the home country for Birth Father 2 and no information on relevant research or relevant other Serious Case Reviews.

14.3 The IMR for **Leicestershire and Rutland Probation Trust** was comprehensive, outlining the high level of contact with both Mother and the children. Mother was noted to have engaged well with the service. The IMR notes the good level of recording about the children, who were often present with Mother and recording noted the cultural issues affecting the relationship between the parents. The IMR author was appropriately critical of recording issues where Offender Manager 1 clearly raised concerns about Mother's relationship with Birth Father 2 in supervision, but this was not recorded on the risk assessment nor is there evidence of it being communicated effectively to other agencies. There was mention of the deficit in management oversight in checking the case notes. The issue of lack of home visits (as per plan) was also noted and the risk assessments were "limited". The lack of attendance or report to the Child Protection Conference was appropriately noted. The IMR author noted the lack of notification about the victim status of Mother when Birth Father 2 was convicted of battery. The service was also unaware of this earlier conviction when Birth

Father 2 was later supervised on his unpaid work requirement. The IMR would have benefitted from some research or information about other relevant SCRs but good practice was noted in early implementation of plans to address deficits.

14.4 The IMR for **Leicester City Council Housing Services** provided helpful context for the services and the environment for the family. The report identified that appropriate services were provided to the family and noted good liaison with local police and Health Visitor 3. The missed opportunity to address domestic violence was noted in early 2011 when a letter of support for a move, outlining family difficulties, was sent by Social Worker 3 to Housing Options. This was filed without any reference to the local housing team so no domestic violence assessment occurred or liaison with other agencies. The IMR author identifies swift action already taken to address the internal communication issue. The IMR would have benefitted from reference to other SCRs.

14.5 The IMR for **University Hospitals of Leicester (UHL)** outlined helpful information about their services and the increase in volume of work. The IMR revealed the extent of missed hospital health appointments for the children, but concluded that the appropriate action was taken in advising the GP and Health Visitor 3, although in fact it is not clear that Health Visitor 3 received notifications. The main issue identified in the IMR was the problem in reliance on self-reporting by a mother booking with the midwife who has no means of accessing previous birth records. While the IMR author does identify this, there could have been more robust analysis of this issue. There were both health and social concerns missed because of reliance on self-reporting, as identified in the health overview report also. The IMR author identified a lack of liaison from other agencies prior to the birth of Subject Child 1 (although other IMRs identify conversations with the community midwife which were clearly not found in UHL records). The IMR author identifies the lack of follow up to historic domestic violence reported by Mother and notes improvement already made to identify such issues on records. It also notes work already undertaken in respect of misfiled community midwifery records. The IMR author makes reference to other SCRs and research in relation to domestic violence and information sharing deficits.

14.6 The IMR for **Leicester City Council, Children's Social Care and Safeguarding,** was comprehensive and strong on analysis. The layout of the statement of facts was slightly confusing to the reader at times although content was good. The increase in volume of work was noted, particularly in relation to domestic violence and there was helpful contextual information about the geographical area and supervision processes. There was also helpful explanation about legal advice offered in relation to care

proceedings thresholds with correct identification of the missed opportunity for legal advice to the Child Protection Conference of 20 October 2009. The IMR notes that Senior Practitioner 1 went to Mother's previous local authority to read the files and information about Mother's background was presented to the Initial Child Protection Conference in respect of the half-sibling. The IMR recognised that this information was not apparently referred to in any assessment. The report correctly highlights the lack of focus on the children's experiences and the lack of visits to them at times. The report criticised the lack of direct work with the children and too-ready acceptance of Mother's assurances. The focus was on her perceived co-operation rather than risk. The optimistic stance taken at crucial decision times was also noted, e.g. when the half-sibling's name was removed from the then Child Protection Register in December 2006 with a new baby due and domestic violence having been revealed in the pregnancy. Details of contact between the half-sibling and Mother and her new family was never recorded and this was identified as a deficit. The IMR author correctly identifies a missed opportunity for a Child Protection Conference before the birth of Subject Child 1 and again in June/July 2010 when concerns were escalating. The report author recognised that no work was done with the parents in respect of domestic violence and the link with pregnancy and increased risk at the point of separation. The focus remained on the risk to Mother and work with Birth Father 2 failed to recognise the increasing pressures he was experiencing and the IMR noted the lack of services offered to him. The IMR recognises the lack of attention to previous experiences of the parents and the effect of cultural differences on the relationship but is relatively light in analysis of how the cultural aspects of the case were addressed in children's social care. There is recognition that management oversight was inadequate on occasions but there is little analysis of the lack of assessment of fathers in this case. This overview author would also disagree with the IMR author who concluded that work in relation to the half-sibling was "exemplary". There were two failed rehabilitation attempts, one literally after the birth of a younger child and no mention of any formal attachment assessment in relation to the Mother and that child and no assessment of her new partner other than a check of the police national computer. There is correct identification of the lack of "respectful uncertainty" in the case and good reference to other relevant SCRs.

14.7 The IMR for **Leicestershire Partnership NHS Trust (health visiting)** included a good use of reflection, analysis and relevant research. The involvement of Health Visitor 3 over a lengthy period is noted and the above average level of contact and support offered to a family recognised as vulnerable. The report notes generally good recording of the children and interaction and significant attempts ("tenacious") by Health Visitor 3 to get additional therapeutic support for the Mother. There was evidence of the

health visitors generally liaising well with other agencies although some instances are identified when this could have been better. The IMR identifies that Health Visitor 3 is reliant on information from Mother about domestic violence and does not proactively ask questions or show "respectful uncertainty". The report notes the lack of training and therefore recognition by Health Visitor 3 of some of the risk factors in relation to domestic violence. The IMR author notes the lack of "whole picture" information and lack of involvement of fathers in any of the assessments, including lack of attention to language issues. Management oversight in the case was seen to be appropriate and Health Visitor 3 sought appropriate supervision, although this begs the question as to why domestic abuse issues were not identified more. There is good reflection by the IMR author in relation to another local SCR and learning identified but lack of analysis as to the cultural issues affecting this family, apart from potential language barriers. There could have been consideration by the health visitors about any differences in approach to child-rearing by the parents, and any tension arising from this. There is also no mention in this IMR of the recorded weight charts of the subject children, both of whom were recorded as slipping down the centile charts. This would normally trigger some assessment. There is also a mention in the chronology of a long discussion between Health Visitor 3 and Mother about head banging in relation to Subject Child 1. This is not reflected in any analysis and might indicate more difficulties than were reported. Some of this child's reported difficulties with toilet training and eating mirrored those experienced by his half-sibling. Head banging was also an issue for him. The health overview report notes that Health Visitor 3 appears to be *"a passive recipient of information"* and suggests more challenge and direct questioning would have been appropriate.

14.8 The IMR for **Leicestershire Partnership NHS Trust** provided information about involvement of community paediatricians and GP involvement with each family member. This IMR was comprehensive and strong on reflection and analysis and very strong links with other local and national SCRs. The IMR correctly identified good care provided by each G.P. on each consultation with family members but noted the general lack of liaison with other professionals (in particular the health visitor and social care) or linking of family information. A reference was made to another SCR which noted the increasing detachment of G.P.s from interagency work. There was also a noted lack of focus on the children when dealing with adult issues and in particular lack of attention to the effects on the children of reported domestic violence and the anger management issues raised directly by Birth Father 2. There were no G.P. reports provided to Child Protection Conferences, when invited, even though this is highlighted in G.P. safeguarding training. It is not known whether the G.P.s involved in this case had received this training or their required annual appraisals. The IMR author notes they "should have had"

these. A new central database has now been developed to record training and appraisal. The issue of separate recording for practice therapists has now been addressed and it is noted in the IMR that there is an intention now to involve health visitors in practice meetings in recognition of the effect of poor communication. A recommendation to encourage the use of "reciprocal share" of the GP records with the health visitor is an important one given the frequency with which this issue is raised in SCRs locally and nationally. The issue was noted of the lack of follow up to notifications of missed health appointments at times as was the dearth of information-sharing about this with others. There was also a complete lack of professional curiosity on the part of the G.P.s involved although the IMR author does not directly address this. They were advised by family members of domestic violence and child protection plans but there was no follow up, reflecting a lack of focus on the children's safety and wellbeing. Although there is a G.P. lead for safeguarding in each practice, there is no mention in this IMR that this was a supportive factor. The IMR author outlines what referrals were appropriately made, but it would have been helpful to have identified what additional referrals should have been made.

The IMR author also reviewed the input of the community paediatricians. The response to requests for child protection medicals was appropriate but the report highlights the lack of explanation for the very lengthy delay in a request for a skeletal survey for the half-sibling in January 2006. This was only provided, and then only partially, in May 2006. There was a reported lack of response to concerns expressed by police and social care to this, outlined in the IMR. The lack of follow up to information on what was presumed as historic domestic violence is appropriately addressed.

Although there is good general analysis, there is little mention of cultural issues being addressed in the IMR. Birth Father 1's ethnicity is not recorded in G.P. records, although this is recorded for Birth Father 2 and he was provided information about Assist, a health service for asylum seeking individuals. There is no evidence of any actual contact with that organisation. The chronology states that Birth Father 2 was provided with a leaflet on Assist and about domestic violence, but again no referral was considered about this. The G.P. records state that no linguistic needs were recorded for any family member, although other agencies were providing interpreters for Birth Father 2. Religious needs are not recorded for any family member. There is reference in the chronology to Birth Father 2 being provided with a leaflet about post-traumatic stress, but there is no consideration in the IMR as to whether this should have been followed up. Mother's recurring depression is treated at each visit but Health Visitor 3's letter requesting a mental health assessment for Mother in relation to safeguarding issues does not appear to have been responded to. The IMR author concludes that the G.P.s carried

out their work in accordance with Working Together, LSCB and other guidance, but this cannot be supported by their lack of attention to information-sharing and lack of focus on the needs of the children.

14.9 The IMR for **Action for Children** outlined the contact with the family at the Children's Centre from 1 April 2010. The report identifies that Mother referred herself for family support in May 2010 and was a regular user of universal services. The report author identified the problem for universal services in reliance on self-reporting as there was no knowledge of Mother's conviction for abuse of her oldest child. The report notes that even when Mother told them of a Child Protection Plan, there was no follow up. There was some knowledge of domestic violence but this was believed to be historic. The report identifies that centre staff were not invited to multi-agency meetings and there was no health visitor liaison recorded, although there was believed to be informal liaison. They did not receive the Minutes of the Family Support Meeting, even though they were on the circulation list and were actually providing family support. The IMR does describe the children but the IMR author noted that the focus was primarily on work with the Mother. The IMR would have benefitted from greater analysis as to why there was little mention of cultural issues in the children's records and the lack of attention to the dual heritage issues of these children. The family lived in a predominantly white British environment and they were of Islamic faith. It was only with hindsight that the team (which was multi-cultural) recognised that they could have been more proactive. It was noted at SCR Panel that action to address some of the identified deficits is already underway with shared allocation meetings for targeted work across the Children's Centres and shared policies. Crucially, there will be an ability to check if the family is known to children's social care. The IMR made brief reference to national research related to SCRs.

14.10 The IMR for **Leicester City Council, Access, Inclusion and Participation,** addressed the local authority early prevention services offered to the family. This covered pre-school playgroup and nursery provision and targeted parenting support, as well as ongoing support through universal Children's Centre provision. The service had significant contact with all of the children and Mother over a lengthy period but the detail about the children in the IMR is not comprehensive. The IMR identifies that the service was commissioned to provide nursery and family support in May 2006 and work with Mother was offered in respect of the half-sibling to support his return to his mother's care. The IMR identifies concerns about management supervision and appropriately raises concerns about the positive recording about progress which is then challenged by an apparent very rapid deterioration leading to the half-sibling returning to foster care. The IMR noted that the visiting pattern did not match the plan and also commented on the lack of mention in

recording about the child and indeed about "minimal" recording at times. There was noted good liaison with social workers with nursery staff invited appropriately to Child Protection Conferences and core groups although less evidence of the community nursery officer's assertion of regular liaison with the social worker as there is no recording to support this. It was also noted that liaison with the nursery could have been better. There was less information shared with universal providers by social care. There is minimal information provided in the IMR about attention to cultural issues which is a real deficit. It is noted that it is not referred to in case records yet these young dual heritage and Muslim children would have been unusual in the predominantly white British locality. It is hard to see how family support could have been offered without reference to the cultural issues affecting the family. The IMR does make brief reference to another local relevant SCR.

14.11 The IMR for the **Education Service** focused on involvement with the half-sibling. This little boy was living with his father when he started school and the school was aware of his history and this was recorded on a confidential section of his file, as were the deaths of his half-siblings and his mother. The IMR noted the sensitive response of the school to this. The school had appropriately recorded information about the family and contacts and had recorded ethnicity and religion. However, the IMR author provided no links to other SCRs.

14.12 The IMR for **Leicestershire Constabulary** provided helpful information particularly about the context of domestic violence statistics which are rising and has led to an increase in workload. The 8 officers in the Domestic Abuse Investigation Unit (DAIU) review over 8000 incidents in a year with the Sergeant reviewing any risk assessed as "high". There is a queuing system for review by DAIU. The IMR author identifies strong links between the DAIU and the Child Abuse Investigation Unit (CAIU) which makes referrals to children's social care. The IMR is comprehensive in detailing all incidents and there is good analysis against procedural guidance and safeguarding needs of the children. The IMR author helpfully distinguishes between domestic violence incidents and domestic violence crimes. The different names used by Mother and particularly Birth Father 2 were noted which made links between incidents more difficult to identify. Despite this, the police were mostly successful in this. The predominant issue identified by the IMR author was the 3 occasions when referral to children's social care should have been made. In addition, there was late notification to social care which is not identified as significant but could have been. The domestic abuse incident noted on 13.9.06 was only reported to children's social care in December 2006 even though the half-sibling was at that stage on the Child Protection Register, and the incident where lighter fuel was allegedly poured on Mother on 31.8.09 was only reported on 17.9.09.

The IMR author was appropriately critical of the failure to follow up with statements and arrest on that incident but identifies that procedures were followed on most occasions and risk assessments were undertaken and reviewed appropriately. There was an identified incident (22.9.07) when the baby's needs were not considered alongside the domestic violence in that the child (7 months) was reportedly shouted at and left alone and the IMR author noted the lack of clarity as to whether the children had always been seen when an incident was investigated. The IMR author describes Birth Father 2's threats to kill himself or "any new partner" but earlier in the report it notes that the threat was to kill Mother, if she was found to have a new partner. The main missed opportunity identified was the lack of referral to Independent Domestic Violence Advisors in June 2010 when the risk was assessed as "high". This should have resulted in a mandatory referral. The IMR author also identifies a lack of timely response to a call from Mother, assessed as vulnerable, and some concerns that management oversight was slow in recognising this. The IMR author queries whether there was effective analysis of potential harassment incidents in June 2010 and whether there was evidence of a "course of conduct" rather than treating incidents as single events. There is also appropriate criticism by the IMR author of the decision to remove the alarm fitted to Mother's home without contact with children's social care or a reassessment of risk. There was good practice noted when an officer returned to check Subject Child 1, after linking an allegation that Mother had bitten Birth Father 2 with the previous history of her biting her first child. The IMR author noted the attention provided by the police to the immigration status of Birth Father 2 and the provision of interpreters and there is recognition that a notification should have been made to the Home Office when Birth Father 2 was convicted of assault/battery of Mother. There is no other reference to cultural issues in respect of this family in the IMR. The IMR does provide information about research and another relevant local SCR and there are relevant recommendations made by the IMR author to address identified learning.

There were some issues not identified in the IMR. The link to pregnancy in two of the domestic violence incidents does not appear to have been made although this is a risk factor, albeit the pregnancy may not have been evident in one of the incidents. There were no links made between issues raised as a cause of the domestic violence incidents – cultural issues, financial pressures and immigration issues, which were present in the incidents with both birth fathers. There was no mention of a lack of contact with children's social care when Mother told officers she had been taking the children to see Birth Father 2, contrary to the assurances she had given to the recent Child Protection Conference which saw the removal of the two subject children from Child Protection Plans. On 22 June 2010 Mother told officer Birth Father 2 *"just wanted to see his children".* This was not

communicated to social care at that time. The IMR author found that most recording was satisfactory. There was a discrepancy over the incident on 5 October 2009 when Birth Father 2 was arrested in relation to a allegedly racially motivated incident with a young woman. The social care chronology states this was a 20 year old, but the IMR author notes "an aggressive schoolgirl". There is a conclusion in the IMR that the information exchange with children's social care was "appropriate, sufficient and effective" where it took place but this description could have been qualified by incidents that should have been referred but weren't.

14.13 The **Health Overview Report** considered the IMRs provided by three health agencies and provides a robust critique of their analyses, well supported by evidence and research. The report notes the inconsistent reporting by the hospital to health visitors of missed health appointments for children and concludes that all the health practitioners "*worked in parallel but not in partnership".* The lack of communication by the G.P.s to other practitioners is also highlighted as a serious deficit. The health overview author notes that systems are in place to support practitioners by highlighting concerns and linking across patients, but this requires individuals to implement effectively. In addition, the health overview author addresses the failure to effectively assess domestic violence and the roles of men in the family.

The health overview author makes a further nine recommendations for health agencies, in addition to those made by individual health agencies. These are practical recommendations designed to bring about the desired change. One is repeated from an earlier local SCR (Child W, 2009) which is for the LSCB to "*explore the role of GPs in inter-agency working to safeguard children".* While it is a timely recommendation in light of the Department of Health's current consultation on the role of GPs in safeguarding, this overview author would suggest there should be a more robust action in order to ensure that changes are embedded in practice. Rather than an exploration, this author would propose that the commissioners of GP services should work with GP practices to assure the LSCB that action is being taken and monitored to show improvement. A recommendation will be made to address this and the issue of consistent invitations to child protection conferences and the importance of seeking information that may be held by G.P.s. They are significant members of the multi-agency safeguarding community and from several local serious case reviews, it would appear that their contribution is not always as effective as might be expected, nor is it always robustly sought.

15. Good Practice identified

15.1 Most agencies list a number of good practice points in their IMRs but these mostly relate to practice that followed agreed policy and procedure.

15.2 There are some instances of practice where professionals went beyond expectations which should be recognised as good practice.

15.3 The first of these was on 23 March 2008 when there was a police investigations into a domestic violence incident in which it was alleged that Mother bit Birth Father 2, causing injury. The police officer recognised the links to Mother's conviction for biting the half-sibling, returned to the home to formally check Subject Child 1 and ensured there was referral to children's social care.

15.4 The second instance also involves the police who responded promptly on 22 June 2010 when there was a reported threat that Birth Father 2 was intending to remove the children to his home country. History markers were placed on relevant addresses, advice provided and an alarm was subsequently installed. Again, officers ensured there was appropriate referral to children's social care.

15.5 Children's social care services arranged for a police "safe and well" check on the two subject children when Mother refused to co-operate in late 2009. There was liaison and police used their good relationship with Mother to encourage her co-operation.

15.6 From 2006, Health Visitor 3 was tenacious in trying to access practice therapy support for Mother, recognising her vulnerability. The support provided was of a high standard, despite a large caseload.

15.7 The G.P. actively ensured that the family would attend hospital follow-up after an injury to the half-sibling's arm in 2005.

15.8 It was noted that midwifery services were well co-ordinated when Mother presented as a pregnant teenager.

15.9 On hearing of the deaths of the subject children and their Mother, there was sensitive response by the teacher of the half-sibling to ensure he had appropriate support.

15.10 The Probation Trust provided continuity for Mother in allocating an offender manager who had worked with her previously, when case transfer was required (Offender Manager 3).

15.11 The SCR Panel members and relevant agencies responded quickly to address emerging issues. The U.K. Border Agency acted swiftly to address

their identified internal communication issue. The Probation Trust set up a review of its domestic violence policies and links to child protection. Housing Services set up systems to ensure their identified communication problem would not recur. Panel members agreed on a programme of work to address consistent standards and cross agency communication in early years settings, which would include the ability to determine if social care were involved when dealing with referrals for targeted work.

15.12 There was good practice in the SCR Panel in seeking involvement of family members in the process, in consultation with the police and the Coroner.

15.13 There was good practice in the SCR Panel in asking the LSCB Manager to view Mother's files in the local authority where she had been in care. This provided important background information, not immediately apparent in agency files.

15.14 There was good practice in the SCR Panel in enabling good dialogue opportunities for the IMR authors and Panel. This supported wider learning. Advice was also sought from an experienced practitioner in relation to domestic abuse. The SCR Panel was robust in seeking amendments and additional information where there were gaps.

16. Theme Analysis of Agencies' Involvement

16.1 The Terms of Reference were comprehensively considered by each of the IMR authors. This was considered in Section 14 and it is not proposed to repeat the detail in this section. However, the sequence of events and agency analysis show that there are a number of themes which emerge where lessons can be learnt to improve the effectiveness of agencies working together to safeguard and promote the welfare of children and young people.

16.2 The nine themes identified are as follows and will be addressed in turn:

- Lack of consideration of the early history of the parents and potential effect on their functioning and risk to children.
- Lack of attention to cultural issues
- Domestic violence/domestic homicide/filicide
- Lack of involvement of men in the family
- Communication/information sharing
- Rule of optimism/potential disguised compliance
- Variable and incomplete focus on the children
- Recording
- Management oversight

16.3 Lack of consideration of the early history of the parents and potential effect on their functioning and risk to children. (This relates to Numbers 1, 4, 5, 6, 7and 10 of the Terms of Reference for this case).

16.3.1 Mother was 17 when she moved to Leicester and was soon pregnant, in receipt of Leaving Care Services from another local authority. She was in a relatively new relationship with a man some years her senior and from a different cultural background. She had no identified friends or family around. There is a high risk of teenage pregnancy for Care Leavers with known additional risks arising from self-esteem issues and dealing with past loss and rejection and unmet dependency needs (Reder, Duncan and Grey 1993).

Although Mother was referred to the specialist midwife for teenage pregnancy, there was no other assessment of her needs or of potential

support for parenting. At that stage there is no evidence that any local professional was aware of the events that led to her being in care which would have raised concerns about her vulnerability. Shortly after giving birth, Mother was reported to be tearful, low, isolated and with relationship problems. Police were called on three separate occasions to deal with verbal arguments. Birth Father 1 was an asylum seeker and there were clearly additional pressures arising from his status. It is not known whether there were additional pressures from his past experiences or from cultural differences as there is no agency recording about this. A year after the birth of the half-sibling Mother was a young lone parent. When her baby suffered a fractured arm that was accepted as an accident, Mother appeared to the health visitor to minimise both the injury and her own emotional difficulties. The hospital raised concerns about late presentation for the injury but there was no referral to children's social care. As the Social Care IMR author states, this would have been an opportunity to have assessed the needs of this child as a potential Child in Need and to support a very vulnerable young mother.

16.3.2 In January 2006, Mother admitted to the abuse of her child (the half-sibling), acknowledging she had been struggling for a while to convince others she was coping. The resultant Child Protection Conference should have been an opportunity to consider the detail of Mother's past history and potential effects on her parenting ability and capacity to make a firm attachment with this child. There is no evidence that this happened although there is clear record of the past history in the confidential section of the Minutes. Although Mother's past allegations were not substantiated, her state of mind and subsequent recourse to serious solvent abuse should have alerted professionals to the level of her vulnerability and potential risks to her child.

16.3.3 A rehabilitation plan was developed with no evidence of a formal attachment assessment and the parenting assessment appeared to focus on development of behaviour management strategies, rather than the underlying cause of the child's behaviour. The planned psychological assessment of Mother which was part of the Child Protection Plan did not take place and the half-sibling was returned to her care although she had failed to attend the Practice Therapy appointment offered by the G.P. This was not communicated to the Child Protection Conference.

16.3.4 The half-sibling was returned home when Mother had just established a new relationship with Birth Father 2, also from a different cultural background to her own and different to that of Birth Father 1. No assessment appears to have been undertaken of Birth Father 2 other than a check of the Police National Computer. As Birth Father 2 was providing different names to the police and had made two separate asylum applications with different names

and dates of birth, records were not immediately linked to a Caution he had received for possession of cannabis.

16.3.5 Mother reported a new pregnancy two months after the half-sibling was returned to her care and a month later there was a report of a domestic violence incident which led to no further action, following which the half-sibling showed upset at nursery and mother presented with injuries. There was discussion of a pre-birth conference for the new baby but this was not progressed. The half-sibling was removed from the Child Protection Register prior to the birth of the new baby and a Child in Need Plan (family support) was substituted. Barely one month later, the half-sibling was back in foster care, at Mother's request, as she could not cope. At a Family Support Meeting, Birth Father 2 was said to be very agitated until an interpreter was sought and it was noted that language and cultural issues were impacting on the parental relationship. There was however, no assessment of these or of Birth Father 2's background history and whether there was anything in this that would support his care of his own child and a step-child of a different background, while dealing with the pressures of his own asylum application.

16.3.6 A rehabilitation plan was again developed with no evidence of assessment to understand the cause of this child's behaviour and no assessment of attachment and the half-sibling was returned to mother's care just after the birth of Subject Child 1. This had been a caesarean birth, following which Mother had required two blood transfusions. There was no evidence of consideration of the post natal depression Mother had suffered after the first birth although Health Visitor 3 wrote to the G.P. proposing a mental health assessment as a result of Mother's childhood experiences and emotional stress. There is no further mention of this. The timing of this rehabilitation is not explained but was certainly optimistic in the extreme, in spite of the range of practical support put in place. Quite quickly Mother was expressing concerns at her capacity to care for the half-sibling and after an incident in which Subject Child 1 (3 months) was allegedly pulled from his chair by the half-sibling, Birth Father 2 insisted he be placed immediately with Birth Father 1 as was being planned. Mother subsequently spoke of the difference in her positive level of attachment to the two Subject Children compared to that with her first child and her sadness at this. An early assessment and planned support addressing the potential effects of her past history may have made a difference. An over-optimistic view of Mother's capacity was apparent as no account had been taken of her history.

16.3.7 In September 2007, Birth Father 2 was convicted of an offence of battery of Mother and received a 2 year conditional discharge. This was not referred to children's social care but Birth Father 2 went on 3 occasions to his G.P. and

revealed his own concerns about anger management issues. He linked these to his past history and spoke of the domestic violence arrest. None of the detail he provided to the G.P. about his past history was provided to any other professional. Birth Father 2 described himself as feeling low and was prescribed tranquilisers and was provided information on Domestic Violence, post-traumatic stress and how to contact Assist, a health service for those seeking asylum. The G.P. assessed that the child was "safe" but no explanation for this assessment is provided in records. Mother also raised concerns about Birth Father 2's use of cannabis and alcohol which she believed altered his behaviour. The police provided a contact for Addaction, a service for substance misuse problems in 2009.

16.3.8 The combination of the two parental histories would certainly raise concerns about parenting capacity and potential pressures on family life. The features regularly appear in Serious Case Reviews – a young Mother, history of abuse, history of substance misuse and a subsequent history of child abuse and lack of attachment to a child, difficulties in managing a cross-cultural relationship then starting a new relationship with a man also from another culture who was struggling emotionally to deal with his past history and with acknowledged anger management issues and substance misuse. The assessments that took place in relation to the two subject children do not appear to have taken full account of these histories which might have led to increased acknowledgement of risk for the children. The Ofsted Review of SCRs, (2009 -2010) comments, "*understanding the background history and context of the adult should enable to the professionals to assess the needs of the child more effectively and to share information appropriately".* Brandon et al (2009) quotes Jaffee et al (2003) stating, "*positive and negative dimensions of fathers' and mothers' life histories can jointly influence their parenting and its impact on their children's lives".* This is described as the "double whammy" effect because of the interacting dynamics. This is very relevant when considering the parental histories in this case. Assessments tended to be reactive, based on recent events and the **learning point** is that agencies would benefit from an historical perspective in their assessments which could lead to better identification of risk and support needs for children. This point was well made in the second SCR into the death of Baby Peter (2010).

16.4 Lack of attention to cultural issues. (This relates to Numbers 1, 2, 3, 5, 6, 7, 10 and 11 of the Terms of Reference for this case).

16.4.1 The police attended three times to domestic incidents when Mother was in a relationship with Birth Father 1. She had met this man while in care in another local authority and followed him to Leicester. He was an asylum claimant and was initially subject to the restrictions on ability to work etc.

Causes for the arguments between the parents were listed as cultural differences, money and immigration issues. The same issues were apparent in domestic violence incidents between Mother and Birth Father 2. Mother wrote on 14 occasions to the UK Border Agency in support of Birth Father 2's application and spoke to her Offender Manager about the pressures his inability to work brought on her. In addition, she revealed that there were cultural differences as sometimes language caused a problem and that when she expressed views, Birth Father 2 sometimes thought she was being aggressive. There is no evidence that any agency focused on the potential differing expectations in respect of the roles of women or child rearing values and expectations. Mother initially spoke of Birth Father 2 as "very supportive" but there is no evidence to identify what this means. Did he share practical care of the children? What activities did he undertake with the children?

16.4.2 There has been no evidence provided for the SCR to show that these issues were considered in assessments or that any assistance was provided to the parents. Mother was left to "work through the issues". Birth Father 2 was never formally assessed in spite of being part of a household when the half-sibling, subject to a Child Protection Plan, was returned to Mother's care. Neither was he assessed when his own two children were subject to Child Protection Plans.

16.4.3 There was variable recording in relation to ethnicity, preferred language and religion. The school for the half-sibling appeared to be the only agency alongside the U.K. Border Agency that formally recorded all three. The police records show preferred language and ethnicity, and religion and ethnicity are recorded on crime reports. Police did arrange for an interpreter for Birth Father 2 when formal arrest and charge was made and there was one occasion when an interpreter was sought for Birth Father 2 at a family support meeting as he was struggling to get his views across. He was offered but declined an interpreter in 2010 during interviews he sought with Social Worker 3 when he was attempting to regain contact with his children but it might have been preferable to insist on an interpreter for what was considered to be a formal assessment. The U.K. Border Agency did use interpreters for interviews but not for reporting appointments. There was also little recording of immigration status (outside of the U.K. Border Agency) of both Birth Fathers meaning that no agency considered the potential pressures on the families.

16.4.4 The government is currently consulting on a cross-government strategy for suicide prevention in England. This notes that "*social isolation, language barriers, racism and legal uncertainties may be experienced by asylum seekers and may lead to depression".* Post traumatic stress disorder is also recognised as potentially of relevance. None of this appears to have been assessed for Birth Father 2 by any of the agencies involved.

16.4.4 All the IMR authors describe the locality in which the subject children lived as predominantly White British (97%) and Mother latterly sought a housing move to be able to access a Mosque more easily. It is therefore surprising that there is a lack of attention to the dual heritage of these two children and little recording in relation to this, especially in the pre-school environment where, as Muslim children, they would have been in a significant minority. It is only with hindsight that the deficits have been noted. There is one mention in the records of Subject Child 1 beginning to talk and having some words in English and in his father's first language. There is no evidence in relation to the language spoken at home and whether the children were learning both. There is also no reference to how Mother experienced life in this environment with husband (s) and children from different cultures. While it is known that she was married to Birth Father 1 and later divorced and known that she approached the U.K. Border Agency for permission to marry Birth Father 2, it is not known whether they were married or whether he held parental responsibility for the children.

16.4.5 Most agency procedures require full recording of ethnicity, preferred or first language and religion to ensure their services are appropriate to need. The **learning point** is that agencies need to be able to ensure this is embedded in practice both to be able to provide culturally appropriate services, but also to support understanding of potential impact on children and their families. Leicester is a highly diverse city, as identified in the social context provided in the IMRs. It is estimated that people from ethnic minority communities will form the majority of the population in Leicester after the 2011 census with more than 50 languages in use. It is crucial that there is due attention to cultural and diversity issues.

16.5 Domestic Violence/Domestic homicide/filicide. (This relates to Numbers 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11of the Terms of Reference for this case).

16.5.1 According to statistics published by Women's Aid Federation, domestic violence account for between 16% and 25% of all recorded violent crime (Home Office 2004). Women are the most likely victims and on average 2 women per week are killed by a male partner or former partner, constituting around one third of all female homicide victims. Brandon et al (2009) notes that nearly three quarters of the children represented in SCRs lived with present or past domestic violence, parental mental health or substance misuse problems – and that these often co-existed, as in this case. The Ofsted Review of SCRs (2010) noted a failure of agencies to understand, accept and assess the impact of domestic violence on the children. This is also true of this case.

16.5.2 Leicester has a comprehensive inter-agency strategy in place for domestic violence (2009 – 2014). This notes that 2 women per year are killed in the city by a partner or ex partner. Leicester is one of a small group of local authorities (22 out of 408 local authorities) with a range of specialist provision. Reporting is said to be rising with over 8000 incidents reported to the police per year (up by 26% since 2006). More than 50% of these incidents have children resident in the household and domestic violence features in approximately 25% of referrals to children's social care with a high correlation, as nationally, to children with child protection plans. The Local Safeguarding Children Board is represented on the Joint Strategic Group for Domestic Violence and the Strategy is clear about the links between domestic violence and risk of harm to children. Domestic Violence is also a key priority in the Leicester City Children and Young Persons Plan.

About 4% (280) of all reports to police are assessed as being at very high risk of serious injury or homicide and it is these cases that MARAC (Multi-Agency Risk Assessment Conferences) consider after referral to local Independent Domestic Abuse Advisors, of whom there are 4 covering the City.

16.5.3 A manager with responsibility for the Leicester Domestic Violence Integrated Response Project attended the SCR Panel on 24 August 2011 to outline the services available in the city in respect of Domestic Violence. The Independent Domestic Violence Advisers (IDVAs) are part of this project. Services offered range from a helpline open to public and professionals alike, specific work with victims and availability of support and outreach services at home which can prevent the need for reliance on refuge placements. There is good capacity for the helpline and professionals can refer on "advocacy perception" of need, even where there may be minimisation of incidents by families and where the need is assessed as low or medium. This is also true of referral for MARAC although it is clear from this case that locally most agencies only perceive this as being available for high or very high risk cases. There was no referral at any time to this project on behalf of these children or family. The manager considered this to be surprising.

16.5.4 The domestic violence incidents in this SCR did not occur with a high level of frequency, did not result in serious injury (or any injury requiring medical treatment) and were assessed mostly as "standard" or "medium" risk, even when taking account of the children present. They therefore need to be viewed in the context of the other 8000+ referrals, a number of which were assessed as "very high risk". There is no suggestion in this SCR that any single incident of domestic violence would have been classed as "very high risk". As per the procedure, the assessments were all reviewed by an officer in the Domestic Abuse Investigation Unit (DAIU) who would make contact with the Child Abuse Investigation Unit (CAIU) when needed, for referral to children's social care. The police IMR details the occasions when this

occurred and identified the three occasions when referral to children's social care would have been beneficial. In relation to the subject children, there were 9 domestic incidents reported. They are listed again as follows so that the sequence of events and responses can be viewed together:

13 September 2006 – not referred to children's social care by police and no further action taken by them but Nursery reported to children's social care that Mother had arrived with injuries from a fight with her partner. No action was taken by them as police reported this to be "a loud t.v." rather than domestic violence. Mother's injuries seen at nursery on 14.9.06 were not visible to police who responded to the incident on 13.9.06. It is feasible that the injuries occurred after they had left. The Police IMR author noted that this incident should have been reported to children's social care. The Nursery did in fact report it but no action followed. This should have been an Initial Assessment as there was reported evidence of injury to Mother.

22 September 2007 – Violence was reported on this occasion and Birth Father 2 was convicted of battery but the crime was not referred to children's social care. Mother was pregnant at the time but this is unlikely to have been apparent. The Probation Trust was never informed that Mother, whom they were supervising, was the victim. The other factors in this incident that should have led to a referral to children's social care were that the incident arose because Mother was said to be shouting at the 7 month old baby (Subject Child 1) and Birth Father 2 assaulted her in response. The baby was also left alone at home as both parents went out of the flat to go to the telephone kiosk. On this occasion it is clear that the child's needs were not considered appropriately.

23 March 2008 – Violence was reported on this occasion. Birth Father 2 contacted police to report that Mother had bitten him. He did not wish to make a complaint and no further action was taken as she alleged self-defence. Mother was heavily pregnant on this occasion. The Officer in the case reviewed the file and returned to check on Subject Child 1, linking the incident to Mother's conviction for having bitten the half-sibling. Children's social care were notified but took no further action. The IMR author criticises this decision and suggests that an Initial Assessment should have taken place. This author would agree, given the history and the heightened risk factor of pregnancy in domestic violence but also that Mother on this occasion could be considered as a perpetrator of domestic violence and given that she was identified as a person who may pose a risk to children, this should have been assessed. .

25 July 2009 – police attended an argument where no injuries were apparent. Police took no further action but children's social care services were notified via CAIU because of links to the previous incident. Children's social care

services took no action after checks with Health Visitor 3 and failed attempts to contact Mother. This is criticised by the children's social care IMR author who asserts that an assessment should have taken place.

31 August 2009 – violence was reported on this occasion. A member of the public reported an attack on Mother by Birth Father 2. Mother also reported this but no police action ensued as she made no Statement and the couple reunited swiftly. Mother told police officers that she blamed Birth Father 2's addition to cannabis and alcohol and was given advice about Addaction services. The incident was reported to children's social care on 17 September 2009 and led to the Child Protection Conference when both subject children were made subject to Child Protection Plans in October 2009. All police information was shared with children's social care at this time. There is no explanation as to why there was a late notification to children's social care other than the continuation of police enquiries.

The SCR Panel expressed surprise that the domestic violence incident in August 2009 was assessed as "standard" risk by the investigating officer who nevertheless asked for an enhanced risk assessment but without indicating why. The incident was upgraded to "medium" risk by the DAIU. Although this is unlikely to be considered legally as a "threat to kill" the idea of pouring lighter fuel on someone and threatening to light it (as detailed in the referral to children's social care) would potentially be viewed as serious by most people. In addition, both children were present and Birth Father 2 is said to have smashed a nearby mirror when Mother tried to leave with them. Even if not "high risk" in domestic violence terms, it does indicate a level of violence in Birth Father 2's thinking and response to stress.

23 May 2010 – Mother called police stating Birth Father 2 was outside her flat causing trouble. The children were not present. Police spoke to both parties and no further action was taken. No referral was made to CAIU or children's social care even though Mother advised she had been taking the children to see Birth Father 2 and that they were subject to Child Protection Plans. There should have been a referral at this point and the children's needs were not adequately considered outside of the reported incident.

26 May 2010 – Mother expressed fear that Birth Father 2 might burgle her flat as he had hinted he was watching it. Some window alarms were provided.

8 June 2010 – Mother reported Birth Father 2 as constantly texting her and wanting to reunite. She found gifts from him. Although assessed by the call taker as vulnerable the police were unable to respond instantly and it was then deferred for an appointment which the police IMR author does not consider the appropriate response. There is some criticism of management

oversight of the delay, although in fact police officers had responded to further contacts from her in the meantime.

22 June 2010 – Mother contacted the police as Birth Father 2 had threatened to take the children back to his country of origin "within the hour". Police attended but Birth Father 2 did not arrive. This was reported to DAIU, CAIU and to children's social care. Mother was said not to be distressed and stated she wanted Birth Father 2 to see the children. The incident was assessed as a domestic incident and classed as a "medium" risk. There is no evidence of any checks undertaken to see whether passports were in place for the children.

24 June 2010 – Mother contacted the police and wanted to report Birth Father 2 for harassment. She also contacted children's social care services in tears, stating she did not feel the police were responding appropriately. Police attended and Mother stated she believed Birth Father 2 had been attempting to gain entry to the flat. She reported how he had appeared on a balcony and showed evidence of an attempted break in although this could not be linked to Birth Father 2. Housing was asked to repair the door and the risk was assessed as "high" with an alarm being fitted to the home. Birth Father 2 was visited and given a Harassment Warning in response to what was considered to be a one-off incident. The incident was reviewed by the DAIU sergeant and tasks were identified but although the risk was maintained as "high" on review, the mandatory referral to the Independent Domestic Violence Adviser was not made. This is a significant missed opportunity to assess the situation fully and consider support needs for the victim and any work required with the alleged perpetrator. Mother had advised the police of Birth Father 2's threats to kill himself on several occasions and to kill her if he found her with another man.

Social Worker 3 also visited the home on that occasion to ensure Mother and the children were safe and had support. It was suggested Mother took legal advice, which she did. Social Worker 3 assessed her as being in fear of Birth Father 2 but no consideration appears to have been given to a Child Protection Conference which should have been the response to the escalating concerns. There is no assessment as to the impact on the children of the escalating concerns or of earlier events. At a Core Group in 2010, Social Worker 3 asked the Mother whether she considers the children have been affected by witnessing domestic violence but this is not an assessment of impact and given her fears about the children being removed, her response should not be relied upon.

No further Domestic Violence incidents were reported to the police and a local decision was made in September 2010 to remove the alarm. This was done

without further assessment and without consultation with children's social care who were still involved with the family.

16.5.5 As well as the missed opportunities for referral to IDVA and children's social care, there was a lack of awareness in agencies of the heightened risk to domestic violence that occurs in pregnancy. There were at least two domestic violence incidents when Mother was pregnant. This was never overtly considered in assessments yet statistics from the Women's Aid Federation quoting from Lewis and Drife (2005) state that 30% of domestic abuse starts in pregnancy. National guidance to midwives has emphasised this in the Royal College of Midwives Position Paper on Domestic Abuse in Pregnancy (1999).

16.5.6 There is also no evidence of consideration by any agency of the increased risk that occurs at the point of separation or afterwards. The Child Protection Plans for the two subject children were discontinued because it was believed the parents had separated and that Mother would maintain this and be able to protect the children. Lees (2000) notes, "*women are at greatest risk of homicide at the point of separation or after leaving a violent partner*". A number of the IMRs point to a link with another local Serious Case Review (Child W) where separation was erroneously perceived to be a protective factor rather than a potentially increased risk.

16.5.7 The manager from the Domestic Violence Integrated Response Project indicated that referrals can be made to the service at any point and at any level of risk. This awareness is not currently apparent in the agency responses but referral could have provided advocacy and support to Mother.

16.5.8 This author would also suggest that there was a lack of awareness of the potential risks linked to Birth Father 2's threats to kill himself. Saunders (2004) undertook a study of 29 child homicides occurring between 1994 and 2004 and of the 13 fathers involved, 9 of them had threatened or attempted suicide. When Birth Father 2 met with Social Worker 3 to try and seek contact with his children in 2010, his evident high emotion was deemed to be an attempt to manipulate. With the benefit of hindsight and knowing the history he explained to the G.P., there could be an alternative hypothesis – that this father was becoming increasingly desperate. Domestic violence is sometimes described as a means of "gaining control" and Birth Father 2 was experiencing a complete lack of control at that point. He reiterated his threats to kill himself to Social Worker 3, although not the threat to kill Mother if she became involved with another man, which she had reported to the police. It is likely that death was already part of his ideation.

16.5.9 Although cause of death is as yet to be ascertained in relation to the children and their parents in this case, the SCR Panel has worked on the assumption

that it is probable that the children and Mother were killed by Birth Father 2 who then killed himself. There is limited research in relation to individuals who kill their families and themselves. Filicide, the killing of a child by a biological parent is rare and filicide-suicide or familicide (killing the whole family) is even rarer although there is a noted higher prevalence of filicide-suicide in biological fathers. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness published a comprehensive literature review (University of Manchester, 2009). Comparison between studies is difficult because of differing cohorts. The review states that there are on average 32 filicides per annum in England and Wales with a fifth of the perpetrators having committed suicide. Filicides that include multiple victims are more likely to end in suicide (Shackleford et al, 2007) and traditional risk factors for violence appear different from commonly occurring factors in filicide-suicide, making prediction and intervention difficult (Friedman et al, 2005).

16.5.10 There are common categories of motivation developed by Resnick (1969) and used in most studies. The categories are - altruistic, psychotic, unwanted children, "accidental", revenge. Studies suggest that in familicide-suicide, almost 50% of the cases suggest altruism as a cause although the categories are noted to have limited benefit as cases are often multi-dimensional and motivation is hard to define following suicide. Factors are noted to be different between countries, suggesting that there are also societal factors to be considered. The data from the National Confidential Inquiry quoted above shows that a fifth of offenders in England and Wales in relation to filicide are from a minority ethnic group. In an article for European Social Work (Volume 7, No 3) by Julia Stroud, she references a Norwegian study by Grunfeld and Steen (1984) where stress on migrant parents, over-represented in two studies, was noted. Data for filicide-suicide is not given. Most studies show a high correlation with mental illness of the perpetrator in filicide-suicide, particularly of anxiety and depression. The summary of risk factors given for practitioners working in childcare and mental health services is as follows:

- Parents having children at a young age
- Prior contact with social services re child abuse and neglect
- Domestic violence
- Social disadvantage/financial instability
- Single parent and lack of social support
- Suicidal ideation – extended to child

- Mental illness (depression and psychosis)
- Delusions around the child's health and wellbeing
- Postpartum disorders
- Substance misuse

16.5.11 It will be noted that a number of the risk factors above are relevant to this SCR – a young parent, history of child abuse, domestic violence, social disadvantage, substance misuse and suicidal ideation. All but the last factor will be present in very many families known to agencies, confirming that prediction and intervention is difficult. It is perhaps the last factor, the persistent threats of Birth Father 2 to kill himself that warrants further examination. Gross, B. (2008) suggests that where a parent expressed suicidal thoughts, it is worth asking what they think would happen to their child as a means of establishing if filicide is part of the suicidal plan. This may have happened if Birth Father 2 had been engaged in a full assessment or been offered work in relation to his domestic violence. The G.P. did not consider whether there was a need for mental health assessment even though asylum seekers are known to have higher incidence of post traumatic stress disorder, as noted in the current government consultation on suicide prevention in England (2011).

One person in England dies every two hours as a result of suicide and this man repeatedly threatened to kill himself. The other relevant factors as identified in the literature are the stresses on a migrant to the U.K. and the pressures he was facing immediately prior to the event by trying to carry out unpaid work for his Community Payback Order and carrying on with his employment. It is noted that he was threatened with a breach for not fulfilling the requirements for unpaid work and that he was "rude" to staff.

There is no suggestion that any of these factors triggered the event but may be part of a complex multi-factorial causation for the tragedy that occurred. The above is an attempt to try to explain, but not to excuse, what occurred.

16.5.12 Particular consideration has been given to the issue of domestic violence as it was the factor that led to the subject children being subject to multi-agency Child Protection Plans and then Family Support Plans (as Children in Need). The author is also mindful that if this event had occurred slightly later, a Domestic Homicide Review would also be carried out and there is relevant learning for such a study in relation to this case. The purpose of a Domestic Homicide Review is to identify if lessons are to be learned and to develop responses that will prevent domestic violence homicide for all domestic violence victims and their children. This is entirely compatible with the purpose of this Serious Case Review.

16.5.13 In terms of the Domestic Homicide Review, there is no evidence that a serious risk that would lead to homicide (or familicide) went unrecognised by agencies. In general, although there could have been improvements in information-sharing at times, the response to the actual domestic violence incidents was in line with procedures. The lack of any agency referral to the Domestic Violence Integrated Response Project and the lack of police referral to the Independent Domestic Violence Advisor (IDVA) was a missed opportunity. The research quoted above would also identify that a suicide threat, especially where associated with a threat to kill other family members should always be followed up. The increased risk during pregnancy or at and after relationship breakdown was not considered in this case and this learning needs to be reiterated. The Areas for Improvement in the Leicester Inter-Agency Domestic Violence Strategy (2009 – 2014) outline four that may have been of benefit for this family and constitute the **learning points**:

- Increase MARAC capacity and effectiveness
- Increase capacity of accredited programmes and one to one interventions following best practice
- Multi-agency training, including drug and alcohol use
- Further multi-agency training/debrief opportunities (to disseminate learning from complex cases)

16.5.14 All relevant agencies in this case determined that referral to MARAC (Multi Agency Risk Assessment Conference) was not appropriate as the case did not meet the "very high" risk threshold. It should be noted that the MARAC arrangements in Leicester have already been independently assessed as good although capacity issues were noted. The number of points required for local referral to MARAC has been lowered from 14 to 12 increasing the number of cases that are referred. However, the risk assessment tool that would have been used by the IDVA is the one recommended by the Coordinated Action against Domestic Abuse (CAADA) and this indicates that risk assessment is a judgement rather than applying a strict numerical assessment of risk. Completing that form in relation to this case suggests that referral might well have been made in 2010 if the context and all the incidents were viewed together. In addition, the manager of the Domestic Violence Integrated Response Project indicated that referral could have been made on the basis of "advocacy perception" of risk. The fact that agencies appear to be unaware of this is something to be addressed in the current review of interagency domestic violence services. A review of domestic abuse services is underway and consideration is being given to a single point of contact and care pathway across levels of risk which should assist with dynamic risk assessment. The CAADA risk assessment tool is being

replaced in September 2011 with the Domestic Abuse Stalking and Harassment (DASH) risk assessment tool which encourages wider reflection.

16.5.15 A 2 year research project (Feb 2011) in the Family Matters Programme sponsored by the Family Rights group has identified issues involved in working with "risky fathers". This has concluded that fathers who have perpetrated domestic violence are rarely offered parenting assessments or programmes to force them to face up to their abusive behaviour. In this case, Mother was offered (finally) the Freedom Programme but there appears to be no consideration of offering father a programme of work. Had agencies been aware of his help seeking approach to the G.P. this may have been considered.

16.5.16 The literature in relation to familicide shows the strong link to alcohol and drug misuse, both factors in this case as with many child abuse and domestic violence situations. The relevance of ongoing training in relation to this for all practitioners is emphasised by this SCR.

16.5.17 The objective of disseminating information from complex cases is relevant to Serious Case Reviews and Domestic Homicide Reviews and co-ordination of the two would be of benefit for agencies and practitioners. A **learning point** is that the literature relating to filicide-suicide is not well known across most agencies but being alert to any threat to kill (self or others) made by a parent is crucial in order to safeguard their children.

16.6 Lack of involvement of men in the family. (This relates to Numbers 1, 2, 3, 4, 5,6,7,8,9,10 and 11 of the Terms of Reference for this case)

16.6.1 This is sadly a familiar theme in Serious Case Reviews and is replicated to some extent in this one.

16.6.2 There is evidence of significant work with Birth Father 1 when the half-sibling was placed in his care but little evidence of work with him prior to that although the domestic violence incidents would indicate a family under pressure. Even when the half-sibling was placed in foster care when Mother was convicted of his abuse, Birth Father 1 did not feature in social care records as detailed to this SCR, although it is noted that he was providing "respite" for Mother. It is not known what assessments were undertaken prior to the half-sibling moving to his care nor is there evidence of consultation with him in respect of contact his son was having with Mother and her family.

16.6.3 Lack of involvement is particularly apparent in respect of Birth Father 2. No agency has recorded whether he held parental responsibility for the two subject children. He was checked via the Police National Computer when he became known as Mother's partner and prior to the half-sibling being

returned to her care, but there is no record of any parenting assessment in respect of him at any time. Birth Father 2 was described as a "polite young man" when first encountered with Mother and there is evidence of at least some direct involvement with the children in his presence at their birth, presence at the hospital with the children on occasions and presence with the family when accompanying Mother to Probation appointments. Warm relationships were observed by Health Visitor 3 between this father and the children on several occasions. The maternal grandfather spoke of Birth Father 2 showing care to his children. The Child Protection Plan put in place in October 2009 referred to a parenting assessment of Birth Father 2 and although it is accepted he was not willing to co-operate initially, there is no evidence of an attempt at real engagement even when he did make contact with Social Worker 3. He was assumed to be attempting to manipulate the situation to gain contact with his children, which was deemed unsafe. The focus of all the early intervention was to support Mother in her care of the children, but she was very clear that she wanted support from her partner. The research quoted in paragraph 16.5.15 above is relevant. There was no recognition that this father may have been important to these children and that some form of contact may have been beneficial.

Brandon et al (2009) comments on the failure to take account of fathers in assessments and that rigid thinking was often apparent where fathers are deemed to be "all good" or "all bad". There is certainly an increasing assumption by agencies that Birth Father 2 was "bad" for the children, but as outlined by the Family Rights Group research into working with risky fathers, this needs assessment to determine if they are a risk or a resource for their children (see 16.5.15 above).

16.6.4 Cultural issues were apparent in Mother's relationships with both Birth Fathers. As Working Together 2010 states (10.11) "*assessments should focus on the way religious beliefs and cultural traditions in different racial, ethnic and cultural groups influence values"*. Had this been undertaken, there may have been an opportunity to alleviate some of the stressors. Working Together 2010 (11.80) also suggests that fathers who are perpetrating domestic abuse should be provided with "opportunities to change". The **learning point** is that fathers should always be considered as part of any assessment of parenting and that Child Protection Plans should not be ended without assessment of the father's position and **the children's views of that**. In this case, the separation of Mother and Birth Father 2 was seen to be a protective factor but as Working Together 2010 states (11.85) *"separation itself does not ensure safety, it often at least temporarily increases the risk to children or mother".*

16.7 Communication/information sharing. (This relates to Numbers 1, 2, 3, 5, 7, 8, 9, 10 and particularly Numbers 11 and 12 of the Terms of Reference for this case).

16.7.1 This is again a familiar theme in national and local Serious Case Reviews and is replicated to some extent in this one.

16.7.2 While there is evidence of generally good information sharing between the social workers, police and health visitors involved, the IMRs reveal some deficits. There is little recording of communication between Health Visitor 3 and early years settings, although it is suggested there was informal contact. The Children's Centre providing a family support service initially had no knowledge of Mother's conviction for abuse of her first child and believed domestic abuse was "historical". They did not receive the Minutes of the family support meeting even though they were actually providing the family support. The maternity unit at the hospital was unaware that children's social care services were involved when Subject Child 1 was born, although it is not clear where the communication broke down in that respect as both the children's social care chronology and that of the health visitor indicate conversations prior to the birth with the Community Midwife. Certainly the Midwifery service should have been invited to the family support meeting in January 2007 as recommended by Health Visitor 3. The Probation IMR indicates that recording was not in place to show that Offender Manager 1 did share her concerns about the relationship between Mother and Birth Father 2 with children's social care.

16.7.3 There is previous reference (see 14.5 above) to the issue raised in the individual management report of UHL highlighting the problem of community midwives' inability to access previous hospital records of women booking in pregnancy. The IT systems differ in hospitals and in community settings. Community Midwives are reliant on women self-reporting problems and this potentially means that both safeguarding and medical problems could be missed. This is believed to be a national problem since ante-natal booking appointments are now carried out in the community rather than the hospital, where records could be accessed. A recommendation will be made to ensure this is raised appropriately at regional and national level.

16.7.4 The Housing service has already addressed the internal communication issue identified where information was not passed to the local team before filing and a similar action has been undertaken by the U.K. Border agency to ensure there is communication when it is intended to remove an individual to a third country. The early prevention IMR notes that there could have been better communication between the community nursery officer and the nursery.

16.7.5 There are two major communication issues that are of real importance in this case. There were a number of missed health appointments for both subject children at hospital clinics and for immunisations at the G.P. surgery. This information did not appear to reach Health Visitor 3 even though the hospital indicates that both G.P. and health visitor was notified of non-attendance. This needs further examination as the result is that Health Visitor 3 was not in possession of the full facts when visiting the family or reporting to multi-agency meetings. The children's social care IMR reflects the belief that the children were attending all health appointments and decisions were made without the true facts. The second and linked communication issue is in relation to the "silo" working of the G.P.s. There are a few occasions where there was communication with the health visitors but this was primarily one-way with Health Visitor 3 making efforts to share information with the G.P. The IMR author and health overview author identify 15 separate failures to communicate with the health visitor. There was some suggestion in discussions at Panel that the move of health visitors from GP practices to be based at children's centres had exacerbated the problem. It was apparent in this SCR that not all GPs knew how to contact the health visitor. This is of major importance and the whole inter-relationship needs further examination. The G.P. IMR author correctly makes three recommendations relating to this issue but it will be important that the commissioners and the LSCB also assure themselves of effectiveness. The non-attendance at appointments was very relevant information that the G.P. should have communicated to Health Visitor 3. In particular the G.P. should have provided reports to Child Protection Conferences which would have given information about both parents' state of mind. It is noted that the G.P. did not always receive an invitation to the Child Protection Conferences. The G.P. did not always receive Minutes of the conferences but the knowledge that child abuse and domestic violence was a factor in this family (as advised by both parents) should have alerted the G.P. to the need for safeguarding of these children and appropriate communication with other professionals. A letter was written from the Department of Health to PCT Chief Executives (Gateway No. 13083) following Lord Laming's Progress Report in 2009. This stated that PCTs should ensure that GP practices and staff have robust systems and practices in place to ensure they can fulfil their role in safeguarding children. This has relevance in this case.

16.7.6 It is a sad fact that Birth Father 2 chose to share with the G.P. practice on three occasions his concerns about anger management, domestic violence, and the stresses emanating from his history that led to him "feeling very low" but this was not passed on to other professionals working with the family. In addition, Mother consulted her G.P. in April 2010 as she was weepy, low and lonely. She was prescribed anti-depressants but this very relevant information was not provided to the Child Protection Conference held a few

weeks later which decided to end the Child Protection Plans for the two subject children as it was believed Mother was capable of caring on her own and protecting the children.

16.7.7 The **learning point** is that information held by individual agencies and practitioners must be shared effectively in order to safeguard children by identifying the "big picture" of their circumstances.

16.8 Rule of optimism/disguised compliance. (This relates to Numbers 1, 2, 3, 4, 5, 9, 10 and 11 of the Terms of Reference for this case).

16.8.1 It is easy with hindsight and the benefit of all relevant information to state that the two subject children should not have had their Child Protection Plans ended in May 2010 and that a Child Protection Conference should have been held when concerns escalated in June 2010. Agencies failed to share relevant information about missed health appointments, concerns about each parent's state of mind and missed the relationship between separation of parents and heightened risk. Decisions were made when not all elements of the Child Protection Plan had been carried out – no psychological assessment of Mother and no parenting assessment of Birth Father 2 and no consideration of the effects on the children of him having no contact. One IMR author notes that it is hard to see what had changed, other than Mother co-operating and the passage of time suggesting it was less likely that the parents would reunite. This was an optimistic view.

16.8.2 Optimism was apparent earlier in the decision to remove the half-sibling's name from the Child Protection Register in December 2006, given the impending birth of Subject Child 1. The timing of the rehabilitation just after the birth showed no consideration as to the vulnerability of this Mother and her history of difficulties in parenting and with a new partner. She appeared able to convince people that she was able to cope without assessing the reality of this. There should have been a warning in her comments that she had been struggling for some time before the abuse but had not wanted to share this.

16.8.3 There was also an optimistic view taken when no pre-birth child protection conference was held in respect of Subject Child 1. Mother was designated as a person posing a risk to children and throughout involvement with the Probation Service she was assessed as "medium risk" of harm to a child. The concerns focused on her relationship with one child, without reference to her vulnerability and history. It was believed to be different as she developed a strong attachment to both subject children. However, attachment by itself is not sufficient to prevent problems and as Brandon et al (2009) comments, *"good parental engagement (*with professionals*) sometimes masked risk of*

harm to the child". In hindsight, it is apparent that Mother was experiencing some of the problems she experienced with the first child - problems with toilet training, eating and behaviour management. A reference in the health visitor chronology refers to a discussion about "head-banging" in relation to Subject Child 1, again something she had experienced with the half-sibling. The Report provided by NHS Direct indicates Mother acknowledging she was "force feeding" Subject Child 1 when he was unwell and not eating. This was one of the findings in her earlier treatment of the half-sibling. The "stay and play" worker recollects that Subject Child 2 was often clingy to Mother and upset if they were parted. This may not support the view that attachment was secure between Mother and this child. There was no consideration of repeating patterns of behaviour.

16.8.2 Mother was able to convince the Child Protection Conference in May 2010 that she was able to protect the children and this was accepted without reference to her vulnerability and isolation, the number of times she had expressed the need for her partner's support, the depression she had experienced over time and her recorded ambivalence as to whether Birth Father 2 should have contact with the two subject children. Health Visitor 3 recording suggests a concern at the decision but no challenge at the time. There was optimism that Mother could be relied on to provide the protection the children were seen to need, but without firm evidence for this. The Child Protection Plans and the Family Support Plan relied on Mother to a substantial degree and her comments were "*taken at face value without considering the effects on the child"* (Ofsted, 2010) There was clearly insufficient challenge to her assertions that contact with Birth Father 2 was "accidental", especially with her reported ambivalence about this issue to several agencies. In decision making there was a focus on the strength of relationship of the Mother with the two subject children and evidence that there were problems was rationalised. Not all information was gathered from all professionals involved as the optimistic view taken did not lead to more stringent investigation. Birth Father 2, not Mother, was deemed to be the problem in spite of her history and conviction and in domestic violence terms, the knowledge that she could also pose a risk was not considered.

16.8.3 Mother was seen to engage well with all professionals, apart from the period of non-cooperation when the Initial child Protection Conference was planned for the two subject children in October 2009. She was likeable, "a nice young woman", and there are suggestions in the IMRs that professionals empathised with her because of her vulnerability and apparent openness and help-seeking. One of the IMR authors attending an SCR Panel spoke of Mother as "disarming by her outpouring". Brandon (2009) talks of professionals being **"***keen to acknowledge the successes of the*

disadvantaged". The openness and help-seeking is not as positive as presumed.

16.8.4 The IMR author for the health visiting service comments that Mother often requested support but did not always act on advice given. Mother expressed herself willing to access universal support services but only attended one behaviour management session in 2009, for example. She also failed to attend the Practice Therapist on a number of occasions in spite of significant encouragement and efforts to secure this on her behalf and she led Offender Manager 1 to believe that she was attending. Mother's period of non-co-operation with the Child Protection Plans in late 2009 was never formally assessed and her assertions that meetings with Birth Father 2 were accidental or in passing were wholly believed, even though she acknowledged to police officers that she had been taking the children to see him. The maternal grandfather described seeing bruising on Mother in November/December 2010 and described a present provided by Birth Father 2 to Subject Child 1 at Christmas that year. Mother was at that stage denying any contact with Birth Father 2. It would appear there was at least ongoing contact, whether by agreement with Mother or as a result of coercion. Either way, there was no disclosure of this to any agency.

16.8.5 It has become apparent that Mother was able to manage selective openness with individual services. When booking with the midwives when pregnant, she did not share the child protection information or her child being in care, although did share the fact that she had been in care herself. She did not tell her Offender Manager, with whom she was said to have engaged very well over a long period of time, of the domestic violence incident in which Birth Father 2 was charged with battery. She did not choose to share the reasons for her first child living with his father with the family support worker or Nursery. However, all of these professionals believed that Mother was extremely open with them and she was "wholly believed" when she insisted she had had no contact with Birth Father 2. Her attendance at the Freedom Programme, finally achieved after many attempts to start this, provided assurance to agencies. Agencies "*confused participation with co-operation*" (Ofsted, 2010) such as Mother's decision to begin to co-operate with the Child Protection Plan after several months of non-co-operation. There appears to be no in–depth assessment as to why this changed.

16.8.6 Since the SCRs into the death of Peter Connelly in 2007, the issue of "disguised compliance" has received more attention, but there has long been an old adage in working with families – "*look at what parents do, not what they say***"**. It is recognised as difficult to maintain "*respectful uncertainty*" as Lord Laming asserts as necessary when some actions and responses would appear to provide positive evidence. Mother's apparent willingness to seek help for difficulties appeared to disarm professionals as

did her strong commitment to the probation order and attendance at virtually all ante-natal appointments. However, there was limited checking on her commitment to following through or acting on the advice. She provided a clear statement about her unwillingness to seek help when struggling to care for the half-sibling and the recognition that this pattern may have been repeated was not considered in spite of her statements of anxiety that the subject children may be removed from her care.

The **learning point** is that all professionals must maintain "respectful uncertainty" in working with parents and should seek evidence to support statements, challenging where necessary.

16.9 Variable and incomplete focus on the children. (This relates to Numbers 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 and 12 of the Terms of Reference for this case).

16.9.1 The Children's Centre (at that stage managed by Leicester City Council) was commissioned to undertake family support work with Mother and the half-sibling in June 2006 to support his rehabilitation with Mother. A twice weekly visiting pattern was agreed, but is not evidenced by the recording. It is noted that there is little mention of the half-sibling in the recording and contact with the Nursery was deemed by the IMR author to be insufficient. The focus is on work with Mother and although she reports that there was improvement, there is no actual evidence to support this. There are a number of "no-access visits" The work was continued to support Birth Father 1 in his care of his son although case notes were unavailable to confirm the detail. There are no recordings available in relation to the half-sibling at the pre-school he attended regularly. Information from the staff was gleaned to support the IMR. The pre-school staff had no knowledge as to why they were being invited to Child Protection Conferences and Core Groups and were not aware of the reasons for the half-sibling being away from his mother's care. Given the serious nature of his abuse, this all shows a poor multi-agency approach to support this child's needs, with the focus being on Mother.

16.9.2 There is more recording to support the second rehabilitation of the half-sibling in February 2007 as nursery sessions were put in place from March 2007. These do record his difficulties and progress although it is noted that he moved from his mother's care shortly after starting at nursery.

16.9.3 There was generally good observation and recording about the two subject children by the health visitors and the offender managers, although the IMR author for the Probation Trust points out that more would have been observed had the planned home visiting taken place. The family support worker at the Children's Centre where Mother referred herself for support in 2010 does involve the children in her work and records the progress. The family support

worker left a message for Social Worker 3 when there was a concern about Birth Father 2 attempting to gain access, but there is no follow up to this message. The agency is clear that another difficulty was the lack of knowledge as to whether the children were subject to a Child Protection Plan or not. They were reliant on Mother's reporting and this shows a lack of focus on children's needs and an organisational problem for universal and open access services. There was some lack of clarity in police recording as to whether the children were always present or seen when domestic violence incidents were investigated and some evidence that their needs were not always fully considered with the lack of referral to children's social care services on 3 occasions.

16.9.4 The children's social care IMR shows that visiting patterns fell below the planned level on a number of occasions and the children were not always seen as sometimes were said to be asleep – even at 4.30 p.m which might have been queried. There was a significant gap in visiting when the case was transferred after the two subject children became subject to Child Protection Plans and this showed a disregard for the needs of the children at that crucial stage. There was another gap on transfer again in February/March 2010 which would suggest there is an organisational issue to be addressed. The Ofsted Report (2011) focusing on the Voice of the Child in serious case reviews raised the issue of frequency of visits.

16.9.5 Subject Child 1 attended both playgroup and pre-school and Subject Child 2 attended playgroup and recollections in interview with the staff show they had good knowledge of the children though were not fully aware of the circumstances surrounding their care, a recurring theme in the early years settings.

16.9.6 It has already been stated that the G.P. contact with this family provided a good standard of response on each occasion, but the treatment involving the parents did not indicate sufficient regard to the needs of the children, nor did the lack of reports for Child Protection Conferences or the lack of notification to Health Visitor 3 of relevant information.

16.9.7 This author was unable to find evidence across the many agencies involved with the two subject children of "*sound assessment of the child's needs and the parents' capacity to respond to these"* (Working Together 2010). The children were deemed "too young" for direct work and only one professional (Social Worker 3) attempted any direct work – and identified Mother's anxiety about this which should have raised concern. Even if it was decided that direct work was unsuitable (although there are many tools for working with young children available), there is a lack of assessment, particularly in respect of the domestic violence, to show the impact and to view the situation from the children's perspective. There is also a lack of account taken of their

relationship with their father prior to insistence on no contact. The children attended a range of pre-school provision but no visits were made by social workers to see them independently of their parents.

16.9.8 The Voice of the Child (Ofsted, 2011) notes that there may be other adults available to speak on behalf of the child/ren, but they are not always heard. This appears to be the case with the maternal grandfather who made several attempts to contact social workers but was advised he could not be involved in discussions because of "confidentiality". Consideration could and should have been given to involving him in child protection conferences. Mother was in regular contact with him and there is no suggestion she would have objected. However, even if she had, the needs of the children would suggest the importance of inclusion of a potentially protective grandparent.

16.9.9 The **learning point is** that even when work has to focus on change required with the parents, the child's perspective must be maintained and there must be assessment of the impact of the work on their day to day experiences. A recommendation will be made to address this.

16.10 Recording. (This relates primarily to Number 12 of the Terms of Reference for this case).

16.10.1 Although the IMRs show no major deficits in recording in relation to agency expectations, there are areas of improvement that could be made.

16.10.2 The problem for the midwifery service in their inability to access previous birth records has already been described (Section 14.5). That IMR author also identified a problem in misfiling of the post-birth community midwifery records for 2007-8 which the Trust is already risk assessing.

16.10.3 Housing recording is assessed as good apart from the issue identified of a letter being filed at a central office and not shared with the local team. This has now been addressed. Health visiting recording is generally assessed as good although systems have changed during the period of this review. The IMR author comments that the recording is primarily a narrative and more analysis would be beneficial. This is also the view of the IMR author for children's social care. The Probation Trust IMR author notes good recording in most instances, but identifies the lack of recording and analysis of concerns about domestic violence, which is noted in supervision records but not on risk assessment so case transfer would not have highlighted these issues. There is also no report provided to the Initial Child Protection Conference, as per agency expectation. The IMR author discounts the explanation that problems arose because of specific needs of an individual officer, as supports were already in place.

16.10.4 Police recording was assessed as good although there were a few occasions where some information was missed or misinterpreted. Education recording in respect of the half-sibling was good, although there was limited recording in the pre-school settings, other than the Nursery, about each of the three children. Recording of the family support worker involved with the half-sibling was deemed poor but was assessed as good for the second family support worker. Work is already underway to consider shared policies across all Children's Centres which should identify expectations for recording. The IMR author points out that the regulated Nursery provision has allocated time for recording which is not reflected in pre-school settings, but there is nevertheless evidence of good child-centred recording in many other pre-school settings.

16.10.5 The U.K. Border Agency IMR assesses the recording as good, but points out the problem of sharing information between two systems. This prevented the removal of Birth Father 2 to a third country where he had already claimed asylum and has already been addressed.

16.10.6 The IMR author who assessed the involvement of the community paediatricians was appropriately critical of the lack of response to concerns expressed by children's social care and the police about a very late skeletal survey. Recording of the G.P.s was rated as generally good but with two occasions where judgments about child safety were not explained. The lack of presentation of reports to Child Protection Conferences is a significant deficit in that the G.P.s held information about parental well-being that no other agency knew about as well as the large number of missed health appointments. There were no child protection markers placed on the subject children's files.

16.10.7 The main concern about recording relates to the information contained in Section 16.9 above. The recording was very often adult-focused narrative with some description about the children, but a lack of analysis about their needs and views. It is also clear that systems are sometimes a barrier to effective recording and information-sharing as is commented on in the IMRs for G.P.s, hospitals, children's social care, probation and U.K. Border Agency.

16.10.8 The **learning point** is that effective recording is essential both in narrative and analysis to understand the situation from the children's perspective and to share appropriate information with others to better safeguard and promote the welfare of the children.

16.11 Management Oversight. (This relates primarily to Number 9 of the Terms of Reference for this case).

16.11.1 Management oversight is essential to ensure that recording is appropriate and that it contains effective analysis on which to base judgments and decisions and to ensure that plans are carried out in a timely manner. A number of IMRs indicated that there could be improvement.

16.11.2 For example, while there was regular and appropriate supervision within probation and recorded discussion about concerns, there was no quality assurance of the recording. The quality of assessment was also judged poor by the IMR author but not picked up by the manager.

16.11.3 Shortcomings in some management oversight in children's social care are well documented. The case was appropriately reviewed by Team Manager 1 during a short period when it was unallocated, but when the allocated senior practitioner indicated it was not possible to undertake visits, there were no further supervision sessions or responses to the lack of visits. The IMR author deems later supervision to be inadequate also but it improves when Social Worker 5 is allocated. The IMR author correctly notes that management oversight was limited at the most critical times in the case. It should also be noted that there were a number of actions which were part of the Child Protection Plan for the two subject children but not carried out. It would be expected that management oversight would have a quality assurance role in this respect.

16.11.4 The three health IMR authors consider management oversight and supervision to be appropriate in most instances. However, it is noted that the supervision of G.P.s failed to highlight the poor communication between the G.P. and Health Visitor 3 and G.P. and children's social care although there is access to specific support around safeguarding. It is noted that Health Visitor 3 sought appropriate supervision at time of child protection conferences to inform the work. There is earlier reference to the lack of specific training in relation to domestic violence for Health Visitor 3, but this does not appear to have been picked up and rectified in supervision. The poor continuity of supervisor is seen to add difficulty.

16.11.5 The Action for Children IMR outlines clear arrangements for management oversight as do the IMRs for Housing, Education and for U.K. Border Agency. The IMR for Early Years indicates that the recollection is that supervision was adequate, suggesting that this is not recorded. There is mention that the information sharing between the family support worker and the nursery could have been improved, but this does not appear to have been recognised by management oversight.

16.11.6 The police IMR indicated that there was adequate management oversight and supervision but notes two instances where more robust management should have occurred. The first was in June 2010 when there was a

significant delay in responding to a call from Mother. The IMR author suggests that the decision to apply a harassment warning could have been more robustly considered as a "course of conduct" which would have led to arrest.

16.11.7 A number of the IMRs note that volume of work was an issue for their agency. In these circumstances, management oversight is crucial to ensure that children remain the focus of the work, that quality of work does not suffer and that professionals are supported to carry out their roles when often under pressure and when they may have little other time for reflection.

16.11.8 The **learning point** is that management oversight is essential to ensure there is both adequate support for staff involved in highly complex work and appropriate challenge to their assessment and analysis, along with sufficient quality assurance systems in place.

16.12 What might have been done differently?

16.12.1 In terms of what might have been done differently, there are a number of missed opportunities which might have enabled a better and more complete picture to be developed of these children's needs. These are summarised as follows:

- A referral and Initial Assessment as a potential Child in Need should have been considered when the half-sibling sustained a fracture aged 15 months.
- Full details of parental histories should have been obtained for presentation to all Child Protection Conferences so that the possible impact could be assessed. Better understanding of parental mental health needs.
- Implementation of the planned psychological assessment of Mother as part of the Child Protection Plan.
- A pre-birth Child Protection Conference should have been in place for Subject Child 1 including a full assessment of Birth Father 2. Involvement of maternal grandfather could have been a protective factor and provided additional information about the impact on the children.
- Appropriate information sharing to inform the Child Protection Conferences and Family Support meetings. Attendance at these meetings should have been reviewed to ensure all relevant professionals were involved and relevant information was shared.

- Greater awareness by G.P.s of their role in safeguarding children when dealing with adult patients and appropriate information sharing, especially when anger management issues are revealed.

- Account taken of the cultural issues impacting on domestic violence incidents.

- Referral to the Domestic Violence Integrated Response Project

- Reporting of the battery conviction by the police to the U.K. Border Agency.

- Removal of Birth Father 2 to the third country where he had previously claimed asylum.

- Missed opportunities by the police to report to children's social care on three occasions and more robust consideration and action following the incident in which Birth Father 2 poured lighter fuel on Mother and in most reports is stated as threatening to set it alight. This is a threat of serious violence, and taken with subsequent threats to kill her if she has a relationship with another man, might have resulted in arrest and full consideration of the level of threat.

- Missed opportunity by agencies to convene a Child Protection Conference in June 2010 when concerns were escalating and risk was assessed as "high".

- More robust consideration of harassment as a course of conduct may have led to arrest.

- Questioning Birth Father 2 about his threats to kill himself may have revealed whether there was intention to include his family in these plans.

- More robust consideration of ongoing risk following separation, may have led the Child Protection Conference to a different decision when it was convinced by Mother in May 2010 that no risk remained. There should have been less reliance on Mother's perspective and more "respectful uncertainty".

- Communication by the police to children's social care of Mother's admission that she was taking the children to see Birth Father 2 even though the Child Protection Conference had deemed this unacceptable risk.

- Referral to Independent Domestic Abuse Advisors when the police assessed the risk as "high".

- Greater attempt to engage Birth Father 2 in assessment and more direct work/frequent visits with the children to gain their perspectives.

17. Conclusions

17.1 It is the opinion of the Serious Case Review Panel and of this author that the tragic deaths of these two children and their parents could not have been predicted.

17.2 These two small children were well known to local agencies. They appeared well loved by both their parents and were meeting developmental milestones, but there was little actual knowledge of their day to day experiences at home. Attention was not always given to their medical appointments by their parents, a common theme in Serious Case Reviews. The National Service Framework (2004) suggests the need for a more vigilant approach to missed appointments.

17.3 It was known that the relationship between their parents was volatile and there were a number of domestic violence incidents. The impact of these on the two children is unknown. However, the incidents were spaced apart and none resulted in any medical treatment required so for the most part were assessed as "standard" or "medium" risk. All were appropriately reviewed as per police procedures. When Birth Father 2 was attempting to reunite and gain contact with his children in summer of 2010, the risk assessment increased to "high" but it was considered that Mother was well able to act to protect her children and concern subsided even though research shows that this is a period of increased risk (Lees, 2000). Concern had lessened to the extent that Social Worker 3 met with Health Visitor 3 on 9 February 2011 to discuss plans to close the case as Mother reported that there has been no contact with Birth Father 2 for the previous 6 months and she was engaged in the Freedom Programme. The children and Mother were possibly already dead by this date.

17.4 The impact of parental histories was never fully assessed. There were no police call-outs to the family home after June 2010 and Mother told all agencies that there was no ongoing contact. This is now known to be false and there are strong links to an earlier local Serious Case Review (W case) where some of the learning for that case is replicated here. That case also identified issues of assumed decrease of risk at the point of separation of parents. In addition, there was acceptance of assurance that the father was not in contact with the family, when this was not in fact the case. In both cases, it is not known whether the mother was willingly allowing father access to the home or was doing so under duress.

17.5 There are many links also to national findings in relation to SCRs with many themes replicated in this case. As the health overview author notes, *"there*

are no new messages" in this SCR. Ofsted (2010) notes a common finding was that none of the agencies had a complete picture of the child's family or a full record of the concerns. Working Together (2010) notes that inadequate sharing of information is a recurring theme of Serious Case Reviews. This is particularly relevant in this case. Had the G.P.s shared the concerns about all the missed health appointments and the anger management concerns shared by Birth Father 2, it is likely that there would have been considerably less optimism about ceasing the Child Protection Plans in May 2010. There are strong links to two other local SCRs in this respect – Case F (2009) and Case W (2009) where actions for G.P.s were included to improve information sharing. This clearly requires local attention as the lessons from those SCRs do not appear to have been learnt so there is an organisational issue about embedding learning in practice.

17.6 Although the theme analysis in Section 16 reveals a number of missed opportunities and learning for agencies in dealing with vulnerable families, risky fathers and domestic violence, there is nothing in the history of involvement that could have led agencies to predict such a catastrophic event that led to the tragic deaths of these children, their mother and their father. As Lord Laming (2009) states, "i*t would be unreasonable to expect that the sudden and unpredictable outburst by an adult towards a child can be prevented".*

17.7 The limited research available points to the difficulty in predicting familicide as the risk factors are not the same as for domestic violence. There is a common link to mental health issues of anxiety and depression and to domestic abuse and substance misuse, all of which were present in this case, but are also common in the general population. As stated in the research review by Manchester University (2009), *"identifying an effective intervention is problematic and it is unrealistic to presume all filicides are preventable".* Causation is noted to be complex and signs and symptoms noted to be often ambiguous. One factor noted in one research paper notes the possibility of an increase in stressors just prior to the event. In this case, it is not known what stressors were apparent and there is no real understanding of motivation. The notes left by Birth Father 2 indicate a concern about his children growing up in British society and his earlier disparaging comments to Social Worker 3 about life in Britain would support this. The maternal grandfather noted how much Birth Father 2 missed his home country and spoke positively and at length about it. The only apparent stressor noted in the chronology were the problems Birth Father 2 appeared to be experiencing in completing his unpaid work requirement alongside his work commitments. A breach notice was withdrawn on 1 February 2011 when evidence of employment was provided, but was initiated again on 7 February 2011 when Birth Father 2 failed to attend. The rudeness to probation staff in January

2011 may have been an indication of increased stress but that agency did not even know that Birth Father 2 had a family. No other agency had knowledge that the parents were together so the true situation in this family was unknown. Certainly suicide and killing his family would be a very extreme act for this man. In the Qur'an suicide and killing another is forbidden, unless in the interests of justice.

17.8 There is less certainty as to whether it could have been prevented. The only known certain preventative factor would have been if the U.K. Border Agency had been successful in their attempts to remove Birth Father 2 to a third country. This opportunity was lost and plans have already been put in place to improve information-sharing which could have identified his status to the National Asylum Support Service. An alternative would have been a swift response to his request for voluntary repatriation, which did not happen. This is not the responsibility of the UK Border agency but it is not known if and when appropriate referral was made to action this.

17.9 It remains possible, though by no means certain that if the missed opportunities identified in Section 16 of this report had been seized, then more shared information may have led to greater identification of risk, greater assessment of both parents and more focus on the children. However, even with the benefit of hindsight, without knowing the motivation for such a catastrophic event, it is not possible to conclude that it could have been prevented. It is unlikely that this was an impulsive act but no motivation is immediately apparent.

18. Recommendations

18.1 IMR authors have made a range of recommendations located in the inter-agency Action Plan. The SCR Panel and this author have endorsed these actions as an appropriate response to the learning identified. The health overview author has also made a further nine recommendations to support the learning identified in health agencies.

18.2 There are however, eight additional recommendations proposed by this author aimed at ensuring learning is embedded, arising from the analysis and learning points identified in this overview report.

18.3 In relation to ethnicity and diversity, it is recommended that:

Agencies with a duty to co-operate must report to the LSCB their arrangements for recording of nationality, ethnicity, first language and religion and how this is monitored.

18.4 In relation to information-sharing, it is recommended that:

NHS Leicester City must report to the LSCB the arrangements for monitoring the response of General Practitioners to requests for provision of reports to Child Protection Conferences and how this is monitored and reflected in commissioning arrangements.

18.5 In relation to anger management, it is recommended that:

Where a parent or carer with children presents with anger management issues that could impact on the wellbeing of their child/ren General Practitioners must liaise with the health visitor or school nurse.

This is a repeat of a recommendation made in another SCR and reported by Ofsted (2010). It is relevant to this SCR.

18.6 In relation to maintenance of focus on the child/ren, it is recommended that:

Agencies with a duty to co-operate must review their quality assurance systems to ensure that they adequately reflect the required focus on the child/ren in work with parents/families and are able to evidence impact on the child/ren. Results of this review must be reported to the LSCB.

18.7 In relation to domestic violence, it is recommended that:

- **The LSCB must liaise with Leicester City Council to ensure that the recommendations arising from this SCR inform the development of a single commissioning strategy for domestic violence services and the development of a new and integrated**

model for the delivery of domestic violence services within Leicester City.

- **The LSCB must liaise with the Leicester Domestic Violence Strategy Group to ensure there is wide dissemination of learning from this SCR, in particular the learning arising from research into familicide and the links to domestic violence, mental health, drug and alcohol issues and the increased risk in pregnancy and at the point of separation in a relationship or subsequent to this.**

- **Training for agencies in respect of domestic violence must ensure it addresses cultural issues and the stresses that may arise in cross-cultural relationships.**

18.8 In relation to information sharing systems, it is recommended that:

University Hospitals Leicester (UHL) will consult regionally and nationally to share concerns about the system constraints on information sharing between hospital and community midwives, in order to seek potential solutions. Consultation will include contact with the Regional Local Supervisory Authority (LSA) officers for midwives in England.

18.9 In relation to Child Protection Conferences and the full sharing of information across all relevant agencies, it is recommended that:

- **The Independent Chair of a child protection conference must review the invitation list and ensure it is sufficient to provide the full range of information required to safeguard the child/ren and promote their welfare. This must include General Practitioners.**

- **In relation to assessment of parents, the Independent Chair must be satisfied that assessment includes all relevant history of both parents, analysis of the potential impact on parenting capacity and what supports are required for the child/ren.**

- **Prior to agreeing the cessation of Child Protection Plans the Independent Chair must check that all elements of the Child Protection Plan have been completed, unless there are strong reasons for discontinuing them.**

18.10 In relation to threats to kill self or others, it is recommended that:

A review of the Leicester Interagency safeguarding procedures must take place to ensure that there are clear references in the procedures at key points about how to respond to any parent or carer of children threatening to kill themselves or others.

19. Arrangements for progressing recommendations and dissemination of learning.

19.1 As the Commissioner of this Serious Case Review, the SCR sub group will monitor the resulting Action Plan. At its monthly meeting, progress will be monitored with colleagues from the key agencies represented on the group.

19.2 Dissemination of the learning will be achieved by a number of means:

- Any future relevant inter-agency Training and Learning content will incorporate the learning from this case.
- The key messages will be shared with partners at a full Board meeting, with the expectation that Safeguarding Leads will then disseminate these messages within their own agencies/organisations.
- Key learning will feature in the LSCB's own 2 monthly Research Digest of the safeguarding messages that are most relevant to the range of disciplines covered by the Board. Briefing packs will be made available to Safeguarding Leads to assist in the sharing of key messages.
- The learning will be shared with County colleagues at a range of joint business meetings (Procedures and Development sub group, the Joint City and County SCR sub group, etc)
- The learning will be shared with colleagues in Adult Services via the mutual attendance on each other's SCR sub groups and Board meetings. It will also feature in a joint conference event planned for February 2012.
- The LSCB website will feature the report outcomes on its "Latest News" section and also on its "Information for Practitioners" section.
- The Procedures and Development sub group will consider whether any amendments/additions are required to LSCB procedures in the light of the learning from the case.
- Local media will be used as part of the publication process to highlight key issues.

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