



LEICESTER SAFEGUARDING CHILDREN BOARD

Serious Case Review concerning child C1

Born: Autumn 2009

Significant Incident October 2014

March 2016

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1.0 Introduction

- 1.1 This review involves an Asian boy called Child C1 and the impact of his mother Adult A's chaotic lifestyle and parenting of him. Adult A and Adult B (Child C1's father) had been in a relationship since January 2009 and were married in May 2009. Child C1 was born in September 2009 and is the first child of Adult A and her husband Adult B.
- 1.2 The following information although outside the timescales of the review is however relevant to it. In 2003, Adult A was 15 years old and was suffering with emotional difficulties and anxieties, which were hidden from the family and not identified by those outside. Leicestershire County Council Children's Social Care was involved and offered Adult A's family a Child in Need (CIN) assessment but this offer was not taken up. It is not known if Adult A's parents ever read the letter offering this as they spoke little English and relied on Adult A and her siblings to read correspondence. It is possible that support for Adult A at this stage in her life would have improved her future parenting skills.
- 1.3 Adult B the father of Child C1 was not accepted by Adult A's family and this caused her difficulties at home. They were married without Adult A's family's favour and support. Upon marrying, Adult A moved into his parent's home where she was controlled by her mother in law (whose details are not known to this review). Adult A was now experiencing domestic abuse from her husband. In November 2009, she could not take this abuse any longer and she fled to her parents' home who received her on a temporary basis. Here she was faced with the knowledge that her parents wanted her to return to Adult B despite the fact that he was violent towards her. Child C1 was only 2 months old at this time and was clearly highly dependent and very vulnerable.
- 1.4 The next few years saw many interactions with the relevant agencies and professionals. Adult A continued to live a chaotic life and her care for Child C1 was often in question by a number of professionals and workers. She slipped into a drug habit which compounded her inability to look after her son.
- 1.5 In the late evening of 3rd October 2014 an Emergency Nurse Practitioner (ENP) from Hospital rang the Police reporting that a 5 year old child had attended the Hospital for a head injury the previous evening and had been treated and then discharged home. This was Child C1. The ENP was now reporting that the child's Uncle Adult C had returned to the Hospital and claimed that the injury to Child C1 was from a non-accidental injury, and that Child C1 was not being looked after properly. Adult C stated further that the family had agreed to lie about where Child C1 received his injuries so that Child C1 could receive medical treatment. Adult A stated that Child C1 had fallen downstairs at her sister's house and this had been accepted by Hospital staff. The ENP stated that the injuries to Child C1 were redness to an eye, a bleed in one eye, a mark to his cheek and three areas of tenderness and bruising to his head and the back of his neck. It was dealt with as a minor head injury and he was discharged. Adult C also stated that Child C1 had what he believed were two human bite marks to his shoulders and two puncture wounds to the soles of his feet.
- 1.6 As a result of this information a child protection investigation was commenced and Child C1 was returned to hospital and found to have a bleed on the brain, a depressed fracture of the skull and 21 other bodily injuries. Child C1 was later interviewed and said he had fallen downstairs from top to bottom whilst he'd been left alone in the house and that Adult A took "ages" to respond to his fall. He said the bite marks were caused by older child at school and the marks on his feet were because he had stood on something sharp. He stated that no one had actually hurt him, but "bad men" came to his house. Adult A was arrested and admitted neglecting Child C1. She stated that she abused drugs namely cannabis and she

misused alcohol. She said some days she would leave Child C1 alone six times a day to enable her to receive drugs. She said she found Child C1 at the bottom of the stairs whilst under the influence of drugs and did try to provide first aid. She received a conditional caution for neglect with the condition that she would engage on a drug/alcohol programme which she started early in 2015.

- 1.7 This review has sought to identify what, if any, factors either inhibited or caused practitioners and their agencies to act effectively to ensure Child C1's safety. The review has found lessons to be learned for agencies.
- 1.8 Observations have been made throughout the review and they are underpinned by a number of recommendations which the Leicester Safeguarding Children Board (LSCB) and its partners are invited to consider.
- 1.9 Good practice in some areas has also been highlighted and good work by individuals recognised.
- 1.10 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) set out an LSCB's function in relation to serious case reviews, namely:
5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
(2) For the purposes of paragraph (1) (e) a serious case is one where:
(a) abuse or neglect of a child is known or suspected; and
(b) either - (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The Independent Chair of the Leicester Safeguarding Children's Board (LSCB) agreed that this case fitted the criteria above under serious harm and has commissioned two independent reviewers - Dr Russell Wate to undertake this SCR and Felicity Schofield to chair the process. Dr David Jones the independent chair of the LSCB agreed with the decision of the Serious Case Review Panel meeting on 27th January 2015 and the panel agreed the scope of the review and identified key lines of enquiry, timescales and identified the agencies who would be required to provide a chronology of their involvement and an Individual Management Report (IMR).

- 1.11 The timescale for the period of the review was agreed to start from 21st January 2009 and end on 6th October 2014. Other information outside of the defined period was to be considered and included if identified as relevant.

This review centres on the following family members.

Child C1: Born September 2009.

Relationship to Child C1	Name
Mother	Adult A
Husband of Adult A and father of Child C1	Adult B
Ex-partner of AS between December 2009 and March 2010	Adult F
Maternal grandmother	Adult D
Maternal grandfather	Adult E
Maternal Uncle of Child C1	Adult C

2.0 Terms of Reference

2.1 The focus and key issues that this review sought to address were as follows:

- What actions were taken by professionals in relation to Adult A and Child C1?
- Why were they taken?
- What else could have been done at the time?
- To establish what lessons are learned to safeguard and promote the welfare of children and by doing so act upon these lessons swiftly identifying change where appropriate.

Contributors to the review

2.2 A number of agencies have contributed to this review as follows:

- Leicestershire Partnership NHS Trust (LPT)
- Leicestershire Police
- Leicestershire County Council Children and Family Service
- Leicester City Council Children, Young People and Families Services
- Leicester City Clinical Commissioning Group (CCG)
- Leicester City Council Housing Department
- University Hospitals of Leicester NHS Trust

Independent author

2.3 Leicester LSCB made a decision to appoint an independent author to carry out the review. The review is supplied by RJW Associates and the lead reviewer is Dr Russell Wate QPM. He is independent of any agency within the Leicester area. He is a retired senior police detective, who is very experienced in the investigation of homicide and in particular child death and child neglect issues. He has contributed to a number of national reviews,

inspections and inquiries, as well as being nationally experienced in all aspects of safeguarding children and public protection. He is also an independent chair of an LSCB.

Methodology

- 2.4 The review took the format of the LSCB inviting all relevant agencies to submit an Individual Agency Summary Report and a chronology of significant events. After these were collated, and considered, the management report authors, and key practitioners attended a workshop on 14th July 2015. This workshop had a relatively poor practitioner attendance; however, valuable and honest contributions were made by all agencies. Analysis then took place of the findings and after requests for further information from certain agencies; a report was completed for sharing and presenting to the SCR subcommittee for comment, prior to submission to the Safeguarding Board. This review was also hampered by the length of time it took to receive the reports from some agencies (10 weeks past the agreed due date, in some cases.)

3.0 Summary of the case

- 3.1 This section aims to provide a picture of the lives of child C1 and his mother Adult A, seen through their interactions with professionals from various agencies.

Initial post-birth period

- 3.2 Child C1 was born in September 2009.
- 3.3 Just over 2 weeks later a Health Visitor (HV 1) made a primary birth home visit to Adult A and Child C1. He was seen asleep but not examined. Adult A was with many other family members and this appears to have affected the Health Visitor from carrying out an examination. This visit took place 17 days after Child C1's birth. Primary visits should occur between 10 and 14 days following birth. There is no reason recorded for this late visit.
- 3.4 On 20th October 2009 a follow up home visit was completed by the Health Visitor (HV1). Child C1 was seen awake this time and examined and jaundice was noted.
- 3.5 On 26th October 2009 a Health Visitor made a pre-arranged visit to Adult A's home to assess Child C1's jaundice. There was no reply at home and a message was left on Adult A's mobile phone and a card left.
- 3.6 After no contact from Adult A the Health Visitor (HV1) rang her on 2nd November 2009 and gave her some strong advice to take Child C1 to her GP regarding his jaundice and for her own post-natal check.
- 3.7 On the 7th November 2009 Adult A (who was known by her husband surname at this time) contacted the Police reporting that her husband had been hitting her and that it had been going on for a few months. Her intention was just to have it recorded but she was persuaded by the call handler to meet with a police officer. She told the attending officers that Adult B had assaulted her the previous night whilst she was holding Child C1. Adult B family were present and witnessed this. She was reluctant to make a complaint due to fear and wanted further advice from the Domestic Abuse Investigation Officer (DAIO). A report of a non-crime domestic incident was recorded but a supervisor upgraded it to assault. The call handler's actions are noted as good practice as the positive response prevented Adult A from changing her mind through fear or persuasion.

- 3.8 On 11th November 2009 the DAIO reviewed the case and the officer completed an enhanced risk assessment and upgraded the risk from Standard to High due to the reported history of domestic abuse from her husband. The report stated that Adult A had been regularly assaulted by Adult B since she was 8 months pregnant and injuries had included black eyes and other bruising. It is recorded that she was ill having suffered a haemorrhage after giving birth and was due to be admitted to hospital on 12th November 2009 for possible surgery. The officer identified that Adult A was a potential victim of Honour Based Abuse (HBA). The DAIO made a Child at Risk referral which was forwarded to Leicestershire Social Services on 12th November 2009; this was processed as an enquiry and didn't progress to an assessment. A MARAC referral was considered but it failed to meet the set criteria.
- 3.9 From 12th November 2009 and the following days the DAIO made several attempts to contact Adult A without success. It was established that she had been admitted to hospital having become very ill and was awaiting surgery. Child C1 stayed with maternal grandparents.
- 3.10 On 17th November 2009 the DAIO visited Adult A at her parent's home after her discharge from Hospital. Adult A was unable to speak openly due to Adult D her mother's presence and a statement could not be taken, nor did she make any disclosures. Adult A had a history of domestic abuse within her family home, so this may not have been the best place to speak to her about this issue. Adult A said she did not feel in danger and was torn between pleasing and disgracing her family, who wished her to return to her husband even though they did not like him. A further appointment was made to follow up potential honour based violence issues, within her parents' home. Child C1 was seen and had been looked after by Adult A's parents whilst she was in hospital. It would have been useful for the DAIO to make contact with County Social Services to update them with the current situation and to see what had happened with the original referral. There is some confusion here which is due to the fact that Adult A was constantly moving between two Local Authority areas and there was an incorrect presumption by the DAIO that these areas were sharing all the relevant information. The SCR panel felt that an initial assessment should have taken place as Child C1 was a young baby. There was also no contact with either HV1 or the GP.
- 3.11 Adult A did not keep her appointment with the DAIO on 19th November 2009 and after many follow up calls she was spoken to on 30th November 2009.
- 3.12 On 24th November 2009 Health Visitor 1 spoke to Adult A who reported that Child C1 had residual jaundice. She was strongly advised to contact her GP that day to make an appointment for the jaundice and his MAP1. (A MAP1 is the first Major Assessment Point and this takes place between 6 to 8 weeks from birth.)
- 3.13 On 25th November 2009 Health Visitor 1 made a follow up telephone call to Adult A who said she had made contact with her GP. She was reminded again to book the MAP1 for Child C1.
- 3.14 On 3rd December 2009 HV1 telephoned Adult A because Child C1 had still not attended his MAP1 or his 1st vaccinations. She was strongly advised yet again to do so.
- 3.15 On 7th December 2009 HV1 contacted Adult A's GP surgery. They stated that there had been no recent contact from Adult A.

Hostel period

- 3.16 On 8th December 2009 Adult A contacted the DAIO stating that she needed to "get out now because she could not take anymore." The call was terminated several times as Adult A's mother in law kept checking on her and the DAIO had to keep ringing Adult A back. Adult A

was whispering and said that she was living with Adult B and his parents. She disclosed that Adult B and his mother were continually assaulting her and she was not allowed out and was alone with Child C1 most of the time. Adult A said, "Please help me." An incident was raised and officers met Adult A and Child C1 and then took them to the safety of a Police Station where they remained all day until accommodation could be found. Adult A could not decide whether to make any complaints of assault as she knew that any prosecutions would end her relationship with her husband and there would be no chance of reconciliation. Adult A said her GP was aware of her injuries received from this abuse but she had not disclosed how she received them.

- 3.17 Adult A and Child C1 were accepted at a hostel. The DAIO went to see Adult A at the hostel later that day with some of her property but she had gone out apparently to meet a male family member. The DAIO's response was immediate that day, albeit focussed on the mother and not on the child. A referral was not made, however, to Children's social care services (CSC) regarding Child C1. The procedure may have been different if Adult A had rang the Police directly rather than through the DAIO, as it is believed that the attending officers would have completed a domestic incident report with a referral to the relevant CSC. The review author believes that there should have been a referral to CSC and that the voice of Child C1 was lost. This is seen as a missed opportunity.
- 3.18 During the morning of 9th December 2009 the DAIO was informed by staff at the hostel that Adult A had left in a rush that morning with Child C1 and had not returned. The DAIO treated this as a missing person incident and action was taken to locate her and Child C1. They were found but the circumstances are not recorded. Adult A made a negative statement not to proceed with any charges against her husband through fear of losing the chance to make their marriage work and dishonouring her Asian culture. The DAIO highlighted that police action would escalate this volatile situation and could cause a HBA situation.
- 3.19 On 11th December 2009 a Health Visitor HV 1 visited Adult A and Child C1 at the hostel. Child C1 was now 11 weeks old. Adult A had been sleeping in the same bed with Child C1, so was advised strongly against doing this. Child C1 was also overdressed and sweating and Adult A said that her mother in law complained if he wasn't dressed this way. The HV 1 gave suitable advice to Adult A. Child C1 had still not received his 1st immunisations, or the MAP1. The health visitor and the DAIO had not communicated with each other.
- 3.20 On 14th December 2009 Adult A was admitted to Hospital with abdominal pains. She was discharged the following day. Child C1 was with the maternal grandparents.
- 3.21 On 15th December 2009 the DAIO made contact with Adult A who said she was being discharged from Hospital and was going to collect Child C1 from her family home and return to the hostel. She was advised to contact her Health Visitor (HV1) to rearrange an appointment. Adult A said she was happy at the hostel and was getting her life back on track. The DAIO contacted the hostel and updated them.
- 3.22 On 16th December 2009 Health Visitor 1 took Adult A and Child C1 to a GP appointment. The MAP1 and 1st immunisations were completed. During this time there is evidence that for the HV, Child C1 moved between normal and high priority, and the HV was proactive and responsive to the child's needs.
- 3.23 On 21st December 2009 the Project Leader at the hostel contacted the Police reporting concerns for Adult A and Child C1 as they had left in a taxi on 18th December 2009 and had not been seen since. The DAIO managed to contact Adult A on the telephone and she said she was with her husband in a hotel. She would not divulge the location of the hotel and

hung up and wouldn't answer further calls. Adult B's mobile phone was also tried but it was switched off. Adult A's mother was contacted who said she had spoken with her by telephone but hadn't seen her for 16 days. She stated that Adult A was not happy staying at Adult B's parents' home as it was too small and she should come and live with her. It is felt by the review officer that more attempts should have been made to trace Adult A and in particular Child C1 given the ongoing domestic abuse and HBA concerns. No supervisor was informed and the review author believes a referral to Children's Services should have been made.

- 3.24 Coincidentally on the same day, City Children's Services received a referral from Health Visitor 1 that had been made on 18th December 2009 and some initial actions were completed, believed to be by a non-qualified social worker. Contact was made with Health Visitor 1 and Adult A was spoken to by telephone who confirmed she had suffered domestic abuse at the hands of Adult B and she would not be going back to him. No safety planning appears to have been discussed, nor the needs of and risks to Child C1 discussed. There was also no contact made with the actual reporting Health Visitor or the hostel staff and the case was closed.
- 3.25 On 24th December 2009 a member of staff at the hostel contacted the DAIO stating that Adult A had been screaming down the telephone at someone saying "I'm doing this. I am asking you to bear with me through this period." The worker had asked Adult A who she was talking to and she eventually said it was Adult B who had been asking her to do something that she did not want to do. Adult A told the worker she was going to stay at her mother's address over the Christmas period and had been seeing her. This is contrary to what mother had stated. It was believed that she was going to stay with Adult B and staff had advised her not to. The DAIO made several attempts to contact Adult A but was unable to do so until 30th December 2009 when Adult A said that she was in Birmingham with a relative of her parents and was returning to the hostel on 1st January 2010. This was contrary to what the hostel knew as they thought she was missing. There is no mention of Child C1 or any checks made on his welfare throughout this period.
- 3.26 When City CSC closed the recent referral on 30th December 2009 noting there were no identified needs and that an initial assessment was not required, thus no further action was required. Adult A was not notified of this and monitoring was left to the hostel and Health Visitor 1 to complete, although they state they did not receive this information, as they should have. This is seen as a missed opportunity, as early help services should have been considered for this vulnerable baby and his mother. It is believed that now this early help assessment would have taken place, due to new processes now in place.
- 3.27 On 11th January 2010 Health Visitor 1 discussed Adult A and Child C1 with her Named Nurse for Safeguarding Children. A Child in Need plan was discussed with a safeguarding plan (this was terminology used by HVs to target services and does not equate to a child in need plan within CSC) the plan was to inform the hostel about concerns and for the hostel inform the HV, CSC and make the police aware. This provides evidence that Child C1 was being considered, but the follow up action focussed on Adult A and her whereabouts, not Child C1. This is a missed opportunity as the plan was not shared. A multi-agency approach under the auspices of a Common Assessment Framework (CAF) would have offered the baby greater protection.
- 3.28 On 12th January 2010 the Project Leader from the hostel rang the DAIO to share information about Adult A. This information was because Adult A had not been staying there regularly and when she was there she was meeting men outside which broke the hostel's rules. She was also taking Child C1 with her late at night and in the cold, and he was not appropriately

dressed for this. Her belongings were missing so they had presumed she had moved out albeit she had not told them this. The hostel had contacted City CSC regarding this although there is no record of this within CSC.

- 3.29 On 13th January 2010 Health Visitor 1 visited the hostel. Staff stated that Adult A and Child C1 had left there on 23rd December 2009 and returned on 5th January 2010. She had stated her husband had assaulted her resulting in a cut head. She then stayed infrequently arriving there in the early hours with Child C1 in cold snowy conditions. She moved her belongings out and left on 12th January 2010. There is little mention of Child C1 or whether staff actually saw him.
- 3.30 On 14th January 2010 the hostel contacted the Police to inform them that Adult A was in rent arrears and they could not contact her. They mistakenly thought this was a Police matter. City CSC had been verbally updated by way of a referral as they were concerned for Child C1. The DAIO tried to contact Adult A but could not reach her by telephone and a request to Housing was made to disclose Adult A's current housing application address. The address was identified but not shared with CSC.
- 3.31 Also on 14th January 2010 Health Visitor 1 contacted City CSC and the Health Visitor was told that no concerns had been received or recorded since the referral made on 18th December 2009 and so the case had been closed. A re-referral was suggested. CSC had not made any contact with the Health Visitor or the hostel either. Health Visitor 1 made a number of calls to gather information and establish where Adult A might be. It was discovered that Child C1 had received his 2nd immunisations the day before.
- 3.32 On 15th January 2010 a second referral was sent to the City's CSC by the hostel staff. There was a general recording of concerns, but there was no contact made with the Police to share information. There is no record of any communication from CSC to the hostel to follow up any enquiries. The concerns centred on Adult A and Child C1 seems to have been overlooked. Once again, the lack of a multi-agency approach is noted.
- 3.33 A further referral is made to City CSC by the Health Visitor 1. The HV worked between the respective Local Authority areas of County and City CSC.
- 3.34 On 17th January 2010 Adult A rang the Police stating she was having problems with her current partner's parents. The Police attended and found no domestic argument and that the partner's parents thought the arrangement was not convenient and that Adult A should return to her own parents. Adult A was clearly looking for assistance to be re housed. She asked for assistance in recovering her possessions from another address as she had been refused entry. On the face of it Adult A was currently homeless with a young baby and this should have prompted a call to CSC.
- 3.35 On 19th January 2010 the latest referral was again closed and the reason recorded as there were no needs identified and no further action was required. Adult A was not contacted so her concerns were not directly fed to CSC. It is possible she was actually unaware of this latest referral. Child C1 was not seen by a Social Worker and the hostel's concerns regarding Adult A's ability to look after Child C1 was over looked.
- 3.36 On 20th January 2010 Adult A's mother in law contacted the Police about some outstanding property at her address. An officer made enquiries and contacted Adult A who said that she required housing and wanted help from the DAIO to do this. The DAIO was contacted and made numerous attempts to contact Adult A without success. Although housing is not a police matter, the officers made genuine attempts to help her.

- 3.37 On 25th January 2010 a taxi driver contacted the Police via a 999 call reporting a domestic incident between a mother and daughter where there was a baby involved. Police attended an address and found that Adult A and her mother Adult D had been arguing about Adult A's separation from Adult B. Adult A stated she had lived in a hostel but had tried to live again with her parents but this was not working because of their disapproval of her relationship. Child C1 was seen asleep. In view of the domestic abuse within this house, was this a safe place for Child C1 to be? This was not considered. This incident was assessed as medium risk and the DAIO updated. No referral was made to CSC despite the officer's concerns. A written child protection referral should have been made, and involve other agencies. The case specific panel agreed this was a further missed opportunity.
- 3.38 On 29th January 2010 it was agreed that Health Visitor 1 would invite Adult A to attend her GP surgery fortnightly. If there was no engagement then a third referral would be made to Social Care.
- 3.39 A third referral was received by City CSC on 3rd February 2010 after a resident at the hostel had told staff that Adult A was leaving Child C1 alone in his room and he was crying. There is some confusion as to who actually witnessed this, staff or a resident. The referral was accepted and concerns acknowledged relating to domestic violence and Adult A's lack of care of Child C1. There was no consideration given to a strategy discussion and a Section 47 enquiry despite the risk of harm posed to a 5 month old baby being left unsupervised being significant. It is known that Health Visitor 1 was trying to instigate a case conference. The referral was progressed to initial assessment.
- 3.40 The DAU was contacted on 5th February 2010 by a Housing Officer to be told that Adult A had been referred to the City Council to be re housed. It was stated that Adult A had admitted using cannabis for pain relief and the Housing Officer was concerned about Adult A's ability to look after Child C1 so she had made a referral to CSC but had been told the case was closed. The information was recorded by the DAU, but no contact was made with CSC.
- 3.41 On 11th February 2010 Health Visitor 1 rang Adult A's mother and was told that they had had no contact from her for 3 weeks. They believed she was in an Asian hostel. A referral to CSC was initiated.
- 3.42 On 18th February 2010 the Social Worker made an unannounced visit to the hostel (believed first recorded visit by SW). Adult A or Child C1 was not seen but current partner was seen and spoken to. He denied there was any violence in his relationship with Adult A. Records are then contradictory with a "full assessment" noted as required to a "tidy up" action only required. There is no record of what the health perspective was.
- 3.43 After various telephone calls towards the end of February 2010 it was established that Adult A was back in a hostel. The records are unclear as to who was contacted and who knew what information.
- 3.44 On 1st March 2010 Adult A was seen at a different hostel by a Health Visitor (HV2). Child C1 was also seen and examined and was found to be well and appropriately clothed. A male partner is recorded as being present and engaging with Child C1 but it is not known who this was. Adult A described her current relationship as stable and she was separated from her husband due to domestic abuse. She stated Child C1 had no contact with his father. There have been a number of males who appear in Adult A's life, but no attempt is made to find out who they are and whether they pose any risk to Child C1.
- 3.45 On 4th March 2010 a telephone call between Health Visitors 1 & 2 is recorded which highlights concerns for Adult A and Child C1 due to domestic abuse, her lack of engagement

with professionals and the possible neglect of Child C1. Social Care was to be liaised with to establish the outcome of the last referral.

- 3.46 On the 8th March 2010, duty officer from the hostel contacted out of hours EDT services to alert them of concern's re Adult A and her vulnerability as a victim of domestic violence and that 3d party information was indicating that she was returning to her current partner. He was allegedly staying in a bed and breakfast/hotel, but had no information regarding which one. EDT was further alerted and concerns were raised that Adult A and Child C1 were "missing" and also vulnerable. The advice from EDT was to contact the police and relay concerns. The police advised if Adult A returned to the hostel, to inform them of this. She did not return.
- 3.47 On 9th March 2010 it is recorded by Health Visitor 2 that there had been a domestic abuse incident between Adult A and her new partner and that her and Child C1's whereabouts were now not known. The record is unclear, but it appears that Adult A went to a hotel with Child C1 leaving the hostel in a hurry. Over these last few days Adult A had a number of one day stays at this hostel, having been re-referred there by housing options. All of the hostel stays prior to this period were in a voluntary sector provided hostel.
- 3.48 On 26th March 2010 a Social Worker made various attempts to contact Adult A and was frustrated by Housing who refused to divulge an address for her. The panel felt that information sharing should have taken place in these circumstances in the interests of safeguarding Child C1. Information received to the review from the hostel was that they didn't in fact have a forwarding address.
- 3.49 On 16th April 2010 Adult A has a new temporary address recorded whilst she waited re housing.
- 3.50 On 28th April 2010 a Social Worker made a home visit and Adult A signed a written agreement in relation to her domestic abuse. It is unclear what this agreement actually says and feedback from City CSC has since said that its contents were meaningless.
- 3.51 On 7th May 2010 Adult A attended her GP surgery with Child C1 and was seen by Health Visitor 1. Child C1 is reported as appearing healthy, happy and well nourished.
- 3.52 On 26th May 2010 the case was closed by City CSC. There is no record of any management oversight or agreement to this; neither is Adult A informed of its closure. The reasons are not clear. This has since been described by the City CSC IMR author as a "superficial piece of work" and that an over reliance on what Adult A said was acted upon. A number of incorrect decisions were made.
- 3.53 On 27th May 2010 Adult A, made four 999 calls to the Police as she was having problems with her ex-partner Adult F and was receiving threats from him. The original call was requesting an appointment to discuss matters with the Police but events escalated as a male partner went to where Adult A was and she was frightened of him. The male partner was refusing to leave and the Police attended and raised a domestic incident report but no criminal complaints were made. Child C1 was present but his name was recorded incorrectly. It is expected that if a child is present during a domestic dispute that a referral is made to CSC but one was not made. The Officers had no concerns for Child C1 and did not see the need for a referral. This was another missed opportunity. This expectation for a referral in a case like this is now firmly in place.
- 3.54 On 23rd June 2010 Adult A and Child C1 were seen by Health Visitor 1 during a visit to see another family at the same address. This was a hostel and Adult A said she had lived in

several hostels over the last few months due to escaping from domestic violence. Adult A was after then allocated the house that she remained with Child A1 in for some significant time.

Child C1 toddler period

- 3.55 At 4: 08 pm on 5th October 2010 Police Officers attended an address as a result of neighbours reporting a domestic incident where it was believed a female was being hit, furniture was being thrown around and a baby was screaming. The female had been heard to beg to be left alone. The officers spoke to a male person and the female who was Adult A and neither of them made any complaints and said it was just a verbal argument. A domestic incident was recorded and the report filed. The recording is poor and there is no mention made of the child's welfare. The male person's details are not recorded. No referral was made to City CSC as would be expected and this is another missed opportunity.
- 3.56 On 17th May 2011 Adult A and Child C1 attended the GP surgery and Health Visitor 1 took the opportunity to carry out a review. Child C1 was in good health but had some hearing issues. No other issues were recorded.
- 3.57 On 23rd May 2011 Child C1 was referred by HV1 to an audiologist due to difficulties with his speech and hearing. A lifestyle coach was appointed who tried to make contact with Adult A but could not get an answer to her phone. A home visit was arranged for 26th May but the lifestyle coach found no one at home, and could not get a reply to Adult A's phone. The visit was rearranged to Adult A's parents' home.
- 3.58 On 3rd June 2011 the lifestyle coach attended the planned visit and was told by Adult A's sister that Adult A and Child C1 had left the address a week ago and there had been no contact since. The lifestyle coach correctly updated the Health Visitor. As a result of this lack of contact by Adult A, Child C1 was discharged from the audiology service despite having never been seen.
- 3.59 An eighteen month period now goes by and it appears that Adult A is more settled. Adult A was contacted on 1st December 2012 by the Leicestershire Children and Family Service (Education) regarding a place for Child C1 at a nursery. He was entitled to a statutory free nursery place. Child C1 was taken by Adult A to the nursery on 8th December 2012 for a visit. Leicestershire Children and Family Service (Education) was being used by Adult A as she wanted Child C1 to go to school in the County, near to where her parents lived.
- 3.60 On 8th January 2013 Child C1 was due to start at the nursery but he did not attend. This review has found that records and registration forms were not kept and that there were no guidelines for how long such information should be kept for. This has subsequently been improved, within this nursery.
- 3.61 On 17th January 2013 Child C1 started at nursery. Again the records are limited and no reason for his late starting is documented.
- 3.62 Child C1 attended nursery for 2 hours a day until 28th January 2013 when Adult A called to say he was sick. He returned after a few days but then on 4th February 2013 he did not attend again as Adult A said he had a high temperature. He then never returned to nursery, there was a break for half term and he did not return again after the holiday. The records state that attempts were made to contact Adult A but there is no formal record.

- 3.63 On 7th March 2013 the GP surgery contacted Health Visitor 3 as Child C1 had not attended 2 GP appointments for his pre-school booster immunisation. The surgery agreed to try to make contact with Adult A. The Health Visitor also tried to contact Adult A.
- 3.64 On 15th March 2013 a mid-term adjustment submission identified Child C1 as a school leaver. Nothing more is recorded.
- 3.65 On 5th June 2013 a City Social Worker contacted Health Visitor 3 in response to her earlier enquiries to inform her that Adult A's case had been closed in 2009.
- 3.66 On 7th June 2013 Health Visitor 3 visited Adult D's home and was told they hadn't seen Adult A or Child C1 for 6 weeks but had spoken to her on the telephone about 3 weeks previously. It was stated that Adult A and Child C1 regularly attended Mayfield Sure Start, a local City Children's Centre.
- 3.67 On 17th June 2013 Health Visitor 3 discovered that Child C1 was registered at a different Sure start but had never attended. Numerous attempts were then made by telephone and a home visit to contact Adult A with no success. Child C1 and his mother had last visited her GP on 29th January 2013.
- 3.68 On 25th June 2013 Health Visitor 3 made a home visit to Adult D's address and located Adult A and Child C1. Both were found to be well with no concerns recorded. Adult A identified her new address and that she had moved again to avoid Child C1's father Adult B, who had not had any contact with Child C1 for 18 months. Adult A agreed to contact local nurseries to enrol Child C1. An appointment was made for Adult A to bring Child C1 to the clinic for a further assessment. She failed to attend this appointment on 2nd July 2013 and a rearranged one on 9th July 2013.
- 3.69 On 17th October 2013 Adult A attended the Clinic at UHL with Child C1 regarding concerns with his eating and swallowing. They were referred by the consultant to a Single Point of Access for Speech and Language Therapy Service (SALT). A worker made contact with Adult A by telephone on 27th November 2013, some 5 weeks later. She stated that Child C1 suffered lots of chest infections and would vomit if given food he didn't want to eat. A home visit was agreed.
- 3.70 A SALT worker made contact with Adult A on 10th January 2014 to arrange the above home visit on 14th January 2014. There is no indication of the SALT worker having carried out any background checks on the family.
- 3.71 On 11th January 2014 Adult A applied for a county school place for Child C1, using her parents' address.
- 3.72 On 14th January 2014 a SALT home visit was cancelled by Adult A stating Child C1 was unwell and she was going to take him to her GP. The visit was rearranged.
- 3.73 On 20th January 2014 the SALT home visit took place and after an assessment, feeding advice was given to Adult A with no other concerns raised. A further home visit was planned for 10th February 2014 but the SALT worker found no one at home on that day.

Immediate pre-incident period including school non attendance

- 3.74 On 16th April 2014 a school place was allocated for Child C1 by Leicestershire County Council. There was some confusion between City and County areas over this and a lack of information sharing which the review has been told has now been resolved. Over the next

few months various attempts were made to contact Adult A regarding this placement in which she failed to answer messages and did not attend the induction evening as requested. She did eventually confirm the place for Child C1 and completed the admission form. Adult A was asked twice to complete a form regarding Child C1's dietary requirements which she ignored.

- 3.75 On 29th May 2014 a SALT discharge letter was sent to Adult A because she had not contacted SALT as requested in SALT letters dated 28th February 2014 and 14th April 2014.
- 3.76 On 8th July 2014 Health Visitor 3 conducted a home visit in response to information from the GP surgery about Child C1 failure to attend SALT appointments and GP Surgery unable to contact mother. A health visiting "no access" card was left at the property and the health visitor planned to visit again.
- 3.77 On 10th July 2014 a family member had found the "no access" visiting card and telephoned health visitor 3 informing that Child C1 and Adult A had left the family home and there had been no contact for 2-3 months. The family have been calling at Child C1 and Adult A's home address in the City but had got no answer and a neighbour had reported seeing Child C1 and Adult A about a month before. Health visitor 3 contacted the nursery who reported Child C1 had not attended for a month and they had been unable to contact Adult A by telephone. In response to the information provided by the family and nursery the health visitor reported Adult A and Child C1 as missing to the police. The police officer recommended that the family attend a police station to make a report. The health visitor contacted the family member advising them to contact the police.
- 3.78 On 10th July 2014 Leicestershire Police were also called by from Adult A's GP Medical Centre by HV 3, as she had serious concerns for Adult A and Child C1 due to their lack of contact over the last few months by telephone, letter and home visit. The Police were told that Adult A's family had not seen her for 2 months. The Police spoke to Adult A's sister and were given an address to check. This address was visited but there was no reply. Later that day the Police managed to speak to Adult A on the telephone and they attended the address they had checked and saw her and Child C1 who appeared to be safe and well. Adult A stated that she had a new boyfriend and elaborated on her previous problems with the father of Child C1 and her family not engaging with her because of the shame she had brought on them by splitting from her husband, seeing other men since and using drugs, which she said she had now stopped doing. A vulnerable adult report was completed and a Child Concern form was sent to City CSC for their information (There is no record within the City CSC of ever having received this referral). The review author considers that if this had been an actual referral then this was clearly a time for a strategy discussion or a professionals meeting in an attempt to find out all the available information. This was a missed opportunity.
- 3.79 On 11th July 2014 health visitor 3 contacted safeguarding children advice line seeking advice on whether to refer to children's social care and was advised to contact First Response manager from County CSC for advice. Later on this day the health visitor received a telephone call from the police who reported that police officers had visited the home address the previous evening. Child C1 was reported to have been found safe and well. A referral was not made to social care as Child C1 had been located.
- 3.80 On the 23rd of July HV 3 submitted a referral to County children's centre support services for rehousing Adult A and Child C1. The referral was processed and after a short delay attempts were made to make contact and an appointment made, but contact was not taken up by Adult A.

- 3.81 On 22nd August 2014 a face to face handover took place between the Health Visitor and the School Nurse. Adult A's historical domestic abuse and her lack of stability were highlighted. She was noted as being vulnerable. This was adult focussed but rightly took place because Child C1 was a targeted child, it was also noted that he had no unmet health needs, that needed to be followed up by the school nurse.
- 3.82 Child C1 did not attend a school induction day on 1st September 2014, nor did he attend his first day at school on 8th September 2014. Attempts were made to call Adult A but without success. By 11th September 2014, the school had contacted the County Admissions Department who could have been more robust in their follow up procedures as Adult A could still not be contacted.
- 3.83 By 24th September 2014 Child C1 had still not attended school and an email was sent by the County School Admissions Service to Adult A telling her that the school place for Child C1 had been lost. No other form of communication was used, which the review author highlights as concerning. It appears that there was no co-ordination between teams for better knowledge of Adult A and Child C1 and there were no procedures to ensure he was in school. A grey area is acknowledged as Child C1 wasn't actually of legal school age and this may have affected actions. The review author has been told that in December 2014 a new Business Code was put in place to resolve cross border issues regarding non-school attendance.

Non-accidental injuries incident

- 3.84 During the evening of 2nd October 2014, Adults A & C took Child C1 to Hospital as he had head and neck injuries which Adult A said had resulted from him falling down stairs. He was examined at 10:40 pm by a doctor and was recorded as having a sub-conjunctival haemorrhage in his right eye, bruising on his left cheek and the back of the head and neck. The child was spoken to directly and had been able to give a clear account of his accident. He was discharged from Hospital with Adult A's and Child C1's explanation for his injuries being accepted as plausible and required no further examination and needed monitoring by parent. Although, the review author finds the fact that this discharge happened quickly, he fully acknowledges that the hospital acted in these circumstances clinically correctly, and adhered to known national guidelines.
- 3.85 At 11:09 pm on 3rd October 2014 an Emergency Nurse Practitioner (ENP) from Hospital rang the Police reporting that a 5 year old child had attended the Hospital for a head injury the previous evening and had been treated and discharged home. This was Child C1. The ENP was now reporting that the child's Uncle Adult C had returned to the Hospital and claimed that the injury to Child C1 was non accidental and that Child C1 was not being looked after properly. Adult C stated further that the family had agreed to lie about how Child C1 received his injuries so Child C1 could receive medical treatment. Adult A stated that Child C1 had fallen downstairs and this had been accepted by Hospital staff. The ENP stated that the injuries to Child C1 were redness to an eye, a bleed in one eye, a mark to his cheek and three areas of tenderness and bruising to his head and the back of his neck. It was dealt with as a minor head injury and he was discharged. Adult C also stated that Child C1 had 2 human bite marks to his shoulders and 2 puncture wounds to the soles of his feet.
- 3.86 As a result of the above information the night rota Detective Sergeant made contact with the Hospital and took further details and interviewed Adult C who had remained at the Hospital. He repeated the account given to the ENP and a criminal investigation was commenced. Contact was made with County Children's Services at 01:53 am on 4th October and a decision was made that the Child Abuse investigation Unit (CAIU) and Social Care

would continue the investigation during the daytime of 4th October and see Child C1. Adult C had stated that Child C1 was now with his mother and father, Child C1's maternal grandparents, and was safe with them. This was accepted as Child C1 being "safeguarded." It is questionable whether he was, due to his non-accidental injuries, and the ability for Adult A to just leave with him, also the fact of previous history between Adult A and her parents.

- 3.87 A joint agency Section 47 enquiry was commenced and a visit made to the maternal grandparents' home. Child C1 was seen and spoken to. He appeared sleepy and the injuries were seen. Child C1 was returned to Hospital where he was examined again and this time a CT scan was completed. Child C1 was found to have a depressed skull fracture and infection and swelling to his feet. He also had iron and vitamin D deficiencies. Safeguarding measures were taken and Child C1 remained in Hospital until 13th October 2014.
- 3.88 Adult A was interviewed by the Police and admitted leaving Child C1 alone whilst she took drugs and then found him injured at the bottom of the stairs. She panicked and didn't seek immediate medical help for him choosing to take advice from her family first. She disclosed daily misusing alcohol and drugs, namely cannabis, to the extent that she was unfit to take Child C1 to school or nursery and that she allowed her home to become an "open house" for drug users, leaving Child C1 unsupervised while she misused drugs. She added that she had experienced domestic abuse and led a transient lifestyle. She received a conditional caution, the condition being that she engaged on a drug/alcohol programme which she started on 21st January 2015.
- 3.89 On 6th October 2014 a multiagency strategy meeting took place which was well attended. Actions from this meeting included the need for a further assessment; clarification on what information was shared at the time of the initial Hospital admission, assessment of the extended family, a referral to the Local Authority Designated Officer (LADO) given Adult C's occupation and the need for legal planning and information sharing meetings.
- 3.90 On 17th October 2014 Child C1 was given a new school place after receipt of an application by Adult A. His place was confirmed by the school on 29th October 2014.

4.0 Further analysis of significant safeguarding events

- 4.1 Throughout the timescales of the review, Adult A was a vulnerable young woman caring for Child C1, an extremely vulnerable young baby and then a small child at the time of the majority of the interventions that have been examined as part of the review. Child C1 was still as vulnerable when four years old; at the time his injuries were discovered after his attendance at Hospital in October 2014 and the follow up investigations.
- 4.2 Adult A was a victim of domestic abuse. She was by her own self-report having confusion about her parenting skills; she struggled around her cultural and religious identity and wanted little family support. She experienced domestic abuse from her husband Adult B which she stated began shortly before the birth of Child C1. She left Adult B, becoming the sole carer for her very young child. She quickly formed another relationship and moved into accommodation with this man Adult F who appeared to some extent to adopt a parenting role for Child C1 and was in fact identified on at least one occasion as his "parent". He also subjected her to further domestic abuse. A further boyfriend also subjected her to domestic abuse. Adult A and Child C1 repeatedly had no fixed accommodation and became increasingly transient with at least 7 known changes of address in the 9 months' following Child C1's birth.

- 4.3 Adult A was a young woman who was very difficult for services to engage with and who was avoidant of support and challenge. She did not answer her telephone or respond to messages and she changed her number without notifying agencies. She moved address without notifying people, twice leaving behind the support that was available to her at safe hostel accommodation. She did not attend appointments with Social Workers or hostel staff and she had a poor involvement with her Health Visitor (HV 1) however hard anyone tried.
- 4.4 Health Agencies and hostel workers had concerns about Adult A and her parenting and care of Child C1 and these were shared with Children’s Services. The interventions of County and City CSC in response to these identified concerns about Child C1 in November 2009, January 2010 and February 2010, showed a standard of work that fell short of accepted standards (it is accepted by the review this is practice from six years ago). As a result key signs and indicators of neglect, abuse, risk and need were overlooked. Assessments and attempts to engage the family were not robust enough and the work was not sufficiently focussed on a positive outcome. This includes actions of other agencies as well and not just CSC. Timeframes for actions were not consistently identified and were not compatible with the needs of such a young and vulnerable baby. Important factors, such as family background, the context of previous referrals and the views of partner agencies and Adult A’s wider family, were not actively considered. Compliance with identified actions was not always monitored and there was false optimism about the levels of support and monitoring available from partner agencies.
- 4.5 The IMR authors and therefore the review has faced challenges in gathering and collating information from both County and City CSC record systems. The case recording is dispersed in case notes, action plans and contact records and there are some anomalies in case records where contradictory outcomes to both “close” and “continue” work with the case appear to be recorded. The quality of the case records is variable with information not consistently recorded. Workers did not always sign off case records and it is not always easy to see “who said what about whom”. This has made it difficult to piece together information and understand accountability for decision making.
- 4.6 It should be noted that at the time of City CSC involvement during 2009 to 2010, records were maintained under the “Care First” electronic recording system. This system was replaced in April 2014 by the “Liquid Logic” system, necessitating the adaptation and migration of earlier records into a range of different templates and formats.
- 4.7 There is evidence of CSC management oversight of this case and some evidence of discussion during formal supervision, albeit not effective. Aspects of this management oversight and decision making highlight confused assessment information, over-optimism and false certainties, for example about the input and support provided to the family by other agencies. This resulted in the premature closure of the first two referrals. Aspects of management advice and direction with respect to the third referral and subsequent initial assessment were not completed. There is no evidence of management agreement to the decision in May 2010 to take no further action with respect to the case. Management oversight overall appeared task centred rather than reflective, bearing in mind this was a trainee Social Worker and should have had added supervision.
- 4.8 Throughout the period December 2009 to May 2010, there is little evidence of City CSC “joined up” working with other agencies. Responses to concerns about Child C1 were not explicitly informed by a shared multiagency understanding of concerns or required improvements. There was a lack of systematic information sharing with and information gathering from other partner agencies, contributing to some of the over-optimistic assumptions about Child C1’s care and welfare. The Police, Housing and Health Services appear to have been consulted randomly or not

at all. Positive information provided by agencies was given undue weight: where this appeared to contradict existing information of concern and there appears to be little sense of question or challenge. Feedback to agencies was offered mainly through telephone discussions and at times, messages. Records of consultations with other agencies do not clearly detail the expectations of those involved, such as what would constitute escalating concern and how these should be responded to.

- 4.9 It would have been beneficial to consider Adult A and Child C1's needs at a multiagency meeting or through a process such as the Common Assessment Framework (CAF) (Called an Early Help Assessment now) or the family support process, which would have offered the opportunity to collate information, analyse risk and protective factors, and enable all agencies to work together to ensure that Child C1's needs were met. Although when it was determined that the threshold for City Children's Services involvement was not met there were some proactive attempts to engage other agencies but these were limited in scope to broad requests or expectations for "monitoring" or "support" and there appears to have been little signposting to appropriate services which would have engaged Adult A.
- 4.10 There was no single agency or multi agency chronology. Had this been established at the start of Child C1's "journey" through a series of Children's Services referrals, it would have enabled workers to promptly study and identify the emerging pattern of concerns about Adult A's transient lifestyle. Each referral should have linked current with historic factors to enable a more accurate assessment of current risk and need. As it was, as new concerns about the family were raised, existing or earlier concerns appear to have become "lost" so that the focus of concern shifted from concern about domestic abuse, to concern about care and parenting, back to concern about domestic abuse.
- 4.11 Interventions with the family took into account some of their cultural and religious needs. Adult A and Social Workers were able to discuss at length her perceptions of family and cultural conflict. Adult A appears to present herself or is presented as very much a victim of such pressures. She is a very articulate young woman, well able to express her views around these issues. This may have combined to make it difficult for Social Workers and other professionals to challenge her and there is no evidence of more probing discussions with her about how she was able to manage family and cultural pressures so that any associated risks and needs could be identified.
- 4.12 The review did not find any triangulation of information about the impact on Child C1 and Adult A of family influences or involvement with other family members or friends. "Significant others" in Adult A's life, such as Adult B, the paternal and maternal extended family and other male partners Adult F and, were not assessed and their views were not sought. Engagement with family members and Adult B would have been a way both of coordinating support to Adult A and Child C1 and evaluating any risks. A family group conference or other formal support process could have been considered which would have enabled better and safer care for Child C1 during his early life and could have developed the understanding of all family members. After the discovery of Child C1's many injuries it appears that some of the family had been trying to "manage" and support Adult A and Child C1 on their own for some time, perhaps because they did not want to expose their family to agency scrutiny and were afraid of an intrusive response, but perhaps because they were simply unaware of what support was available.
- 4.13 There was no assessment which focussed on the impact of Adult A's parenting and lifestyle on Child C1's care or the range of risk and protective factors for him. There were clearly missed opportunities to consider interventions and assessment that did not establish views about the impact to Child C1 of his numerous home moves, changes in routine and environment, his apparent loss of contact with his father and wider family and the impact to him of domestic abuse

and drug misuse in the home. The overall approach was reactive rather than pro-active and not child focussed. There was no real sense of what specific positive outcomes agencies aspired to for Child C1 beyond, as detailed in the written agreement of April 2010, “safeguarding” and not being exposed to domestic abuse and substance misuse. An assessment should have considered risks, needs, and vulnerabilities, protective factors, likelihood of change, timescales for required change and, crucially, the desired outcome for Child C1.

- 4.14 The response of Adult A and her partners to concerns about domestic violence and childcare was one of minimisation and denial. This was further challenged and there was some reflection with Adult A on the potential impact to Child C1 of being exposed to domestic abuse and generalised offers of support to Adult A. However there was no clear signposting to specific services or proactive support and certainly by the time the initial assessment was concluded in May 2010 Adult A appears to have been assumed to be competent to seek her own support.
- 4.15 Overall, procedures were followed in October 2014 when information came to light that Child C1 may have more injuries and more significant injuries than had been disclosed when he attended hospital on 2nd October 2014. However, the initial strategy discussion on 4th October 2014 involved only the Police and the Duty Team Manager and appeared to ratify a decision made earlier in a discussion between the Police and the County based Social Workers about the timing of a visit to the family. Health agencies were not involved. This could have resulted in further significant harm to Child C1 because there was then a delay in seeking further medical treatment for him. An early discussion with Health partners as part of the strategy process would have been beneficial in ensuring a more timely response to Child C1’s immediate health needs.
- 4.16 Adult A acknowledged having exposed Child C1 to neglectful parenting, a transient and drug misusing lifestyle and “dangerous men” over a number of years. It is likely that at the time of CSC’s involvement during the period under review she was already becoming entrenched in the chaotic and unsafe lifestyle which would ultimately result in significant ongoing harm to Child C1. The injuries and poor care that Child C1 later experienced were not necessarily predictable at the time of the earlier period under review during December 2009 to March 2010. However, it is clear that there were a large number of missed opportunities to reflect on, evaluate and influence the care that he was receiving which would even at that early stage of his life made a positive impact on his welfare, development and outcomes.
- 4.17 Members of the Health Visiting team were clearly aware of the potential impact of domestic violence, homelessness and Adult A’s non engagement. There is good evidence of tenacity and persistence in trying to engage with Adult A and provide support. There is a pattern of non-engagement and disguised non-compliance throughout Adult A’s relationship with involved agencies and Adult A kept her distance from professionals for long periods of time which created gaps in the understanding of Child C1’s day to day life and risks to his safety and welfare. Processes for responding to non-engagement need to consider the pressure between the need to identify and act on risk without impinging too much on family life where families choose not to engage without any detriment to the welfare of their children.
- 4.18 Leicestershire Police had a number of contacts with Adult A and Child C1. The DAIO was also heavily involved. Officers who saw or spoke to Adult A did not appear to consider Child C1 was at risk in Adult A’s care and did not see anything that would make them believe Child C1’s welfare was not being attended to. The observations seem to have been based on the visible sight of Child C1 and not the lifestyle of Adult A with all her issues. There was no recognition that these many issues would impact on Child C1’s welfare which may have placed him at risk of neglect or made him a child in need of services to ensure his wellbeing.

There are at least four occasions where the review considers that the Police should have made a referral to CSC. There is a further three occasions where the Police should have at least made contact with CSC to update them on events.

- 4.19 The review found that despite the best intentions, the focus of the DAIO was mainly on Adult A as a victim of abuse and providing support for her to live safely meaning a failure to recognise the social needs of Child C1 and the impact his mother had on his welfare. Further information that came to light was not shared and there was a lack of understanding about the separate Local Authorities and an assumption that a referral to one Local Authority would automatically be known to the other. The review has learned that "Project 360" is currently being piloted within Leicestershire Police where a team of victim engagement officers work alongside the DAIU to provide support to repeat victims of domestic abuse.
- 4.20 Child C1's first primary home visit was completed after 17 days when such visits should occur between 10 and 14 days following birth. There appears to be no explanation for this. Child C1 was then seen briefly at this visit and not examined. The reasons given are that Adult A said the visit was not convenient and that the house was busy with many of Adult A's family. It was a further week before Child C1 was examined and jaundice was then found.
- 4.21 Child C1 was identified as requiring some additional assistance regarding concerns with his speech and hearing and he was referred to an audiologist. Over the next few months Adult A failed to keep appointments and Child C1 was never seen by this service. Child C1 was subsequently discharged. It is felt that a better process for non-attendance of small children is considered as the child is being disadvantaged by the parent's failings. Similarly, Child C1 was also referred to the Single Point of Access for Speech and Language Therapy Service (SALT).
- 4.22 After the non-attendance at school by Child C1 an email was sent to Adult A which she never replied to. School admissions should consider if an acknowledgement should be requested from a parent when they send out an email confirmation that a school place is being withdrawn. It should be considered how a lack of response to the email should be followed up to support the Children Missing Education (CME) processes. The review considers that a solitary email is not sufficient and more follow is required. The process now involves liaison with CSC.
- 4.23 Clearer good practice guidance and guidelines are needed for providers around CME particularly those who are not of statutory school age.
- 4.24 It is questionable whether Child C1 was properly "safeguarded" when he was known to be with his maternal grandparents, Adult A and extended family after Adult C made his disclosures. There may also have been an urgent need for further medical treatment for Child C1 given that he had been presented with head injuries on 2nd October and now 2 days on there was ambiguity as to how these injuries had been caused or how extensive they were.
- 4.25 Although there were good examples of information being shared in a timely and appropriate way, for example with the Health Visitor and the School Nurse, there were also times where communication between professionals could have been improved. This case is similar to many others where improvements must be made in information sharing.
- 4.26 During the course of different agency intervention, there is no real evidence that the GPs involved were made aware of safeguarding concerns relating to Adult A and Child C1.

Records do not suggest that the GPs were asked to contribute their opinion or knowledge. Had the GPs been made fully engaged in the safeguarding processes, primary care information and input could have formed part of any plans made. It is noted that Adult A was not a regular visitor to her GP. HV's are now better aligned to GP practices.

- 4.27 In her 'Review of Child Protection' (2011) Professor Eileen Munro reminded professionals of the need to have a degree of caution when working with families and to maintain what Lord Laming called "respectful uncertainty" and "Healthy scepticism". Opportunities were missed when Adult A gave inconsistent reports related to her situation and her non engagement.
- 4.28 Staff should feel confident to appropriately challenge service users. Professional curiosity and healthy scepticism should be included in all levels of safeguarding training to give staff confidence and the skills to challenge and check information provided by service users.
- 4.29 Adult C's involvement in the incident in which Child C1 went to Hospital in October 2014 became the subject of a multi-agency strategy meeting. This was due to his occupation. The conclusion was that no further action would be taken and that the threshold of harm had not been met. The meeting decided that his suitability to work with children and young people had not been brought into question.
- 4.30 This review found that a lead professional was not identified nor in place. A lead professional would have ensured that there was oversight and ownership of dealings and interaction with Adult A, Child C1 and her extended family. This does not detract from the responsibility of all professionals working with vulnerable children. This review concludes that the lead professional could have been the health visitor or could have been from Social Care.
- 4.31 University Hospitals of Leicester NHS Trust have reviewed the events on the 2nd, 3rd, 4th October 2014. Consultation has taken place between the senior medical staff in the Emergency Department and the Children's Hospital. This Hospital review has satisfied the Trust that on 2nd October a thorough clinical examination took place and the "voice of the child" was heard. Safeguarding questions around school, information about Health Visiting and the involvement of Social Care were asked but not recorded (no reason has been found why the questions were not recorded). A history was taken from Child C1 which gave the apparent cause of his injuries. A fall downstairs is a very common explanation for injuries in this age group and dealt with as such and it is standard practice in a busy Emergency Department to restrict an examination to the area of concern, the head and neck. The examination was based on a minor fall, and Child C1 appearing to be well. The examining doctor identified no signs of concern. No other examination, investigation or action was thought to be necessary. Thus the injuries to Child C1's shoulders, feet and crucially a fracture to the skull of a small child were missed, which although a concern to the lead reviewer, he understands that everything was dealt with clinically correctly.
- 4.32 The Hospital review has found that upon Adult C's return to the Hospital on 3rd October they demonstrated good practice. Advice was taken, urgent discussions took place with the Police and Social Care which resulted in Child C1 being admitted for a child protection medical examination and the standard safeguarding pathway followed. The Trust has found no concerns during this second admission and this review would agree that actions taken were appropriate. Training figures for children's safeguarding across the whole trusts workforce (circa 11,000 staff) at the time of this incident were above 90% and this performance has improved to 92% at current time.

- 4.33 In order to assist the panel and the review author the Designated Doctor for the area has carried out a review of the circumstances of the both the first visit on the 2nd of October and the subsequent re-visit by Adult C. He has established that the actions taken based on the information available to practitioners and clinical findings on the first visit were in line with established practice. It is clear from the records and the practitioners involved that on this visit Adult C did not disclose any further concerns.
- 4.34 In relation to the visit by Adult C on the 3rd of October, the designated doctor has come to the conclusion that the actions taken are sound, justified and rational.
- 4.35 There was then a delay in action to see Child C1 after the hospital had alerted both the police and County CSC. The decision was to wait to the morning for the police CAIU and duty CSC to take on the enquiry. Whilst it is accepted that Child C1 came to no further harm, the Designated Doctor feels that appropriate and immediate discussion which includes a doctor will be helpful amongst partners. This should be considered as an opportunity to ascertain whether there could an urgent need to commence medical treatment in an absent child.
- 4.36 Adult A had her details recorded by the Police in three different ways. She was recorded under her family name, married name and a misspelt form of her family name. Although it is fully accepted that these are the names Adult A provided. However, the impact of this was that officers who checked the systems for the name they had recorded for her were unlikely to be in possession of all the information relating to her and her circumstances. This has meant that some incidents attended were not linked to other incidents and meant officers decided not to make referrals.
- 4.37 The Health Visitor 3 and the School Nurse carried out a face to face handover before Child C1 was due to start school. This was completed because of Adult A's historical domestic abuse and her lack of stability. She was noted as being vulnerable. The review recognises this as good practice.
- 4.38 The DAIO spent a considerable amount of time with Adult A with some of these occasions being non Police matters. The review author recognises the positive role the DAIO played in helping Adult A, completing an enhanced risk assessment and dealing with this sensitively and correctly.

5.0 Family perspective.

Adult A and Child C1.

- 5.1 The review author has met Child C1 who came across as a very happy child. He was articulate and seemed extremely settled at his maternal grandparent's home and with his mother Adult A. He is really enjoying school.
- 5.2 The review author has also met Child C1's mother Adult A and she described her early life as very traditional and how that when she met her husband Adult B and the father of Child C1, she had to change her outlook to adapt to her husband's way of life as he was from a different upbringing, albeit from the same Asian community.
- 5.3 It was not long after she started a relationship with Adult B that she became pregnant with Child C1 and they were married. Adult A's parents stood by her, despite their disapproval of Adult B and they wanted her to remain in the marriage and make it work. After getting married Adult A moved in with her in-laws and that was the start of the domestic abuse against her and she was already a victim of it when Child C1 was born. Child C1 had no problems immediately after his birth although he did have some health problems in the

period sometime after that. Adult A said that there were times when she was the victim of domestic abuse when she was holding Child C1 who could have been hurt. She had lost everything, a good job, a good family, a lovely home for a life with a husband who misused substances, which she then started to do.

- 5.4 Adult A praised the police officer (DAIO) stating she was fantastic and who took her to the first hostel. Adult A said this was okay, but it wasn't supervised and so after working hours there was a lot of drinking by other residents. Adult A said she had tried to keep out of it due to her respect for her marriage and also the community and her family, as she was trying to get back with her husband Adult B.
- 5.5 Adult A considered that this would have been an ideal time for people to explain to her what needs that she had, and provided advice about how to avoid being a victim of domestic abuse and what her future life would look like if she carried on and went back to her husband.
- 5.6 Adult A was challenged about her lifestyle and non-engagement with the Health Visitor and her GP and that they both struggled to get hold of her. She stated that personal contact should have taken place as part of that assessment when she first went to the hostel. She said one of the problems with both the Health Visitor and the GP was that she had no money to travel to see them and all the contact regarding appointments was in a written form which she felt was not the best form of communication for somebody with a transient lifestyle.
- 5.7 Adult A felt strongly that there was no plan to safeguard her or Child C1 and this would have been a crucial intervention that she now realises would have been really useful.
- 5.8 Adult A said she needed time to get over her marriage and she did have contact with a Social Worker who visited her. She signed a written agreement to ensure that she looked after Child C1 and not let him witness any dangerous people. This was really, in her view, putting the entire onus back on herself, when she really couldn't look after herself and Child C1, let alone have this responsibility too. Adult A felt that a lot more should have been done in terms of a full assessment at this time. She did get a three bedroomed house which was really great and they made a plan for her. Adult B tried again to get back in with her and tried to help her, however, he was still drug dealing and subjecting her to lots of domestic abuse which went on for two years. Adult A said that nobody seemed to see what was going on and was critical of all agencies. She said it would have really helped her to have the Social Worker involvement to learn what to do and to look further ahead. She said there was never any follow-up in place.
- 5.9 Adult A stated that Child C1 started at nursery but then he missed days. Two years then went by where Child C1 never went to school because some people living in her house were drug dealing and she herself was caught up in taking drugs. The Police came to see her, as did the GP and the Health Visitor as she had been reported as missing, but nobody actually looked deeper to see what the problem with her was.
- 5.10 Adult A felt that anybody who doesn't attend school should have some sort of personal visit follow-up rather than just taking them off the list. She felt that such a personal visit would have seen the state she was in and at that stage done something to help her and this could have prevented the event on 4th October when she wasn't in a good place.

- 5.11 Adult A talked about the October incident and said that Child C1 had already hurt his feet while she was asleep during that day and he was struggling to walk. She said she was outside smoking drugs and Child C1 fell down the stairs and hurt his head, plus he had blood in his eye which grew bigger and bigger. She panicked and called her father Adult E and her brother Adult C and they came and made her take Child C1 to Hospital. She realises now that she should have called an ambulance at the earliest opportunity. At the Hospital she said that they made her believe that he was okay but feels that they should have looked at her whole lifestyle and the truth could have been revealed then. As that didn't happen Adult C went the next day to the Hospital and said that something needed to be done and that the injury was not accidental. After this injury the Police and Social Workers were very supportive to her and her GP also really helped her. She reiterated that she needed this help much earlier in Child C1's life in order to try and help her and she had needed that wake-up call sooner. She thought that the Hospital staff was negligent by sending Child C1 home and he should have really been fully examined and more could have been done at the time.
- 5.12 Adult A said that she now knows what help is available for women like her and talked of the "freedom project", which is great for all women and Asian women, in particular. She was also now aware of programmes such as, the recovery toolkit, living with abuse and "you and me," which is about domestic violence and protecting your children. She said that her parents had tried to support her marriage as they wanted her to remain within it and they had been extremely supportive to her throughout her ordeals.

Maternal Grandparents Adult D and Adult E and Uncle

- 5.14 The review author has met Child C1's grandparents Adult's D & E and further Uncle. Child C1 is on a 12 month supervision order to their house and is doing really well. They feel that case management is still patchy and the recording and documenting of involvement by Social Workers is unprofessional. They stated that Adult A gets conflicting advice and a Support Worker should really have been deployed earlier in order to help to rehabilitate her back to looking after Child C1 properly. A number of misunderstandings have taken place such as over visiting times and they feel there is no formal recording or clear direction. They said they are a strong family but worry about other families who are not as strong and how they cope.
- 5.15 Child C1 was taken to Hospital and as stated they believe he didn't receive a thorough examination or proper treatment for his injuries. Adult C was worried about this all the next day so he went back to the Hospital, Child C1's eye was also getting worse, and he told the Hospital staff that he thought Child C1's injuries had been caused through neglect and/or physical abuse. His motivation was solely for Child C1 and this caused him a few family issues as their culture is such that the family deal with its own issues and he had stepped out of this, which was a big cultural step. He felt it was wrong that the injuries were not picked up earlier.

6.0 Conclusion

- 6.1 The above commentary and analysis shows what happened over the preceding years leading to the significant event which put Child C1 in hospital with serious injuries. Arising from the analysis a number of themes as detailed below have emerged.

Key Learning Themes

- Voice and lived experience of Child C1
- Impact of Domestic Abuse on Child C1
- Drugs and alcohol issues of Adult A impacting on Child C1
- Failure by all agencies to use CAF process.
- Moving across Local Authority boundaries , evasive and chaotic lifestyle of Adult C1
- Joint agency working including lack of information sharing, lack of relevant meetings, lack of a lead professional, lack of assessments or acknowledgement of neglect
- Non- school attendance

- 6.2 This review has also recognised a number of missed opportunities that if acted on may have improved Child C1's life and welfare. Interventions could have occurred earlier. The police, for instance, had four opportunities to make a referral to CSC.
- 6.3 It is felt that there was too much focus on Adult A and not what affect her lifestyle might have had on Child C1. The voice and lived experience of Child C1 was regularly missed.
- 6.4 The DAIO is praised by the review for her persistence and commitment to Adult A and her varying circumstances. Adult A has described her DAIO as "fantastic". The DAIO also formed an excellent liaison with the hostel staff which helped Adult A find alternative accommodation and allowed a smooth flow of information sharing with the hostel and other contacts. However, more contact with other agencies would have benefitted Child C1.
- 6.5 The review author considers that close supervision and proper management oversight were not always evident as is vital in the effective safeguarding of children. It was observed that professionals were not completely aware of hidden harm¹ and that the voice of the child was not the priority. The review recommends training to remedy this situation.
- 6.6 The review has not found any clear evidence that would lead to any conclusions that what happened to Child C1 on 2nd October 2014 could have been definitely avoided. It could be said that if interventions had been made earlier and successfully, Adult A would not have been taking drugs on that day and therefore neglected Child C1 by not being with him when he fell. This can be argued either way or that regardless of every agency's efforts, Adult A would still have been open to drug misuse because of the people she mixed with and who influenced her.
- 6.7 There was a missed opportunity to assess the needs of Adult A and Child C1 when a series of referrals were made to CSC relating to domestic violence, homelessness and instability and evidence of failure to understand and prioritise Child C1's needs. There was enough concern from Health, the hostel staff and the police to trigger an initial assessment. This of course would have helped to co-ordinate information gathering and analysis of the needs and risks

¹ Hidden Harm – is described in the Government's report in 2003, as 'the impact on children and young people experiencing a level of *harm* because of the presence of parental substance misuse' (although the original report was in relation to drug misuse, it is widely acknowledged that this includes alcohol).

that never really took place until after Child C1 was identified with his injuries in October 2014.

- 6.8 There are two different procedures between City and County CSC. This review has been completed on behalf of the Leicester LSCB and has heard that recent improvements to Early Help services within Leicester City that would have been of use in this case, if it happened now. These are: Early Help now has its own front door where all requests for services go through and are screened. Contacts made to Social Care (DAS) that do not meet their threshold for intervention are offered the opportunity to be referred to Early Help. All work is consent based and the referrer is encouraged to gain this. Early Help (front door) after screening would visit and make an assessment regarding the level of need. Referrals are then passed to the relevant locality for work with the family for up to 12 Weeks (Single agency response with two unmet needs) from Family Support/Childcare Early Learning/targeted youth. If there are three or more unmet needs and work requires a multi-agency response then an Early Help Assessment would commence with regular 'Team around Family' meeting to monitor the progress. Advice points are established in all localities where professionals and members of the public can ring receive advice/arrange one off visits (members of the public can assess low level advice, signposting and short-term support without it becoming a case.)
- 6.9 The City Council now records all Early Help case work on 'Liquid Logic' Early Help Module (EHM). This is the City CSC computer system and is used between early help services and social care and is available to partners. Partners who are trained can access the system to view information about families they are working with. If they are also trained on EH assessments they can upload these onto the system.
- 6.10 It has also been noted that failings still exist with information sharing and that these barriers must be overcome. The cross border information sharing between the City and County areas was a significant issue in this case. It is for example of significance that Child C1 is under a supervision order from City CSC, but lives in County CSC area, but they have not been informed that he has been placed in their area. Agencies must adequately share routine information and in order to do this, professionals need to understand the organisational context in which they are working. Practitioners have expressed frustration in attempts to share and gain information through a smooth process.
- 6.11 The further potential for missed opportunities is noted by the then disjointed City CSC records. Further contact should have been made with Health professionals to discuss concerns after they had made a referral.
- 6.12 The Health Visitors (1 & 3) provided good care and their documentation of events and tenacity is commended by the review. Referrals were timely and correctly made, but more follow up enquires could have occurred.
- 6.13 There are a number of similarities in this case and a Wandsworth Serious Case Review around "Zara". The key issues of domestic violence, substance misuse, isolation from support and family, cultural factors and lack of support from the father are shared. In the Wandsworth case there were indicators of disengagement and risk at an early stage, whereas this case has a pattern of limited engagement and a lack of priority which never really changed. Help and support is vital at the earliest opportunity, long before the need for support becoming a need for safeguarding. There was no evidence that a CAF was considered which would have been appropriate.

- 6.14 As part of a recent reviewing process of a case in another SCB in Sandwell, the reviewing author was very impressed with the Neglect Policy and Practice Guidance report that Sandwell Safeguarding Children Board (SSCB) had produced. It highlighted the strategic aim, provides learning lessons from previous serious case reviews and offers some very useful advice and guidance for professionals. Leicester City LSCB should consider reviewing its guidance.
- 6.15 This Serious Case Review concerning Child C1 has made a number of recommendations as detailed below and the implementation of these will assist the partnership to deal more effectively with children and vulnerable young people in the Leicester area. The SCR panel have not however made any recommendations where they have known that the partnership have already implemented any changes for example the practice changes relating to thresholds, escalation and professional challenge.

7.0 Recommendations

Recommendation 1

Leicester City, Leicestershire and Rutland LSCBs should ensure there is in place a robust pathway for sharing information including those Children that require early help who move between these local authorities.

Recommendation 2

Leicester City, Leicestershire and Rutland LSCBs should ask the partners to consider using the principles of a Multi-Agency Safeguarding Hub (MASH) to ensure better information sharing and partnership working which will lead to enhanced safeguarding.

Recommendation 3

1) Leicester City LSCB should consider reviewing its Neglect Policy and Practice Guidance. This would highlight their strategic aim, provide learning lessons from this and previous serious case reviews and offers some very useful advice and guidance, and how to respond to neglect, chaotic lifestyles, and failure to engage for professionals. This should include a definition on what a transient family is and how to safeguard them.

2) Leicester City LSCB should initiate a multi-agency audit of neglect cases. This is to identify where there should have been a strategy or professional meeting in that particular case, but where one didn't take place. This should also look to see that there is a lead professional to provide oversight and ownership.

Recommendation 4

Leicester City LSCB should review its use of written agreements (including its written agreement policy last updated in 2012).

Recommendation 5

1) Leicester City & Leicestershire County Council Children & Young People's Service should send out clearer good practice guidance for providers around Children Missing Education (CME) particularly those who are not of a statutory school age. Guidance is also required in

relation to retaining records and starting to record concerns, observations and accounts from the point of registration at a setting.

2) Leicester City & Leicestershire County Council Children & Family Services should ensure that there are clear processes in place to follow up any non-response to communication by the Admissions Department to parents when school places are withdrawn. This would support the CME agenda. Schools should follow up when children do not start school as expected and support children and their families appropriately at times of transition.

3) Leicester City LSCB should ensure that there are systems, policies and procedures in place within all health providers within their area that deal with those clients who 'do not attend' (DNA) or in the case of young children are not taken.

Recommendation 6

The LSCB should issue practice guidance and/or training on the need for a focus to be placed on the lived experience of the young person/child in question. They could use this case as a good example.

Recommendation 7

There should be included in any commissioning agreements with hostels and housing providers (as well as those in the voluntary sector), a clause emphasising their responsibility for ensuring staff can identify and respond appropriately to safeguarding concerns and principles.