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SERIOUS CASE REVIEW

Under Chapter VIII

'Working Together to Safeguard Children'

In respect of the death of

Case No.SOT12(1)

Report by:

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Presented to Stoke-on-Trent Safeguarding Children Board

on

16 July 2012

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Serious Case Review SOT12(1)
Executive Summary

INTRODUCTION

The purpose of this serious case review is as outlined in Chapter 8 (8.5) of the Working Together to Safeguard Children 2010 guidance, namely to:

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

Serious case reviews are not inquiries into how a child died or was seriously harmed, or into who is culpable. These are matters for Coroners and criminal courts, respectively, to determine as appropriate.

In production of this report agencies have collated sensitive and personal information under conditions of strict confidentiality. The Stoke-on-Trent

Safeguarding Children Board (SOTSCB) has balanced the need to maintain the privacy of the Child and family with the need for agencies to learn lessons relating to practice identified by the case and has authorised the publication of sufficient information to enable this to take place.

A decision to undertake a Serious Case Review was made on the 1 February 2012. The SOTSCB determined that agencies would secure and review their files from January 2009 until the date of the Child's death. Agencies were required to compile an Individual Management Review (IMR) to provide an independent, open and critical analysis of individual and organisational practice. The IMRs should identify lessons learnt by the individual agencies, highlight any good practice and include recommendations for single agencies to improve practice. A health overview report (HOR) was also requested in order to evaluate the practice of all involved health professionals with the intention of focussing on how health organisations interacted together and to produce any additional recommendations if appropriate.

Terms of Reference

In addition to the generic terms of reference contained within the Working Together to Safeguard Children Guidance 2010, the most important issues to address in trying to learn from this case were identified as:

A. What was the impact of domestic abuse on each child?

B. What was the quality of the sharing of information/concerns between

and within local authorities and services involved with the family and the impact on the Children?

C. What is the evidence of the assessment of mother's capacity to parent safely and the impact of any parenting interventions undertaken? Are the aims of the intervention clear and is there evidence that they impacted on the mother's capacity to parent?

D. What evidence is there of the mother's active engagement with services? Is there evidence of offer of service being refused and if so, were these followed up / communicated to others?

E. What was the quality of the analysis of risk informed by previous history in assessments undertaken including the success or otherwise, of the domestic abuse screening tools used?

F. Were contemporaneous records kept, and did they reflect the quality and process of decision making:-

i) across local authorities and agencies?
ii) within the local authority and agencies?
iii) identify purposeful intervention and integrated planning?

G Can the agency evidence what it was like for the Child to live in that

household?

H Were appropriate safeguarding policies and procedures in place, were they appropriate and were they followed by professionals. If not, what were the barriers?

I Were the professionals involved in the case sufficiently experienced, trained and supervised to undertake work with vulnerable Children and families and did they demonstrate sufficient 'professional curiosity' about the previous history of the family case?

J At any time during the timeframe of the serious case review, should child protection procedures have been triggered?

K What procedures have you got in place relating to making referrals to Children and Young People's Services?

L What are the MARAC procedures - were they followed?

SYNOPSIS

A '999' call was received when it was reported that the Child, an infant of pre-school age had stopped breathing. An ambulance crew arrived at the Child's home address and found the Child to be in cardiac arrest. Resuscitation was commenced and was continued during transportation to and upon arrival at hospital but was unsuccessful and the Child died. In

view of injuries which had been sustained by the Child a criminal investigation was instigated and the partner (partner 3) of the Child's mother was arrested and charged with the murder of the Child. Partner 3 indicated a not guilty plea, but later changed his plea to guilty.

The Child initially lived in Sandwell with the mother, the father and three elder siblings who were of primary school age. Two of the siblings (sibling 1 and 2) are the children of the mother by different partners and the third sibling (sibling 3) is the child of the father.

The Child was born into a household where repeated, frequent and escalating domestic abuse existed between the mother and the father which began prior to and continued after the Child's birth. The Child and half siblings were present during incidents and were to witness verbal abuse and physical assault against the mother. Sibling 1 was the subject of offensive and demeaning verbal abuse. There was little stability for the Child and siblings 1 and 2, who experienced a somewhat transient lifestyle with the mother as she moved away from, and back to the father and sibling 3, had two stays in separate Refuges and then returned to Stoke-on-Trent staying with friends before being allocated council accommodation. The mother quickly formed new relationships to which the children had to adapt and was content to leave the Child in the care of partner 3 within a relatively short period of time. The mother was in debt, was reliant on charitable donations for furniture and clothing and there is evidence and concerns of poor hygiene, untidy accommodation and lack of food. The mother's previous

relationship with partner 2, prior to the birth of the child, had also been abusive and several reports of domestic violence were made to the police

There was considerable involvement of agencies with the family prior to and after the birth of the Child. Whilst exchange of information did take place there were delays in transferring data, a lack of professional curiosity, a lack of lateral checks particularly across local authority boundaries and a failure to take a holistic approach in respect of assessing the welfare and safety of all of the children in the family. Risk assessments in respect of the domestic abuse incidents did not adequately focus upon the impact upon the children and did not take into account the history of the abuse. Initial Assessments undertaken by Children's Social Care (Sandwell and Stoke-on-Trent) were made only upon the Child's siblings and the Child was repeatedly overlooked. Whilst some support was provided to the family there was no follow up or co-ordinated plan which was a missed opportunity to address the vulnerabilities of the family.

CONCLUSION

Whilst it was known that the mother had been subject to domestic abuse within two relationships and that the Child and the siblings had witnessed abuse, it was believed by agencies that the children were safeguarded as both relationships had ended. Indeed both the father and partner 2 were under the supervision of Probation and there was a court order preventing the father from contacting the mother. The mother had disclosed that she had a new partner who did not live in the household. The identity of partner

3 was not known and in any event there would in all probability have been no indication that he would have been a risk to children. There had however, never been any assessment of the capability of the mother to protect and care for her children.

SCR RECOMMENDATIONS

- ***All Schools to notify the School Nursing Service of new pupils enrolling in schools within one month of the date of enrolment.***

- ***A check list be created for professionals to utilise to enable efficient, timely and appropriate telephone checks and referrals to Children's Social Care when there are child protection concerns, to ensure the full circumstances and history of the incident and family background are obtained***

- ***Stoke-on-Trent and Sandwell Children's Social Care to ensure that upon referral for initial assessment on a child, in a domestic abuse situation, that initial assessments are conducted upon all children within the family unit/household.***

- ***To raise awareness and embed the identification of low level domestic abuse, focusing on early intervention and prevention and to ensure that the risks to the emotional and physical wellbeing of child(ren) in the household are assessed.***

- ***Stoke-on-Trent Safeguarding Children Board require all agencies that have completed an IMR to implement and monitor any internal recommendations.***

- ***Information to be exchanged with Staffordshire Safeguarding Children Board to assist with Agencies' implementation of recommendations.***

SERIOUS CASE REVIEW PANEL CHAIR AND MEMBERS

Independent Chair Jackie Carnell

Panel Members

- Chief Executive, ARCH North Staffs
- Senior Manager, North Staffordshire Combined Healthcare NHS
- Divisional Manager Safeguarding, Sandwell
- Detective Chief Inspector, Staffordshire Police
- Designated Nurse, Staffordshire PCT Cluster
- Director of Nursing, Staffordshire and Stoke-on-Trent Partnership NHS Trust
- Head of Staffordshire and West Midlands Probation Trust, Stoke-on-Trent Delivery Unit

- Assistant Director, Stoke-on-Trent Adult and Neighbourhood Services
- Assistant Director, Stoke-on-Trent Children and Young Peoples Vulnerable Children and Corporate Parenting Division
- Senior Manager, Stoke-on-Trent Clinical Commissioning Group
- Lead for Stoke-on-Trent Youth Offending Service
- Senior Manager, University Hospital of North Staffordshire

Independent Author Gill Baker OBE – Independent Consultant

ENSURING LESSONS ARE LEARNT

The report findings were ratified by Stoke-on-Trent Safeguarding Children Board on 16 July 2012. All Safeguarding Board Members welcomed the report findings and agreed to ensure that all recommendations would be fully implemented within the agreed timescale. Stoke-on-Trent Safeguarding Children Board will closely monitor implementation requiring each agency to demonstrate and evidence that lessons have been learnt from this tragic case.

Single Agency Recommendations

A total of 42 single agency recommendations were made which were progressed whilst this serious case review was on going.

SERIOUS CASE REVIEW

1. Introduction

1.1 On 27 January 2012, a '999' call was made by the mother's partner (partner 3) who reported that the Child, who was an infant of pre-school age, had stopped breathing. An ambulance crew attended the home address and found the Child [redacted] The Child appeared lifeless, had bruising to the head and was in cardiac arrest. Resuscitation was commenced and continued whilst the Child was taken to hospital 2 but proved unsuccessful and the Child died. In view of injuries which had been sustained by the Child a criminal investigation commenced. The mother's partner was subsequently arrested, charged with murder. Initially Partner 3 indicated a not guilty plea and a trial date was set for January 2013.. However at the end of 2012 Partner 3 pleaded guilty to murder and received a life sentence. He will not be eligible for parole before serving 15 years of the sentence.

1.2 The case was reviewed at Stoke-on-Trent Safeguarding Children Board (SOTSCB) Serious Case Review Sub-Group meeting on the 31 January 2012 when a recommendation was made that the case met the criteria for a Serious Case Review (SCR). On the 1 February 2012, the Independent Chair of the SOTSCB decided to pursue a SCR. Liaison and consultation took place between SOTSCB, Sandwell

Safeguarding Children Board (SSCB), Birmingham Safeguarding Children Board (BSCB), Walsall Safeguarding Children Board (WSCB), Dudley Safeguarding Children Board (DSCB) and Staffordshire Safeguarding Children Board (StSCB), in view of the fact that agencies involved with the Child and family spanned these six local safeguarding Children board geographical areas.

2. Purpose, Scope and Terms of Reference

2.1 The purpose of this serious case review is as outlined in Chapter 8 (8.5) of the Working Together to Safeguard Children 2010 guidance, namely to:

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

2.2 It was determined that this SCR should focus on the period from January 2009 until the date of the Child's death, and it should include contact with extended members of the family and any other significant

persons only in so much as it is relevant to the decision making and care of the Child. The time parameter was chosen in order to provide a detailed picture of the family including the common themes relating to transience, domestic abuse, mother's choice of partner and number of incidents witnessed by the children. However it was stipulated that should agencies identify information from an earlier date which is relevant to the findings of the SCR then that should be included.

2.3 The most important issues to be addressed by agencies, in trying to learn from this case were identified in the Terms of Reference as:

The generic 'Working Together to Safeguard Children 2010' Terms of Reference

- *Were practitioners aware of and sensitive to the needs of the Children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a Child's welfare?*
- *When, and in what way, were the Child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of Children's services? Was this information recorded?*
- *Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of Children and acting on concerns about their welfare?*
- *What were the key relevant points/opportunities for assessment and decision making in this case to the Child and family? Do*

assessments and decisions appear to have been reached in an informed and professional way?

- *Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?*

- *Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for working during normal office hours and others providing out of hours services?*
- *Where relevant, were appropriate Child protection or care plans in place, and Child protection and/or looked after reviewing processes complied with?*
- *Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the Child and family, and were they explored and recorded?*
- *Were senior managers or other organisations and professionals involved at points in the case where they should have been?*
- *Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of Children, and with wider professional standards?*
- *Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in*

post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

- *Was there sufficient management accountability for decision making?*

Specific key issues to be addressed by all agencies

A. *What was the impact of domestic abuse on each child?*

B. *What was the quality of the sharing of information/concerns between and within local authorities and services involved with the family and the impact on the children?*

C. *What is the evidence of the assessment of mother's capacity to parent safely and the impact of any parenting interventions undertaken? Are the aims of the intervention clear and is there evidence that they impacted on the mother's capacity to parent?*

D. *What evidence is there of the mother's active engagement with services? Is there evidence of offer of service being refused and if so were these followed up / communicated to others?*

E. *What was the quality of the analysis of risk informed by previous history in assessments undertaken including the success or otherwise, of the domestic abuse screening tools used?*

F. Were contemporaneous records kept, and did they reflect the quality and process of decision making:-

- *i) across local authorities and agencies?*
- *ii) within the local authority and agencies?*
- *iii) identify purposeful intervention and integrated planning?*

G Can the agency evidence what it was like for the Child to live in that household?

H Were appropriate safeguarding policies and procedures in place, were they appropriate and were they followed by professionals. If not, what were the barriers?

I Were the professionals involved in the case sufficiently experienced, trained and supervised to undertake work with vulnerable Children and families and did they demonstrate sufficient 'professional curiosity' about the previous history of the family case?

J At any time during the timeframe of the serious case review, should Child protection procedures have been triggered?

K What procedures have you got in place relating to making referrals

to Children and Young People's Services?

L What are the MARAC procedures - were they followed?

2.4 It was anticipated at the commencement of this review that a delay in publication would occur due to the criminal investigation. SOTSCB operates to legal advice given in respect of serious case review reports while criminal proceedings are ongoing. It was agreed that criminal proceedings should at no time be compromised by publishing any findings and that further information may be gleaned from such proceedings and could usefully be included in this report.

3. Process

3.1 Notification of the serious case review was sent to agencies who were asked to undertake a management review of any contact with the Child and the family. The agencies were requested to look critically and openly at individual and organisational practice to ascertain whether changes could and should be made and, if so, how this should be achieved. It was requested that a senior member of staff who had no involvement with the case, complete the management review. Guidance notes which included a template for the review report were provided to each agency. It was requested that upon completion, each individual management review (IMR) be agreed by that organisation's senior managers who would be responsible for ensuring

that their single agency recommendations are acted upon. If agencies had no contact with the Child or the family they were asked to complete a 'nil' return. Those agencies which had minimal involvement provided an information report.

3.2. A health overview report was also requested in order to review and evaluate the practice of all involved health professionals, including GPs and providers commissioned by the Primary Care Trusts (PCTs).

3.3 A Serious Case Review Panel was established to actively manage the serious case review process and to obtain all relevant information from agencies and any parallel processes. The Panel's role was to ensure robust analysis of IMRs and that the overview report accurately reflected agency contributions and met 'Working Together' requirements. The Panel was set up with an Independent Chair and representatives from a range of agencies relevant to this case. The Independent Author attended all of the Panel meetings.

3.4 At the first meeting of the SCR Panel, the terms of reference provided by the SOTSCB Serious Case Review Sub Group, were reviewed and amendments were made.

3.5 A briefing session was held for IMR authors and the Health Overview author on 28 February 2012. In addition, on the same day, a briefing

was held between the Health Overview report author and Health IMR authors.

3.6 Upon receipt of IMRs from agencies, a composite chronology of events was produced. The IMRs and integrated chronology were discussed by the SCR Panel and any discrepancies or need for further information was resolved by verbal and written communication. As a result, amended final IMRs were received from the agencies as indicated in paragraph 6. The same process was undertaken in relation to the Health Overview Report.

3.7 Contact was made with the Senior Investigating Officer of the criminal investigation who provided information regarding the case and progress through the criminal justice system. Reference was made to a '*Guide for the Police, the Crown Prosecution Service and Local Safeguarding Children Boards to assist with liaison and the exchange of information when there are simultaneous Chapter 8 Serious Case Reviews and Criminal Proceedings'* published in April 2011.

3.8 The Review Panel met on five occasions to consider all of the IMRs, the Health Overview Report, information reports and to progress this Overview Report.

3.9 The Overview Report and Action Plan was presented to, and agreed by, the Stoke-on-Trent Safeguarding Children Board on 16 July 2012.

4. Timeliness of Review

4.1 This review was completed on 16 July 2012 which is within six months of the date of the decision to proceed, thus complying with *'Working Together to Safeguard Children' guidance 2010.* However, the criminal proceedings were still on-going and after completion of that process additional information and lessons to be learnt will be included in the final review report.

4.2 The progress of the case was tracked through the Serious Case Review Sub Group of SOTSCB. Agencies were requested to progress their single agency recommendations, in a timely manner prior to the publication of the serious case review.

4.3 Key milestones in the completion of the report

1 February 2012 - Independent Chair of SOTSCB decided to pursue a Serious Case Review

14 February 2012 - Panel members established

14 February 2012 - Independent Chair commissioned

14 February 2012 - Independent Author commissioned

16 July 2012 - report submitted to SOTSCB

5. Serious Case Review Panel Members and Independent Overview Author

5.1 **Independent Chair:** Jackie Carnell

The chair of this SCR has been the independent chair of the Stoke-on-Trent Safeguarding Children Board since April 2007 and is not an employee of any of the local service providers. She retired from the Stoke-on-Trent Primary Care Trust in January 2007 where she had the role of Designated Nurse for Child Protection and the Trust Board member with the portfolio for Children's Services and Safeguarding Children and Young People. She is still registered as a nurse and Health Visitor with the Nursing and Midwifery Council

5.2 The members of the panel are senior managers from the key statutory agencies who had no direct contact or management involvement with the case and were not the authors of Individual Management Reviews.

Panel Members:

- Chief Executive, ARCH North Staffs
- Senior Manager, North Staffordshire Combined Healthcare NHS
- Divisional Manager Safeguarding, Sandwell
- Detective Chief Inspector, Staffordshire Police
- Designated Nurse, Staffordshire PCT Cluster
- Director of Nursing, Staffordshire and Stoke-on-Trent Partnership NHS Trust

- Head of Staffordshire and West Midlands Probation Trust, Stoke-on-Trent Delivery Unit
- Assistant Director, Stoke-on-Trent Adult and Neighbourhood Services
- Assistant Director, Stoke-on-Trent Children and Young Peoples Vulnerable Children and Corporate Parenting Division
- Senior Manager, Stoke-on-Trent Clinical Commissioning Group
- Lead of Stoke-on-Trent Youth Offending Service
- Senior Manager, University Hospital of North Staffordshire

5.3 Independent Overview Author: Gill Baker OBE

The author of the overview report is a retired police officer and is independent of all the local agencies and professionals involved in the case, and of the SOTSCB. During the last ten years of her thirty year police service she was a Detective Inspector specialising in Child protection, domestic violence, sexual offences, sex offender management and vulnerable adult protection. Within her role she was responsible for compiling police individual management reviews and was a member of many serious case review panels across the West Midlands area. She was involved in the development of local, national and international multi-agency projects and initiatives as well as policy and procedures for the police service. Her work in this field was recognised when she was awarded an OBE in 2006 for services to the police. Since retirement she has been independent chair and author of

two serious case reviews and independent author of a further four serious case reviews.

5.4 The Panel met on the 14 February 2012 to agree the terms of reference for the SCR and on the following dates to consider all the IMRs and to progress the Overview Report:

24 April 2012

25 April 2012

8 May 2012

14 June 2012

3 July 2012

The independent overview author was present at each meeting.

6. Individual Management Reviews

6.1 On the 14 February 2012 agencies were asked to provide an IMR or a nil return, i.e. no contact with Child or family, with a return date of 17 April 2012. Additionally on the same date a Health Overview Report with the same return date was requested.

6.2 IMRs were received from the following agencies who were involved with the Child and the Child's family.

Agency	Original IMR received	Amended Final IMR received
ARCH (North Staffs Limited) – Family Support Network	17.04.12	17.05.12
Sandwell Children's Social Care	17.04.12	16.05.12
Sandwell & West Birmingham NHS Trust Community Services	17.04.12	10.05.12
Staffordshire Police	19.04.12	21.05.12
Staffordshire & Stoke-on-Trent Partnership NHS Trust	17.04.12	10.05.12
Stoke-on-Trent Children & Young People's Services, Vulnerable Children & Corporate Parenting	17.04.12	21.05.12
Staffordshire & West Midlands Probation Trust	16.04.12	17.05.12
Stoke-on-Trent Children & Young Persons Learning Division	16.04.12	21.05.12
University Hospital of North Staffordshire NHS Trust (Hospital 2)	17.04.12	21.05.12
West Midlands Police	19.04.12	22.05.12
Health Overview Report	17.04.12	18.05.12

6.3 Information Reports

Due to a minimal involvement with the Child and/or family information reports were obtained from the following agencies on the dates shown.

Agency	Date report received
Birmingham Crisis Centre	09.05.2012
Children & Family Court Advisory & Support Service (CAFCASS)	15.05.2012
Dudley Group of Hospitals NHS Foundation Trust (Hospital 1)	22.05.2012

Rowley Regis Sure Start Centre	11.05.2012
Sandwell Organisations Domestic Abuse Services (SODA)	11.05.2012
Walsall Domestic Violence Forum	02.02.2012
West Midlands Ambulance Service	18.05.2012

6.4. Nil Returns, indicating no contact with the Child or family, were received from the following agencies on the dates shown:

NSPCC – 8 February 2012

Brighter Futures Stoke-on-Trent – 3 May 2012

Walsall Children's Social Care – 1 February 2012

North Staffs Combined Healthcare NHS Trust – 10 February 2012

6.5 Methodology, Quality and Timeliness of Independent Management Reviews and the Health Overview Report

6.6 The Panel have considered ten IMRs, and a Health Overview report.

6.7 Agencies reviewed their computer and paper records, details of which are itemised within their respective IMRs. Each of the agencies conducted interviews of their staff to enhance the quality of their IMRs and to try and get an understanding of not only what happened but why something did or did not happen. Contextual information relating to volume of work, staff turnover, training, sickness, organisational change management and supervisory practice is contained within each IMR. Available for agencies is a leaflet issued by SOTSCB which explains the

reason, process and what can be expected when a professional is asked to contribute to a serious case review. Guidance was also provided to IMR authors regarding the interviewing of staff.

6.8 The Panel robustly scrutinised and quality assured each IMR and information report as well as the health overview report. Specific issues in written form were raised with each of the IMR authors, which resulted in amendments and additions. There was a timely response from all of the agencies involved to the issues raised.

6.10 A total of 42 single agency recommendations are contained in the IMRs and within one of the information reports. These were scrutinised by the Panel and are considered appropriate.

6.11 The Health Overview Report is comprehensive and effectively focuses upon how the health organisations interacted and provides a robust analysis of how and why events occurred. The Health Overview Report author was in agreement with the recommendations included in the IMRs from health agencies which address the issues raised. No further recommendations were made within the Report.

7. Parental and Extended Family Involvement

7.1 In view of the fact that criminal proceedings were ongoing and after liaison with the Senior Investigating Officer (SIO) and the Crown Prosecution Service (CPS) it was not felt appropriate to engage

personally with the parents or extended family during this review. However the parents and partner 3 were informed of the serious case review process verbally by the police Family Liaison Officer. The Panel members are committed to seeking the involvement of the family. It was therefore intended upon the conclusion of the criminal proceedings that the views of the family would be sought. An addendum will be added to this report if and when the family agree to contribute to this review.

8. Ethnicity & Diversity

8.1 Stoke-on-Trent is a city made up of six towns and is a unitary local authority with a population of 240,100 (June 2010) of which 25% are aged under 19 years. The black and ethnic minority population was estimated to be 10.63% in June 2009. Health in Stoke-on-Trent has steadily improved with life expectancy at 76.9 years for men and 81 years for women compared to the national average of 78.3 and 82.3 respectively. In April 2012 unemployment claimants amounted to 8.1% of the working age population compared to a national figure of 4.1%. In 2009 in Stoke-on-Trent 30.2% of households were in receipt of Council Tax Benefit compared with 22.0% in England and Wales.

8.2 Sandwell is a Metropolitan Borough formed in 1974 and is one of seven authorities that make up the West Midlands conurbation. Sandwell consists of six towns and has a population of 292,800 (June 2010). An ethnically diverse Borough, the black and ethnic minority population was

estimated to be 23.3% in June 2009. In absolute terms health in Sandwell has been improving over time, but at a slower rate than the country as a whole. Life expectancy is 74.9 years for men and 80.7 years for women. In Sandwell in February 2012, 7.7% of the local working age population claimed Job Seekers allowance compared to 5.1% in the West Midlands and 4.1% in the private sector. In March 2009 Sandwell had approximately 126,000 dwellings, of which 24% were council housing, and 5% registered social housing.

8.3 The Child is of white British ethnicity as are the immediate and extended family members. The family lived in socially deprived areas of both Stoke-on-Trent and Sandwell and resided in council owned property. The known family history included reference to a lack of money, alcohol use, multiple moves and domestic abuse. The mother, father and partner 2 were all unemployed. It is believed that partner 3 was in employment prior to his arrest. It is not believed that there are any disability issues for any members of the family.

9. Family Composition

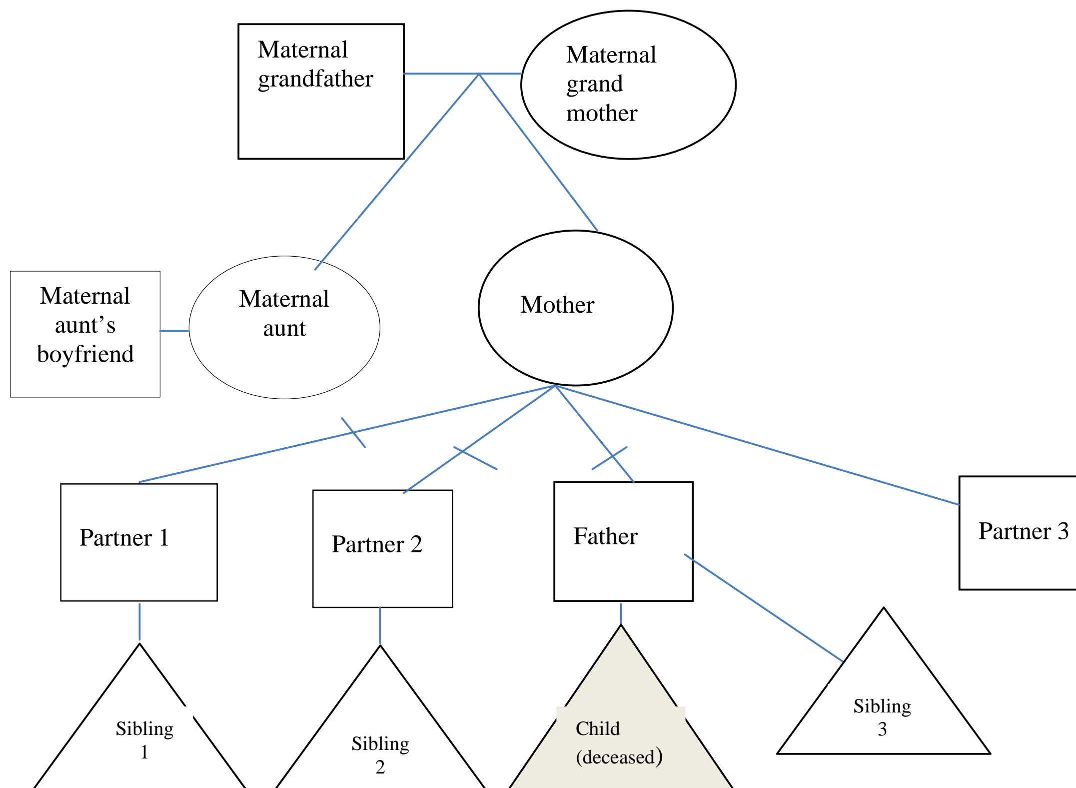
IDENTIFICATION KEY

Name	Relationship to the Child
Child	Subject Child
Mother	Mother of Child
Father	Father of Child
Sibling 1	Half sibling child of mother and partner 1

Sibling 2	Half sibling child of mother and partner 2
Sibling 3	Half sibling child of father
Partner 1	Father of sibling 1
Partner 2	Father of sibling 2
Partner 3	Partner of mother
Maternal Grandmother	Mother of Child's mother
Maternal Grandfather	Father of Child's mother
Maternal Aunt	Sister of Child's mother
Maternal Aunt's Boyfriend	Boyfriend of Child's mother's sister

10. Genogram

The Genogram refers to individuals using the family composition identification key.



11. Family Background

11.1 The Child initially lived in Sandwell with the mother, the father and three elder half siblings who were of primary school age. Two of the siblings (siblings 1 and 2) are the children of the mother by different fathers, (partner 1 and partner 2). The other sibling (sibling 3) is the child of the father. The relationship between the mother and the father was abusive and lasted approximately 16 months during which time nine domestic abuse incidents were reported to the police, one occurred whilst the mother was pregnant with the Child and the remainder whilst the Child and siblings were present in the home. The domestic abuse incidents featured the father's heavy drinking, controlling behaviour and often the arguments centred upon the children. The father has been described as a strict parent who was particularly verbally abusive towards sibling 1. The mother fled the home with the Child and siblings 1 and 2 to stay in Refuges on two occasions. Eventually after the father was charged and subsequently convicted of assault against the mother, she and the children moved back to Stoke-on-Trent from where she originated and where her extended family live.

11.2 Initially the Child lived with the mother and siblings 1 and 2 at friends' addresses until being allocated housing and the mother went on to form a new relationship with partner 3, whom it appears, did not live with the family but did stay with them on occasion.

11.3 The mother was in debt and received financial support and charitable donations of furniture and clothing. It was reported that during the family's stay in Refuge 2, their unit was untidy, and prior to the birth of the Child concern was expressed about the state of the home and whether the children (siblings 1 and 2) were being fed properly. The mother expressed a desire to become a teaching assistant at the school (school 3) her elder children attended. Indeed the mother enrolled on a Teaching Assistants training course, having been given guidance by the Headteacher of the school about how to access this training. Following her Criminal Records Bureau (CRB) clearance, during her training period she did some voluntary support work at the school on two or three occasions.

11.4 Prior to her relationship with the father, the mother's relationship with partner 2 had also been volatile and aggressive and a number of domestic abuse incidents were reported to the police.

11.5 The mother has a conviction for Benefit fraud, the father has convictions for assault, partner 2 has convictions for criminal damage and arson and partner 3 has convictions for arson endangering life committed against a previous partner. Partner 1 has no convictions and there appears to have been no domestic abuse incidents reported involving him.

11.6 Further information may be obtained after engagement with the family which hopefully will take place after the conclusion of the criminal proceedings as per paragraph 7.1 of this report.

12. Chronological Sequence of Events

12.1 Information known to individual agencies and professionals involved with the family has been aggregated together into a single detailed chronology. The following extracts from that integrated chronology and from Agency IMRs, are the independent author's view of the significant events which occurred prior to the death of the Child.

Family living in Stoke-on-Trent – prior to the Child's birth

12.2 On **8 January 2009**, Stoke-on-Trent Children's Social Care Duty Team was contacted by a volunteer from a charitable organisation which had provided financial assistance to the family but was concerned about the state of the property where they were living and the children (primary school age) not being fed properly. Checks were made with the children's school (school 1) and a letter was sent to the mother and partner 2.

12.3 On **10 January 2009** at 13:52 hours the mother reported to the police that partner 2 had 'kicked off' and was refusing to leave the home address. She reported that they had separated 12 months earlier and she had allowed him to stay over after Boxing Day (26 December

2008) but he kept coming back to the home after being asked to leave. The mother stated that she was unable to lock the back door as she 'didn't know where the key was'. When the police (Staffordshire Police) arrived partner 2 had left but the mother phoned the police on two occasions three hours later to report that partner 2 had returned and was shouting abuse. When the police returned neither the mother nor partner 2 were present at the address. Police officers returned later and spoke with both mother and partner. Siblings 1 and 2 were both present in the house when mother was spoken to. The incident was recorded as a 'non crime domestic'. It was noted that the address was well known to the police for previous reports of domestic abuse.

12.4 On **14 January 2009** the mother and partner 2 were seen by a duty social worker at a Stoke-on-Trent Children's Social Care office. It appears that this contact was as a result of receipt of the letter but there is no indication in case records as to the involvement of the charitable organisation with the family. In any event advice was given in respect of improving the home, e.g. access to furniture. In addition school 1 was contacted when no concerns were raised about the children but it was agreed that the mother would engage with professionals and a referral was to be made to Integrated Family Support by school 1.

12.5 On **21 January 2009** the police received a telephone call to report that Bailiffs were at the home address to repossess a washing machine and

dryer and that the mother was being abusive and threatening. Police attendance was requested to prevent a breach of the peace. Police officer 3 attended and the property was removed from the premises. It is not recorded whether the children were present but the mother was unhappy about the situation and threatened to complain about the Bailiffs and the police.

12.6 On **28 January 2009** partner 2 reported to Staffordshire Police that the mother had been in contact with a male on an internet chat line for about 12 months and she had informed him that she wanted to cease contact. As a result a text message was received threatening the mother. Partner 2 was concerned for the safety of the children as the male had stated that he had access to weapons. Police officers attended the address but the mother stated that partner 2 had 'blown things out of proportion' but he would be staying with the family overnight. Attention was paid to the address overnight by the police but nothing further came of this incident. Details were recorded on an intelligence database.

12.7 On **6 February 2009** a referral was received by the Integrated Family Support Service from school 1. Incorrectly recorded by school 1 as an anonymous referral to Stoke-on-Trent Children's Social Care, there is reference to a history of domestic abuse, partner 2's offending and some medical history, recent separation of the couple and the state of

the home. It was suggested that Triple P parenting[1] would benefit the family. Records are unclear but it appears that the mother had access to services prior to this referral.

12.8 On **12 February 2009** Partner 2 reported to the police that sibling 1 had been shown an indecent picture by an unknown male and had been threatened by him. This was investigated by the police when it was discovered that the incident had occurred a few months before but sibling 1 had only just disclosed the matter to the mother. Police officers investigated the allegation and the male was later identified. He was known by partner 2 who two weeks later claimed that he had been threatened by the male. Counter allegations were made, both were advised about their conduct and no further action was taken. No referral was made to Children's Social Care.

12.9 On **6 April 2009** siblings 1 and 2 were to access an interactive group for children at a Children's centre, but records are sparse and there is no further information or description regarding the children.

12.10 On **15 April 2009** sibling 2 failed to attend a 3 year health check and as this was the third failed appointment no further appointments were sent

12.11 On **20 April 2009** partner 2 accessed Parent – Child interaction training provided at the Children's centre but there is little information recorded. However, it is known that Partner 2 participated in the activities of the

[1] Triple P is a parenting and family support programme that aims to enhance knowledge, skills and competence of parents

Children's centre which included accredited training and he was to achieve a sports leader award.

12.12 On **25 April 2009** the mother reported to Staffordshire Police that partner 2 had been aggressive and threatening towards her when she had visited his address and they had discussed matters concerning the children. She stated that he had thrown her and the children out of his house. Police officers attended the mother's home address the following day but could get no reply. She was seen the next day when she was reluctant to speak with the officers but stated that the disagreement with partner 2 had been resolved and that the children were with him. The matter was recorded as a 'no crime domestic'.

12.13 On **28 May 2009** sibling 1 was taken by ambulance to hospital 2 having sustained an injury to the right side of the forehead having fallen in the garden. The injury was found to be a small superficial laceration which was consistent with the account given. The mother was given advice on caring for a head injury and sibling 1 was discharged home. No lateral checks were made with other agencies, which complies with current internal hospital procedure in respect of a minor injury of this nature.

12.14 On **16 June 2009** the father who was living in Sandwell, saw his GP reporting a stress related problem as his ex-partner was trying to take custody of sibling 3. No medication was prescribed but the father was

advised to cut down on his alcohol consumption. (It should be noted that this was prior to the father's relationship with the mother).

12.15 On **23 June 2009**, an anonymous call was made to Sandwell Children's Social Care reporting concerns for sibling 3 due to the father's drinking. No further action was taken and it was recorded that 'nothing to suggest that a child is at risk because dad is seen with a can of beer'. Lateral checks were not made with other agencies.

12.16 During **July 2009 and August 2009**, both mother and partner 2 attended parenting groups at the Children's centre and sibling 1 and partner 2 attended community event/fun days. Again records are sparse and there is no further information in respect of the children or adults.

12.17 On **8 August 2009** the mother reported to the police that partner 2 was at the home address to pick up the children and he was 'kicking off', and wouldn't leave. Police officers attended and reported that there were no complaints and partner 2 had left. The argument was about the mother being out with the children until 10 p.m. the night before. The matter was recorded as a 'non crime domestic'.

12.18 On **13 August 2009** an anonymous referral was made to Sandwell Children's Social Care concerned about sibling 3. It was alleged that the father consumed a lot of alcohol, had a lot of parties and was being

investigated for anti-social behaviour. The father was the single carer since his separation from the mother of sibling 3.

12.19 On **17 August 2009** an initial assessment was completed on sibling 3 but despite clear manager instructions the assessment was not thorough and there is no record of any checks with other agencies. A home visit was made when father and sibling 3 were seen. It was assessed that sibling 3 was well cared for and the case was filed but with the absence of manager comments.

12.20 On **7 September 2009** the Integrated Family Support Service (IFSS) closed the case. Records of involvement with the family are poor but information has been gleaned from the Integrated Family Support worker which indicate that both the mother and partner 2 engaged well with the service and the activities provided by the Children's centre. School 1 did not receive any feedback following their referral to IFSS and so were unaware if any Triple P training or other support or advice was accessed, nor of any evaluation of the effectiveness of this support.

12.21 On **9 September 2009** sibling 1 was taken to hospital 2 by ambulance after running into a gate and metal bin while running around outside. There was a history of a nosebleed and appearing sleepy and drowsy. Sibling 1 was assessed and diagnosed as having a minor head injury and was discharged home. No checks were made with other agencies,

which complies with current procedure in respect of a minor injury of this nature.

12.22 On **30 October 2009** the mother reported to Staffordshire Police that partner 2 was at the home address 'kicking off' and causing trouble in respect of his child, sibling 2. She stated that she was there with her current boyfriend believed to be the father. A police officer attended but the only person present was the mother who stated that partner 2 had become angry after she told him she was going to live with the father in Wolverhampton. The police officer obtained details, advice was given and the incident was recorded as a verbal domestic. The children were not seen.

Family moved to Sandwell

12.23 The exact date that the mother and siblings 1 and 2 left Stoke-on-Trent to live with the father and sibling 3 is not known. However on **27 November 2009** siblings 1 and 2 left school 1 to relocate to school 2 in Sandwell.

12.24 On **7 December 2009,** partner 2 visited Stoke-on-Trent Children's Social Care duty team and reported concerns about not having seen his child (sibling 2). He believed that the family had moved to Wolverhampton and he expressed concern about the safety of the children. He claimed that mother's new partner, the father, was an

alcoholic and was 'bi-polar' (an unsubstantiated allegation). Partner 2 was advised to take legal advice regarding contact with his child (sibling 2) and it is recorded that a telephone referral was made by Stoke-on-Trent Children's Social Care to Wolverhampton Children's Social Care when information was shared. It has since been established that the address given by partner 2 does not exist but there is no record of Stoke-on-Trent Children's Social Care or Partner 2 being informed of this fact and clarification or lateral checks being sought. Wolverhampton Children's Social Care can find no record of this referral. At that time paper records were being transferred to an electronic system and it is possible that the referral data was lost in the transfer.

12.25 On **21 December 2009,** the mother visited her GP in Sandwell and was found to be 10 weeks pregnant with the Child.

12.26 On **24 December 2009,** West Midlands police officers attended the father's address following a report of a domestic violence non-crime incident. The father stated that the mother had his keys and wouldn't return them and he did not want the mother and siblings 1 and 2 in his house. The father was found to be unsteady on his feet, spoke with slurred speech and smelt of intoxicating liquor. Siblings 1, 2 and 3 were present and they and the mother were taken to the local police station. The paternal grandmother who lived locally was contacted and the mother and the three children went to stay with her. A referral was

made to the West Midlands Police public protection unit but was filed without further action. This was due to a backlog of referrals when only referrals classified as high risk were progressed.

12.27 On **6 January 2010** the mother was seen by a community midwife at her GP surgery when an assessment was made including previous pregnancy history. No concerns were identified and no routine questioning regarding domestic violence was undertaken. The mother attended a further antenatal appointment one month later when no issues were identified.

12.28 On **1 March 2010** notification was received by Sandwell Child Health Department of the movement of siblings 1 and 2 to school 2.

12.29 The mother went on to attend most of her antenatal appointments with some concern expressed about her smoking and advice was given about cessation.

12.30 On **4 July 2010** the Child was born of normal delivery and notes indicate that the father was not present. The mother and Child were discharged the next day and were visited the following day by a community midwife when no concerns were noted. Four further home visits were made by the community midwife when no concerns were noted.

12.31 On **19 July 2010** a primary visit by the Sandwell Health Visitor was made and safer sleeping, prevention of cot death and breast feeding was discussed. Details of the father, ethnicity, language, religion and details of siblings were recorded. However domestic abuse was not discussed.

12.32 On **26 July 2010,** the mother and Child were discharged from community midwife care. The mother had expressed unhappiness about still being visited by midwives at this stage and wished to complain. The Child had previously had an eye infection which resulted in extended midwifery involvement but mother felt that she was being blamed. It seems that she did not pursue a complaint.

12.33 On **9 August 2010** the mother reported to the police that she had a verbal altercation with the father. Upon arrival of police officers the father was found to be intoxicated and holding the Child. The mother, Child and siblings 1 and 2 left the address and went to stay with maternal grandparents. The attending officers assessed the incident as a medium risk but this was downgraded by a supervisor as it was felt that the mother and children were safe as they had left the address. It is unclear as to the whereabouts of sibling 3. The incident was referred to the West Midlands police public protection unit and to Sandwell Children's Social Care and was received two days later. On **14 August 2010,** details of the incident were discussed at a Barnardos

Screening Tool (BST)[2] meeting involving police child protection officers, social workers and health representatives. The screening decision is recorded as scale 2, i.e. *basic information sharing and recording, possible targeted support with single practitioner involvement, signposting to other services. Possible use of Common Assessment Framework (CAF).* No further action was taken in respect of this referral.

12.34 On 2 **September 2010** the Child was seen at the GP surgery to receive first immunisations and at the same time the mother received her post natal check. No issues or concerns were identified.

12.35 On **5 September 2010** police officers attended the home address when the mother reported that during an argument the father punched her in the face and pushed her over. She sustained bruising and swelling and the mother stated that the father had sworn at, and spat in the face of sibling 1. The father was arrested for assault against mother and sibling 1. The attending police officers completed a risk assessment questionnaire with the mother who disclosed that she was afraid of the father using further violence against her but not the children. The father was drinking heavily each day and on one occasion had put his hands around her neck. However the level of risk was not graded and due to this oversight there was no supervision of this incident which

[2] BST is used to assess the risk to children/unborn children resident or normally resident in households where domestic abuse occurs. There are four threshold scales of intervention, i.e. 4 being the most serious with a need for a child protection investigation (Sect 47 Children Act 1989)

resulted in the risk assessment questionnaire being filed and not referred to the police public protection unit. Hence there was no consideration of a child protection referral and none of the details contained in the risk assessment were referred to Children's Social Care. However Sandwell Children's Social Care were contacted and informed of the incident with the focus being on re-housing for the mother. Bed and breakfast accommodation was provided for the mother, the Child and siblings 1 and 2 and the following day the mother was offered and accepted accommodation at Refuge 1. The father was allowed conditional bail pending advice from the Crown Prosecution Service. Records indicate that the basis of this decision was that the mother had moved away from the home address which meant she was safeguarded and that the father was the carer for sibling 3. This decision was flawed as no consideration appears to have been given to the safety of sibling 3 particularly considering the fact that he had been arrested for an offence of assault against a child (sibling 1). At the Refuge the mother disclosed information about the incident and the controlling behaviour of the father who believed that 'children should be seen and not heard', and expressed her concern over the safety of sibling 3. She further stated that sibling 3 had no toys and was reliant on her paternal grandmother to supply clothing.

12.36 On **7 September 2010** the referral was received from Refuge 1 by **Sandwell** Children's Social Care and the duty social worker commenced an initial assessment on sibling 3.

12.37 On **17 September 2010** notification was received by Sandwell Children's Social Care that the mother of sibling 3 had applied to the Family Proceedings Court for contact with sibling 3 and a Section 7 Children Act 1989 report[3] was requested. Subsequently a social worker made contact with the mother, father and siblings 1, 2 and 3 as part of the assessment. There is no record of the Child being seen or considered during this process. The violence in the relationship between the mother and the father and the father's drinking was considered as part of the assessment but was not seen as a significant risk to sibling 3 who was the only child considered. The mother (recorded by the social worker as stepmother of sibling 3) was described in the records as being 'quite volatile' during the court process. This was not however further considered or pursued.

12.38 Shortly after this the mother returned with the Child and siblings 1 and 2 to live with the father on or around **20 September 2010.** She informed the police that she wished to withdraw the statement she made in respect of the incident on 5 September 2010.

12.39 On **24 September 2010** the mother appeared at a Magistrates Court for Benefit fraud. She pleaded guilty and was sentenced to a Community Order with supervision requirement for 9 months.

[3] A welfare report on a Child

12.40 On **28 September 2010** an unannounced visit was made to the family by a social worker when mother, father and sibling 3 were seen. It is unclear in records as to whether the Child, sibling 1 and sibling 2 were present. The focus of this visit therefore appeared to be about the court application in respect of sibling 3. The mother minimised the domestic abuse previously reported and stated that she and her children were happy living with the father.

12.41 On **8 October 2010** the Probation initial assessment in respect of mother's offending was completed and an assessment of low risk of harm was concluded. The mother disclosed previous domestic violence in a previous relationship but stated it was not an issue with her current partner (the father). The sentence plan proposed objectives in relation to victim awareness and thinking skills.

12.42 On **13 October 2010,** the father appeared at a Magistrates Court charged with the two offences of common assault, one against the mother and one against sibling 1. However the mother had indicated that she wished to withdraw her statement and hence the charges were withdrawn due to insufficient evidence. The evidence regarding the assault against sibling 1 was contained in the statement made by the mother as it had not been judged appropriate to obtain a statement from sibling 1 at the time of the incident.

12.43 On **29 October 2010** the initial assessment was completed by

Sandwell Children's Social Care on sibling 3. During this process it is recorded that siblings 1, 2 and 3 were spoken to alone and school checks were undertaken on sibling 3 but not in respect of siblings 1 and 2. The focus was entirely upon sibling 3 and the Child and siblings 1 and 2 were not considered at all during this assessment and were completely overlooked. It was concluded that there were no concerns for sibling 3.

12.44 On the same day sibling 1 reported to West Midlands Police that the mother and father were arguing. When police officers arrived the father appeared intoxicated. It was agreed that the father would leave the home address and stay with a friend overnight. The children were seen by the officers and the officers completed a risk assessment questionnaire with the mother and the risk was graded as standard. A referral was made to the police public protection unit and the incident was later shared with Sandwell Children's Social Care.

12.45 On **1 November 2010** the mother reported to West Midlands Police that the father was being violent and upon arrival the police officers were told that the father had asked the mother to leave but she had nowhere to go. She stated that the father had not assaulted her. She stated that the arguments were always about the children, particularly sibling 1. The father agreed to leave the address overnight allowing the mother and children to remain at the address until she could seek accommodation the next day. A risk assessment conducted again

graded the risk as ‘medium’. The incident was referred to the public protection unit and a warning marker was placed against the home address to indicate repeat domestic abuse incidents. The mother was also to be contacted to discuss a safety plan.

12.46 On **5 November 2010** a telephone call was received by West Midlands Police from the mother in a distressed state but the call was ended and no details were given. The telephone number was traced to the home address and when officers attended the mother was found to have visible injuries to her left eye and she stated that she had been assaulted by an unknown woman. The father was present and due to inconsistencies in her story the officers arrested the father on suspicion of assault. The mother was spoken to alone and continued to insist that the father was not responsible for her injuries. However she did co-operate with the officers in answering the questions to enable a risk assessment to be conducted which indicated a medium risk. The father was released without charge due to insufficient evidence.

12.47 On **15 November 2010** the incident which occurred on 29 October 2010 was discussed at a Barnardos Screening Tool meeting.

12.48 On **16 November 2010** the mother contacted West Midlands police and reported an argument with the father who had asked her to leave. As she had nowhere to go the police officers arranged a place for her in Refuge 2 and she was taken there with the Child, sibling 1 and

sibling 2. The mother was accepted into the Refuge and the family were provided with a food parcel. The children were described as being very hungry. The mother made a statement to the police and she was assisted by a Refuge worker in the completion of paperwork in respect of benefit claims. Contact was made with the mother's Probation Officer, the children's school, Health Visitor and Sandwell Children's Social Care. Arrangements were made for the mother to receive legal advice in respect of access to the Child by the father and Residence Order applications for the children. Mother continued to receive support from the Refuge, including the collection of belongings from the home address. She also initially kept her Probation appointments with her offender manager. During the stay at the Refuge, siblings 1 and 2 continued to attend school 2 in Sandwell and the family remained registered at the Sandwell GP practice.

12.49 On **3 December 2010,** the Health Visitor carried out a 'new to area' visit, saw all three Children at Refuge 2 and was happy with their health and development. At the time of the visit the Child was asleep in a Moses basket but was awoken to be weighed. The mother reported that the Child was being breast fed but she was weaning the Child and appropriate food was discussed. The Child was observed to be sociable and smiling with no health concerns. There was good interaction between mother and Child. The mother was advised to make an appointment for the Child's second immunisation which was outstanding. The Health Visitor discussed the impact of domestic

abuse on a child's emotional and psychological health. There is no recorded contact made with the previous Health Visitor.

12.50 On **5 December 2010** the mother booked out of Refuge 2 overnight with the children and was to book out again three nights later. She also booked out a further night the following day which was challenged as this is against the rules of Refuge 2 but this was allowed as she stated she had a doctor's appointment the next day and it was easier to stay nearer to the GP practice. It is unclear where she and the children stayed during these three nights.

12.51 On **10 December 2010** two childcare support workers entered the mother's unit within the Refuge as there was a 'terrible smell' which caused some concern as the mother had booked out of the Refuge again. It is not recorded whether any action was taken regarding this.

12.52 The mother continued to receive support from Refuge 2 in respect of clothing, application for housing and general advice and she joined in social evenings with other residents. She booked out of the Refuge overnight on two more occasions. She did however fail to attend her probation appointments. The Child received the 2nd immunisation at the GP surgery on **21 December 2010.**

12.53 On **7 January 2011** the School Health Nursing Service received notification from the out of schools team that the mother had moved

into Refuge 2. There was no liaison with the Health Visitor but it was planned to make contact with the school (school 2).

12.54 The family remained at the Refuge with the mother regularly booking out overnight and on **30 January 2011** a risk assessment and support plan was completed with the mother by a new allocated key-worker of Refuge 2. No risk areas were identified and the mother stated that she felt safe since moving into the Refuge. She indicated that the maternal grandparents were continuing to support her and that she had a close friend who she could trust (details of whom were not recorded). She stated that she wished to train as a teaching assistant and was planning to attend college the following September. She admitted to being in substantial debt and needed support to manage that. She indicated that she required some support in respect of sibling 1 in view of difficulties in communication. She stated she had no issues regarding the father wanting contact with the Child. She claimed that the children had not witnessed or been subject of abuse by the father. The risk assessment failed to assess the risk posed by the father or any other males but focussed upon the risk the mother posed to herself and to staff of the Refuge.

12.55 On **2 February 2011** the mother was contacted by Sandwell Children's Social Care social worker requesting information in respect of sibling 3. The mother stated she had no concerns for sibling 3 and that her relationship with the father had improved since their separation. There

was however no discussion about the referral in respect of sibling 3 which was made by the mother in September 2010 when she was staying in Refuge 1 with the Child and siblings 1 and 2.

12.56 On **7 February 2011** Probation offender manager 1 made a referral to Sandwell Children's Social Care due to mother's contact with the father. The mother had informed the Probation offender manager that she had been visiting the father on a daily basis and had the Child with her. Concern centred around the history of domestic abuse and the fact that the mother had a history of other abusive relationships and that the father had been charged with an assault on sibling 1. The duty social worker recorded that a letter was sent to mother to advise of concerns about the children being exposed to domestic abuse. No copy of the letter could be found within records and there is no indication of consideration to discover more about the incident on 5 September 2010 when the father was charged with assault on sibling 1.

12.57 The mother and children continued to live at Refuge 2 but were regularly booking out for overnight stays and she stated that she was staying with a female friend. She was given support for the housing application and was able to bid for properties but no suitable accommodation was found.

12.58 On **24 February 2011** sibling 2 reported to staff at Refuge 2 that the Child was in the unit screaming. The staff found that the Child had

rolled or crawled off a play mat (behaviour which was age appropriate) but was lying under the bed very distressed. The Child was taken to the mother who in another room was making a telephone call about housing. She was insistent that the children were all safe when she left them to make the telephone call. The unit was found to be very untidy and the mother was advised to clean it.

12.59 On **1 March 2011** the Sandwell Health Visitor received notifications of the domestic violence incidents which occurred on 22 October 2010 and 5 November 2010. Additional health records and care plan for the Child and mother were initiated to ensure that the mother had contact numbers for support if and when needed. There was however no liaison made with the School Nurse or Children's Social Care.

12.60 On **7 March 2011** information was received by Refuge 2 staff that the mother was still having contact with the father and that he was picking up the family at the top of the road where the Refuge was located. He was then taking siblings 1 and 2 to school in the morning and returning them in the evening. In addition a new resident at Refuge 2 knew the mother and it was feared that she would tell the father where the new resident was living and hence the information could be passed on which would endanger her. The mother was informed that she would have to leave Refuge 2 as the placement had been seriously compromised. A place was found for the mother at Refuge 1 but she did not want to go there as she stated she could not settle there before

and she wanted to stay in Refuge 2. Further bidding for housing properties was made to no avail and the mother then asked to stay one more night after which she would then make her own arrangements. This course of action was approved by the Refuge Manager. The mother stated that she would be staying with a friend and would make her own arrangements to remove property from the Refuge.

12.61 On **8 March 2011** the mother, Child and siblings 1 and 2 left the Refuge but no 'moving on' support was provided. No forwarding address was left but the mother was eventually traced by the Sandwell School Nurse who passed the information to the Sandwell Health Visitor who contacted the mother by telephone on **23 March 2011.** The mother stated she was staying with a friend in Sandwell. She claimed to be moving into a new home in Sandwell and arrangements were made for the Health Visitor to visit when the family had settled in.

12.62 On **11 April 2011** the mother reported to West Midlands Police that she had been assaulted on two occasions by the father. The first was on **7 April 2011** when he had physically assaulted her, and the second was on **11 April 2011** when he had again physically assaulted her causing bruising and grazing. The argument began about sibling 1 to whom the father was extremely verbally abusive. Sibling 1 and 2 witnessed the assault and were shaken and crying. During the assault the father had put his hands around the mother's neck but she managed to escape by biting his fingers. She had left the home address and was at a friend's

house. Police officers attended, obtained a statement from the mother and the father was arrested and charged with two offences of common assault. He appeared at a Magistrates Court on **13 April 2011** when he pleaded not guilty and was remanded on bail with conditions. A referral was made to Sandwell Children's Social Care but this does not appear to have been received until **27 April 2011.** The police reported that sibling 1 had witnessed the assault and 'the children had been extremely affected by this incident and other incidents'. The incidents were risk assessed using the Barnardos screening tool at level 3, i.e. *basic information sharing and recording, quite likely to be sec. 17*[4] *and consideration of joint visits.* Hence the case was allocated to a duty social worker for an initial assessment on the Child, sibling 1 and sibling 2. Information was included in sibling 3's record but a new initial assessment was not opened for sibling 3.

Mother returned to Stoke-on-Trent with the Child and siblings 1 and 2

12.63 On **4 May 2011** the mother informed Sandwell Children's Social Care that she had returned to live in Stoke-on-Trent with the Child, sibling 1 and sibling 2. In view of this the initial assessments on the three children were closed by Sandwell Children's Social Care and a written referral was made to Stoke-on-Trent Children's Social Care. The following day the Sandwell Health Visitor spoke with mother who stated

[4] Section 17, Children Act relates to the provision of services for children in need, their families and others by every Local Authority

that she had moved to Stoke-on-Trent and was staying with friends. The health records for the Child and mother were sent to the Sandwell Health Department for transfer to Stoke-on-Trent. There is no record of any liaison with the School Nurse or of a verbal handover to Stoke-on-Trent Health Visitor service or School Nursing Service.

12.64 On **16 May 2011** Stoke-on-Trent Children's Social Care received the referral from Sandwell Children's Social Care together with a copy of the notification which was received from West Midlands Police regarding the incidents of 7 and 11 April 2011. The referral was detailed and cross referenced the previous domestic abuse notifications from the police and the referral from Probation (7 February 2011). Initial assessment on the family was initiated. No lateral checks were made with Stoke-on-Trent Health services. The Child was named on the referral form but was not added onto the [redacted] database. Two days later an initial assessment was opened on sibling 1 only, despite the fact that the referral was in respect of all three children.

12.65 On **25 May 2011** the School Nurse in Sandwell reviewed health records for sibling 1 and no further concerns were identified. The following day a home visit to the mother was made by the Stoke-on-Trent Probation Offender Supervisor when the mother again raised concerns about sibling 3 who was still living with the father. She was advised to write to Stoke-on-Trent and Sandwell Children's Services. The Child was seen during the visit and no issues were identified.

12.66 On **3 June 2011** the father contacted West Midlands Police to report problems with the mother over access to the Child and collection of property. The mother was contacted by the police officers who advised her not to have contact with the father who was awaiting trial for the two offences of assault against her which took place in April 2011. Information was referred onto Sandwell Children's Social Care and no further action was taken

12.67 On **7 June 2011** siblings 1 and 2 were admitted to school 3, both still of primary school age

12.68 On **13 June 2011** the father again reported to West Midlands Police that the mother was constantly calling him to arrange collection of some items but he was not answering her due to the impending criminal trial. No action was taken. The father appeared at a Magistrates Court two days later when the case was remanded for trial and he was granted conditional bail.

12.69 On **22 June 2011** the mother contacted Sandwell Children's Social Care again raising concerns about the father's care of sibling 3. She stated that she would put her concerns in writing and was given the relevant address to send it to. No written record from mother was found in records or documented as being received.

12.70 On **23 June 2011** the school health records for siblings 1 and 2 were sent from Sandwell to Stoke-on-Trent. However the health visiting records for the Child were not sent. Details of the report by the father on 3 June 2011 were recorded on the database and the Barnardos risk assessment was noted as scale 2. This was not recorded in the health visiting records of the Child or the mother. On the same day a final supervision home visit was made by the Stoke-on-Trent Probation offender supervisor but the mother was not at home. The supervision order expired on that day

12.71 On **27 June 2011** the Stoke-on-Trent Children's Social Care Social Worker visited three addresses in an effort to complete the initial assessment but was unable to locate the mother.

12.72 On **6 July 2011** a referral was made to a Family Support Network for family support which followed an initial assessment by Stoke-on-Trent Children's Social Care when the mother, Child, sibling 1 and 2 were seen at a friend's address. The support was to include domestic abuse counselling for sibling 1 and the mother, housing support and financial/legal advice. No role was identified for children's 'specialist' services and the case was closed. There was no contact with Health services. The focus of the initial assessment was upon sibling 1 only, despite the fact that all of the children were subject of the referral received from Sandwell.

12.73 On **18 July 2011** Sandwell Children's Social Care sent a letter to the father advising him to ensure adequate care for sibling 3. This was the result of concerns raised by the school regarding hygiene, no lunch or money provided for a school trip, an unknown man collecting sibling 3 from school, and sibling 3 being tired and reportedly staying up until 0100 hours. Sibling 3 also spoke of 'feeling down' since the mother left the family home. The case was closed after a number of unsuccessful attempts to speak with father by telephone.

12.74 On **7 September 2011** the Domestic Violence Outreach Service (ARCH)[5] in Stoke-on-Trent received a referral from Sandwell Organisation Against Domestic Abuse (SOADA) requesting support for the mother who was subsequently offered an appointment at a Community Outreach session.

12.75 On the same day Sandwell Children's Social Care closed the case on sibling 3 as the private court proceedings had been concluded because the mother of sibling 3 was no longer pursuing the case. A further letter was sent to the father advising him that he should ensure that sibling 3 was cared for and protected at all times. School 2 was notified and asked to re refer in the event of any further concerns.

[5] ARCH is a registered charity which provides a diverse range of services for children, young people, adults and families in local communities across Stoke-on-Trent, Staffordshire Cheshire. This includes working with people in housing need or crisis including but not solely victims and perpetrators of domestic abuse. Also provided is a range of complementary activities and programmes to support people to develop the skills and confidence to live independently and return to education, training or employment.

12.76 On **9 September 2011** the mother attended a domestic violence outreach session when she was informed of the services available. The mother requested counselling and she agreed to participate in the Freedom Programme[6] which was due to begin in January 2012, but she failed to attend and the case was closed.

12.77 During this month the mother registered at a GP practice in Stoke-on-Trent and new patient checks were conducted on the mother, the Child, sibling 1 and sibling 2. The health records for the mother and the Child were sent from Sandwell to Stoke-on-Trent.

12.78 On **7 October 2011** the Family Support Network Co-ordinator made an initial visit to the family, and the mother requested help with council tax arrears and access to furniture and therefore a referral was made to the furniture mine and arrangements were made for a benefits worker to visit.

12.79 On **10 October 2011** the Child's health records were sent to the Stoke-on-Trent Health Visitor who made a 'removal in'[7] home visit **on 17 October 2011** to the mother but the Child was not seen. It was recorded that the family had returned to the area after fleeing from domestic abuse and the partner (the father) was not with the family. The mother stated she now had extended family support as she was

[6] The Freedom Programme is an 11 or 12 week programme which provides information about male violence to women

[7] 'Removal in' is terminology used in Stoke-on-Trent for the first visit by a health visitor to a child who has newly moved into the area.

living near the maternal grandmother. The mother did not have the Parent Held Personal Child Health Record (red book) for the Child and an appointment was made for the mother and Child to be seen in the clinic on **25 October 2011** but the mother failed to attend. The Stoke-on-Trent Health Visitor 1 telephoned the mother but there was no response. However the Child was seen at the GP practice six days later to receive third immunisations.

12.80 On **28 October 2011** the father was found guilty of the assault charges and was remanded on conditional bail for a pre-sentence report.

12.81 On **8 November 2011** partner 2 contacted Stoke-on-Trent Children's Social Care to enquire whether he would have to undergo an assessment before he could see his child (sibling 2) or 'step child' (sibling 1) as he had just been released from prison after serving a sentence for arson. He asked this because he had wanted contact with another child of his by a woman who lived in another part of the country and had been told he would have to undertake an assessment before he could have contact with that Child. Partner 2 had also spoken with his Probation Officer based in Lancashire who told him to contact Stoke-on-Trent Children's Social Care. After liaison with the Probation Officer it was agreed that partner 2 could have a supervised visit.

12.82 During this month, **November 2011** the mother was to receive support in relation to welfare benefits and council tax repayment agreement.

The Child was present when the worker visited the home address on two occasions and was described as being 'well presented, communicative and happy'. The mother's risk assessment and support plan was also reviewed by the Family Support Network manager who visited the mother at the home address. It was agreed that the mother would receive weekly support from the Domestic Abuse Support officer and counselling to include childcare for the Child.

12.83 On **22 November 2011** the father was sentenced to a Community Order – 2 years plus supervision requirement and 21 day activity requirement, plus a restraining order for 2 years.

12.84 During **December 2011**, the mother was visited by the Home Start Family support worker who explained the support that could be provided and gave information about resources that could be accessed. As the children were short of clothing a referral was made to a charity which could provide clothing. The mother stated that she had no problems with parenting and that she was training to be a classroom assistant. The mother was reminded of a developmental check up which was due for the Child and mother stated she was in contact with the Health Visitor. The Child was in bed, taking a nap, during this visit. Also a Counsellor visited the mother who agreed to begin counselling after Christmas 2011 by which time childcare for the Child could be in place. The Child, sibling 1 and sibling 2 were present during this visit. The mother and the three children also attended a

Christmas meal provided by the Family Support service when it was observed that the mother interacted well with all of her children and there were no concerns.

12.85 On **13 December 2011** the Lancashire Probation Officer of partner 2 contacted Stoke-on-Trent Children's Social Care to report that partner 2 claimed that the mother had contacted him and asked him to look after sibling 1 and sibling 2 over the Christmas period. Concerns were expressed about this potential arrangement and as a result a social work assistant spoke with partner 2 by telephone. Partner 2 stated that he had refused to have the children due to the unsuitability of his accommodation. His contact with the mother was via an internet social networking site. He wanted to pursue contact with siblings 1 and 2, but was informed that any contact would have to be supervised. The social work assistant spoke with the mother who was persistent in her view that contact was appropriate and as such disagreed with advice given. Therefore a decision was made to visit the family the next day. Social Worker 3 saw and spoke with siblings 1 and 2 and the Child was 'observed'. The initial assessment was only conducted in respect of siblings 1 and 2. Checks were made with the Health Visitor but the School Nurse was not contacted.

12.86 On **21 December 2011** the Child was seen at the Stoke-on-Trent GP surgery when the Child's ears were examined and no concerns noted.

12.87 On **3 January 2012** Stoke-on-Trent Children's Social Care closed the case in respect of the referral from Lancashire Probation. The Social Worker 3 made a referral for support for sibling 1 to ARCH (Family Support Network). The Lancashire Probation Trust were informed of the result by letter as was the mother who was also provided with a copy of the initial assessments on siblings 1 and 2 with confirmation of the referral for support for sibling 1.

12.88 On **6 January 2012** the ARCH Family Support Network Domestic Abuse officer visited the mother to outline the emotional and practical support which could be offered in respect of the mother's experience of domestic abuse. They discussed the contact by partner 2 and the 'injunction' in place in respect of the father. The mother agreed about the inappropriateness of the child contact request during the Christmas holidays in respect of partner 2. The Child was seen during this visit and appeared well presented and happy.

12.89 On **9 January 2012** the Child was seen by the GP regarding discomfort in the chest and upon examination the chest was clear and the Child's general condition was described as good.

12.90 The Family Support Network Domestic Abuse Officer visited the mother on two further occasions to continue to provide emotional support. On the second occasion the mother discussed her current partner, believed to be partner 3, who she stated she had known for a long

time. She stated that she had a trusting relationship with him and that he had a good relationship with the children. She did not disclose his name and he was not present during either visit. The mother did report having received nuisance calls and she was advised to report the matter and change her number. The mother also attended counselling whilst the Child was cared for in a Home Start crèche. The Child was described as quiet but there were no concerns.

12.91 On **23 January 2012,** sibling 2 presented at school 3 with a burn to the hand which had received some medical attention. The mother explained that the burn to the hand had occurred when sibling 2 had fallen by the cooker. Sibling 2 corroborated the explanation and was accepted by the class teacher and the designated officer for safeguarding. No further action was deemed necessary.

12.92 On **24 January 2012, in** the morning the Child was seen by Stoke-on-Trent GP when it was reported that the Child had a one day history of difficulty walking. It was documented that the mother was unsure if the Child had an injury. The Child was able to stand and there was no joint swelling. A full range of passive movements was noted and a prescription given for Ibuprofen. It was arranged to review the Child in the afternoon. When seen it was noted that the Child had walked two steps but was still reluctant. There was no fever, joint pain or tenderness of hips, knees or ankles. The mother was advised to ring the following day and if still not weight bearing will ‘admit’. At 19:04

hours on **24 January 2012** the Child was taken to the Accident & Emergency department of hospital 2 by the mother and mother's friend. A history was taken by the Triage Nurse from the mother who stated that the Child may have been injured three days previously. The mother had not been present but understood that the Child had fallen off a bed and had been grabbed by the maternal aunt's boyfriend and had not walked since. The mother appeared to be withdrawn and quiet and the friend did some of the talking but the history was provided by the mother. The mother was seen by a junior A & E Doctor when mother reiterated the history given, adding that the Child's feet had been grabbed to stop him falling. She stated that the Child appeared okay initially but the following day the Child was not walking but was crawling although was not in distress. The next day (24 January 2012) as the Child had not improved the mother took the Child to the GP who thought there was a problem with the Child's right hip and had told her to return if the Child's condition did not improve. The mother was concerned as the Child was not walking and decided to present at the hospital. It was noted that upon examination the Child seemed quite happy, quite normal, sitting on the mother's lap. An x-ray was taken which revealed a fracture of the tibia of the child's right leg. The junior A & E Doctor consulted with the Paediatric A & E Consultant who did not examine the Child. The opinion was that the explanation of the history of the incident seemed reasonable. It was observed that the Child was not obviously distressed and seemed comfortable with the mother. The Consultant felt that in view of the delay in presentation, a history given

that was not witnessed by the mother and the potential involvement of a third person, there was a need to consider child protection. A management plan was made as follows:

1. To check whether the Child was subject of a Child protection plan
2. Child to be admitted and to be assessed by the paediatric team with regard to possible Child protection concerns.
3. Child to be referred to the Trauma and Orthopaedic team for further management of the fracture.
4. The Child to have an above knee plaster
5. To have further pain relief

It was noted that there was no other obvious evidence of injury, i.e. bruising. A check was made with Stoke-on-Trent Children's Social Care to inquire whether or not the Child was known to them or had a child protection plan. Information was received that the Child was not known to Stoke-on-Trent Children's Social Care but that siblings 1 and 2 were known because of domestic abuse problems with one of the mother's previous partners but that the case had been closed. The Social Worker who passed on the information recorded that it was requested that the hospital should call back if there were any concerns. When the mother and the Child were seen on the Children's Trauma and Orthopaedic ward, Ward Nurse 1 obtained during the admission process, information from the Mother that there was an injunction order

against the Child's father to stay away from the mother although there was no official paperwork stating the Child was to have no contact with him. The name of the Child's father was given by the mother together with a request not to contact or to inform him of the ward admission, nor to allow the Child's father to visit the ward, and that no correspondence was to be sent to him. This was documented in the medical notes.

12.93 The A & E consultant explained to the mother that the Child would be admitted for a Child Protection Review the following morning. The mother stayed with the Child overnight and it was recorded that partner 3 had later arrived on the ward and stayed until 04:00 hours before returning home. It is unclear who was looking after siblings 1 and 2. It was also recorded that there was an Injunction against the father to stay away from the mother and that the Child to have no contact with the father who lived out of the area.

12.94 At 09:50 hours on **25 January 2012,** Paediatrician 1 took a detailed history of the presenting injury, as well as past medical and social history from the mother. The account given was consistent and it was noted that there was good interaction between the mother and Child who was described as a happy Child. The Child's development was normal for age and there were no bruises or injuries seen on the rest of the Child's body. The mother disclosed information about the involvement of Children's Social Care due to the domestic abuse by the

father and that she had a new partner (partner 3) who was not living with the family. She stated that she had a domestic abuse support worker and that she had support from her family living nearby. The Paediatrician concluded that the history was compatible with the injury sustained, that the mother's explanation for the delay in presentation was reasonable and that there were no child protection concerns. It was agreed that the Child could be discharged when treatment concluded. The Paediatrician attempted to speak with the Health Visitor but as there was no reply a message was left and when the Health Visitor rang back the Child had been discharged and the Paediatrician was unavailable. Subsequently, Paediatrician 1 liaised with Paediatrician 2 who agreed with the conclusions from the information shared. The GP was not contacted but as part of the discharge procedure written information was sent to the GP and the Health Visitor.

12.95 The following day the mother informed office staff at school 3 about the Child's injury to leg which was in turn reported to the head teacher but no further action was deemed necessary. The Health Visitor was provided with the information from the telephone call the previous day from hospital 2 and a home visit was planned for the following week.

12.96 On **27 January 2012,** at 10:07 hours partner 3 called for an ambulance stating that he had found the Child not breathing. In the background a woman could be heard screaming and very distressed. The call

handler tried to calm partner 3 and give instructions of how to carry out resuscitation. The call handler tried to clarify the age of the Child but partner 3 said it was too late the Child was dead.

The caller then changed to a woman's voice and a male and female could be heard arguing in the background. The call handler asked the unknown female to go somewhere quieter so that instructions regarding resuscitation could be given but she too said there was no point as the Child was dead, declined to stay on the phone and ended the call. Upon arrival the ambulance crew found the Child [redacted] lifeless and was in cardiac arrest [redacted] so CPR was commenced and the Child was taken to hospital by ambulance. The Child was admitted to the resuscitation area but attempts to resuscitate the Child were unsuccessful. On arrival at the hospital the mother stated that she had taken siblings 1 and 2 to school, leaving the Child in the care of partner 3. Upon her return from the school she found the Child in bed and not breathing and hence called an ambulance. The police had been informed by ambulance control and a criminal investigation commenced and child protection enquiries on siblings 1 and 2 began.

13. Criminal Proceedings

13.1 Partner 3 is charged with the murder of the Child and is currently remanded in custody. He entered a plea of 'not guilty' and the Trial

was expected to be heard in January 2013. However, Partner later changed his plea to guilty and was sentenced to a custodial sentence of life.

13.2 Parallel Investigations

13.3 An Inquest was opened and adjourned until a date to be fixed after the conclusion of the criminal proceedings.

13.4 Family Court proceedings are ongoing in respect of the care of siblings 1 and 2, [redacted] in order to continue to meet their safeguarding needs. [redacted] [redacted]

14. ANALYSIS OF AGENCIES INVOLVEMENT

14.1 The Child was born into a household where repeated, frequent and escalating domestic abuse existed between the mother and the father which began prior to and after the Child's birth. The Child and siblings were present during incidents and were to witness verbal abuse and physical assault against the mother. Sibling 1 was the subject of offensive and demeaning verbal abuse. There was little stability for the Child and siblings 1 and 2, who experienced a somewhat transient lifestyle with the mother as she moved away from, and back to the father and sibling 3, had two stays in separate Refuges and then returned to Stoke-on-Trent staying with friends before being allocated

council accommodation. All of which was in the space of approximately two years. The mother quickly formed new relationships to which the children had to adapt and was content to leave the Child in the care of partner 3 within a relatively short period of time. The mother was in debt and was reliant on charitable donations for furniture and clothing and there is evidence and concerns of poor hygiene, untidy accommodation and lack of food.

14.2 There was considerable involvement of agencies with the family prior to and after the birth of the Child. Whilst exchange of information did take place there were delays in transferring data, a lack of professional curiosity, a lack of lateral checks particularly across local authority boundaries and a failure to take a holistic approach in respect of assessing the welfare and safety of all of the children in the family. Risk assessments in respect of the domestic abuse incidents did not adequately focus upon the impact upon the children and did not take into account the history of the abuse. Initial Assessments undertaken by Children's Social Care (Sandwell and Stoke-on-Trent) were made only upon the Child's siblings and the Child was repeatedly overlooked. Whilst some family support was provided there was no follow up or co-ordinated plan which was a missed opportunity to address the vulnerabilities of the family.

KEY ISSUES

- **Communication and Information Sharing**

14.3 The extent and quality of communication and information sharing between agencies was variable and on occasion there was delay both in receipt of data and action by relevant agencies. No information was shared by the police with other agencies in respect of domestic abuse incidents reported between the mother and partner 2 which appears to have been due to systems in place at that time. During that period, with the exception of the school, lateral checks were not made when a referral (January 2009) concerning the conditions in which the children were living was received by Stoke-on-Trent Children's Social Care. A referral was subsequently made to Integrated Family Support by the school and the family accessed services but the school was never informed of the outcome of the referral.

14.4 When the mother and children fled domestic abuse on the first occasion (September 2010) there was a failure by West Midlands police officers to refer details to the West Midlands Police public protection unit and to Sandwell Children's Social Care which does appear to have been an oversight as a referral system was in place. However during the mother's relationship with the father information was generally shared with all relevant agencies. There were delays in

receipt of notifications, for example the Health Visitor did not receive notification of a domestic abuse incident which occurred on 5 November 2010 until 1 March 2011.

14.5 When the family moved across local authority borders there was often limited or no contact made between professionals. In December 2010 when the family moved into Refuge 2 there was no recorded contact made by the new Health Visitor with the previous Health Visitor. Likewise when the School Nursing Service received notification about the move into the Refuge no liaison was made with the Health Visitor. When the mother and children returned to Stoke-on-Trent in May 2011 there is no record of any liaison between the Health Visitor and the School Nurse or of any verbal handover to Stoke-on-Trent Health Visitor service. Health records were forwarded for transfer from Sandwell to Stoke-on-Trent which in respect of sibling 1 and 2 were not received until seven months later and in respect of the Child were not received until 5 months later. This caused a considerable delay in the Child being seen for a first visit (removal in visit). Currently there is no robust system in place for schools in Stoke-on-Trent to notify the School Nursing Service when new pupils transfer to a school. Some schools do have systems in place but these vary and practice is inconsistent. However, in this particular case the school nurse was informed by School 3.

RECOMMENDATION 1

All Schools to notify the School Nursing Service of new pupils enrolling in schools within one month of the date of enrolment.

14.6 When the Child was presented at hospital 2 on 24 January 2012 with a history of not walking checks were made with Children's Social Care only to ascertain if the Child was subject to a Child protection plan. Information was exchanged at this point regarding the domestic abuse but it was left that the hospital would contact Children's Social Care if 'there were any concerns'. The third hand explanation given by the mother was accepted without verification of the account given to the GP. Whilst appropriate action was taken by hospital 2 in keeping the Child in overnight to undertake a Child Protection Review, a further contact with Children's Social Care should, in the view of the Author, have been undertaken in order to probe the account given by the mother, particularly in view of the history of domestic abuse within the family. The decision in respect of the Child Protection Review undertaken by hospital 2 was made almost in isolation and was reliant in the main upon the third hand account and information about the family circumstances provided by the mother. Although it is noted that an attempt was made to consult with the Health Visitor the only actual contact made with other agencies was a cursory check with Children's Social Care and even the GP who had seen the Child earlier in the day was not consulted.

RECOMMENDATION 2

A check list be created for professionals to utilise to enable efficient, timely and appropriate telephone checks and referrals to Children's Social Care when there are child protection concerns, to ensure the full circumstances and history of the incident and family background are obtained

- **Child Protection Referrals**

14.7 A total of five contacts were made in respect of the children to Stoke-on-Trent Children's Social Care and nine contacts were made to Sandwell Children's Social Care. This resulted in two initial assessments in respect of sibling 3 alone, one in respect of sibling 1 and one in respect of both siblings 1 and 2. The Child was born during the time of the initial assessments and indeed was initially included during the referral and instigation of the initial assessment conducted as a result of the domestic abuse incidents reported on 11 April 2011, but was overlooked and the children were at no time assessed as a family unit. Hence the initial assessments were superficial and not thoroughly conducted as they were to focus upon the Child's siblings in isolation. It is understood that within procedures for both Stoke-on-Trent and Sandwell Children's Social Care that when an initial assessment is required in circumstances such as domestic abuse, that this should be carried out on all of the children in the family unit which

clearly did not occur in this case.

14.8 A critical referral and initial assessment emanated from the incidents on 7 and 11 April 2011 which provided an opportunity to consider all of the history of the family. A co- ordinated approach should have been taken to ensure that all relevant agencies, such as the school and health, could work together in recognition of the vulnerabilities of the family. The referral for family support was appropriate but there was no follow up plan in place and it is apparent that the full history of the number of incidents, relationships and movements of the family were not known.

RECOMMENDATION 3

Stoke-on-Trent and Sandwell Children's Social Care to ensure that upon referral for initial assessment on a child, in a domestic abuse situation, that initial assessments are conducted upon all children within the family unit/household.

- **Identification, Assessment and Management of Risk**

14.9 Risk assessments were completed by the police who attended domestic abuse incidents in Stoke-on-Trent and Sandwell. The incidents were rated as standard or medium risk and despite an escalation in their frequency and nature within Sandwell, the risk level was not increased and failed to reach the threshold for discussion at a

Multi Agency Risk Assessment Conference (MARAC) which would have led to a more detailed holistic examination of the risk to the mother and children and the development of a risk management plan. Screening processes were in place in Sandwell and the Barnardos Screening Tool was utilised but it is apparent that there was delay, not all information was considered, and incidents were viewed in isolation. Measures are now in place to ensure that incidents are screened in a timely manner and an improved searchable IT system being utilised.

14.10 At the time of the domestic abuse incidents which occurred in Stoke-on-Trent it is understood that there were no screening processes in place but it should be noted that since January 2012 a system, Multi Agency Safeguarding Hub (M.A.S.H.) has been developed. This provides information based risk assessment and decision making; victim identification and harm reduction; and co-ordination of all safeguarding partners. No risk assessment was ever undertaken on the mother and of her ability to protect and care for her children.

- **Domestic Abuse**

14.11 It is known that domestic abuse featured heavily in two of the mother's relationships and she was repeatedly to minimise the extent and nature of the abuse. She withdrew her statement in relation to the assaults reported on 5 September 2010 and was to deny that the children had witnessed or been subject of abuse when assessed in Refuge 2.

Support was provided to the mother in terms of counselling and the provision of a Domestic Abuse Support worker. The focus of interventions was upon the mother and the impact upon the children was not fully appreciated. Due to the abuse directed towards sibling 1 it was recognised that support was needed but did not materialise. The effects on the Child and the other siblings do not appear to have been considered. In the 'Working Together' guidance 2010 it is stated that *'Some 200,000 children (1.8%) in England live in households where there is a known risk of domestic violence or violence[8]. Prolonged and/or regular exposure to domestic violence can have a serious impact on children's safety and welfare, despite the best efforts of parents to protect them. An analysis of Serious Case Reviews found evidence of past or present domestic violence present in over half (53%) of cases[9]'.* It is however understood that training in respect of this has been delivered to practitioners and is part of ongoing multi agency training provided by both Stoke-on-Trent and Sandwell Safeguarding Children Boards.

14.12 Whilst the domestic abuse which occurred in Sandwell escalated in both frequency and extent, those which occurred in Stoke-on-Trent were reportedly of a low level and certainly would not have reached the threshold of intervention, either at M.A.S.H or MARAC. A previous serious case review conducted in Stoke-on-Trent (ref BSK410) in 2010

[8] Source Lord Laming (2009 The Protection of Children in England: Progress Report

[9] Source Brandon, et al (2009) Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-2007

also featured domestic abuse at this level. A system is needed to identify these types of domestic abuse incidents when children are in the household. The Government have a current initiative whereby funding can be provided to Local Authorities to tackle problems related to 'Troubled Families' to reduce issues such as anti-social behaviour and youth crime plus local discretion to tackle such matters as frequent police call outs. Additionally within Stoke-on-Trent there exists a Locality Programme, which involves regular multi agency meetings, referred to as JOGs (Joint Operational Groups) held in three localities with the aim of early intervention and preventable measures to ensure that families receive the most effective services in times of need.

RECOMMENDATION 4

To raise awareness and embed the identification of low level domestic abuse, focusing on early intervention and prevention and to ensure that the risks to the emotional and physical wellbeing of child(ren)in the household are assessed.

15. Good Practice

15.1 In the main professionals adhered to procedures and guidelines with some evidence of good internal and interagency working, however there were no instances of good practice over and above expected levels of service identified during this review.

16. Single Agency Recommendations

16.1 Recommendations made by single agencies address issues and missed opportunities by those individual agencies, and have been progressed whilst this serious case review was on going.

16.2 SOTSCB requires that all agencies implement the internal recommendations contained within their Individual Management Reviews, to evidence that action has been taken prior to the publication of this overview report.

Recommendation 5

Stoke-on-Trent Safeguarding Children Board require all agencies that have completed an IMR to implement and monitor any internal recommendations.

17. Lessons Learnt

- Whilst exchange of information did take place between agencies and professionals there were delays in transferring data
- There was a lack of professional curiosity
- There was a lack of lateral checks particularly across local authority boundaries
- A failure to take a holistic approach in respect of assessing the welfare and safety of all of the children in the family
- Risk assessments in respect of the domestic abuse incidents did not

adequately focus upon the impact upon the children and did not take into account the history of the abuse.

- Initial Assessments undertaken by Children's Social Care (Sandwell and Stoke-on-Trent) were made only upon the Child's siblings and the Child was repeatedly overlooked
- Whilst some family support was provided there was no follow up or co-ordinated plan which was a missed opportunity to address the vulnerabilities of the family.

17.1 Conclusion

17.2 Whilst it was known that the mother had been subject to domestic abuse within two relationships and that the Child and the siblings had witnessed abuse, it was believed by agencies that the children were safeguarded as both relationships had ended. Both the father and partner 2 were under the supervision of Probation and there was a court order preventing the father from contacting the mother. The mother had disclosed that she had a new partner who did not live in the household. The identity of partner 3 was not known and in any event there would in all probability have been no indication that he would have been a risk to children. There had however, never been any assessment of the capability of the mother to protect and care for her children.

17.3 It can be concluded that there was always a possibility that the mother would continue to make poor choices in her relationships which could

pose a threat of potential domestic abuse which in turn would be detrimental to the emotional and physical health of the Child and siblings. However, in this case it is the view of the Panel and the Author that the death of the Child could not have been predicted or prevented.

18. Future Safeguarding of Siblings

18.1 From an early stage of this SCR process concern was expressed by the Panel and the independent chair and independent author about the safety of the Child's siblings. Sibling 3 is still in the care of the father. Hence assurance was sought, in the light of information gleaned from this serious case review, that sibling 3 was safeguarded. It was notified via Sandwell Children's Social Care that sibling 3 had been assessed was considered safe in the care of the father and the situation continues to be monitored. Robust Safeguarding Plans in respect of Sibling 1 and sibling 2 are in place.

19. Progressing Recommendations and Dissemination of Learning

19.1 At a full meeting of the SOTSCB on 16 July 2012 all of the recommendations were accepted and agencies agreed to ensure that the identified action is implemented by the agreed target date. The SOTSCB Serious Case Review sub-group will receive progress reports

from named agencies within six months and will conduct compliance audits to seek tangible evidence that lessons have been learnt. The SOTSCB Business Manager will also liaise with the Department of Education to monitor and scrutinise the implementation of recommendations and audit compliance.

19.2 To assist with dissemination of the key learning to as wide a group of practitioners as is possible the SOTSCB Training Steering Group deliver a programme of multi-agency interactive briefing on 'Lessons Learnt' from serious case reviews. In addition all agency safeguarding leads are provided with a copy of the executive summary, action plan and recommendations together with additional contextual information as an aid to learning lessons.

19.3 In view of the fact that a number of agencies within Stoke-on-Trent who have contributed to this Serious Case Review also provide services to Staffordshire, it would be beneficial for the findings and information gleaned from this Serious Case Review to be exchanged with the Staffordshire Safeguarding Children Board.

RECOMMENDATION 6

Information to be exchanged with Staffordshire Safeguarding Children Board to assist with Agencies' implementation of recommendations.

19.3 After completion of the evaluation process, redaction of some of the content of the SCR will be necessary prior to publication due to sensitive information and to protect the identity and privacy of family members and professionals involved in the case.

Bibliography

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Acronyms

A & E	Accident & Emergency
BSCB	Birmingham Safeguarding Children Board
CPS	Crown Prosecution Service
DSCB	Dudley Safeguarding Children Board
HOR	Health Overview Report
IMR	Individual Management Review
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
SCR	Serious Case Review
SIO	Senior Investigating Officer
SSCB	Sandwell Safeguarding Children Board
SOTSCB	Stoke-on-Trent Safeguarding Children Board
STSCB	Staffordshire Safeguarding Children Board
WSCB	Walsall Safeguarding Children Board

Recommendation (SMART)	Action	Responsible Person	Timescales	Expected Outcomes	Evidence	Summary of Action Taken
All Schools to notify the School Nursing Service of new pupils enrolling in schools within one month of the date of enrolment.						
A check list be created for professionals to utilise to enable efficient, timely and appropriate telephone checks and referrals to Children's Social Care when there are child protection concerns, to ensure the full circumstances and history of the incident and family background are obtained						
Stoke-on-Trent and Sandwell Children's Social Care to ensure that upon referral for initial assessment on a child, in a domestic abuse situation, that initial assessments are conducted upon all children within the family unit/household.						

To raise awareness and embed the identification of low level domestic abuse, focusing on early intervention and prevention and to ensure that the risks to the emotional and physical wellbeing of child(ren) in the household are assessed.						
Stoke-on-Trent Safeguarding Children Board require all agencies that have completed an IMR to implement and monitor any internal recommendations.						
Information to be exchanged with Staffordshire Safeguarding Children Board to assist with Agencies' implementation of recommendations.						