OVERVIEW REPORT

SERIOUS CASE REVIEW

SIGNIFICANT INCIDENT LEARNING PROCESS

Child M: Year of birth: 2008

SILP Lead Reviewer and Report Author: Adrienne Plunkett

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CONTENTS: **PAGE**

1. Statutory Framework:

1.1. Regulation 5 of the Local Safeguarding Children Boards (LSCB) Regulations 2006 sets out the functions of LSCBs, including the requirement for LSCBs to undertake reviews of serious cases in specified circumstances.

> 5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
>
> (2) For the purposes of paragraph (1) (e) a serious case is one where:
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> a. abuse or neglect of a child is known or suspected; and
> b. either (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

1.2. Working Together to Safeguard Children 2015[1] contains the statutory guidance for undertaking Serious Case Reviews (SCR) and states that LSCB's should ensure that:

- Reviews are conducted regularly, not only on cases which meet statutory criteria, but also on other cases which can provide useful insights into the way organisations are working together to safeguard and protect the welfare of children and that this learning is actively shared with relevant agencies;
- Reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings.

2. Significant Learning Incident Process (SILP):

2.1. The SILP methodology reflects on multi-agency work systemically and aims to answer the question why things have happened. The model engages frontline staff and managers in the review of the case, focussing on why those involved acted in a certain way at that time. Importantly, it recognises good practice and strengths that can be built on.

2.2. The SILP model of review adheres to the principles of:

- Involvement of families
- Active engagement of practitioners and frontline managers
- Systems methodology
- Proportionality
- Learning from good practice

2.3. SILPs are characterised by practitioners, managers and Agency Report Authors coming together for a Learning Event. Agency Reports are shared in advance with participants. The perspectives and views of all those involved are discussed and valued. This same group meets again at a Recall Event to consider the first draft of the Overview Report.

3. Process for Serious Case Review:

3.1. On 4 May 2015 Dudley Safeguarding Children Board's Independent Chair, following a recommendation from the SCR Sub Group, made the decision that injuries to Child M in October 2014 did not meet the criteria, as set out in Working Together to Safeguard

[1] Working Together to Safeguard Children, DFE, 2015.

Children 2015[2], to undertake a SCR. Whilst Child M had suffered extensive injuries, these were not life threatening and had not resulted in long term physical impairment. However, it was agreed, as encouraged by Working Together to Safeguard Children, that a Case Review should be initiated to consider the circumstances leading to Child M's injuries and identify the learning, for individual agencies and for multi-agency working.

3.2. Furthermore, a decision was taken that this Case Review would be undertaken using the SILP methodology. A Scoping Meeting to discuss the Terms of Reference (Appendix A) was held on 1 October 2015 and the Agency Report Authors' Briefing on 15 October 2015.

3.3. There was a delay in commencing this Case Review, due to changes in responsibilities within the Board, notably in the Chair of the SCR Sub Group. DSCB's Chair acknowledged that this should have been avoidable.

3.4. The first draft SILP Overview Report was presented to the Serious Case Review Sub Group on 4 March 2016.

3.5. A new Independent Chair of DSCB took up post on 1 April 2016. The Independent Chair requested that the SCR Sub Group reconsider the decision that the criteria had not been met to undertake a SCR. This was undertaken and the Sub Group unanimously recommended that the criteria were met. Therefore, the status of the Review changed and in response the SILP process has been reviewed to ensure that it has been rigorous and the Overview Report received further scrutiny by the SCR Sub Group.

3.6. The Scoping Period for this SCR was agreed to be from August 2012, when Dudley Children Social Care (CSC) received the referral from another local authority CSC team in respect of the sexual abuse of Child M, to October 2014, when Child M received non-accidental injuries.

3.7. Agencies were also asked to provide brief details of any significant events and safeguarding issues prior to the Scoping Period, e.g. domestic abuse episodes, substance misuse. This material would be used to provide the background context.

3.8. Agency reports were commissioned and received from:

- West Midlands Police (WMP)
- Children's Social Care services, those known to have been involved with child M
- Education (School)
- Black Country Partnership NHS Foundation Trust: Health Visiting and School Health Services
- The Dudley Group NHS Foundation Trust (Acute Hospital)
- Clinical Commissioning Group: General Practitioner

3.9. The SILP Learning Event was held on 7 January 2016 and the Recall Day on 11 February 2016. All the Agency Reports were shared with the participants prior to the Learning Event, so that they had a wider understanding of agencies' involvement. The draft Overview Report was circulated to participants prior to the Recall Day, in order that it could be checked for accuracy and the findings and recommendations fully discussed on the Day. The Overview Report was amended following this discussion.

3.10. The Learning Event was attended by practitioners, managers and Agency Report Authors from the Police, the NHS Foundation Trusts, the Clinical Commissioning Group and

[2] Working Together 2015, DOE

Children's Social Care. It was positive that the Lead GP from the family's Practice and the Named GP attended, as well as the Deputy Head and Head Teacher. The LSCB Business Manager and Child Death Overview Panel (CDOP) Co-ordinator were also in attendance. Representation at the Recall Event included the Police, the Clinical Commissioning Group (CCG), the NHS Foundation Trusts, the GP Surgery, the School and staff from the DSCB Business Unit.

3.11. CSC was unable to provide representation at the Recall Day. This was significant as CSC could not contribute to the multi-agency discussions in respect of the learning and recommendations from the SCR.

3.12. The Lead Reviewer for this Serious Case Review was Adrienne Plunkett; a qualified Social Worker, with a MA in Child Studies. Ms Plunkett has substantial experience working in the area of CSC, including as a Senior Manager, and has managed a LSCB. Ms Plunkett is a trained SILP Lead Reviewer.

3.13. In the Overview Report the names of family members have been anonimised

4. Background to the Serious Case Review:

4.1. This SCR concerns Child M, who as a child suffered serious physical injuries, inflicted by Mother and her partner, who were both convicted of criminal offences in relation to this assault. Child M did not sustain any long term physical or mental impairment as a result of the assault, although she has suffered emotional harm.

4.2. Child M and mother had been known to a range of agencies during Child M's life and were first referred to Dudley CSC in July 2012, following the alleged sexual abuse of Child M by a family member. AM has a significant criminal history and had been released from prison in June 2014, having served a three-year sentence for supplying Class A drugs. At the time of Child M's injuries an assessment was underway by Children's Social Care into the risk posed to Child M by AM joining the family.

4.3. Child M is described as a bright and lively child, who has good communication skills, and progress at school is good.

5. Engagement with the family:

5.1. The aim of meeting with family members is to ascertain their views of the services offered and whether there are any lessons to be learnt. Contact with Child M's Mother and Father was facilitated by the Dudley CSC Social Worker.

5.2. Mother agreed to meet with the Lead Reviewer in January 2016, however, subsequently cancelled this. A follow up letter was sent, suggesting that she could write or phone the Lead Reviewer or speak to her Social Worker, who could then pass on the information to the Reviewer. No response was received.

5.3. Father also agreed to the Lead Reviewer making contact with him. Attempts were made to contact him by phone, which were unsuccessful. A follow up letter was sent asking him to make contact with the Lead Reviewer, but no response was received.

5.4. Both parents were again contacted following the decision to change the status of the review to a SCR and offered the opportunity to meet with the Independent Reviewer. No response was received.

5.5. During the Review process consideration was given as to whether the views of Child M should be directly sought. The view of the practitioners working with Child M at the time was that this would be emotionally difficult and could well be confusing for Child M to comprehend. Therefore, a decision was taken not to approach Child M directly, but to ensure that the Overview Report provided full information about what Child M was telling the multi-agency network, both directly and through presentation and behaviour about life, so Child M's voice would be heard through this.

6. Pre-Scoping Period:

6.1. Child M, Mother, and AM, had been known to a range of agencies for many years prior to the Scoping Period of this SCR.

6.2. Child M's Mother had a disruptive childhood, with parental alcohol and mental health difficulties and allegations of inter-generational sexual abuse. Mother's younger siblings were the subjects of Child Protection Plans. As a child, Mother was referred to Child and Adolescent Mental Health Services (CAMHS).

6.3. Mother has a history of difficulties in her personal relationships, which are characterised by domestic abuse. Medical information indicates that she had emotional/mental health problems, with low mood and depression. In November 2010, the Health Visitor noted that Mother's score on the Edinburgh Post Natal Depression Scale was indicative of depression. A year later Mother attended the GP. She presented as depressed and agoraphobic and was commenced on an antidepressant.

6.4. Health Visiting records indicate that Mother bonded well with Child M after birth. However, in June 2011, whilst Child M and Mother were living in outside of Dudley, the Maternal Gran Mother (MGM) expressed concern to the Health Visitor about Mother's care of Child M and alleged physical and verbal abuse. The Health Visitor referred the matter to Children's Social Care and a Strategy Discussion was held between the Police and CSC in the area. However, the outcome is not known, despite several requests for the information.

6.5. Allegations of sexual abuse of Child M were made by Mother and MGM in December 2010. This was investigated, but no evidence was identified and the investigation proved inconclusive. At the time, Mother reported Child M had a poor appetite, difficulty sleeping, and was wary of male figures.

6.6. Mother's partner, AM, also had a disruptive childhood and was the subject of a Child Protection Conference as a teenager. He has a substantial criminal record, many of the crimes being drug related. In June 2014, AM was released from Prison, having served a 3-year sentence for the distribution of Class A drugs. He had been released earlier on licence, but was recalled to Prison due to breaching his conditions, and a release planned for November 2013 was withdrawn due to a deterioration in his behaviour.

6.7. In 2005 AM, had been charged with Abstracting Electricity and Assaults on his then partner and her 3-year old child. At Court, he pleaded guilty to Abstracting Electricity. The CPS view was that it was not in the public interest to pursue the assault charges and offered no evidence. The letter to the victim explained that, as AM had been sentenced to two and a half years' imprisonment for Abstracting Electricity, and the maximum period of imprisonment in relation to the assault charges would be six months, it was not in the public interest to pursue the assault charges as any additional sentence would run concurrently with the already imposed sentence.

7. Scoping Period: Key Episodes

7.1. Referral to Dudley CSC in respect of Child M's alleged sexual abuse:

7.1.1. The CSC service from another Local Authority area referred Child M and the family to Dudley CSC in August 2012. The referral was made by phone and there is no evidence it was followed up in writing. Child M and mother were living in Dudley and the wider maternal family were in another area. The MGM had reported to the local CSC that Child M had been sexually abused by a family member. It was noted that Child M's mother 'wanted to minimise' the incident. Child M's relative had been abused by a family member and had emotional and behavioural difficulties.

7.1.2. Attempts were made to obtain further information from the referring CSC, notably to establish whether Section 47 enquiries had been undertaken and, if so, what the outcome was. Further information was provided during telephone calls, but a letter sent to the area CSC by the Team Manager early in September, did not receive a response. The Team Manager also contacted the area Police Protection Unit. They had no further information about the allegation, although they did have information about allegations of domestic abuse made by Mother against Child M's Father and a subsequent partner.

7.1.3. In mid-August Mother attended the GP. She reported twelve months of low mood and anxiety**.** She was having occasional thoughts of self-harm and suicide, but would not act on these for the sake of her child. Mother had been prescribed medication previously, but had not taken this. It was agreed she should do so and counselling was discussed.

7.1.4. Three weeks after the out of city referral was received, a decision was taken by Dudley CSC to invite Child M's mother to the office to assess her ability to safeguard Child M. Having cancelled two appointments, she was seen early in September. Mother explained that she was not happy to visit her family, as she could not supervise Child M adequately. Advice was provided regarding supervising Child M and a referral made to the Children's Centre for Keep Safe work.

7.1.5. The decision to undertake an Initial Assessment was taken on 5 September, which was allocated on 12 September, with a home visit being undertaken on 21 September. Mother had moved to Dudley to make a '*fresh start'*. She was in a new relationship with a male she had met on Facebook 7 years previously. There had been court proceedings in respect of Child M's contact with father and this was to be supervised. It was not recorded whether Child M was seen by the Social Worker on this visit. However, it is recorded that Child M was seen a week later (7 weeks after the referral was received) and presented as a *'happy, chatty and confident child'.* The Nursery reported that Child M's *'speech and language are excellent and Child M is always well presented.'*

7.1.6. Further information was obtained that an assessment was undertaken by another local authority CSC in November 2011 due to concerns about the relationship between Child M's Parents. Father had mental health needs and Mother alleged that he had subjected her to domestic abuse and abused Child M. Mother was believed to be agoraphobic and had previously taken anti-depressants. The allegations were investigated, but proved inconclusive, although Child M's contact with Father was to be supervised.

7.1.7. The Initial Assessment was completed by Dudley CSC on 17 October 2012 and the case closed on 9 November 2012. The assessment concluded that Child M and Mother had a positive relationship and Mother was viewed as protective. It was noted that Child M had a good relationship with Mother's partner, although there is little evidence to support this assertion. Child M had an awareness of the domestic abuse between parents and was due to have supervised contact with father. CSC has no record of the Health Visitor or GP being contacted, although Health Visiting records would indicate that there was contact. The position regarding the investigation undertaken by the other area CSC remained unknown.

7.1.8. At the SILP Recall Day previously unknown information was provided by the GP. Mother had taken Child M to a GP appointment in June 2012, due to symptoms which could be indicative of sexual abuse. Oral antibiotics were prescribed and when Child M was seen a week later there was an improvement. This was a week after Child M had been registered as a new patient with the GP Practice, so when seen, the medical records were not available to the GP. If CSC had contacted the GP whilst undertaking the Initial Assessment, helpful safeguarding information would have been shared by both agencies.

7.1.9. The Health Visitor attempted to visit Child M and Mother through October and November 2012, but was unsuccessful. This was achieved early in December. Child M was observed to be clean and appropriately dressed. Child M was sociable, with good language skills and played with age-appropriate toys. Mother was planning for her current partner to move in, as he provided her main support. The Health Visitor advised regarding Mother's responsibility to keep Child M safe and to consider this carefully. A plan was made to review Child M in Clinic, but Mother did not attend as arranged.

7.2. A Referral to Dudley CSC from out of area Hospital:

7.2.1. At the end of January 2013 Dudley CSC received information from a hospital in another local area that Child M's father was in hospital. The Duty Team Manager took the decision that, as there was no evidence that Child M was having contact with her father, no further action would be taken.

7.3. Referral from Child M's GP to Dudley CSC:

7.3.1. In January 2014 Child M attended the GP Surgery with Mother having complained of abdominal pains for several months, although Child M was eating and drinking well. Child M told the GP about the sexual abuse by a family member. The GP noted that Child M had recounted this *'slowly and clearly'* and that Child M presented as '*alert and happy',* apart from when recollecting what had happened.

7.3.2. The same day the GP contacted West Midlands Police to report the allegation of sexual abuse (101) and was advised to inform CSC. The Call Handler recorded this call on 'E-Notes', noting that the Public Protection Unit were aware. However, there is no record in PPU, which raises the question as to whether the PPU was notified, but it was not recorded, or the PPU was not notified. The Call Handler should have added a log on Oasis and identified the Officer spoken to and has been advised regarding this matter. The Call Handler phoned the GP, but the Surgery was closed and no further contact was made.

7.3.3. The GP made a referral to CSC by phone, requesting support for Child M

7.3.4. Mother contacted the Police two days later (at 04.03 a.m.), stating that Child M had made a disclosure of sexual assault two years previously. The matter was passed to the Child

Abuse Investigation Unit (CAIU) and Detective Constable 1 visited the Mother the same day. She was advised that West Midlands Police would undertake the initial investigation, but overall responsibility was with the Police area where the incident took place.

7.3.5. The GP received no feedback from CSC in respect of the referral and phoned the Duty Team on 20 January, but could not get through, so sent a letter outlining the concerns. The GP also wrote to the Consultant Paediatrician on 20 January outlining that Child M had been seen '*on multiple occasions with abdominal pain'* and had now disclosed sexual abuse. It was unclear why the GP sent this letter and what, if anything, was being requested, so an Administrator sought clarification from the Police regarding this.

7.3.6. A Strategy Discussion was held on 20 January which agreed that the Police would undertake a single agency investigation. Health agencies were not involved in this discussion. An Achieving Best Evidence interview was undertaken and Child M made the same disclosure to the Police Officers as that made to the GP. Papers were forwarded to the investigating Police Force area. There was consideration of a medical being undertaken, but a decision was taken not to pursue this, without seeking medical advice.

7.3.7. CSC did not open the case for an Initial Assessment and neither Child M, or Mother were seen. Neither the School, Health Visitor, or School Nurse were informed of the referral. In November 2013, Mother had returned the screening questionnaire to the School Health Service detailing that she had concern about Child M following contact with Father. No action was taken in respect of this.

7.3.8. CSC closed the case on 13 February. There is no evidence that the GP's request for support for Child M was considered or acted upon, or that the GP received any feedback in respect of the referral. In addition, there is no evidence that following the actions on 20 January the GP followed this up with CSC.

7.3.9. Also in January 2014 Mother was seen by the GP regarding depression. She had previously attended the GP in December 2013 as she was feeling low. A Biopsychosocial Assessment had indicated severe depression and she was prescribed anti-depressants. She had been taking these and was feeling a bit better, but experienced social anxiety and was reluctant to go out. Mother was to be referred for counselling and to continue with her medication. This information was not shared with health colleagues or other agencies.

7.4. GP's referral to CSC in respect of AM living with Child M and her Mother.

7.4.1. AM was released from Prison in June 2014, having served a three-year sentence for supplying Class A drugs. He had been released on licence earlier, but was recalled due to breaching his licence conditions. As he had served the full sentence, he was not on licence on release. Within a few days, Police received intelligence that AM was using heroin and dealing in drugs outside the hostel where he was living.

7.4.2. On 17 July 2014 CSC received a telephone call from the Health Exchange GP (Practice for Homeless) expressing concern that AM had moved in with Child M and her Mother. There were concerns that he was a known drug user and had recently been released from prison, having served a five-year sentence for the distribution of Class A drugs. CSC do not have a record of the GP sharing any information about AM's mental health history.

7.4.3. The Duty Social Worker pulled together information from CSC's records, including that in 1999 AM had been the subject of a Child Protection Conference, in 2002 he was convicted of the robbery of two victims aged 16 years and in 2005 had been charged with assault on

his partner and her son, aged under 3 years. The Duty Social Worker recommended that an assessment was required due to *'Child M's vulnerabilities and concerns in respect of AM'.* Four weeks later the case was allocated to Social Worker 2 for an Initial Assessment.

7.4.4. Mother attended a GP appointment on 23 July. She was living alone, without support from her family. She was tearful and had suicidal ideations, but would not act on these because of having Child M. Mother admitted to smoking cannabis, as she could not afford alcohol. Mother had been taking anti-depressant medication intermittently since 2013**.** This was continued and in addition she was to be referred for counselling. GP records note an earlier attendance in May 2014, when Mother stated she had been intoxicated and had fallen down the stairs, sustaining rib injuries. She was prescribed anti-inflammatory medication and X-rays were arranged. Domestic abuse was not considered and neither incident was discussed with the Safeguarding Lead in the GP Practice or referred to CSC.

7.4.5. Social Worker 2 contacted Probation at the end of July. The Probation Officer expressed *'extreme concern'* about AM living in a household with children and advised that the Social Worker should not visit alone as he can become aggressive. The Probation Officer also advised that AM had a Police Sex Offender Manager. The same day the Police Offender Manager 1 (POM1) contacted CSC and advised that, as AM had served his entire sentence, he was not supervised by Probation. According to CSC's records, POM1 confirmed that AM had been convicted of an assault on an under 3-year old. This was not correct, as AM had been charged but not convicted, so either inaccurate information was provided by the Police or it had been misunderstood, or incorrectly recorded.

7.4.6. Social Worker 2 and a colleague undertook a home visit, but no one was at home. This was followed by another home visit, two weeks later, when Child M and Mother were seen. Mother was defensive, denied that AM was living at the address, despite AM telling his GP that he was, and stated that he should be allowed to move on with his life. Child M was seen alone by the Social Workers and showed them drawings, included one drawn of Mum and Dad. Mother confirmed that Child M referred to AM as 'Dad' and this was allowed as Child M often became upset that other children at school had a Daddy and Child M did not. It was recorded that there was no physical evidence that AM was living in the home, but clearly the information provided by Child M meant that Mother's assurance that AM was not living in the family home was open to challenge.

7.4.7. There is a note in Police records on 1 August 2014 that AM was being managed by WMP Offender Managers as a Prolific Priority Offender (PPO). He was not required to meet any conditions and co-operation was on a voluntary basis. Police were monitoring intelligence.

7.4.8. Mother failed to attend the rearranged counselling appointment early in August and on 18 August she saw the GP again. She was feeling low in mood and requested a further referral for counselling.

7.4.9. AM registered with the same GP as Mother and Child M on 14 August. (Same day as the Social Workers' visit to the home.) He gave his home address as that of Child M and Mother, and gave Mother as his next-of-kin. The next day he phoned and requested medication for his '*personality disorder'*, which he stated led to aggression. He was advised that he should make an appointment to discuss his mental health needs and was seen by a GP on 18 August. It was agreed that he would be referred to mental health services and mood stabilising medication was prescribed by the GP. The referral was not made by the GP until 4 weeks later. This stated that AM had an anti-social personality

disorder and had been known to the Mental Health Team whilst in prison. There had been no recent incidents, but AM was requesting mental health follow up.

7.4.10. On 19 August, the Police received a 999 call from a neighbour, reporting a disorder at the family's address. Some people had arrived, there was '*shouting and swearing'* and it sounded like '*they are smashing the house to bits'.* The neighbour noted that there was a child and puppy in the home. Uniformed Police Officers attended and Mother was found to have a head injury. She stated she had fallen over the puppy and hit her head on the corner of a wall, and was taken to hospital for treatment. Mother's explanation was accepted and no further inquiries were made, e.g. with neighbours. There appears to have been no consideration of the possibility of domestic abuse or of a referral to the Domestic Abuse Referral Team (DART). Police records do not indicate whether AM was in the home or whether Child M was seen. Children's Social Care was not informed of this incident.

7.4.11. Unrelated to the above incident, the following day Social Worker 2 contacted Police Offender Manager 1 (POM1) regarding the concerns about Mother's partner. Information was shared about AM's criminal history. This telephone call is recorded in the Police records, but not in Children's Social Care's records. There was a further discussion between Social Worker 2 and Police Offender Manager 2 (POM2) on 21 August, when POM2 agreed to undertake checks and conduct a home visit. POM2 recorded that the information shared by CSC would suggest that the relationship between Mother and AM was more than she was declaring it to be.

7.4.12. On 29 August POM2 checked with the Hostel where AM had been living following his release and was informed he had left just days after his release. POM2 also contacted his Drug Worker and was informed that AM had failed to attend appointments and was not in receipt of a methadone script, despite being on a drug rehabilitation programme.

7.4.13. On the same day, the Police received two phone calls. The first caller alleged that AM and another male were trying to gain access to a flat. Police attended, but there was no trace of the men. The second caller alleged that AM and Child M's Mother were selling drugs on the High Street. Again, Police attended but there was no trace. No further action was taken.

7.4.14. POM 2 and 3 visited the family home early in September, but no-one was at home. A card was left, asking AM to make contact, which he did. He confirmed he was living with his new partner who was pregnant. He was drug free and did not require support.

7.4.15. AM was discussed at the One Day One Conversation (ODOC) meeting, involving Probation and Police, on 8 September. Police reported that AM was living with a new partner, who was pregnant. As AM had not accessed, and was not requesting, any support it was agreed to begin the process of deregistering him from the Prolific and Priority Offenders scheme. He would then be managed by the WMP's High Offender Management Team. There is no evidence that a risk assessment was undertaken.

7.4.16. Mother failed to attend the second counselling appointment on 9 September.

7.4.17. On 11 September, a week after AM's telephone call, POM2 confirmed with CSC that AM was living with Mother, who was pregnant, and that his case was being closed as he did not want any support from the Unit. Social Worker 2 was on leave and this information was passed to the Assistant Team Manager. There is no record of what action was then taken.

7.4.18. Child M was absent from school on Friday, 12 September. No reason was given for this, which was unusual.

7.4.19. On 13 September, at 10.34 p.m., the Police received a phone call from AM, who reported that a drunken male had attacked his pregnant girlfriend. Police attended and this involved an incident with a relative of Mother's previous partner, who AM alleged had chased them with a knife. Subsequently the Police tried several times to obtain statements, but were unsuccessful and the case was closed. As this incident involved the family of an ex-intimate partner, a referral should have been made to the Domestic Abuse Referral Team (DART), but was not. It is understood that Child M was present during the incident, but there is no reference to Child M's wellbeing in Police records. CSC was not informed.

7.4.20. AM attended an appointment with his GP on 17 September. He was feeling stressed, as *'his life was not going according to plan',* although he said his relationship was okay.

7.4.21. On 23 September, 5 weeks after the last contact, CSC sent Mother and Step-father (AM) a letter inviting them to the office on 30 September. On the same day, Social Worker 2 informed Police Offender Manager 3 that a child protection investigation was being initiated, with a view to convening an Initial Child Protection Conference. Mother and AM did not attend the appointment with CSC.

7.4.22. AM again attended an appointment with his GP (same GP) on 24 September. He was wanting to be seen by Mental Health Services and was very anxious about having to wait.

7.4.23. Child M was unwell at school on 25 September and there were difficulties contacting Mother. School staff had become increasingly concerned about Child M's care this term, including not always in the correct uniform nor regularly bring a book bag and, Child M's hair was not always brushed and the clothes worn were creased. In addition, staff and parents were '*not comfortable'* with Mother's new partner, who sometimes came to collect Child M. This was *'a professional hunch'*. Child M's class teacher was '*monitoring'* the situation.

7.4.24. On 30 September CSC contacted Child M's school to inform them of the concerns regarding Mother's new partner. CSC's records note that the school were already aware of AM. Child M was looking dishevelled at school, and there were incidents of unexplained absence. Child M appeared to be concerned about the family's puppy. The school had concerns about AM, he was seen as intimidating and had been aggressive to other parents. He was taking and collecting Child M from school.

7.4.25. Social Worker 2 and the Assistant Team Manager undertook an unannounced visit early in October. AM was present and stated he had moved in three weeks earlier. He presented as polite and compliant, wanting to work with CSC. Child M's Mother was 10 weeks pregnant. This visit, and the subsequent discussion between Social Worker 2 and the Assistant Team Manager, was not recorded until 28 October (3 weeks following the visit and after the assault on Child M) and is not detailed. It notes that there was a subsequent discussion between Social Worker 2 and the Assistant Team Manager as to whether AM should be asked to leave the family home whilst an assessment was undertaken. The Assistant Team Manager was to discuss this further with the Team Manager, however, there is no evidence that such a discussion took place

7.4.26. Mother and AM presented at DMBC as homeless on 7 October. They were facing eviction due to rent arrears. Housing advice was given, followed by a further interview to collect information.

7.4.27. AM was assessed by the Consultant Psychiatrist (locum) on 13 October, two months after the initial GP appointment. The Consultant's outcome letter was received by the GP Surgery one month later. It did not contain a risk assessment.

7.4.28. AM had informed the Consultant Psychiatrist that he had been in and out of prison for 13 years, his offences included burglary and armed robbery and many were drug related. He had been using drugs for many years and was currently using heroin. He stated he had previously consumed large quantities of alcohol, but was currently not drinking. As a child, he had been referred to CAMHS due to family problems. AM said he was happy, but became irritable over trivial issues and often got into fights. He spoke about a *'red line'* which if crossed led him to become violent. AM currently had a partner, who had a young child and was 15 weeks pregnant. This baby would be AM's fourth child. He wanted help to amend his ways, so that he could be a good father.

7.4.29. In the assessment letter to the GP, the Consultant Psychiatrist identified no evidence of psychosis or depression. There was no clinical evidence of a deterioration in AM's mental state, with mood assessed as stable and no evidence of any risk in relation to his mental health. As AM did not have a treatable illness, requiring mental health services, the Consultant discharged him to the care of his GP and recommended counselling. There is no evidence that the welfare and safety of Child M or the unborn child were considered by the Consultant Psychiatrist, nor that the Trust's Safeguarding Lead was contacted for advice or CSC informed.

7.4.30. On the same day, Child M was not collected from school on time. A message was sent to Mother, but no response received. Child M was placed in Out of School Care and collected at 5.33 p.m. The reason for the late collection is not known. Also, in October the School Site Manager had reason to speak to Mother and AM about smoking and bringing a puppy on to the school site and this was being monitored. The puppy subsequently disappeared. Child M worried about the puppy and school staff felt this played on Child M's mind.

7.4.31. The Team Manager recorded the decision to proceed to Section 47 enquiries on 14 October and on 15 October a referral was made to the Public Protection Unit via email. In response, the Tactical Co-ordination Group undertook intelligence checks, which identified that AM had a significant crime record and had previously been charged with an assault a three-year old child, but was not convicted. Subsequently on 16, 17 and 20 October the Police phoned and left messages for the Team Manager about arranging the Strategy Discussion. The Team Manager did not return the calls and on 20 October, the Detective Sergeant recorded that staff '*do not have the capacity or time to continually chase up partners*' and that the matter *'will be filed until such time as the matter is followed up by them (CSC)'.*

7.4.32. Mother and AM attended an antenatal appointment in mid-October. AM disclosed that he had a *'violent personality disorder'*. The Midwife was highly experienced, but felt worried by his behaviour. She referred the family to the Duty Team, CSC, on the same day, following this up with a written referral. The Midwife also informed the GP that the family were known to CSC and the GP added a safeguarding alert to Child M's records.

7.4.33. The Duty Social Worker contacted Social Worker 2 who advised that the information should be passed to the Team Manager, who was arranging a Strategy Discussion. There is no evidence that this information was acted upon.

7.4.34. AM attended an appointment with his GP on 20 October, the day of the assault of Child M. He reported feeling stressed and extremely anxious and felt that he was '*spiralling out of control'*. He was worried about the threat of eviction; a letter of support to Housing was provided and he was advised to contact the Citizens Advice Bureau (CAB). There is no evidence that consideration was given to the impact of his mental health on the family or that this information was shared with any other health practitioners or agencies.

7.4.35. The school reported to the Duty Social Worker that there had been further late collections of Child M and requested that these were logged.

7.4.36. Later on 20 October, at 21.05 p.m., the family's neighbour attended the local Police Station. He was extremely upset, refused to speak to the Officer on the front desk and demanded to speak to an Officer from the Child Abuse Investigation Unit. He reported that, between 19.30 and 20.00 p.m., he had heard a child being shouted and sworn at and physically assaulted. He had recorded this on his phone. The neighbour stated that this was not the first time he had heard such things. He was concerned for his own safety, but felt that he could not ignore what was going on. Uniformed Officers were dispatched immediately and attended the home at 22.29 p.m.

7.4.37. The Officers found Child M sleeping on a bare mattress in a sparsely furnished room and had extensive bruising. Police Powers of Protection were assumed and Child M was taken by ambulance to hospital.

7.4.38. On examination Child M had multiple bruises and scratches. Child M told the Consultant Paediatrician of being woken by Mum and Dad and made to go into the shower due to being naughty at school. Some of the injuries were thought to be caused by the forceful impact from a hard object, such as a shower head. Prior to the photography of the injuries, Child M expressed fear of getting in to trouble if Dad saw the photos.

7.4.39. Mother and partner were arrested and charged with the ill-treatment of a child. They were convicted and received custodial sentences. Child M and the unborn baby became the subject of Care Proceedings by the Local Authority. Mother has served her sentence and been released from custody. AM was released in March 2016 and will be supervised by the Probation Service, with certain licence conditions, until April 2017.

7.4.40. Subsequent information provided by Child M indicates that there had been a physically and emotionally abusive 'punishment regime' in place in the family home. Previously when Social Workers had visited, Child M had a bedroom that was appropriate for Child M's age. At the time of the injuries Child M was sleeping in another bedroom and all toys had been removed.

8. ANALYSIS: Terms of Reference:

The Analysis section of the Serious Case Review is shaped by the Terms of Reference, but includes further issues identified through the Learning and Recall Events. It will consider the information above, gained from the Agency Reports and discussions at the Events. The Analysis leads to the lessons from this Review and recommendations for Dudley

Safeguarding Children Board. It is important to guard against hindsight in drawing conclusions and to bear in mind the context that practitioners were working in at this time.

8.1. Quality of information sharing, including the making of referrals:

8.1.1. The Information Sharing guidance for practitioners (DCSF, 2008)[3] highlighted that Information sharing is *'vital to safeguarding and promoting the welfare of children and young people'.* It encouraged practitioners, from all agencies, to remember that *'there can be significant consequences to not sharing information, as there can be to sharing information'.* The guidance made it clear that practitioners must use professional judgement to decide whether to share or not, and what information was appropriate to share. The Government's revised advice for practitioners on information sharing[4] highlighted that a key factor identified in many serious case reviews (SCRs) has been a failure by practitioners to record information, share it, understand its significance and then take appropriate action

8.1.2. Evidence submitted for the Serious Case Review indicates that in the main this case is characterised by poor information sharing between agencies and the significance of information was not always understood and acted upon.

8.1.3. There are some examples of timely information sharing, but also examples of when agencies should have contacted Children's Social Care to alert the agency to their concerns. Dudley CSC did not appropriately seek information in a timely way and agencies did not proactively share information. A number of agencies had highly relevant information, but this was never pulled together to give a full picture of the family history and current circumstances, and of the immediate and significant risks to Child M.

8.1.4. There are three examples of timely information sharing:

- The GP promptly contacted both the Police and CSC in January 2014 following her discussion with Child M in respect of the alleged sexual abuse.
- In July 2014, when the GP learnt that AM had joined the family, he/she applied 'think family' principles, recognised the potential risk to Child M and informed CSC.
- When AM attended the ante-natal appointment in October 2014, the Midwife was concerned by his presentation, and the potential risk to Child M and the unborn baby, and referred the matter to CSC on the same day

8.1.5. An Initial Assessment was undertaken by Dudley CSC in 2012 following the referral from the CSC team from another local authority are concerning the alleged sexual abuse of Child M. The referral lacked crucial information, e.g. regarding Section 47 enquiries, and the Social Worker and Team Manager tried hard to obtain this, but were unable to do so. The Assessment was completed and the case closed without contacting the family's GP.

8.1.6. Following the referral from the GP in July 2014, informing CSC that AM had moved in with the family, there was a delay in undertaking the assessment and it was not completed by the time of the injuries to Child M in October, i.e. three months later. The information received from the Police on 11 September confirmed that AM was living with Child M and Mother and this should have triggered an immediate Strategy Meeting. However, it was not until 14 October that a decision was made to initiate child protection procedures and

[3] Information Sharing: Pocket Guide, Department for Children, Schools and Families, 2008

[4] Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers, HM Government, March 2015.

convene a Strategy Meeting. This did not take place, despite a further referral from the Midwife on 15 October. Therefore, at no point did agencies come together to pool information and gain a full picture of the family's circumstances and of the risks and protective factors.

8.1.7. The Police attended various domestic incidents concerning Mother and AM in August and September, but none of these incidents were referred to CSC. It is known that on 19 August the Police had been informed that there was a young child in the household, however, it is not apparent on the other two occasions whether Officers were aware that there was a child in the home. There is no evidence that Officers sought to ascertain Child M's welfare on any of the occasions, nor that they accessed information available in the Police records, which would have alerted them to wider issues in the family and to AM's criminal history.

8.1.8. Discussion at the Recall Day highlighted the significance of the superficial approach taken by the Police Officers in August and the distinct lack of professional curiosity. Mother's explanation that her injury was caused when she tripped over the dog was taken at face value by Officers, without consideration of the nature of the report from the neighbour or further discussion with the neighbour. If this had been recognised as a potential incident of domestic abuse, then a referral would have been made to the Domestic Abuse Referral Team (DART), which would have triggered notifications to CSC and the GP Practice, where a safeguarding alert would have been added to the records of Mother, Child M and AM. This would have alerted the agency network to the potential risk posed by AM. A further opportunity to trigger a referral to DART was missed following the incident in September.

8.1.9. Both Mother and AM had a history of mental health difficulties and egularly attending their GP in respect of these. In May and July Mother disclosed concerning information about her low moods and use of alcohol and drugs. Similarly, through September and October, AM was raising concerns about his level of anxiety and on 20 October reported that his mental health was '*spiralling out of control'*. There is no evidence that the GPs considered the fact that there was a child in the family home and Mother was pregnant. The CCG Report Author notes '*There is evidence that mother's needs were put before those of Child M and her mental health issues were deemed to be the focus rather than the impact that these issues could have had on her ability to safely parent Child M'.* There was no discussion with the Safeguarding Lead or with other health practitioners involved with the family, e.g. School Health. There is no evidence that the GPs accessed past information about the adults and it seems likely that each presentation was viewed in isolation.

8.1.10. When AM was assessed by the Consultant Psychiatrist on 14 October, he talked openly about his history of drug and alcohol issues and the time he had spent in prison. He shared his irritation over trivial matters and the '*red line'*, beyond which he became violent. The assessment letter was not sent to the GP until November and it appears no consideration was given to the immediate risk AM might pose to himself and others.

8.1.11. The General Medical Council's short guide, Protecting children and young people[5], highlights that '*all doctors have a duty to act if they think a child or young person is at risk of abuse or neglect, even if they don't routinely see them as patients*.' Further that *'Doctors who treat adults must be alert to the possibility that their patient poses a risk to a child or young person, and know how to act on such concerns.* There is no evidence that

[5] Protecting children and young people, short guide for doctor who treat adult patients, GMC, 2012

the doctors in Dudley who dealt with Child M's Mother and AM were working to this guidance.

8.1.12. The School became concerned about Child M's presentation after the summer holidays in the Autumn Term 2014. Staff were also concerned by the presentation of Mother's new partner and they were '*monitoring the situation closely'.* There is a question for the school about how long they would have monitored the situation before seeking advice from the Education Safeguarding Lead or contacting CSC. At the Learning Event school staff expressed the view that their concerns would not have been considered sufficiently serious by CSC. However, it is important to be mindful of the fact that each agency will have certain information and it is only when the information from all agencies is pulled together that the full picture is obtained. Also *'monitoring'* on its own does not safeguard children. An agency must be very clear what they are monitoring and why and what action they intend to take and when.

8.1.13. The Government's information sharing advice makes it clear that '*No practitioner should assume that someone else will pass on information which may be critical to keeping a child safe. If a practitioner has concerns about a child's welfare, or believes they are at risk of harm, they should share the information with the local authority children's social care,*[6]

8.1.14. *Lord Laming emphasised that the safety and welfare of children is of paramount importance and highlighted the importance of practitioners feeling confident about when and how information can be legally shared. He recommended that all staff in every service, from frontline practitioners to managers in statutory services and the voluntary sector should understand the circumstances in which they may lawfully share information, and that it is in the public interest to prioritise the safety and welfare of children.* [7]

8.1.15. As outlined above, a number of agencies, including the GP, Consultant Psychiatrist and Police, had information which should have been shared urgently with CSC but was not. This indicates a failure by agencies to fulfil their safeguarding responsibilities and a lack of focus on Child M's welfare and safety. Child M was invisible. Practitioners failed to demonstrate professional curiosity. Additionally, when CSC was provided with information, they failed to respond to this in a timely way and to seek further information from agencies.

8.2. How well did practitioners recognise and understand the complexity of factors contributing to the risk to the child, including the family history and neglect, substance misuse and sexual and domestic abuse (Mental Health)?

> *'Assessment should be a dynamic process, which analyses and responds to the changing nature and level of need and/or risk faced by the child.'*[8]

8.2.1. The importance of timely, good quality, robust risk assessments cannot be overstated. Assessments should inform the planning and interventions with a family. Working Together to Safeguard Children, 2015,[9] states that the aims of assessment are '*to use all the information to identify difficulties and risk factors as well as developing a picture of strengths and protective factors'*. It is apparent through Agency Reports and discussion at

[6] Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers. HM Government, March 2015
[7] The protection of children in England: A progress report. DCSF March 2009.
[8] Working Together to Safeguard Children, DFE, 2015
[9] Working Together to Safeguard Children, DFE, 2015

the Learning Event that there was a paucity of timely and good quality assessments in this case, which considered the significant changes in the family's circumstances.

8.2.2. CSC completed an Initial Assessment following the referral in July 2012. However, the CSC Report Author considers that this '*lacks depth and is adult focused. It pays little attention to the impact issues of domestic abuse, sexual abuse, parental mental health and parental instability will have had on Child M. There is no attempt to contact Child M's father, who has parental responsibility, to seek his views.'*

8.2.3. CSC did not undertake an assessment following the referral from the GP in January 2014 which requested support for Child M, who was displaying distress in relation to the sexual abuse. Child M and Mother were not seen. There was no assessment of Child M's emotional and developmental needs and there was no consideration toward the need of support or counselling, despite the request from the GP.

8.2.4. Following the referral from the GP in July 2014, informing CSC that AM had moved in with the family, there was a delay in undertaking the assessment and it was not completed by the time of the injuries to Child M in October, i.e. three months later. A decision was made on 14 October to initiate child protection procedures and convene a Strategy Discussion/Meeting, but this did not take place. Hence, an Initial Child Protection Conference was not triggered. Therefore, at no point did agencies come together to pool information and pull together a full picture of the family's circumstances and hence the risks to Child M and any protective factors. A chronology was not compiled, which would have assisted in identifying any patterns, e.g. with Mother's partners. Actions are characterised by a lack of urgency and timeliness.

8.2.5. There is no evidence that the Police (and Probation) undertook risk assessments. When Police Officers attended the domestic incident in August they accepted Mother's account of how she sustained her injury, displaying no professional curiosity. There was no consideration of whether this could be an incident of domestic abuse and hence a referral was not made to the Domestic Abuse Referral Team, which would have undertaken an assessment of risk.

8.2.6. At the One Day One Conversation Meeting, attended by Police and Probation, the decision was taken to begin the process to deregister AM from the Prolific and Priority Officers scheme. Officers were aware of AM's family circumstances, however, there was no consideration of the risk he posed to Child M and the unborn baby and no follow up action agreed in terms of liaison with CSC regarding this.

8.2.7. Both Mother and AM were regularly attending appointments with their GP and expressing concerns about their mental health. It is understood that AM saw the same GP on four or five occasions, including on the day of the injuries to Child M. However, it does not appear that consideration was given to the impact of the adults' difficulties on their parenting capacity. The local GPs did not 'think family'. Similarly, there is no evidence that the Consultant Psychiatrist undertook an assessment of the risk AM posed to himself or others.

8.2.8. In the course of the Serious Case Review a number of historical and current factors have been identified which contributed to the risk to Child M, as well as to the unborn child. Risks were heightened by the combination of risk factors present. There is no evidence that practitioners fully recognised the serious risks or acted upon them.

8.2.9. The risks identified include:

- Mother's dysfunctional family background, including intergenerational sexual abuse.
- Mother's long-standing history of emotional/mental health difficulties.
- Mother's pattern of abusive relationships.
- Allegation by MGM that Mother had behaved in an abusive manner to Child M.
- Child M's abuse by a family member.
- AM's childhood history.
- AM's criminal history, including drug offences.
- AM's mental health – anti-social personality disorder.
- AM's charge of assault on the three-year old child of a previous partner.
- Probation Officer expressed extreme concern about AM living in a family with children
- Mother's lack of compliance and lack of honesty about her relationship with AM.
- Deterioration in Child M's care observed by School in the Autumn Term 2014.
- Police attended three incidents between August and October 2014, in two there were indications of domestic abuse.
- Deterioration in the mental health of Mother and AM.
- Mother's use of alcohol and drugs (cannabis).
- AM's continued use of heroin.
- Threat of eviction, due to rent arrears.

8.2.10. Cleaver, Unell and Aldgate[10] stress that *'while caution is needed in making assumptions about the impact on children of parental mental illness, problem alcohol or drug use or domestic abuse, if the issues coexist the risk to the children increases considerably. There is substantial independent evidence from research into both parental mental illness and problem alcohol or drug use, that the combination of issues, particularly the link with domestic violence, is potentially dangerous for children.*' Evidence provided for this Serious Case Review shows that such issues coexisted in the family.

8.2.11. Records indicate that Mother was seen as protective towards Child M. However, there is minimal evidence to support this assertion. It appears that Mother had a neglectful childhood and there were attachment difficulties in her relationship with her own Mother (MGM). She had a history of emotional and mental health difficulties, with low moods and suicidal idealisation. Her intimate relationships were characterised by domestic abuse and she failed to access support offered to her in this respect. The MGM had raised concerns about Mother's behaviour towards Child M, indicating there may have been some underlying ambivalence. Therefore, there are grounds to question whether Mother had the mental strength, and determination, to safeguard and prioritise the needs of Child M or indeed to protect herself.

8.2.12. A stark element of this Review is that Mother and AM did not conceal their difficulties. Between them they provided significant information to the GPs and Consultant Psychiatrist, which indicated that their mental health difficulties were worsening. AM commented to the Consultant Psychiatrist that there was a *'red line'*, beyond which he became violent and to the GP that he was 'spiralling out of control'. This last comment could well be viewed as a 'cry for help'. The Dudley CCG Agency Report Author commented that *'The care for both Child M's mother and AM was adult focused and did not consider that the risks to Child M's safety were escalating with the carers deteriorating mental health'*. '*Men with antisocial*

[10] Children Needs – Parenting Capacity, The Impact of parental mental illness, problem alcohol and drug use and domestic violence of children's development. Department of Health. 1999

personality disorder have been found to be three to five times more likely to misuse alcohol and drugs. This in itself should have led professionals to consider that Child M may be at risk of harm, particularly from someone who struggles to control his anger.'

8.2.13. In the Beyond Blame study, Duncan and Reder [11] identified that a number of families had provided a '*covert warning'* to practitioners. They had *'approached professionals and communicated what was, in retrospect, a disguised admission that abuse was critically escalating'*. Such warnings require professionals to translate the presentation into the risk of child abuse. Whether AM's comments were covert warnings is worthy of consideration.

8.2.14. Duncan and Reder [12]also highlighted that parents who kill children usually come from depriving, hostile or abusive backgrounds, leaving them with '*unresolved care and control conflicts'*. Care conflicts show in later life as excessive reliance on others and fear of being left by them. Control conflicts were enacted through violence, low frustration tolerance, attempts to exert control over others or intolerance of others perceived as controlling. Evidence would suggest that AM is someone with control conflict.

8.2.15. In summary, there were no single or multi-agency assessments of the family circumstances, of the parenting capacity, the child's needs and the wider family, and practitioners did not fully recognise or understand the complexity of the factors which presented serious risks to Child M. It is true to say that there was no greater understanding of the risks and any protective factors at the point of Child M's injuries in October, than there was at the time of the referral in July 2014, i.e. after three months. The lack of assessment and analysis of the available information by agencies, contributed to this failure.

8.3. Was the voice of the child heard, including an understanding of the child's lived experience?

'Seeing the world from the child's point of view and understanding the risks of harm he or she faces, is dependent on front line staff getting to know the child.'[13]

8.3.1. Child M is a bright child, who was, and still is, achieving academically at an age appropriate level. There is evidence that Child M is well able to articulate what has happened and how this feels. In January 2014 Child M provided a very clear account to the GP of the abuse by a relative. This was dealt with sensitively by GP, who took appropriate action leading to the Achieving Best Evidence interview. The CAIU Officers built a rapport and understanding with which allowed Child M to disclose details of the abuse experienced. In October 2014, Child M gave a full account to the Consultant Paediatrician of what had occurred on 20 October, including expressing some anxiety about what would happen if 'Dad' saw the photographs of the injuries. However, in general agencies did not promote Child M's voice or gain an understanding of the day to day lived experiences for this Child.

8.3.2. There were ways in which Child M's presentation was giving clues to what had been happening/was happening. The anxiety about sexual abuse being repeated was manifested in abdominal pains and difficulty sleeping. Following AM joining the family Child M's presentation at school had deteriorated and there was anxiety about the

[11] Beyond Blame, Reder et al, 1993
[12] Predicting Fatal Child Abuse and neglect, Reder and Duncan. Early Prediction and Prevention of Child Abuse, A Handbook. Wiley 2002.
[13] Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005 – 07, DCSF, 2009

disappearance of the family's puppy. Child M shared drawing with the Social Worker, which included a picture drawn of Mum and Dad. This provided clear evidence that AM was spending considerable time with the family. It is highly likely that time spent alone with Child M would have provided a good picture of the day to day life, including the worries and fears and how life had changed since AM had joined the family.

8.3.3. Whilst the family were residing in Dudley, Social Workers visited the family home on just three occasions, Child M was seen and spoken to alone on two of these visits. It was not recorded whether Child M he was present on the third. No attempts were made to visit Child M at school, i.e. in a neutral environment. There is no evidence that a relationship was developed between the Social Worker and Child M. The Biennial Review of SCRs 2005 – 2007[14] stresses the importance of building a relationship with a child and suggests *that the 'starting point is to have a sound understanding of the children's day to day experience of life at home, but this is not possible without first seeking to discover what the infant, child or adolescent thinks and feels, as a person, not just someone potentially at risk of harm.' 'Seeing the world from the child's point of view and understanding the risks of harm he or she faces, is dependent on front line staff getting to know the child.'*

8.3.4. To some agencies, Child M appeared to be invisible, as was the unborn baby. This invisibility of children has been highlighted in many SCRs and The Biennial Analysis of SCRs [15] noted that '*The way that children of all ages were able to slip from view was a powerful theme of this report.'* Following AM's release from Prison, the Police were called to several incidents involving Mother and AM in August and September. There is no record as to whether Child M was seen and spoken to on these occasions and none of the incidents were referred to CSC. As described earlier the safety of Child M was not considered by the Police and Probation at the One Day One Conversation Meeting.

8.3.5. Both Mother and AM had a history of mental health difficulties and were regularly attending their GP in respect of these. In May and July, Mother disclosed concerning information about her low moods and use of alcohol and drugs. Similarly, through September and October, AM was raising concerns about his level of anxiety and on 20 October reported that his mental health was 'spiralling out of control'. There is no evidence that the GPs considered the fact that there was a young child in the family home and Mother was pregnant. It is not difficult to picture what Child M's lived experience would have been like living in a family with adults with such complex difficulties.

8.3.6. Ofsted's thematic review, The Voice of the Child[16], which analysed 67 SCRs undertaken between April and September 2010, found that children were not seen frequently enough by the professionals involved, were not asked about their views and feelings, and practitioners focussed too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child. In addition, agencies did not interpret their findings well enough to protect the child.

8.3.7. There is clear evidence that Ofsted's findings were mirrored in this Serious Case Review. Whilst there were occasions when Child M was seen and spoken to by practitioners, this was not frequent enough, including being seen alone. Child M's views and feelings were not obtained nor was Child M's voice heard. The agencies which worked with the adults,

[14] Understanding Serious Case Reviews and their Impact, DCSF, 2009
[15] Understanding Serious Case Reviews and their Impact, DCSF, 2009.
[16] The voice of the child: learning lessons from serious case reviews, 1 April to 30 September 2010. Ofsted, April 2011.

i.e. Police, Consultant Psychiatrist, GP, focussed very much on the adults' difficulties, without any consideration of the implications for the welfare and safety of the child and unborn baby. In effect Child M was invisible to these agencies and the Needs of Child M were not prioritised by practitioners.

8.4. To what extent did practitioners Think Fathers?

8.4.1. The Biennial Analysis of SCRs 2005 - 2007[17] highlighted the *'urgent need to consider in what ways the mother's husband or boyfriend or partner, or lodgers or other adults living in the family, might pose a risk to the child's safety or, conversely, act as a protective presence'. 'Assessment and support plans tended to focus on the mother's problems in caring for her children and paid little attention to the men in the household and the risks of harm they might pose to the children given the histories of domestic violence or allegations of or convictions for sexual abuse.'* Following on from this, Working Together 2013, Chapter 10,[18] *highlighted the need for agencies to 'Think Fathers', noting that Fathers can have a significant impact on outcomes for children and that Children's Services can often be 'Mother focussed', without giving due regard to the role of the Father.*

8.4.2. The Agency Reports and discussions at the Learning and Recall Events would indicate that in this case the risks posed by Mother's partner(s) were not recognised or assessed by agencies, or acted upon. Mother had four partner during Child M's life and these relationships were characterised by domestic abuse. However, despite Mother being seen as protective by practitioners, she did not recognise the potential risks that a new relationship posed to herself and Child M. When CSC tried to alert her to the concerns in respect of AM, Mother was keen to minimise them, and denied he was living in the family home. Mother failed to prioritise Child M's needs and safety.

8.4.3. Natalie Valios's article in Community Care in 2009[19] pulled together research into the risks posed to children by stepfathers. Overall evidence would indicate that there is '*considerable excess risk at the hands of stepfathers'*. Further that deaths caused by stepfathers tend to be rage driven, *'impulsive acts motivated by hostility towards the child and characterised by violently beating or shaking them'*. Stepfathers have no genetic stake in the child and can see them as competition for attention and time and their own offspring. David Finkelhor, Director of the Crimes against Children Research Centre, concluded that these men '*do not feel a natural affinity or protectiveness about the child of the women they are involved with. These are not men who are nurturing'.*

8.4.4. Cavanagh, Dobash and Dobash [20] found that the risk was increased when stepfathers had disrupted, disadvantaged and problematic childhoods, a history of drug or alcohol abuse and offending. There was a reluctance to invest in other men's children and they viewed the child as a nuisance. This profile would fit with AM, who is known to have had a difficult childhood, with a history of drug and alcohol abuse and persistent offending. Daly and Wilson[21] compared step-fathers and genetic fathers who had killed children and concluded that they kill in a different way and for different reasons. Stepfathers were often motivated by resentment of the victim and the cause of death likely to be by beating. The

[17] Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005 – 07, DCSF, 2009.
[18] Working Together to Safeguard Children, DFE, 2013
[19] Natalie Valios, Lurking in the Shadows. Community Care, 9 April 2009
[20] The Murder of Children in the Context of Child Abuse, Cavanagh, Dobash and Dobash. 2006
[21] Some Differential Attributes of Lethal Assaults on Small Children by Stepfathers versus Genetic Fathers, Daly and Wilson, 1994.

picture of AM's negative attitude and approach towards Child M, for example the imposition of a punishment regime, indicates that he had developed a sense of resentment towards her, which culminated in the serious physical assault.

8.4.5. Mother and AM were seen together by the Social Worker and Team Manager just once, early in October at the family home. They confirmed that AM had moved into the home and he appeared to be compliant and co-operative. Evidence would indicate that the Workers were falsely reassured by this visit, without given due consideration to the complex background information.

8.4.6. Whilst neither the Police or Probation had a supervisory role in respect of AM, as he had served his custodial sentence in full, he was well known to both these agencies. He was managed on a voluntary basis by the Police Offender Managers as a Prolific Priority Offender. However, as he was not accessing any support it was agreed at the One Day One Conversation meeting between the Police and Probation early in September that the process should commence of deregistering him from the scheme. The Police were aware that AM was living with the family and his partner was pregnant, but at this meeting there appeared to be a complete lack of consideration of the potential risks that AM could pose to Child M and the unborn baby.

8.4.7. The role of mothers in such cases has been considered by Kennedy, Consultant in Clinical and Forensic Psychology. He found these mothers tended to be depressed, overwhelmed or so distracted by their own difficulties that they do not feel able to protect their child. They were usually highly vulnerable women, who have a confused understanding of relationships. Their backgrounds were characterised by abuse and they were highly dependent on being in a relationship, even if it was dysfunctional because it provided them with security.[22] Child M's Mother's history very much reflects this picture, a difficult childhood, abusive relationships, and a history of low moods and depression, with a failure to protect Child M, which had gone unrecognised.

8.4.8. Therefore, the evidence presented to this SCR indicates that agencies did not 'Think Fathers'. The Daniel Pelka SCR[23] highlighted the lack of understanding of *'the role of the fathers and of other significant males in the home'* and this finding is mirrored in this Serious Case Review. Overall, there was insufficient consideration of the impact of AM spending time with the family and no recognition of the risks he was likely to pose to Child M and the unborn baby. There was no sense of urgency of the need to assess the impact of AM's presence in the family home and to take any action deemed necessary.

8.5. How did practitioners approach challenge and/or escalation and what was their level of knowledge around the processes for these?

8.5.1. There is little evidence of challenge or the use of escalation in this Serious Case Review, though there are examples of when this should have occurred. The GP made a referral to CSC for support for Child M who was showing signs of anxiety following the alleged sexual abuse, however, this was not acted upon and the GP did not follow up with CSC or raise as an issue with the GP's Safeguarding Lead.

8.5.2. The Police had difficulty in getting hold of the Team Manager to arrange the Strategy Discussion, though phone calls were made and messages left on three occasions in October. After the third attempt the Officer added a note to the records to the effect that

[22] Valios. Community Care, 9 April 2009

[23] Overview Report, Serious Case Review, Daniel Pelka, Coventry Safeguarding Children Board, Sept 2012

no further attempts would be made, there was not the time to do so and Police would wait for contact from CSC. Given the Police's knowledge of AM's history and the risks he posed to Child M, this clearly should have been escalated internally as a matter of urgency to a Manager. It is understood that the Officer has been advised regarding this matter.

8.5.3. Another area where challenge would have been appropriate was Mother's assertion to Social Workers in August 2014 that AM was not living with the family, despite Child M showing the workers drawings of Mum and Dad, who Mother agreed was AM. There appears to have been too great a focus on whether there was physical evidence of AM living in the family home, when Workers had clear evidence from Child M that he (AM) was now a significant person and they were spending time together. Mother should have been challenged by Social Workers regarding this.

8.5.4. There is no evidence of challenge within Children's Social Care. The Assistant Team Manager (ATM) does not appear to have challenged the Social Worker about the delay in progressing the assessment and there was no challenge by the ATM of the Team Manager about the delay in arranging the Strategy Meeting.

8.5.5. Overall, there is no evidence of challenge and escalation in this case. This may well indicate an underlying lack of recognition of the immediate and serious risks to which Child M was exposed daily. In addition, there may be a lack of awareness in agencies about when and how to challenge and escalate concerns, both within agencies through Safeguarding Leads and via DSCB's multi-agency processes.

8.6. Provide some analysis of the quality of management oversight and decision making. Was there evidence of understanding of the complexity of the family/the use of a genogram?

> *Effective professional supervision can play a critical role in ensuring a clear focus on a child's welfare.* [24]

8.6.1. Overall the Agency Reports and discussion at the Learning and Recall Events demonstrate a lack of timely and evidence based decision-making, both single and multi-agency. Additionally, they demonstrate a lack of supervision and management oversight in most agencies, as well as a lack of use of agency Safeguarding Leads, e.g. Education, GP, Police.

8.6.2. The Social Worker, Assistant Team Manager and Team Manager have advised CSC's Report Author that the concerns about Child M were frequently discussed in formal and informal supervision sessions. However, there is a lack of recorded evidence of management oversight, timely decision-making or supervision in CSC's records. The first record of supervision taking place is on 30 October 2014, i.e. after the injuries to Child M. Certainly, there is no evidence that the complexity of the family situation and the inherent risks to Child M were understood or acted upon. Significantly, there is a lack of evidence of managerial action following the visit on 3 October when AM confirmed that he was now living with the family. The visit was not written up until 28 October, after Child M's injuries.

8.6.3. There was a delay in the Team Manager making the decision to convene a Strategy Discussion/Meeting. This should have taken place immediately after the confirmation that AM was living with the family, which was received from the Police on 11 September 2014, if not before.

[24] Working Together to Safeguard Children, DFE, 2013.

8.6.4. The CSC Report Author suggested that the case lacked direction and that staff in CSC were unsure which direction to go in, notably whether to request that AM leave the family home whilst the assessment was undertaken. The lack of supervision undoubtedly contributed to the lack of direction, sense of urgency and adherence to timescales. There were no opportunities for reflection and analysis to aid decision making.

8.6.5. The CSC Report Author referred to Working Together 2013 [25] which states that *'Effective professional supervision can play a critical role in ensuring a clear focus on a child's welfare…….The Social Worker and their manager should review the plan for the child and together they should ask whether the help given is leading to a significant positive change for the child.'* It was the author's view that there was a lack of clear focus on Child M's welfare and no record of supervision to suggest otherwise.

8.6.6. It is understood that the Strategy Discussion in January 2014 decided to undertake a single agency investigation, as it related to an 'out of Borough' allegation. This meant that CSC took a back seat and did not meet with Child M and Mother before closing the case. The issue of support for Child M was not addressed. The rationale for this decision is open to challenge as it is contrary to the guidance contained in Working Together to Safeguard Children, 2013 [26], which was in force at that time and states that CSC should be the lead agency in undertaking child protection enquiries. Health were not involved in the discussion and advice was not sought regarding the appropriateness of undertaking a medical.

8.6.7. The Learning Event discussed the decision of the Crown Prosecution Service in 2005 not to proceed with the charge against AM in respect of the assault on the three-year old son of his partner. The reasoning behind this appears to have been that, if convicted he would receive a lesser sentence for the assault than for a conviction for Abstracting Electricity, so this was the charge that should be proceeded with. This may have seemed expedient at the time, but did not address the long-term risks that AM would pose to children. If he had been convicted of the assault on a child, he would then have been managed as a Person Posing a Risk to Children, which would have helped to ensure the safeguarding of any child that AM subsequently had contact with.

8.6.8. It has been difficult to evidence the course of decision-making in this case, there is lack of evidence of consistent management oversight and of timely and effective decision-making. Within CSC there is a paucity of evidence of supervision, which undoubtedly reflects the lack of momentum in the management of the case.

8.7. What were the barriers to providing an adequate response?

8.7.1. It is important to understand why there was not a more proactive, timely and robust multi-agency response in this case. Some potential barriers have been identified through the Serious Case Review process, including:

- Child M's voice was not promoted and made the child invisible to some agencies.
- Lack of assessment, and analysis, of the risks and protective factors, which was regularly updated to reflect the changes in the family's circumstances, and of recognition, and understanding, of the complexity of risk factors.
- Lack of an assessment of Mother's parenting capacity,

[25] Working Together to Safeguard Children, DFE, 2013.
[26] Working Together to Safeguard Children, 2013, DFE.

- Lack of understanding across agencies of the principles of effective information sharing.
- Lack of recognition and understanding of safeguarding responsibilities by some agencies (GP/Mental Health Services/Police).
- Too greater focus on trying to establish whether AM was actually 'living with the family', so that the lack of physical evidence of his presence in the home reassured the Social Workers. The key factor in terms of risk to Child M was whether AM was spending significant amounts of time with the family and this information was graphically provided by Child M and would have been provided by the school if contacted sooner.
- Mother's lack of honesty with professionals regarding her relationship with AM.
- Mother and AM were co-operative and AM appeared 'compliant' when the Social Worker and Assistant Team Manager visited. This may well have given them a false sense of reassurance about Child M's safety.
- Each incident was seen in isolation by some agencies, without reference to previous occurrences or family history (Police/GP).
- The incident in August when Mother had sustained a head injury was not investigated robustly and Mother's '*superficially plausible account'* (Police Agency Report) was '*unequivocally accepted'* without question, i.e. without professional curiosity. WMP domestic abuse procedures were not implemented which meant that the matter was not referred to the Domestic Abuse Team and other agencies were not alerted to the potential risk of domestic abuse, i.e. GP, CSC.
- Culture of delay in Dudley CSC led to a serious delay in responding to the referral in July 2014 in respect of AM being in the family home. There was no sense of urgency in dealing with the referral, despite its serious nature and the early recognition of risk by the Duty Social Worker. Were timescales for response to referrals/completion of assessments monitored and reported on at this time?
- Lack of effective supervision, management oversight and direction which led to a lack of clear planning and challenge when actions were not completed within timescales.
- Lack of evidence of the use of agency Safeguarding Leads.
- Perceived high thresholds for agencies raising concerns with CSC. (School)
- School were concerned about making a judgement about AM based on his attitude and appearance, though he made staff and parents feel *'uncomfortable'*. It was a '*professional hunch'.* Need to be mindful that if AM made staff feel this way, then what would be the day to day impact on the life of a young, and vulnerable, child.
- Referral made/Information shared by CSC to the Police in August 2014 was not made through the designated gateway, i.e. Central Referral Unit, in line with procedures. This delayed the Police response.

9. Examples of Good Practice:

- The out of area Hospital identified that Father was linked to Child M and alerted Dudley CSC to concerns.
- The Health Visitor was persistent in her attempts to see Mother and Child M when they moved to the Dudley area.

- The Team Manager make several attempts to seek greater clarification from another local area CSC, including following this up in writing.
- The Police responded on the same day to Mother's report of the sexual abuse.
- The GP's discussion with Child M regarding the alleged sexual abuse was sensitive and is well recorded, not only noting exactly what Child M said, but also noted the child's demeanour.
- The GP at the Health Exchange recognised safeguarding concerns about AM moving in with Mother and Child M and notified CSC.
- The Midwife recognised the risks AM presented to the unborn baby and referred these concerns to CSC.
- The Consultant Paediatrician who undertook the child protection medical spent time talking to Child M about what had happened and this is fully recorded.
- Post the incident, the school have provided excellent support to Child M.

In addition, the role of the neighbour in safeguarding Child M should be fully recognised. He had been concerned about his own safety, but fortunately his concerns regarding Child M took priority.

10. Findings:

- Local LSCB procedures were not adhered to. Following the referral in July 2014, there was a lack of timeliness in reaching the decision to convene a Strategy Discussion, compounded by a further delay in arranging this. If a Strategy Meeting had been held, and Section 47 enquiries undertaken, it is likely an Initial Child Protection Conference would have been convened. This would have ensured that all the available information was shared in order to build a more holistic picture of the family circumstances, and of the serious risks to Child M. In addition, agencies, e.g. GP, School, would be informed of the potential risks to Child M. **(Recommendation One)**
- Lack of an assessment, chronology or genogram being completed, which should have fully analysed the risks and protective factors.
- Practitioners failed to gain an understanding of Child M's lived experiences and to promote the voice of the child. Child M was invisible to some agencies and the clear ability to provide a picture of what life was like through the 'child's eyes' was not harnessed. **(Recommendation Two)**
- Social Workers failed to spend sufficient time with Child M in order to establish a trusting relationship to enable Child M to feel able to confide and share any worries.
- Practitioners did not fulfil their safeguarding responsibilities and apply a 'Think Family' approach. There was a lack of recognition by agencies of the immediate risks posed to Child M by the adults' difficulties, and of the increased risk due to the complexity of factors present, i.e. parental mental health needs, drug and alcohol misuse, criminality and domestic abuse. This led to a delay in a risk assessment being undertaken and action taken to safeguard Child M. **(Recommendation Seven)**
- Police Officers did not recognise potential domestic abuse, or follow WMP procedures, i.e. referral to DART, which would have alerted other agencies, e.g. GP, CSC, to the risks of domestic abuse. The GP Practice would have added a safeguarding flag to the patient records. **(Recommendation Five)**

- The Police treated each contact with the family as a single occurrence, without reference to previous history or contacts. Child M was invisible to the Police and there was a serious lack of attention to the wellbeing or safety of Child M, e.g. One Day One Conversation meeting. **(Recommendation Six)**
- Lack of understanding by GPs, and the Consultant Psychiatrist, of their safeguarding responsibilities, leading to important safeguarding information not being shared with CSC or discussed with Safeguarding Leads within their organisations. Lack of a 'think family' approach. **(Recommendations Seven, Eight, Nine and Ten)**
- Effective management oversight and supervision was lacking, notably in Children's Social Care which contributed to the lack of direction, delay and challenge. **(Recommendation Four)**
- The decision by the CPS in 2005 not to proceed with the assault charges against AM was short sighted, and did not consider the long-term implications in respect of safeguarding children with whom AM would come into contact in the future. **(Recommendation Eleven)**

11. **Recent Developments:**

- Regular meetings are now held in some GP Practices in Dudley between GPs and Health Visitors to discuss children where there are safeguarding concerns.
- Child M's GP Practice now routinely check members of the household at a mother's post-natal check and a baby's 6 weeks' check.
- Child M's GP Practice ensures that notes of all new patients under the age of 18 years are reviewed within 24 hours, so that safeguarding issues can be identified and safeguarding flags triggered when necessary.
- Child M's GP Practice is looking at putting in place a system for the Safeguarding Lead to monitor and 'progress check' referrals that have been made to Children's Social Care.
- Dudley Safeguarding Children Board has revised its Threshold Guidance and multi-agency events have been held to raise awareness of this. Participants at the Learning Event were of the view that there was now less of a 'block on referrals'.
- Dudley CSC now has a Single Point of Access (SPA) and a Multi-Agency Safeguarding Hub (MASH) went live in May 2016.
- Health agencies in Dudley have developed a strategy to enhance communication and the sharing of information between GPs, Health Visitors and School Nurses.
- Dudley and Walsall Mental Health Partnership Trust has provided Level 3 safeguarding training to all doctors, including Consultants, and invested in additional resources to ensure safeguarding alerts are actioned appropriately.
- Police have a rolling programme of Child Protection Training for all staff, not just those working in child protection, this includes recognising and responding to domestic abuse.
- DSCB's Resolution and Escalation Protocol was relaunched in April 2016.

12. Conclusion:

12.1. It is a sad reality that Child M was no safer at the time of the physical assault in October 2014 than when the GP made the referral to CSC raising concerns about AM's presence in the household in July 2014, three months earlier. The multi-agency safeguarding system, which should have offered protection to Child M, did not operate effectively and appropriate action was not taken to safeguard the child.

12.2. There was a lack of recognition and understanding of the complex family circumstances and of the considerable risks to Child M, and to the unborn child. The deteriorating family situation was not recognised, despite the worrying presentation by Mother and AM to various agencies, e.g. GP, Consultant Psychiatrist.

12.3. Child M, and the unborn baby, were invisible to some agencies and insufficient time was spent talking to Child M in order to gain an understanding of what life was like, despite Child M being known to be a bright and articulate child. If more time had been spent talking to Child M, it is likely that there would have been some indication of the changes in the family circumstances and in the safety and emotional wellbeing of Child M.

12.4. Child protection procedures were not adhered to. A Strategy Meeting was not convened, nor were Section 47 enquiries undertaken. Hence, an Initial Child Protection Conference (ICPC) was not triggered. If procedures had been followed, and an ICPC had been convened, then information would have been shared, and analysed, in a multi-agency setting. It is highly likely that a decision would have been made that Child M was at risk of significant harm and required a Child Protection Plan to safeguard Child M. This would have enabled the safeguarding network to operate more effectively together, with a Core Group and multi-agency plan in place.

12.5. Additionally, West Midlands Police procedures were not followed. Referrals to the Domestic Abuse Referral Team (DART) were not triggered following the incidents in August and September. If they had been then agencies, i.e. GP, School Nurse, CSC, would have been alerted to concerns about potential domestic abuse in the family and action taken, e.g. a safeguarding flag would have been added to the GP records.

12.6. Despite clear evidence of the presence of a range of significant risk factors to Child M, notably parental mental health needs, criminality, drug and alcohol abuse and domestic abuse, safeguarding action was not taken. Crucial information had not been shared with, or sought by, CSC. This meant that health agencies, notably the GP Practice, were not party to significant information. A risk assessment had not been undertaken by any agency and there is no evidence that advice was sought from Safeguarding Leads within health organisations or Education.

12.7. Overall, the safeguarding system, which should have been working together to keep Child M safe, was not well informed or co-ordinated. Agencies were working independently, rather than together, which is recognised to be the most effective way of keeping children safe.

12.8. If local procedures had been followed steps would have been taken to safeguard Child M, and the unborn baby, and it is reasonable to conclude that Child M's injuries could potentially have been prevented.

13. Recommendations:

Individual agencies have made recommendations (See Appendix B), which have been implemented. These recommendations, together with the ones below from the Serious Case

Review, have been incorporated into an Action Plan by Dudley Safeguarding Children Board, the progress to completion has been monitored by the Serious Case Review Sub-Group.

13.1. Single agency:

- The Dudley Group NHS Foundation Trust should consider the feasibility of informing GPs when a child protection referral is made to CSC.

13.2. Dudley Safeguarding Children Board

1. Dudley SCB should seek assurance that the local Inter-Agency Child Protection Procedures, e.g. timescales for Strategy Meetings and assessments, are adhered to, through Multi-Agency Case File Audits and an Audit of contact, referral and assessment services. **(DSCB's Quality Assurance Sub Group)**
2. Dudley SCB should seek assurance that children and young people's views are sought and that these inform assessments and decision making through Multi-Agency Case File Audits. **(DSCB's Quality Assurance Sub Group)**
3. Consideration should be given to arranging Strategy Meetings, rather than telephone Strategy Discussions, whenever possible, ensuring that key agencies, including health, education and Probation, are invited and full information shared. DSCB's Inter-Agency Child Protection Procedures should be amended to reflect this and an Aide Memoire developed for practitioners. **(DSCB Policy and Procedures Sub Group)**
4. DSCB should seek assurance that CSC has a robust Supervision Policy in place and that this is adhered to. This should be monitored through the Performance Information presented to the Board. **(DSCB's Quality Assurance Sub Group)**
5. DSCB should seek assurance from West Midlands Police that the Domestic Abuse procedures are being followed in Dudley and a process is in place to provide schools and GPs with information following the Domestic Abuse Referral Team (DART) meetings. **(DSCB's Quality Assurance Sub Group)**
6. DSCB should seek assurance from West Midlands Police that where 'One Day One Conversation' meetings are held, full consider should be given to any safeguarding concerns in relation to children and young people to include taking appropriate action to ensure children are safeguarded.
7. DSCB should promote the importance of the role of agency Safeguarding Leads in advising staff and facilitating communication between agencies, and individual agencies should raise awareness of their role and responsibilities, notably within health. **(Designated Nurse and Named GP)**
8. DSCB should promote a 'Think Family' approach in their communications and guidance. Safeguarding Leads should play a key role in this promotion. **(DSCB Policy Group)**

9. DSCB should seek assurance that the system for GPs to 'flag' adults and children where there are safeguarding concerns is being implemented, through an audit of patient records. **(Named GP).**

10. The findings of this case should be shared widely with GPs and the Mental Health Services, and the General Medical Council's guidance; Protecting Children and Young people promoted, to raise awareness of their safeguarding responsibilities and what action to take when there are concerns about the risk posed by adults living with children. **(Designated Nurse)**

11. The Chair of DSCB should write to the Crown Prosecution Service to request that there is a review of the decision-making in 2005, which led to the charges of assault against AM being dropped and the charge of abstracting electricity continuing. **(DSCB Chair)**

12. Discussion should be held between DSCB and the Caldecott Guardian to ensure that there is a common understanding of the principles of information sharing when there are child protection concerns, and when the LSCB is fulfilling its statutory responsibility to undertake a Serious Case Review or Case Review**. (Designated Nurse)**

Appendix A

DUDLEY SAFEGUARDING CHILDREN BOARD

SIGNIFICANT INCIDENT LEARNING PROCESS

SUBJECT: Child M

Year of birth. 2008

1. SCOPE:

The subject child, Child M is in scope

Time period: August 2012 (when the case came to the attention of Children's Social Care) to October 2014 (Child M was made subject to Police Powers of Protection)

2. FRAMEWORK:

Serious Case Reviews and other case reviews should be conducted in a way in which:

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

(Working Together to Safeguard Children, para 10, March 2015)

3. AGENCY REPORTS TO BE COMMISSIONED:

1. Children's Social Care
2. School (and Nursery)
3. Police
4. Police Offender Managers
5. Probation
6. GP
7. Children's Centre
8. Health Dudley Group NHS Foundation Trust
9. BCPFT School Health Adviser

An anonymisation key will be used to anonymise family members.

4. TERMS OF REFERENCE:

1. How well did practitioners recognise and understand the complexity of factors contributing to the risk to the children including neglect, substance misuse and sexual and domestic abuse?

2. What were the barriers to providing an adequate response?

3. Was the voice of the child heard (including an understanding of the child's lived experience)?

4. How was the family history incorporated into assessments?

5. To what extent did practitioners Think Fathers?

6. How did practitioners approach challenge and/or escalation and what was their level of knowledge around the processes for these?

7. Comment on the quality of information sharing including the making of referrals?

8. Provide some analysis of the quality of decision making. Was there evidence of use of genogram/understanding of the complexity of the family?

5. A TEMPLATE FOR AGENCY REPORTS:

Attached

6. AGREED TIMETABLE BEFORE THE REVISED STATUS OF THE REPORT:

Scoping/Terms of Reference	1 October 2015
Commissioning letters	12 October
Agency Report Authors' Briefing	15 October
Agency Reports Submitted	14 December
Distribution of material to Learning Event attendees	21 December
SILP Learning Event	7 January 2016
Drafting Overview Report and distribution	3 February 2016
SILP Recall Day	11 February 2016
Revising Report	25 February 2016
Presentation to DSCB SCR Sub Group	3 March 2016

7. Meetings with Family/Significant Others

Explanation of Process	15 October 2015
Feedback re: experience of services	6 January 2016
Discussion of final report	25 February 2016

Key single agency recommendations: Appendix B

Children's Social Care:

- All referrals must be allocated within 24 hours of the decision for an assessment.
- Where a Child in Need referral has been accepted, the child must be seen within five working days of the referral.
- Assessments must be child centred, include the views of a child, holistic, focused on action and outcomes and informed by evidence.
- Assessments must be completed and authorised within the timescales as per the Practice Standards.
- Management direction and decision making should be clearly recorded on the child's electronic care file from allocation to closure.
- Supervision must take place on a monthly basis as stated in Dudley's Supervision Policy.
- Practitioners must capture the voice of the child throughout all interventions and ensure this is recorded and evidenced.

West Midlands Police:

- Offender Management training to ensure staff and supervisors are aware of the importance of identifying potential child abuse matter from both contact with managed offenders and with partner agencies**.**

Clinical Commissioning Group:

- Reiterate the 'Think Family' approach, particularly with those working with adults.

NHS Foundation Trust 1:

- When information is shared and there are concerns that correct procedures have not been followed the support and advice from Named and Designated Professionals should be requested.

NHS Foundation Trust 2:

- School Health Nurses to ensure all school health questionnaires/assessments are reviewed, health issues actioned appropriately and documented.
- Health Visitors and School Health Nurses to ensure that the voice of the child is heard, including directly asking the child their views/feelings when seen.

Education:

- Review the ways in which records are transferred and ways in which absent records are pursued on transition, including statutory guidelines.
- Review with Social Services' colleagues the sharing of key information and needs of troubled families with schools.

- Review with social Services colleagues the sharing of information on identified 'risky adults' with school.

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