The Overview Report into a Serious Case Review of the circumstances concerning:

Jack and Harry

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June 2019

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The family structure during the review period

Pseudonym	**Relationship**		**DOB**
Jack	Subject	M	b. 14 Dec 2013
Harry	Subject	M	b. 3 April 2015
FP	Mother	F	b. Jan 1994
MP1	Father of Jack	M	b. Sept 1994
MP2	Father of Harry	M	b. March 1980
P	Mother's partner at time of incident	M	unknown

1. Introduction

1.1 Who are Jack and Harry?

1.1.1 The subjects of this Review are two brothers who are currently being looked after by the Local Authority. Although they suffered significant injuries earlier in their lives, they are now in foster care.

1.1.2 In order to protect the privacy of the children and other family members, everyone involved in the case has been anonymised using either initials, or in the case of the children, pseudonyms.

1.1.3 During the period with which this Review is concerned Jack and Harry were both living with their mother, FP, and at different times her male partners.

1.1.4 There is considerable evidence of domestic abuse taking place within their household, and the boys may well have been subjected to a frightening atmosphere of violence and hostility.

1.1.5 Some practitioners considered that the adult carers in Jack and Harry's life were living a chaotic lifestyle with frequent house moves across England which adversely affected the stability of universal services provision for the two children. The family were non-attenders at some vital child health assessment appointments for the children, and as a consequence it was sometimes difficult to ensure that the children were provided with adequate universal services.

1.2 Brief Summary of Circumstances Leading to the Review

1.2.1 The case in question was triggered by Jack being taken to the Emergency Department by FP in the early hours of Monday 7th September 2015.

1.2.2 FP reported that Jack had not been using his right arm for two days. He was noted to have a blood shot effect in both eyes, bruising and swelling around his right wrist, and old bruising to his head and face. Jack was just under 2 years old at this time.

1.2.3 His baby brother, Harry was also taken into hospital a short while later and he was also examined by a Doctor after a Police Officer was suspicious about how the injuries occurred. The examinations showed that Jack had a fractured arm, multiple bruises including bruising to his

nipple and bruising to the back of the head. Harry was X-rayed and was also found to have a historical fracture to his arm.

1.2.4 It was the view of West Mercia Police that the children had been victims of criminal assault, and FP and her partner (P) were arrested on suspicion of causing grievous bodily harm and child neglect.

1.2.5 Jack had previously been made subject of a Child Protection Plan in October 2013 under the category of physical abuse but the plan was discontinued at a Child Protection Conference in February 2014.

2. Process of the Review

2.1 The Statutory Basis for Conducting a Serious Case Review

2.1.1 The Government guidance, *Working Together to Safeguard Children* (2015), mandates when and how Serious Case Reviews (SCR) should be conducted. This case met the mandatory criteria for carrying out a Review because abuse or neglect of a child was known or suspected, a child had been seriously harmed and there was cause for concern as to the way in which the authority, their Board partners or other relevant persons worked together to safeguard the child.

2.1.2 LSCBs may use any learning model for an SCR, including 'systems methodology', and in this case the Board decided to implement the systems methodology provided by the Significant Incident Learning Process (SILP).

2.1.3 The key principle of SILP is the engagement of frontline staff and first line managers in conjunction with members of LSCB Serious Case Review Panels or Subcommittees. The process focuses on understanding *why* someone acted in a certain way. It highlights what factors in the system contributed to their actions making sense to them at the time. This process is NOT about blame or any potential disciplinary action, but about an open and transparent learning from practice, in order to improve inter-agency working. Importantly, it also highlights what is working well and patterns of good practice.

2.1.4 The process includes:

- Individual agency reviews being commissioned by the LSCB

- A Learning Event comprising the relevant practitioners, managers and Safeguarding Leads coming together for a day
- A Recall Event at which the first draft of this Overview Report is debated.

2.2 Independence

2.2.1 Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed. To ensure transparency, and to enhance public and family confidence in the process, the TWSCB Chair appointed two independent people.

Ms Donna Ohdedar – SILP Lead Reviewer and Review Chair

2.2.2 Donna Ohdedar is Head of SILP and is a safeguarding advisor and trainer. She has been involved in child and adult safeguarding and domestic homicide reviews.

John Fox MSc, PhD. – SILP Lead Reviewer and Report Author

2.2.3 John Fox is a Senior Lecturer at the University of Portsmouth and previously was the Head of Public Protection in a large police force. He has conducted many SCRs as Independent Overview Report Author, is trained in SCIE and SILP systems review methodology, and has completed the 2010 NCH/NSPCC national training for SCR authors.

2.3 SILP Agency Reports

2.3.1 Although Individual Management Reviews are no longer required under Government guidance, the SILP process includes individual agency reports.

2.3.2 The following agencies and organisations were asked to contribute to the learning of this Review.

Telford & Wrekin Child Protection and Family Support Service
Telford & Wrekin Family Connect Service
Telford & Wrekin Safeguarding Advisory Service (Independent Reviewing Officers)

Worcestershire Children's Social Care (including health involvement)
Essex County Council Children's Social Care
Telford & Wrekin Children and Family Locality Services
Telford & Wrekin Legal Services
Health Visiting Service, Shropshire Community Health NHS Trust
North East London Foundation Trust (NEFT)
Basildon and Brentwood Clinical Commissioning Group
GP services, Telford & Wrekin Clinical Commissioning Group
Shrewsbury and Telford Hospital NHS Trust (SATH)
Shrewsbury and Telford Hospital NHS Trust Maternity Services
West Mercia Police
National Probation Service, West Mercia
Youth Offending Service, West Mercia
Telford & Wrekin Drug and Alcohol Rehabilitation Service
Adult Mental Health Services, South Staffordshire and Shropshire Foundation Trust

2.4 Learning from Practitioners

2.4.1 The Government guidance includes as one of its key principles, *"Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith".* It is concerning that despite this Review focusing very much on decisions made, and action taken, by Children's Social Care both in Telford and Wrekin and Worcestershire, the respective Agency Reviewers initially reported that they could not interview the Social Workers and Managers involved with the family as they no longer work for the Local Authority. After a further request at

the Recall Day the main Telford and Wrekin Social Worker (SW1) was traced and she agreed to contribute to the Review. The resulting interview provided extremely valuable learning, particularly concerning the context within the Child Protection Team at the relevant time. Nevertheless, the Independent Reviewer feels that more should have been done by the two Local Authorities to try and trace the other former practitioners and Managers, and to invite them to contribute to the Review if they wished. No-one, whether they are still employed in the area or not, is compelled to assist in the learning for a Serious Case Review but practitioners deserve the opportunity to contribute and to explain the context in which they worked. This Review would certainly have been better informed had the voice of the Social Workers and their managers been more fully heard and TWSCB should try and avoid this information gap in any future SCRs.

2.4.2 To help ensure that all practitioners involved in the case had the opportunity to be fully involved in the SCR learning, a practitioner's Learning Event was held on 17th March 2016 and a Recall Day, to which the same participants were invited, was held on 27th April 2016.

2.4.3 On the day, 18 practitioners attended the Learning Event and 15 attended the Recall Day and their contributions helped inform the learning and analysis in this Overview Report.

2.5 The Voice of the Family and Significant Others

2.5.1 The statutory guidance *Working Together* (2015) requires that families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. A commitment to providing the fullest opportunity for the family to be invited to participate in the review was agreed at the first Panel meeting.

2.5.2 Repeated attempts were made to engage with the Mother and Grandmother of the two children but the Grandmother declined. The Mother on the other hand did agree to meet the Independent Reviewer at her home. The Reviewer and a Board Officer arrived at the prearranged time but a male person answered the door and said that the Mother was not in. Later enquiries by her case worker indicated that she said she had forgotten about the meeting. Due to the tight timescales for completing the Review it was not possible to attempt a further appointment so regrettably, this Review is not informed by the voice of the family.

2.6 The Parallel Criminal Justice Proceedings

2.6.1 Many SCRs are delayed, sometimes unnecessarily, because of a request by the police or CPS to avoid holding practitioner events or interviews or to engage with the family. In their 2015 annual report, the National Panel of Independent Experts on Serious Case Reviews were critical of the fact that many SCRs were not being completed within the appropriate timescale.

> *"The panel is also concerned about delays. Many SCRs still seem to take a very long time to progress to conclusion and publication."*

2.6.2 It is therefore worthy of note that in respect of this SCR the Senior Investigating Officer and other members of West Mercia Police were very supportive of the review process, and they were also conscious of the need to complete the work quickly so that the learning could be disseminated. As such neither the Police nor the CPS asked for any restrictions or delays to any part of the process and this has assisted greatly in producing a timely Overview Report.

3. Brief summary of key events

This section is designed to summarise the key relevant information that was known to the agencies and professionals involved about the parents, and the circumstances of the child. Since the review is primarily concerned with Jack and Harry, only events which may have affected them, or the capacity for adults to look after them, have been included in this section.

3.1 Significant events before Jack was born

3.1.1 Certain facets of FP's background and early life were extremely significant for practitioners working with her. These key events include:

- Between June 2008 and May 2011 FP she was subjected to child protection incidents on eight occasions, and she spent a period in local authority care. These incidents included witnessing her parent's domestic violence, and being a victim of serious sexual assault.

- In 2010 the Youth Offending Service became aware of FP's alcohol dependency syndrome and misuse of drugs.

- August 2012, FP was victim of an assault by MP1 who poured petrol over her saying he would set her on fire and also held a large kitchen knife to her throat.

- Further incidents of domestic abuse involving FP and MP1 occurred during the latter part of 2012 but she was reticent to engage with agencies. Despite at least 5 incidents of domestic abuse to which the police were called, FP refused to support the police in prosecuting MP1 and she continued to live with him.

- August 2013, Worcester Midwifery reported to Worcestershire CSC that they had concerns with FP's lack of honesty and her understanding about domestic abuse.

- September and October 2013 further domestic abuse incidents occurred between MP1 and FP. At that time, she was around 20 weeks pregnant with Jack.

- Worcestershire CSC convened an Initial Child Protection Conference on 17th October 2013. The outcome was that the unborn baby, Jack, was made subject of a Child Protection Plan.

3.1.2 On 14th December 2013, Jack was born at the Royal Shrewsbury Hospital. It is of note that when Jack was born, FP was 19 years old. She was a young, first time single parent of a baby.

3.2 The period after Jack was born

3.2.1 Following Jack's birth, he and FP stayed with the Maternal Grandmother.

3.2.2 The first Core Group meeting in relation to the Child Protection Plan was held on 12th December 2013. A second Core Group meeting was cancelled and a further Core Group was convened on 31st January 2014.

3.2.3 A review Child Protection Conference was held on 3rd March 2014. The decision of this conference was to discontinue Jack's Child Protection Plan.

3.2.4 On 6th April 2014, T&W CSC closed the case. A few days after the decision to discontinue the Child Protection Plan, but before the case was closed, there was a domestic argument involving the Grandmother and he was taken by FP and MP2 to live in Essex.

3.2.5 Jack and FP moved back to Telford in June 2014, reportedly after an argument with MP2's sister. In July or August 2014, FP became pregnant with Harry and MP2 was declared as the Father.

3.2.6 On 3rd April 2015, Harry was born at Princess Royal Hospital, Telford.

3.2.7 FP retrospectively reported to Police that MP2 had assaulted her sometime in May, when he put his hands around her neck, applying pressure, and then followed her into the house where he held a knife to her throat.

3.2.8 At some unknown point in May or June 2015, the family went back to stay in Essex but on 7th July 2015 T&W CSC received a telephone call from their counterparts in Essex to the effect that FP and Harry had returned to Telford again following a domestic abuse incident at MP2's house in Essex.

3.2.9 In early July 2015, T&W CSC received information from MP2's sister that FP was now living with a new male partner (P). Children's Social Care were concerned about the risk he may pose to the children.

3.2.10 Jack witnessed a domestic abuse incident on 12th July 2015 at Wellington Railway Station when MP2 brought him to FP from Essex.

3.2.11 Jack was admitted to Princess Royal Hospital in Telford at about 1.30am on Monday 7th September 2015 where both children were discovered to be seriously injured.

4. A Day in the lives of Jack and Harry

4.01 In his 2009 report Lord Laming made the observation:

"Professionals can find it very difficult to take the time to assess the family environment through the eyes of a child or young person. The failure to see the situation from their perspective and to talk to them was highlighted in Ofsted's first annual report of evaluations of Serious Case Reviews. Staff across frontline services need appropriate support

and training to ensure that as far as possible they put themselves in the place of the child or young person and consider first and foremost how the situation must feel for them."

4.02 During the 18 month period covered by this Review Jack moved home on at least 4 occasions. He lived with a variety of different adults including his mother, Grandmother, MP2, P, and various relatives of MP2. The atmosphere in the household was often tense and aggressive due to the high prevalence of domestic abuse.

4.03 Because the Review was unable to hear from the family it was difficult to establish what the daily routine was like within the home when the children lived there but when the Health Visitor visited the home for the pre-arranged visits, she reported that she always saw the children and mother in the lounge, the lounge was warm, carpeted and furniture was in good repair. The Health Visitor did not see where the boys slept, but recalls FP holding Harry during the visit and Jack playing in the room. The lounge and kitchen were open plan. Age appropriate toys were evident and the older child played, appeared happy (smiling) and came to FP and interacted as would be expected. The kitchen and lounge area were seen and nothing stood out to the Health Visitor as unusual.

5. Analysis of Key Episodes and the Lessons Learnt

5.0.1 Jack and Harry were both 'visible' children in the sense that they were seen appropriately by many professionals including Midwives, Health Visitors, GPs, and Police Officers. Social Workers from Telford & Wrekin, Worcestershire, and for a short time Essex, were involved with the family, and there were two periods when an Initial Assessment was carried out and a short period of a few months when Jack was made subject of a Child Protection Plan. This latter period is subject to considerable analysis in this Report but suffice to say at this point there was a divergence of views between Social Workers from two different Local Authorities as to how safe Jack was living with FP, and the headline conclusion from this Review is that this was a key period in Jack's life when better safeguarding options should have been put around him. Decisions, based upon flawed reasoning, made by Telford & Wrekin Children's Services in early 2014 in respect of Jack, may have had a profound influence on the lives of both the children. Ultimately those decisions may have contributed to the fact that for many weeks in the late summer of 2015 Jack and Harry were suffering pain having been seriously physically abused whilst no professionals were actively

visiting the family home, or monitoring the children, or a violent adult man who had come into their household.

5.0.2 The focus of this review is on the children and their welfare, and this analysis will concentrate upon the following case specific questions prescribed by the Terms of Reference:

- How well did assessments inform decision making and how visible were assessments?
- Were the children's 'voices' heard, (including an understanding of their lived experience)?
- How was the family history incorporated into assessments? Were assumptions made in the absence of assessments?
- To what extend did practitioners consider the impact of domestic abuse on the children?
- To what extent did practitioners 'Think Fathers/partners'?
- How effective was the child protection planning process, including core group working?
- Was the decision to step the case down appropriate?
- What was the quality of information sharing including the making of referrals?
- Were arrangements for the children appropriate upon admission and during their stay in hospital?
- What effect did mother's lack of engagement have in this case?
- The transition arrangements between local authorities.
- Examples of good practice, both single and multi-agency.

5.0.3 The remainder of this analysis section covers 7 key learning periods or themes, and will examine whether there was any reasonable possibility that an agency or individual professional could or should have been able to predict the events which occurred in September 2015.

5.1 Awareness of male partners and domestic abuse

5.1.1 During the 2 year period covered by this Review, it is now known that FP and her children had lived with 3 separate male partners, MP1, MP2 and P. All these men were violent and were perpetrators of domestic abuse. P was arrested by the Police on suspicion of causing grievous bodily harm to Jack and Harry.

5.1.2 Whether or not the children actually witnessed domestic violence, there is every likelihood that simply being in a household with a hostile, aggressive atmosphere between the adult carers would have been a

frightening and upsetting experience. For example, when Jack was admitted to the hospital in September 2015, the Police Officer noticed that Jack was 'silent' when P was present at the hospital yet, when he left, Jack's presentation changed in that he was happier and chatty. This is perhaps a small illustration but serves to suggest that every day, for the whole of their lives until removed into care, the two children were exposed to an adult domestic abusive relationship. That is not to say that there is evidence of specific incidents every day, (although plenty *are* evidenced) but, by her choice of partners, FP probably exposed Jack and Harry to a generally unpleasant atmosphere within their home. This section of the Report will examine whether professionals were aware of which male figures were caring for the children at any given time, and whether enough consideration was given to domestic abuse as a form of child maltreatment.

5.1.3 It is accepted that many new mothers may be apparently unattached, or may decide to bring up a child alone. However, in both pregnancies involving Jack and Harry the Fathers/partners were acknowledged and declared during the booking appointment and history taking, and in Harry's case the Delivery Suite Birth Register records 'partner' as being present for delivery. In other words, in both cases Midwives knew that a male figure was likely to be closely involved with the care of the new-born child.

5.1.4 In respect of Jack, Midwives were aware before the birth of extensive Social Care involvement, and they had attended multi-agency meetings where his Father, MP1, was reported to be a violent man. When Harry was born however, despite him being present at the birth the name of the Father was not recorded or sought, and no other information was known or sought about him by Midwives. Had some curiosity been shown, and information been sought about MP2, perhaps through Family Connect (the Children's Services Help Desk) there was information potentially available which would have been highly relevant to his capacity to act as a primary carer for Jack and Harry. Since 2008, MP2 had a history of Social Care involvement in a different county which centred around allegations over a long period of time of being physically abusive towards his previous partner's child, culminating in an occasion in 2011 when the child presented at hospital with fractures and bruising. Accessing this important information would not have been straightforward, and would have required firstly Midwives to ask for MP2's details, including the area he lived in, and then for Family Connect to contact their counterparts in that area. The question for this Review is whether it would have been reasonable, given the specific known circumstances of FP and Harry, for Midwives

to have begun the process of triggering such an enquiry about Harry's Father.

5.1.5 The need to be curious about male carers was highlighted by Brandon et al (2009) in one of the Biennial Analysis Reports of Serious Case Reviews:

"The failure to know about or take account of men in the household was also a theme in a number of serious case reviews. Assessments 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 histories of domestic violence or allegations of or convictions for sexual abuse." (Brandon et al, 2009)

5.1.6 This Review was informed by the Named Midwife for Safeguarding and Domestic Abuse that it is not normal practice for Midwives to access any health records or to contact the GP of a baby's father or partner, unless they have given their express permission. Whereas it is fully accepted that the *routine* checking of all male figures is not necessary and would be overly intrusive, it is important that the threshold for acting on professional curiosity and seeking further information about all potential carers of a baby is not set too high by Midwives. It is also very important that the perceived need for 'express permission' from the father or male carer is not seen as a barrier to good information sharing. If there is a perception amongst Midwives that they are not able to access paternal notes then this perception is wrong, and should be dispelled. Midwives can access paternal notes if necessary – with or without consent.

5.1.7 Sometimes a poor interpretation of the Data Protection Act 1998 can create a barrier to checking information and it would be useful to draw from Lord Laming's (2009) report in which he pointed out that data protection laws rarely, if ever, prevent professionals from accessing information which could help safeguard children. '*Whilst the law rightly seeks to preserve individuals' privacy and confidentiality, it should not be used (and was never intended) as a barrier to appropriate information sharing between professionals. The safety and welfare of children is of paramount importance, and agencies may lawfully share confidential information about the child or the parent, without consent, if doing so is in the public interest*' (Laming, 2009). There is no need for a full blown child protection concern to allow information sharing between professionals; a '*public interest'* has been

interpreted (Laming, 2009) as simply being *'the promotion of child welfare.'*

5.1.8 It is good practice in Telford and Wrekin that when complex needs have been highlighted to the Safeguarding Midwife these cases are discussed at the Vulnerable Women's Group (VWG) when women are approximately 24-30 weeks gestation. This is a multi-agency meeting where agencies are encouraged to share information to support women and their families through early help, and the system was established in 2009 after a recommendation from an earlier Serious Case Review. The Named Nurse from the Acute Trust who attends this meeting will search for more information on the electronic health record system (SEMA) about the members of the family which will then be shared during the meeting, and if necessary further information will be sought from Children's Social Care via Family Connect.

5.1.9 The fact that any complex case is brought to the Vulnerable Women's Group demonstrates a positive 'think family' approach rather than an emphasis on the mother alone being seen as the client for Midwives. It is also encouraging to report that at the Recall Day the practitioners confirmed that there is a good culture of information sharing in Family Connect, and that if a request is made by Midwives for information about the father of a child, Family Connect would be prepared to carry out a check and share relevant information even in cases where there is merely a 'welfare concern' rather than a full 'child protection concern'.

5.1.10 This philosophy fits in with the spirit and interpretation of the law as suggested by Lord Laming in his 2009 Report in which he also firmly reminded us about the role of fathers within parenthood. He stressed, *'parenthood incorporates not only rights but also responsibilities: it is a lifetime commitment. Particular mention should be made of the part to be played by fathers.'* The spirit of this comment seems to be that with fatherhood should come an acceptance that one's own personal rights to privacy will be subordinate to the responsibility that one's child is properly safeguarded.

5.1.11 The practice in respect of the two pregnancies was different in the sense that during the first pregnancy the family was correctly discussed at the VWG and full information sharing took place. When FP became pregnant with Harry however, although complex social issues were identified including the fact that his brother had been subject to a Child Protection Conference, the Midwives did not consider it

necessary to add an alert to the Maternity Information System (MIS), and consequently there was no multi-agency discussion at the VWG. As discussed above, MP2 was visible at the birth yet no steps were taken to find out more about him. Because this was far from a straightforward family this Review concludes that more professional curiosity should have been demonstrated by Midwives. Certainly, the family should once again have been discussed at the VWG, and had that happened there is a good chance that professionals would have discovered the information (outlined above) that 3 years beforehand, MP2 had been subject of allegations of violence towards a child.

5.1.12 Learning for Midwives from this Review should include a reminder that whereas in most cases it is not necessary to carry out further checks on the father of a child, they should always 'think family' and be prepared to seek information on all potential carers of a baby if they feel it would help to promote the welfare of the child, and in particular that the fathers in potentially vulnerable families, or those with complex social needs, will be subject to the same level of enquiry as mothers.

Recommendation 1

TWSCB should be concerned about a perception by midwifery staff that they cannot access relevant notes of the father of a child without 'express permission'. It is recommended that after a review of the legal position is undertaken, the Independent Chair writes to the Chief Executive of Shrewsbury and Telford Hospitals NHS Trust to seek reassurance that caregiving fathers in potentially vulnerable families will be subject to the same level of enquiry as mothers.

5.1.13 The domestic abuse charity Refuge, has warned about the detrimental effect domestic abuse may have on children by saying that:

> *The physical, psychological and emotional effects of domestic violence on children can be severe and long-lasting. Some children may become withdrawn and find it difficult to communicate. Others may act out the aggression they have witnessed, or blame themselves for the abuse. All children living with abuse are under stress*
>
> *(http://www.refuge.org.uk)*

5.1.14 At the midwifery booking appointment before Jack was born, a medical and social history was taken. FP disclosed that she had been involved with social services as a child when she said she had behavioural problems, but was having no ongoing involvement. It was good practice that, because of this disclosure, the Midwife contacted Family Connect for more information. The Social Worker on the help desk shared further information that FP was already known to social work teams in Telford and Kidderminster and that there was a history of domestic abuse in 2012 when MP1 had poured petrol over FP and threatened to set her alight, and also threatened to kill her using a knife against her throat. Although the Social Worker indicated FP was no longer with him, which was probably incorrect, it is clear that from the moment they started to work with FP, Midwives were well aware that she had been the victim of extreme domestic abuse, and that there was a very abusive man connected to the household.

5.1.15 Midwives then correctly documented that FP had been a victim of domestic abuse and an alert was added to the Maternity Information System to highlight to all maternity professionals that there were complex social issues. As described above, during this first pregnancy the family was appropriately discussed at the Vulnerable Women's Group.

5.1.16 When FP was about 20 weeks pregnant a Midwife was made aware that FP had moved to Kidderminster which is where MP1 lived. Contact was made with a Worcestershire Social Worker who had been allocated the case and the Midwife also made contact with the Kidderminster midwifery team to highlight the risks regarding FP's return to the perpetrator of domestic abuse.

5.1.17 It was important that this communication was carried out because FP denied to Midwives in Kidderminster that she had been a victim of domestic abuse so the fact that they were already armed with contrary information enabled them to assess the FP's general veracity and the safety of the unborn child. It was this denial being shared with Worcestershire Children's Services that contributed to their decision to convene an Initial Child Protection Conference before Jack was born.

5.1.18 The concern of domestic abuse was the main factor causing the escalation the case to a Child Protection Conference and therefore, it is very positive that well before Jack was born, Worcestershire Children's Services were making plans to protect him and mitigate the effect of the abusive relationship that FP was at that time having with MP1. It is acknowledged by that Authority that more should have been

done to try and engage FP with domestic abuse support through 'Women's Aid' to help her understand the risks, and had she not moved out of the area to Telford before the Child Protection Plan had taken effect this may have been done. In fact, Worcestershire Social Care were considering with their Legal Team the possibility of seeking an Order to share Parental Responsibility and, if necessary, remove the baby, once born, to a safe environment. The note from a Team Manager sent with the file to Telford when FP moved away was unequivocal, saying, *'It will need to be stressed to* FP *that should she decide to resume her relationship with the baby's Father, it is almost certain that Telford/Worcestershire Children's Services will have no option but to remove her child as the risks of immediate physical harm are too great.* FP *will need to co-operate with agencies in order to ensure some safety and stability for herself and her child."*

5.1.19 It is clear that in respect of Midwifery Services in Telford and Kidderminster, as well as Children's Services in Worcestershire, they were very cognisant of the risks posed by MP1 because of his domestic abuse attacks, and a plan was in place to remove Jack from the abusive environment if FP persisted with the relationship.

5.1.20 Later in this Report there will be a full analysis of the transfer between Worcestershire and Telford but suffice to say at this point, in the context of domestic abuse, at the 'receiving in' Child Protection Conference held in Telford a few days before Jack was born, domestic abuse was certainly discussed, but delegates at the SILP Learning Event commented that in their view it was, "*played down as being an important issue*". This is in stark contrast to the weight given to it by Social Workers in Worcestershire and an exploration as to why that may have been the case is found in a later section of this Report.

5.1.21 The clear documentation and recognition of domestic abuse by Midwives when Jack was born was undoubtedly beneficial a few months later when FP became pregnant with Harry. At the booking appointment for Harry's birth, a different Midwife took the medical and social history and all the historical information about the family and domestic abuse with the ex-partner was available. However, FP disclosed she was with a new partner, who was Harry's Father, and there was no longer any Social Care involvement. This was correct because the Child Protection Plan around Jack had been discontinued a year before and the case was closed, so an assumption was made by Midwives that that there were no significant safeguarding concerns and a further social assessment was not offered. This was an over-optimistic assumption by the Midwife and, as discussed above, little or nothing was known by Midwives about the Father of Harry. In view of

the significant history of domestic abuse involving the Mother, the fact that her older child had been on a Child Protection Plan, and the fact that at this time she was just 20 years old, more professional curiosity should have been shown as to whether she had entered into another abusive relationship.

5.1.22 The Police Agency Reviewer provided a thorough analysis of the Police response to the many domestic abuse incidents, and in general it is felt that during police engagements with the family risk assessments were completed and utilised to assist police in providing support and referrals to FP and children. DASH risk assessments[1] were completed and passed within the relevant departments within the police for example the Domestic Abuse Officer and Protecting Vulnerable People unit.

5.1.23 The Police were frustrated in their efforts to prosecute the men who were abusing FP because she would, in almost every case, fail to support the prosecution. However, the Police acknowledge that an opportunity to take the case to Multi Agency Risk Assessment Conference (MARAC) was missed when information could have been shared, regardless of FP's reluctance to engage. The nature of the domestic incidents and the repeat victimisation should have led to a referral to MARAC. This process could have shared details of FP's domestic situation, to better inform each respective agency as they sought to provide care and support for FP and her children. This could also have resulted in greater encouragement for FP to break the cycle of domestic abuse and provide a better and safer environment for her children.

5.1.24 This Review has sought to establish why the Police failed to discuss the family at a MARAC meeting and it was accepted by Police delegates at the Practitioners Recall Day that this was an opportunity which was missed - probably because the family were frequently moving from area to area and FP refused to engage with the Police as a victim of domestic abuse. The Police fully acknowledge that the nature of the domestic incidents and the repeat victimisation should have led to a referral to MARAC, whether or not FP was co-operative, and they stressed that the referral process for MARAC is now much more robust and consistent with all medium and high risk cases being assessed by a specialist Domestic Violence Officer and referred for a

[1] The introduction of the new Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model means that for the first time all police services and a large number of partner agencies across the UK will be using a common checklist for identifying and assessing risk. The Police nationally accredited the DASH (2009) Model to be implemented across all police services in the UK from March 2009.

MARAC. A key learning point arising from this Review has to be that if there are children resident within the household they are also indirect victims and the decision to refer for MARAC must be based upon *their* needs as well as the direct victim of the violence/abuse.

5.1.25 The policy within West Mercia Police complies with national College of Policing guidelines in that they always refer children who are part of domestic incidents to Children's Services and a referral is also made in respect of any domestic incident where children are present, or where children are known to part of the family group, regardless of the established risk level. This is good practice and in respect of each individual incident during the relevant period of this Review there is evidence that such referrals were made appropriately by the Police.

5.2 The context within Children's Social Care in 2013

5.2.1 A considerable element of the analysis in the sections which follow revolves around the services provided by Telford and Wrekin Children's Services to Jack, Harry, and the adults responsible for their care. This Review is grateful for the contribution by the key Social Worker (SW1) who was holding the case during 2013, and then again when the family moved back to Telford after their short stay in Worcestershire. This particular Social Worker made decisions and judgements which have attracted critical comment in the Report but in order to put those comments into context it is very useful to have a first-hand perspective of what she felt it was like working in Children's Services at that time. It is important to note however, that this is a single person's view and some of her perceptions, particularly concerning difficult workflow, recruitment issues and over-reliance on agency staff, are challenged by the Local Authority as being unjustified.

5.2.2 This short section is informed by the interview with SW1 carried out for this Review and this social worker feels that due to a lack of adequate supervision and an overly high case-load she was not able to carry out her role as effectively as she would have liked. Although some of her feelings about her working environment are supported by the Agency Reviewer and some delegates at the Practitioners Events, most of those delegates were not in post at the time so their view might not assist in determining how the Children's Services teams were operating during the relevant time. It is also important to note that Telford & Wrekin's Children's Services was inspected by Ofsted in 2013 and this detailed and robust inspection did not identify systemic failing at the time, nor has systemic failing since been identified.

5.2.3 SW1 was an experienced agency Social Worker, which meant that although she had worked in Child Protection for 16 years she was not directly employed by, or trained by the Local Authority. She began working in Telford from 2011 and left in 2015. During the relevant time, SW1 worked in what was then known as the Child Protection Team, and all new CP referrals were dealt with in this team, and their work included Initial Assessments, Section 47 investigation's, preparation of Initial Child Protection Conferences and court reports.

5.2.4 At the Recall Day, Social Care delegates explained that the structure in place during 2013/2014 consisted of a small Child Protection Team (to which SW1 belonged) and 3 'Long Term Teams' whose function was to take on cases post CP Conference. It was reported that there was a problem with retaining Social Workers in the Child Protection Team which led to a high proportion of agency workers being employed to fill the gaps. The agency workers had a mixed degree of competence, and because they could leave with just a week's notice the continuity of cases was sometimes difficult to achieve. However, further evidence provided to the Review by Children's Services indicates that in fact the overall proportion of agency social workers employed in Telford and Wrekin Children's Services was around 7% (which was under half the average for the West Midlands area), however it is not known what proportion of agency workers contributed to the frontline workforce in SW1s specific team.

5.2.5 During her interview, SW1 stated that the feeling within the Child Protection Team was that it was the Service Area's "*dumping ground*", with the points of transfer out of the Team being "*too woolly*". She explained that Social Workers were holding cases for far too long and the majority of workers had allocations of 50+ cases. (To put this figure into context, a survey conducted in 2012 by the Social Care professional journal *Community Care* revealed that the average number of cases held by Social Workers across the UK was 25). The perceptions of SW1 about her workload are only partially supported by the evidence. Records have since been checked within Telford & Wrekin Council Organisational Delivery and Development, which show that some workers had 30+ cases. Senior managers at the Council have stated that some of this may have been down to open referrals where the case was inactive and had not been closed down. The average caseload in March 2013 was 11.7 cases; in December 2013 it was 15.8 cases. The caseload of SW1 who contributed to the Review was 14 cases in January 2013; 15 cases in March 2013; there was a spike to 45 cases between June 2013 to January 2014 – of which 22 were open referrals.

5.2.6 SW1 also expressed her view that the whole service area was "*bogged down*", and that the management of cases became a "*numbers game*" of getting cases turned around and closed as quickly as possible. This latter point is of great relevance to an analytical discussion concerning the closing of Jack's case which will appear later in this Report.

5.2.7 Effective safeguarding work relies largely on good supervision and oversight by experienced managers, indeed, in his Report into the death of Victoria Climbié (2003) Lord Laming remarked, *"Supervision is the cornerstone of good social work practice"*. As will be discussed in later sections, some of the decision making concerning Jack was poor and it is important to recognise that all key decisions should have been ratified by SW1's Team Manager. During her interview, SW1 was asked to explain the situation regarding her own supervision.

5.2.8 She told the Review that she thought the visibility of Senior Managers was low, and that they seemed to be having to cope with managing other things going on in the wider organisation. In terms of direct supervision SW1 recalled it being once every two months whereas the practice standard at the time, (and now), is that supervision sessions should take place every 4 weeks. SW1 explained that the Social Workers did not see the supervision notes, but that they were explained by the Team Manager and placed on the child's file. During the interview Jack's file was checked by the Reviewer and in fact only one supervision record by a Team manager was found to be on the file. This is an indication that SW1 was provided with supervision even less than her recollection of it being every 2 months. Such scarce supervision is inadequate and highly concerning, and this may serve to explain why some decisions were flawed in respect of Jack. Delegates at the Recall Day explained that at the time the supervision ratio was around 9 Social Workers to 1 Team Manager, (instead of a desired ratio of 4 to 1), and that supervisors did not have enough time to give effective managerial oversight. This concurs with SW1's recollection which is that she believed there were not enough Team Managers within the service to provide good oversight of cases.

5.2.9 In respect of the specific Team Managers, SW1 worked with two whilst on the Child Protection team. She thought that her first manager was both experienced and managed the Team well, but felt that the other lacked Child Protection experience and there was conflict in her relationship due to SW1's frustration with this Team Manager's decision-making which SW1 occasionally disagreed with. Regrettably,

the Team Managers were not contacted and asked for a contribution to this Review and as such the Report is unable to provide a balanced discussion about whether or not SW1 was adequately supervised.

5.2.10 The evidence provided to this Review from Social Care delegates at the Recall Day is that the Service is now much improved. There is a new structure in place in terms of the teams, and a better supervision ratio. However, when reading the themed analysis below, and in particular the sections dealing with decision making by Children's Services, it is important to reflect upon these paragraphs to understand that the key Social Worker, SW1, felt that she was floundering under a heavy case load which she was pressured into reducing by closing cases at the earliest opportunity, and that she had almost non-existent supervision whilst managing a very difficult and high risk case involving a child who had been newly born into a family with many critical social problems, and a strong element of domestic abuse.

5.3 The first Initial Assessment

5.3.1 During the relevant period of the current Review, the first occasion that FP came to notice of Children's Services was on 6th June 2013. A Midwife contacted Family Connect stating that the Mother had returned to Telford to live with Maternal Grandmother following a DV incident with her partner in Kidderminster. At the time FP was fifteen weeks pregnant with Jack.

5.3.2 An Initial Assessment[2] (IA) was carried out by SW1 and completed on 25th June 2013. Within the analysis it stated that FP had told the Social Worker that she was not going back to live with MP1, that she had good quality family support, and that she would engage with the Freedom Project (a domestic abuse support group). This information was accepted and no further action was recommended.

5.3.3 During her interview for this Review, a more detailed picture emerged about how SW1 viewed the case at the time. She remarked that she was concerned about FP's relationship with MP1, and the level of violence involved, and she thought that FP was easily led but could also be quite stubborn. On the other hand, FP seemed receptive to social work intervention and understood Social Care's concerns about her continuing relationship with MP1 and that she had ended that

[2] Under the framework set out in the *Framework for the Assessment of Children in Need and their Families* (2000), the initial assessment is meant to be simply a short assessment of a child referred to Children's Services focusing on establishing whether the child is in need or whether there is reasonable cause to suspect that the child is suffering, or is likely to suffer significant harm.

relationship. It was SW1's view that FP had a very supportive family and she spoke regularly to the Maternal Grandmother who also participated in the meetings concerning FP and Jack. In terms of the Grandmother's previous history with Social Care, SW1 stated she was not aware of it, and neither did she not seek any information from the Youth Offending Service. Within the initial stages of working with FP, SW1 said that the Freedom Project had been discussed and FP originally said she would engage with the project but later refused, saying she was not ready.

5.3.4 It is considered by the T&W Children's Services Agency Reviewer that this initial referral was dealt with in a reasonable and timely manner and that the IA was completed within the required timescales. There was however information available at the time (i.e. FP being subject of a Youth Rehabilitation Order) that should have cast doubt on the assumption that there was good family support. In addition, the apparently unreserved acceptance that FP had ended her relationship with MP1 seems unduly complacent and raises concerns about SW1's understanding of the nature of domestic abuse relationships. She would have been aware of the extreme incident in 2012 when MP1 had poured petrol over FP and held a knife to her throat, so for FP to still be in a relationship with him during 2013 should have made SW1 sceptical that the relationship had actually ended, and certainly more should have been done to test that hypothesis. Indeed, during her interview for this Review, SW1 acknowledged that she was not surprised to later discover that FP was still contacting MP1 via Facebook, but at the time she finished the IA she thought that the Grandmother was honest and could be relied upon to tell Social Care if she had any concerns about her grandson.

5.3.5 The reliance on the Grandmother was over-optimistic and this Review supports the view of the T&W Child Protection and Family Support Agency Reviewer that the Initial Assessment should have been moved onto a Core Assessment[3] rather than being closed with no further action, so that a more in-depth look at FP and her relationships could have been explored.

5.3.6 Since Jack was due to be born in a few months' time it was crucial to know if MP1 was in fact still within the family sphere during the pregnancy. With this first Initial Assessment there was a lost

[3] A Core Assessment is an in-depth assessment carried out by a Local Authority. Its purpose is to clarify and identify the needs of the child by gathering information to gain a greater understanding of a child's circumstances. One of the main principles of a Core Assessment is that it is a multi-agency assessment, incorporating the specialist knowledge of all the professionals working with a child and their family.

opportunity to move onto a Core Assessment and provide a more in-depth analysis of FP's relationship male figures and to begin to understand mother's experience of parenting and whether her family did actually offer good support to her and her children. Although it is unhelpful to use hindsight in a Review such as this, it is of relevance that four weeks after closing Children Services involvement, a further referral was received indicating that mother had, in fact, been maintaining contact with her violent partner and not been honest about it, so had a Core Assessment been conducted this assessment would have probably still been taking place at the time of this incident.

5.4 The Child Protection Plan and Conference Decision Making

5.4.1 This section of the analysis will consider the period just before and after Jack's birth when he was placed on a Child Protection Plan for a short while. As required by the Terms of Reference, this section will also discuss the transition arrangements between the two Local Authorities.

5.4.2 In August 2013, Worcestershire Children's Services received a referral from their counterparts in Telford to the effect that FP, who was pregnant with Jack, had moved into the Worcestershire area. Information was provided that there were concerns of substantial domestic abuse, such as FP being hit by the Father of the baby, MP1, and having petrol poured over her. The referral stated that mother had resumed a relationship with MP1 and moved into Worcestershire.

5.4.3 At the time, FP was engaging well with Midwifery Services while she was living in Telford, attending all her appointments or informing them when she was unable to attend. Between 20 to 31 weeks gestation FP moved to, and remained in, Kidderminster under the care of the Kidderminster Midwifery team and there was close liaison between the Telford and Kidderminster Midwifery teams regarding ongoing care. However, Worcester Midwifery reported to their local Children's Services that they had concerns with FP's honesty and her understanding about domestic abuse. Specifically, Midwives were aware that the domestic abuse incidents had taken place but despite being asked, FP refused to disclose information to them about previous domestic abuse incidents.

5.4.4 It is noteworthy good practice in respect of Midwives in Telford and Kidderminster that during FP's pregnancy with Jack there was a clear recognition and acknowledgment of her vulnerabilities, and in particular the risks resulting from the history of domestic abuse, the fact that FP had moved and wanted to get her own accommodation, and the fact that FP was a teenager. It is good practice that these

concerns were shared appropriately with Children's Social Care in Worcestershire and this helped inform their later decision to convene an Initial Child Protection Conference.

5.4.5 The actual trigger for the CP Conference was probably an incident of domestic abuse on 19th September 2013 when Police were called to a shop where FP and her partner, MP1, were shouting at each other. FP informed Police that she was 27 weeks pregnant and this incident was correctly referred to Worcestershire Children's Service by Police.

5.4.6 At this point Worcestershire Children's Service started an Initial Assessment based on the referral and concerns of FP's relationship with MP1 and the consequent risks to the unborn child. This Assessment led to a decision being made that the unborn child needed to be protected through a Child Protection Plan[4].

5.4.7 An Initial Child Protection Conference (CPC) was convened for 17th October 2013. It is noted in Children's Services files that the conference was attended by parents, grandparents, Police and Children Services. A Health Service representative was invited to the conference but did not attend which meant that representation from the agencies working with the family was inadequate. It is good practice that the Conference Chair did manage to get a view from the Health Service by making a telephone call to the Worcestershire Named Nurse for Safeguarding. In the end a unanimous decision was made that Jack should be subject to a Child Protection Plan under the category of physical harm as an unborn child. A key piece of information which emerged at this conference, and which should have been pivotal in all future decisions, is that FP said she is no longer in a relationship with MP1, the perpetrator of the domestic abuse incidents.

5.4.8 The Worcestershire Children's Service decision making up to this point was appropriate. Although concerns had been raised since August about FP and her unborn child, a period of assessment was reasonable in the circumstances and once it became apparent that the unborn child was still being subjected to an atmosphere of domestic abuse a correct decision was taken to bring the case before a CP Conference.

5.4.9 Shortly after the Initial CPC FP informed a Social Worker that she was moving back to Telford and would remain living there during and after Jack's birth. Once it became clear that Jack would be born in Telford, Worcestershire Children's Services informed their counterparts in Telford that the family were moving back into their area. They

[4] A child protection plan is the plan put together at a child protection case conference detailing the ways in which the child is to be kept safe, how his health and development is to be promoted and any ways in which professionals can support the child's family in promoting the child's welfare

informed Telford that Jack was on a child protection plan which would have to be managed by them.

5.4.10 The procedure in these circumstances is that the Local Authority 'receiving' the family needs to arrange a 'receiving in' Child Protection Conference in order to ratify the child protection plan (or discontinue it), and to set up a new Core Group in their area. The arrangements for the family's transfer from Worcestershire in to Telford were marred by a lack of prompt co-ordination between the two Local Authorities.

5.4.11 Worcestershire Children Services claim that a telephone conversation took place on 29th October 2013 between their worker and a worker from Telford and Wrekin Children's Services to advise that the unborn baby Jack was back living within the Telford area and that a 'receiving in' conference would be needed. However, an audit of the Telford and Wrekin Children's Services case files indicates that the request for a 'receiving in' conference was not actually received until 29th November 2013. Despite extensive enquiries it has not been possible for this Review to resolve the one month discrepancy in these dates. It is known that the family decision to move back to Telford was made known to a social worker in Worcestershire shortly after the 17th October 2013, and therefore whatever the reason, a delay of 6 weeks before the 'receiving in' conference was held, is not good practice and there was clearly some sort of breakdown, or delay, in communication between the two local authorities.

5.4.12 The 'receiving in' Conference was convened on 5th December 2013, about a week before Jack was born, and the Social Worker allocated to the case was SW1 who already knew the family. A consequence of the delay in arranging the conference was that it left little time for the new group of professionals who had to manage the child protection plan to co-ordinate their actions and understand the risks around the child and family. This conference was attended by FP, the two Social Workers from the respective local authorities, the Police and a Midwife.

5.4.13 At the 'receiving in' CPC it appears there was a stark difference between the two Social Workers from the respective Local Authorities about the way that FP was viewed, and the risk to which Jack may be exposed. FP shared that she was now living with her mother in Telford and had no plans to resume the relationship with MP1. The Telford Social Worker (SW1), who would thereafter be primarily responsible for co-ordinating the child protection plan, expressed very optimistic opinions about FP's ability to put her child before a violent partner. The conference was too narrowly focused on whether MP1 was still associating with FP, and there was also an over reliance on the

assumption that FP's mother would be a protective factor for the child. A Police report was read out to Conference, and other reports were also shared by the Police, which indicated several incidents of domestic abuse to which they had been called. The T&W Child Protection and Family Support Agency Reviewer expressed the view that '*There does not seem to have been any in-depth assessment of the pattern of relationships that mother had established both with partners and with her immediate family*'.

5.4.14 On the other hand, at the conference, the Social Worker from Worcester reported that they had huge concerns about the physical and verbal abuse to FP from MP1, and that FP did not accept the potential risks to the baby. Worcester Children's Services expressed concern that MP1 may come back into FP's life following the birth of the baby and suggested that they felt that legal proceedings should be considered due to the nature of the risk.

5.4.15 It is a conclusion of this Review that SW1 had, at that time, an over-optimistic view of FP's genuine willingness to work with Children's Services and to put her new baby first. As revealed in Section 3 of this Report, FP had a very troubled childhood, and from an early age she probably 'learnt' to be mistrustful of the authorities. To effectively work with her and the family, SW1 should have demonstrated a greater understanding of how FPs early life might have affected her willingness to truly engage in a partnership with professionals, and her basic honesty with them. There is a more detailed discussion later in this Report about the difficulties of working with parents who deceive professionals, but suffice to say at this point, it is possible that FP did not break off contact with MP1 at that point and in any case, very soon it became apparent that a new unknown male partner had entered her life.

5.4.16 The decision of the 5th December CPC was to continue to keep Jack on the Child Protection Plan instigated by Worcestershire. This was the correct decision, and on the basis that the Plan had been disrupted due to the move from Worcestershire to Telford, (and was therefore effectively starting again with a new Core Group), it is reasonable to accept that legal proceedings would have been premature at this time. However, a substantial period of time should have been allowed for the Child Protection Plan to achieve its aims and for FP's willingness to break her cycle of abusive partnerships to have been more fully tested.

5.4.17 The work carried out after the 5th December CPC was substandard. Jack was born on 14th December 2013 and remained in hospital for 10 days. As soon as he was discharged a Health Visitor became involved to provide targeted services to the family. Although

the 'receiving in' Conference was attended by professionals from most of the key agencies, it is of concern that the Health Visitor who would shortly be commencing universal service provision for Jack was not informed of, or invited to, the Conference. This was an error, and created an information gap in respect of that key service. Specifically, as one of the key 'eyes and ears' involved in managing the Child Protection Plan the Health Visitor should have known that she was about to work with a child about whom there were safeguarding concerns, in order to prepare for the New Birth Visit and to contact relevant professionals in Children's Social Care.

Recommendation 2

The TWSCB should seek reassurance from Children's Social Care that in respect of any pre-birth child protection conference, the relevant Health Visiting Service will automatically be invited.

5.4.18 An important element of a Child Protection Plan is that a Core Group of professionals is then created to work with the family, meet regularly and share information on progress and the welfare of the subject child.

5.4.19 It has been recorded in the T&W Independent Reviewing Officer (IRO) records that the first Core Group meeting was held on 12th December 2013 which was the day before Jack was born. A second Core Group meeting scheduled for 15th January 2014 was cancelled and the reason recorded was *'social worker attendance at Court'*. It is accepted that Court appearances are important but a Core Group meeting is an opportunity for all agencies working with the child and family to meet and it is disrespectful to other agencies for the meeting to be arbitrarily cancelled. In this case this was further compounded by the fact that no-one informed the Health Visitor that the meeting had been cancelled and she turned up to an empty room. The consensus view of delegates attending the Recall Day is that a Core Group meeting should always go ahead and if the Social Worker is unavailable another Social Worker should be designated to act as the Chair.

5.4.20 A further (and final) Core Group meeting was convened on 31st January 2014 and this was attended by FP, SW1, a Midwife and Health Visitor. This was the only multi agency meeting held following the

Jack's birth and prior to the Review CP Conference. The practice standard for Core Group meetings requires that they should be held every 4 weeks as a minimum. Jack had been on a child protection plan for over 9 weeks before the first Core Group meeting was held on 12th December which was far too long a period before the Core Group was assembled. This Review has not been able to discover why this was, but it can be speculated that the move by the family back to Telford, and the delay in organising the 'receiving in' CPC, were contributory factors. Because of the Court related cancellation there was then a 6 week gap before the other Core Group meeting on 31st January.

5.4.21 On 27 February 2014, a Review Child Protection Conference was held, and the delegates at the meeting unanimously agreed that Jack was no longer in need of a Child Protection Plan. It was noted at the Learning Event that even in the event of a unanimous decision by conference delegates, the Chair can override decisions made, although this is, and should be, a rare occurrence otherwise it would undermine the concept of shared decision making.

5.4.22 The decision of this Review CPC to discontinue Jack's Child Protection Plan was premature, and was largely based upon a premise that FP was no longer seeing MP1. In fact, even if she was not still with him it is likely that she had commenced a relationship with an older man, MP2, about whom nothing was known at that time. It is the view of the T&W IRO Agency Reviewer that the cycle of domestic abuse was not well understood or explored within the CPC discussion – particularly the research relating to the number of times a victim of abuse will often return to the relationship or the heightened risk to the victim at the point a relationship ends.

5.4.23 Before the Child Protection Plan was discontinued no assessment was completed on FP's ability to recognise and respond to risk in potential future relationships in order to keep herself and her child safe, and it was also reported FP was on anti-depressants and was planning to move out of the Maternal Grandmother's house and into her own accommodation. Although SW1 reported to the Conference delegates that FP had engaged with the CP plan, this was in fact incorrect because part of the plan was that she should access the Drug & Alcohol Recovery Service (DARS) which she had failed to do.

5.4.24 Bearing in mind this mother was still only 19 years old, she was a repeat victim of domestic abuse and alcohol/drug related problems and she was about to bring up her first child and remove herself from the immediate family support around her, it is the conclusion of this Review that there was ample reason to keep Jack on the CP plan for

several more months. However, even if those were not sufficient reasons, an indication emerged during the Conference that FP may be hiding a relationship with a male partner, and had that been confirmed, this should have thrown a great deal of doubt on FP's honesty with Children's Services and the safety of Jack.

5.4.25 During the Review CPC, FP stated that she had ended the relationship with MP1 several weeks earlier, and this was accepted at face value. MP1 did not volunteer that she was in any other relationship. An indication that FP may have been lying to SW1 and conference delegates came from the Police Delegate at the Review CPC who reported that someone driving FP's Mother's car had recently failed to pay for petrol at a filling station. Police records indicate that on 18th February 2014 (a few days before the Review CPC) FP's Mother was interviewed and she told Police that FP had been using the car but that FP had told her she had assumed that her 'boyfriend' had paid for the fuel. This was an indication that at that time FP was in a relationship with a male who may have been MP1 or MP2. The Police delegate at the Review CPC was vaguely aware of this verbal transaction and asked FP a direct question about it, but FP then claimed that it was actually her sister's boyfriend who was being referred to. This story should have been challenged at the time on the basis that since she apparently had been using the vehicle, why would FP have thought that her sister's boyfriend had paid for the fuel? The confusing tale may well have been a smokescreen and for some reason the discrepancy was not followed up yet, had more curiosity been shown, it would have been very easy to have deferred any decision making and check with the Police exactly what they had originally been told on 18th February.

5.4.26 If enough doubt had been raised that FP was in a relationship with either MP1, or an as yet unknown male, it is unlikely that conference delegates would have agreed to discontinue the Child Protection Plan at least until a proper assessment had been carried out concerning this new and unknown male figure in Jack's life. In fact delegates at the Learning Event expressed their view that had this information been checked out they would, in hindsight, not have agreed with the decision to discontinue the Child Protection Plan. Another view expressed by the Police and Health Visiting Agency Reviewers is that at the very least a 'step down' approach should have been adopted at the February CPC, which would have meant that Jack would have been considered a 'child in need' for a period of time rather than there being an abrupt ending of all social work input. According to the Health Visitors notes, this idea was actually suggested by the Social Worker at the final Core Group meeting, but for some reason not implemented when the time came to make a decision at the CPC.

None of the delegates appeared to challenge the complete removal of the child protection plan but the Health Visiting Service Reviewer feels that the Health Visitor should have challenged the decision and requested a 'step down' plan for Jack particularly as this is what had apparently been agreed at the Core Group a few weeks beforehand.

5.4.27 The decision to discontinue the Child Protection Plan at 3 months was discussed when SW1 was interviewed for this Review. SW1 said she believed that FP had not had any contact with MP1 and that she was adamant that she was not going to let him control her. A further reassuring point in SW1's view was that FP and Jack were living with the Grandmother, with her sister nearby and that this apparent close family network was one of the key-factors to agreeing to de-plan. SW1 stated that FP was 'saying all of the right things', but she was aware at the time that this could be just 'lip service'.

5.4.28 The evidence arising from this Review is that at the final Child Protection Conference the hasty and over-optimistic acceptance of FP's confusing story about the petrol incident and the male partner/sister's boyfriend was wrong, and it wasted a clear and simple opportunity to test FP's general veracity in terms of her dealings with professionals. Together with SW1's over-optimistic view of the Grandmother being a key protective factor for Jack, it led to the premature ending of the work being carried out by the Core Group. As discussed earlier, there is no evidence of managerial oversight in terms of SW1's decision making to 'de-plan', and she felt she was working within a culture which encouraged cases to be closed as early as possible. This was a highly dangerous mix of factors which may help explain this erroneous decision.

5.4.29 However, this is not just an issue for Children's Services to be concerned about. Indeed, all delegates at Child Protection Conferences have a responsibility, and indeed a right, to challenge decisions they are unhappy with. The Child Protection Conference should never be viewed as a 'rubber stamping exercise' and agency training needs to

Recommendation 3

The TWSCB should conduct an audit of the training provided to agency delegates who attend Child Protection Conferences. Such training needs, in the first place, to be delivered, and it must equip safeguarding professionals with adequate knowledge of their role at CP Conferences, as well as the confidence to fully engage in the decision making and challenge where necessary.

not only equip safeguarding professionals with adequate knowledge of their role at CPCs, but also the confidence to fully engage in the decision making.

5.4.30 As a final observation about the decision making within the Child Protection Plan, it is noteworthy that although consideration was given to requesting early help through Children and Family Locality Services (CFLS) to support Jack and the family while the Plan was in place the request was never made to that Team. A key element of the support from CFLS would typically be the allocation of an Early Intervention Practitioner who would work as part of the Core Group, Child in Need meetings, or Team Around the Child process, dependent where a child is on the continuum of need. The Early Intervention Practitioner could have provided proactive support in areas such as:

- Income maximisation with the support of Citizens Advice Bureau;
- Parenting support through the Incredible Years parenting programme, an evidence based programme focussed on children ages 2-8 years and their parents to promote positive behaviour;
- Support in accessing domestic abuse support through the Freedom Programme, Power to Change programme and Me, My Child and Domestic Abuse programme which can be accessed in succession;
- Signposting to appropriate housing support;
- Access to local universal or targeted group based support focussed on young children and their families offered through the Council's Children's Centres. The targeted group support is offered to families with vulnerable or complex needs who may find it more challenging to access universal provision;
- Partnership work and communication with any other agency supporting the family;
- Any other appropriate family support as determined by the respective Core Group, Child in Need plan or Team Around the Child.

5.4.31 The service might have been of great benefit to Jack and yet it was not actually utilised despite it being considered by the Core Group as part of the Child Protection Plan. It appears that this is another consequence of the family's nomadic existence because the family moved to a new area before the necessary CFLS engagement, and it is a further example of how the fact that the family frequently moved

around the country in order to live with, or escape from, different abusive male figures, the children were denied vital services and a settled regime.

5.4.32 The case was formally closed by Telford & Wrekin's Social Care in April 2014. The decision to close the case was however precipitated by Children's Social Care Emergency Duty Team being notified by Police at midnight on 5th March 2014 of a domestic abuse incident that had taken place at Jack's home whereby his Maternal Grandmother had been drinking and began arguing with FP. This culminated in the Maternal Grandmother telling FP and MP2 to leave the premises. They left with Jack, who was 2 months old, and travelled that night to Essex.

5.4.33 Upon receipt of this new referral, Children's Services should have immediately convened a Section 47 Strategy Meeting with a view to arranging a new Initial Child Protection Conference, or else strongly recommending that Children's Services in Basildon, Essex do so if it transpired that the family had relocated there for any length of time. The reason for this is that two key pieces of information which led to the Child Protection Plan being discontinued a few days earlier had now been confirmed to be wrong. Firstly, FP was clearly in a relationship with a new partner whom she had not declared, and about whom nothing was known, and the Maternal Grandmother, who was considered by SW1 to be a stabling and supporting figure, was either not capable of such support or, for the time being at least, was not going to be able to provide it. The only outcome of the referral on 5th March was that a Duty EDT Social Worker asked Police in Essex to conduct a 'safe and well' check on Jack. This was good initial practice by the individual EDT Social Worker, but overall it was a totally inadequate response by the Local Authority, particularly bearing in mind that at that time the case was still 'open' to Telford and Wrekin Children's Services. As such, SW1 and her Team Manager should have taken an active role in assessing this new information and deciding on a course of action. In fact, when interviewed for this Review, SW1 claimed that she had not been made aware by EDT of the domestic abuse incident involving the Grandmother, or that FP had a new male partner, which if correct, is evidence of poor communication between different sections of Children's Services.

5.4.34 Even without this new development on 5th March, delegates at the SILP Recall Day felt that it was premature to close the case in April and that it would have been good practice to allow for a period of at least 6 weeks after the removal of the Child Protection Plan before considering closing the file. It is ultimately a managerial decision to close a child protection case yet, as discussed earlier, it is not possible

to establish whether there was any managerial oversight of the decision because the Team Manager concerned was not traced and interviewed by the Children's Services Agency Reviewer and no supervision notes relating to the decision were located.

5.4.35 As discussed in an earlier section, the Social Worker in question was one of many agency workers employed at that time by the Local Authority. Under the structure in place in 2014, Team Managers were expected to carry out supervision with their staff every 4 weeks, however delegates at the Learning Event reported that this did not happen and SW1 recalled that supervision took place every 8 weeks.

Recommendation 4

The TWSCB should seek reassurance from Children's Social Care that supervision arrangements for Social Workers involved in child protection cases is adequate, and in particular that the minimum standard of supervision every 4 weeks is now adhered to, and that no Child Protection Plan can be discontinued without full managerial oversight.

The Child Protection Team that SW1 belonged to was small with a high turnover of staff, and at times during 2013 practitioners had a higher than average workload . It was further reported at the Learning Event, and by SW1, that Team Managers did not always have good oversight of the cases their staff were dealing. This paints worrying picture but may serve to explain why erroneous decision making occurred, leading to a premature withdrawal of Jack's Child Protection Plan and a failure of the Local Authority to properly act on Jack's behalf when the new information emerged on 5th March.

5.4.36 It is impossible to know how a decision in March 2014 to retain or re-institute the Child Protection Plan around Jack may have affected him over the next 18 months, (which includes the period he suffered serious physical abuse), or how it may have affected Harry. It is very likely however that if a proper risk assessment had been carried out, and proper checks made as to whether FP was genuinely engaging with professionals or whether she was in fact deceiving them about her involvement with male partners, either the Child Protection Plan would have been left in place or, as was considered the appropriate course of action by the Social Worker from Worcestershire, a Care Order may have been applied for long before the physical abuse took place. Had the correct decisions been taken by Children's Services between February and April 2014, it is reasonable to suggest that the children may not have suffered the serious injuries which occurred a year later.

5.5 Identifying and working with resistance

5.5.1 Any experienced safeguarding professional, such as a Social Worker or Police Officer, should be aware that sometimes parents and carers may be less than truthful about their willingness to work with them, but in respect of universal service providers such as Midwives and Health Visitors, although they will assess and plan their work around the identified needs of the child/family across the spectrum of safeguarding/child protection, there is an expectation that they should be able to do their job within in an atmosphere and relationship of trust and support. Therefore, they may be more susceptible to a parent who takes advantage of this trust in order to deceive. This short analysis section will explore whether there was any evidence that the carers of Jack and Harry were in any way resistant to the agency involvement and if so whether there were signs which should reasonably have been picked up and factored in to decision making.

5.5.2 There is a great deal of literature on the subject of resistant parents in a safeguarding context, for example, it is identified that deception is '*a significant feature of everyday child protection practice*' (Tuck, 2013, p.5) and in their relations with professionals, parents were sometimes found to be *'intentionally deceptive or manipulative'* (Lord Laming, 2009: 51) and capable of going to '*great lengths to hide their activities from those concerned for the wellbeing of a child…*'(Lord Laming, 2003:3). Reder at al. (1993) discuss how calculating and convincing parental conduct of doing just enough to keep workers at bay impairs their professional judgments, a behaviour known as disguised compliance (Reder et al., 1993). Both deceitful behaviour and disguised compliance are evident in 'assessment savvy' (p.65) parents, willing to adopt their behaviour to come across as compliant when needed (Brandon, et al. 2008)

5.5.3 It is the view of the Children's Services Agency Reviewer that FP's feigned positive engagement with workers, coupled with the fact that she was a victim of domestic violence, minimised consideration around the potential risks that her parenting would bring to her children. It seems that SW1, who undertook the Initial Assessment in the latter half of 2013 and then the Child Protection Conferences in early 2014, had a good relationship with FP, and a view of her within a domestic violence context that led to an over optimistic view as to her ability to disengage from violent relationships and in her honesty.

5.5.4 It is recognised that Social Workers can be too preoccupied with anti-oppressive practice. According to Thompson's (2006) PCS model, anti-oppressive practice occurs on 3 levels: personal, cultural and societal. As a Social Workers' job is also to facilitate change (on an

individual level and in the surrounding environment), they tend to let oppressive factors dominate their involvement in the case. So if a mother is suffering from mental illness and/or is a victim of domestic violence/drug abuse etc. *she* becomes a 'priority' for any social workers involved rather than the child who is meant to be at the centre of thinking. Social Workers feel they cannot ignore the mother; they feel they must help her first. As far as they access the situation she is the victim of oppressive practice (which she is) who is in need of help. This may be a benign phenomenon if the mother in question is an honest person who genuinely wished to engage in a constructive way with professionals.

5.5.5 In fact, far from being a trustworthy client to professionals, this Review has found evidence that FP, and possibly the Grandmother, were engaged in a strategy of deceiving professionals who were attempting to work with FP in a trusting partnership, and an example of the implications of this were seen in the premature decision to discontinue Jack's Child Protection Plan in February 2014. Based upon the evidence gathered during the Police Agency Review, it is the view of that Agency's Reviewer that FP manipulated all agencies, and that there was *'lots of worrying information that* FP *was 'managing' people*'.

5.5.6 Examples of deceit by FP in this case include denying to Midwives that she had been involved in domestic abuse incidents, whilst at the same time appearing to engage well with Maternity Services during both episodes of maternity care, deceiving a Social Worker and conference delegates about breaking off her relationship with her abusing partner, lying to doctors in the Emergency Department about the cause and extent of Jack's injuries, and on the same day lying to the triage nurse by saying that she lived alone with Jack when in fact she was clearly living with P as well as Harry.

5.5.7 In hindsight this 'disguised compliance' was critical as had they known that, for example, she was maintaining a relationship with either MP1 or MP2 in early 2014, this would have put a different complexion on a person the health professionals considered as 'engaging well', and whom SW1 considered had 'fully engaged' with the Child Protection Plan. As such, they may have taken more steps to discover exactly what parenting care and support was actually present for Jack and later Harry.

5.5.8 In addition, it should be noted that on many occasions, going back to 2012, FP refused to support Police in their attempts to prosecute the perpetrators of domestic abuse where she was the victim. The point here is that once she was pregnant with Jack, she was not the only victim, and it should have been recognised by her that

any incident of domestic abuse to which Jack or Harry were exposed made them victims as well, yet FP continually put maintaining her own relationship with her abusive male partners above the needs of her children, thereby preventing them from being protected by the law. It is perhaps understandable that a vulnerable 19 year old parent may not clearly think this through but professionals working with her should have recognised that every time she failed to allow the police to protect her from her abusers, the children were also remaining at risk of the emotional or physical effects of domestic abuse. There is no evidence that this was factored into the assessments or decision making by Children's Services, or indeed the Police in respect of the decision making around MARAC.

5.5.9 It should be reiterated at this point that FP was almost a child herself and as such may well have been influenced and manipulated by her abusing male partners, making it difficult for her to engage with professionals even if she had wanted to. She had a very troubled childhood and it is likely that she would have learnt to be mistrustful of the 'authorities' from an early age. It is likely that someone in this situation puts on a mask depending on who she is speaking to and professionals need to be 'savvy' enough to understand these dynamics and see behind the mask. This can only be achieved by effective training in working with deceiving carers.

5.5.10 Domestic Abuse is about power and control. One person having power and control over the other and the possibility of coercive and controlling behaviour by the abuser may make it difficult for the victim to work with agencies trying to support her. A recent information sheet published by the NSPCC (2016) indicates, *"Disguised compliance is a common factor in families living with domestic abuse. In some cases, the mother tells agencies that she is no longer in touch with her ex-partner. Only too late does it become apparent that he is still seeing her and /or the children."* It is not known if this was a factor in FP misleading practitioners, but the possibility should be considered as part of the learning from this Review. It is therefore important for professionals working with parents who are victims of domestic abuse to have a full and thorough understanding of how coercion and control may influence parenting and how often those behaviours of the victim can be interpreted as not acting protectively. Victims of domestic abuse need to build up trust in those professionals trying to work with them to protect them and their children, and remember that the responsibility for the risk lies with the perpetrator. Staff must be aware of the most recent NSPCC (2016) research on working with domestic abuse, and how they support, and interact with, the non-abusing family

members. This can only be achieved by effective training in working with feigned compliance.

Recommendation 5

Safeguarding professionals are likely to encounter feigned compliance, resistance and deceit not only from parents and carers, but sometimes also from the young people themselves. TWSCB training should be reinforced to better impart information on this facet of safeguarding so that managers can ensure that their staff are equipped with the ability to recognise and counter such resistance.

5.6 The provision of Health Visiting during the summer 2015

5.6.1 When Jack and Harry were examined in hospital in early September 2015 it was discovered that Harry had a healing arm fracture which may have been between 2 to 6 weeks old. Because of the difficulty in aging old fractures this allows for the remote possibility that the injury occurred during late July 2015, a time when the children were still being seen by Health Visitors. This short analysis section will therefore examine the quality of the provision of Health Visiting services during that summer period.

5.6.2 In general terms the evidence provided for this Review is that the Health Visitors working with Harry and his family were fully qualified, were well trained, and they had adequate safeguarding supervision. There is evidence of good multi-agency communication during the summer period of 2015 with Children's Services appropriately informing the Health Visiting Service of any concerns and correctly involving them as part of the team assessing any potential risks to Jack and Harry. On some occasions the Health Visitors were able to identify areas of concern and reported this to Children's Social Care or clarified information with them when needed.

5.6.3 The Health Visiting records indicate that FP's engagement with the Health Visiting service in Telford was generally good. She was proactive in attending child health clinic, and registered the children with the GP practice when she moved.

5.6.4 The practice standard for contacts for the Health Visiting Service is based on the guidance in Healthy Child Programme (Department of Health 2009). When Harry was born, the Health Visitor completed the appropriate number of checks as prescribed by the Healthy Child Programme. These included the New Birth Visit on 14th April 2015, the 6/8 week check on the 18th May 2015 and the 4 month review on the 13th July 2015.

5.6.5 The 6/8 week check for Harry was completed, at home with both parents and the older sibling present. Because Harry had been weighed at the GP practice a few days beforehand he was not weighed at that visit and therefore not undressed. The Health Visitor noted that Harry seemed to be alert, smiling, looking around for familiar voices and making eye contact.

5.6.6 On the 13th July 2015, a Health Visitor visited Harry's home to complete his 4 month review. On that occasion Harry was weighed, and although it is not recorded in the notes whether or not he was undressed this would be viewed as normal practice for a child under 2 years old. The Health Visitor did not record any concerns in respect of Harry's physical presentation or development, and during this visit Jack was also seen and noted to be 'a happy and well little boy'.

5.6.7 It was at this visit that P was first seen within the household. This was significant because earlier in July, Children's Services had passed to the Health Visiting Service information that they had received that FP was growing drugs, and that she was in a new relationship with a risky male called P. The Health Visiting records indicate that Family Connect had a *'concern regarding possible new partner'*. The day after the visit the Health Visitor reported to Family Connect by telephone that she had seen P at the home. This is a good example of prompt, integrated multi-agency safeguarding practice, and a 'think family' approach.

5.6.8 However, two issues arise from this. Firstly, it would have been good practice before the visit for the Health Visitor to have made more enquiries with Family Connect as to what the specific risks about P related to, and then to have documented the response in the Child's records. Secondly, since the information from Family Connect specifically indicated that FP was *'in a relationship'* with P, the fact that she denied this to the Health Visitor by saying he was just a friend who had slept on the sofa the night before, should have warranted some curiosity and been discussed with Family Connect, as it potentially fitted in with the earlier pattern of deceiving professionals about her

male partners. There is no record in either the Health Visiting notes or the Family Connect notes that this anomaly was either discussed or considered, but it is also important to say that because Children's Services had earlier closed the case, and because the children seemed to be developing well, even had this anomaly been picked up there is no reason why, on its own, it should have triggered any further action. Had the Child Protection Plan or a stepped down Child in Need support regime still been active, undoubtedly P, and his status within the family, would have been subject to greater scrutiny at this point.

5.6.9 The final home visit by a Health Visitor was a non-routine visit, and was undertaken on 20th July 2015 because the Health Visitor offered to provide FP extra support. During the visit both Jack and Harry were seen and the Health Visitor recorded that no concerns were expressed by the parent. There is no record of any physical examination of the children although both children were seen so it is unlikely that they were exhibiting any signs of pain at that time.

5.6.10 To summarise this period, it is highly unlikely that either child had suffered the significant injuries prior to the last home visit because the service provided by Health Visitors was exemplary and they would almost certainly have detected any distress. The Health Visiting Team recognised that the mother of Jack and Harry may need extra support and this was provided, over and above the standard set of visits which would normally be undertaken. Finally, by good communication with their partners the Health Visitors demonstrated that they are fully integrated into the professional safeguarding network.

5.7 The admission to Emergency Department and safeguarding

5.7.1 Jack was brought into the Princess Royal Hospital Emergency Department at 01.29am on 7th September 2015 by FP who reported that Jack could not move his arm. They were accompanied by another adult female and FP told the Triage Nurse that she lived alone with Jack.

5.7.2 It was noted that Jack had old and new bruises to his head and face as well as a bruise was seen above his left nipple. In the early stages FP gave no clear explanation as to how the injuries were caused although she did say that the bruise on the nipple was caused by Harry 'pinching' Jack (Harry was 5 months old at this time so that explanation was highly unlikely to be true).

5.7.3 The hospital dealt with this admission in a faultless way and the Nurse assessing Jack immediately had concerns that the injuries may have been caused by maltreatment.

5.7.4 The Acute Trust receives notification of all children from the local authority who are put on a Child Protection Plan. This information is then added to the SEMA system by means of a child protection alert, which is seen instantly as soon as a child is booked into the hospital, ED, clinic or as an in-patient. On this occasion the IT system worked as intended and the ED staff were able to see that Jack had previously been subject to a Child Protection Plan. The nurse had already formed the view that the injuries were suspicious but this new information heightened that view.

5.7.5 Jack was then seen by an ED Doctor and when asked by the Doctor how the injuries may have occurred, FP changed her story from *'not knowing what had happened'*, to *'Jack falling downstairs with her partner three days previously'*, to *'it might have been when Jack climbed out of his cot'*. FP told the Doctor that she had noticed the bruises on Jack's face six days ago, and that they came and went on their own. She also said that she had noticed that for the last two days Jack was not using his right hand. There was no explanation given as to why Jack had not been brought into ED earlier. When interviewed for the current Review, the Doctor described the whole situation as being *'one of the most worrying of his career',* but commendably he recognised within his differential diagnosis that the injuries were probably non-accidental, and ordered that Jack was to be admitted overnight to the ward, for investigations the following day.

5.7.6 Jack had an X-ray which subsequently showed that he had a new fracture on one forearm and an older fracture on the other forearm. In line with the Hospital's suspected non accidental injury pathway he was then referred to the on call Paediatric Team which was the correct decision. It is accurate to report that the medical assessment carried out by the ED Staff was prompt, pragmatic and decisive, and thus Jack was immediately identified as probably a victim of serious child abuse.

5.7.7 It appears that FP telephoned P and told him that Jack had been admitted to the ward. Staff overheard them having a heated argument on the telephone and a short while later P brought Harry to the hospital. By chance, a Police Sergeant was patrolling in the area and saw Harry and P in the vicinity of the hospital at about 02.30am. The Sergeant accompanied Harry into the hospital and upon speaking to medical staff and ascertaining that Jack was there with suspicious injuries, they

asked that Harry also be examined. While this examination was taking place, the officer made the decision to contact the Children's Services Emergency Duty Team, and also to arrest P. FP was also arrested by investigating officers later that day.

5.7.8 Harry was later X-rayed and it was discovered that he also had a fractured arm which a Radiologist considered to be '*in the region of 2-6 weeks of age*'.

5.7.9 The Police Sergeant demonstrated good practice by engaging with P and following up with enquiries in the hospital. The officer then worked well with hospital staff and social workers in making a fast and effective decision for the children to be placed in Police Protection[5] at the hospital.

5.7.10 Although this Review has revealed that the steps taken by Medical Staff, Police and Social Workers in the early hours of Monday 7th September were exemplary, there is also evidence that later during that week the decision making around the safeguarding of both children was tardy, and that for a short time they were allowed back into a risky situation where they were not under any form of legal protection. There are lessons which can be learnt from this episode hence it is discussed in some depth.

5.7.11 Under Section 46 Children Act 1989, the Police have a power to take children away from the control of their parents in certain emergency circumstances. The Police may also order that a child is to remain in a safe place, such as a hospital. This emergency power can only remain in force for a maximum of 72 hours and the Home Office Circular which explains how it should be used states that '*wherever possible, the decision to remove a child from its parent or carer should be made by a court'*. Therefore, as soon as a child is taken into Police Protection the Local Authority needs to be informed, and they should quickly decide whether to return the child to the parents or to proceed to activate their own legal powers of protection. In the first instance this would normally include, under Section 20 Children Act 1989[6], a voluntary agreement by the parents to allow Children's Service to place the child in foster care, or under Section 44 Children Act 1989, they

[5] Under Section 46 Children Act 1989 the Police may take a child into police protection, or cause a child to remain in a safe location such as a hospital, if they believe there is an immediate risk that the child may otherwise suffer significant harm. This must be constantly reviewed by a Designated Officer and can only last for a maximum of 72 hours.

[6] A 'Section 20' agreement with the parents is often a quicker and preferable option than applying for a court order. Such an agreement is a form of contract between the parents of a child and the Local Authority, which allows the children to be placed in temporary safe accommodation. The parents cannot be compelled to sign a Section 20 agreement and they could revoke it at any time.

may apply for an Emergency Protection Order which will allow the Local Authority to accommodate the child for up to 7 days. Whichever course of action is decided upon by the Local Authority, they must make that decision well within the maximum 72 hour period allowed for by Police Protection.

5.7.12 In the case of Jack and Harry, a Police Officer took both children into Police Protection at approximately 4am on the morning of 7th September 2015. This decision was made following consultation, and agreement with, the Social Worker present and the medical staff involved in the treatment of the boys. This was good practice by the Police Officer and Social Worker who both recognised that this was a serious case of child abuse and that potentially FP, or any other relative on her behalf, could otherwise decide to remove the children from the hospital.

5.7.13 The Officer, as the 'Initiating Officer', submitted a Police Protection form, and by consulting the Social Worker had fulfilled the requirement to inform the Local Authority. The Police view is that once informed, the Local Authority should have started proceedings for a replacement court order within hours[7], and also commenced Section 47 inquiries. In the meantime, the Police Protection papers would remain with the 'Designated Officer' for the police area, (a Duty Inspector), who had a continuing responsibility to ensure that the Police Protection was still necessary and that the Local Authority were aware of the need to take the case over as soon as possible.

5.7.14 Through the Social Worker at the hospital, the Local Authority was party to the decision to take Jack and Harry into Police Protection, and by virtue of the fact that they subsequently applied for Care Orders it is clear that their view was that the children would not be safe in FP's care. It is concerning therefore that the correct steps were not taken in time to replace the temporary Police Protection Power with a more permanent legal order. In fact, for a period of 29 hours, before a Section 20 agreement was negotiated, Jack and Harry were not safeguarded by any legal order and, theoretically at least, could have been removed from the hospital by somebody on FP's behalf, or by MP2 who claimed to have parental responsibility.

5.7.15 Furthermore, it is noted by the Shrewsbury and Telford Hospital Agency Reviewer that their staff feel there was insufficient information

[7] It is also technically possible for the Police to unilaterally apply to the Court for an Emergency Protection Order under Section 46(7) Children Act 1989, although this course of action would be extremely rare if there is active involvement by Children's Social Care.

sharing from the Police to the hospital staff about the Police Protection arrangements. Although both Jack and Harry were subject to Police Protection none of the hospital staff appeared to know exactly why, and, when asked by the Named Nurse for Safeguarding, neither did the Police Officers who were sat outside the children's cubicle on the ward. It is important that when Police Protection Powers are invoked to ensure that a child should remain in a hospital, there needs to be a co-ordinated approach between the Police and Hospital, and both agencies need to ensure that their front-line staff are clear about the situation and any contingency plans.

5.7.16 Although the Initiating Officer will have had discussions with Hospital Staff and Social Workers, ultimately, because the Police are at that time de-facto responsible for the welfare of children in their protection, the Police Designated Officer (usually the duty Police Inspector) should take responsibility for requesting that the child(ren)'s medical records clearly indicate:

- The grounds for Police Protection,
- A risk assessment which considers whether anyone is likely to attempt removal,
- The course of action which should be adopted should anyone try,
- The time that Police Protection ceases,
- The contact number for the Duty Police Inspector and the relevant Social Worker.

In turn, Hospitals have a responsibility for ensuring that the above information is sought from the Police and added to the medical records so that all staff are fully aware of the situation. The evidence provided to this Review indicates a failure in respect of clear information sharing, and the TWSCB Safeguarding Procedures should be updated to be quite specific about the process, information sharing, and record keeping requirements, when Police Protection is used in this way.

Recommendation 6

The TWSCB Safeguarding Procedures should be reviewed to ensure they are clear and specific about the process, responsibilities and information sharing requirements when Police Protection Powers are used to ensure that a child remains in hospital.

5.7.17 As pointed out above, the Police Protection Power in respect of Jack and Harry lapsed after the statutory maximum 72 period and there was a period when no legal order was in force. No doubt had anyone tried to remove the children from hospital the staff would have tried to find a way to retain them, but this would have put staff in a legally dangerous position, so apart from the obvious safeguarding issue with the children, the Local Authority had a responsibility to other professionals to carry out their duties promptly and efficiently. The fact that no-one did attempt to remove the children from hospital is fortunate, but this Review needs to highlight this episode because in a future case such tardiness may have greater repercussions.

5.7.18 The detailed guidance for the use of S.46 Police Protection is found in a Home Office Circular (017/2008). This document states,

> *"It should be extremely rare that a child remains under police protection for 72 hours. Normally arrangements for children's social care to provide accommodation for the child or to apply for an EPO should be undertaken within a few hours of the child being taken into police protection."*

5.7.19 Telford & Wrekin Council Legal Services were informed by a Social Care Team Manager at 11 am on 7th September that the children had been taken into Police Protection at around 4am that morning. This Review has been informed by a report from the Council's Legal Services Branch and it appears that there was not enough appreciation given by the Local Authority to the fact that the Police Protection Power was a very temporary solution which would expire in less than 3 days. According to Social Care records the initial telephone call between the Team Manager and Lawyer at 11am did not include any specific discussion about needing to replace the Police Protection, and it ended with advice given to the Team Manager to *'keep an eye on progress, i.e. when children were ready to be discharged from hospital - possible options etc.'* This record of the conversation appears to be rather vague and ideally, there should have been a clear file note arising from this conversation about the timescales for action, what the exact legal/voluntary options were, and when they needed to be applied. For their part, the Legal Services record of the same conversation indicates that the advice provided to the Team Manager was for '*…Children's Services to consult the parental responsibility holders for the children about Children's Services proposals for the children and whether those proposals were for the children to remain looked after'*. There is no record of a specific reminder to the Team Manager that the Police Protection Power would expire at 4am on 10th September 2015, and this should have formed an explicit part of the legal advice, along with

a reminder that if Children's Services decided that they required an Emergency Protection Order the application to Court would need to be made before the expiry of the Police Protection action period, and that Children's Services would need to provide evidence in support of any application to, in turn, enable Legal Services to prepare the C110A application form. It is possible that this advice was provided verbally, but in the absence of any formal record to that effect this is mere speculation. It is reasonable to conclude that a learning point from this Review is that any similar conversation in future be followed up by a written legal advice note setting out all the options and the timescales for potential action.

5.7.20 At 5pm on 9th September 2015 a Police Officer contacted the Social Worker managing the case requesting an update on the status of the children, and giving a reminder that Police Protection was due to expire eleven hours later. The Social Worker told the officer that FP had refused to sign a Section 20 Agreement and that they had arranged to meet with her again at 3:30pm on 10th September 2015. The Officer expressed concern that by the time the meeting would be convened the Police Protection would have expired, but the Social Worker responded that FP's bail conditions would be sufficient to protect the children. This argument was flawed because neither the Grandmother nor MP2 were subject to any bail conditions so it would have been difficult for medical staff to resist them, or someone else on the mother's behalf, taking the children out of the hospital. There is no indication in the records that either Children's Services or Legal Services considered or discussed the possibility that a third party who was not subject to any bail conditions may attempt to assert their right to remove the children from hospital.

5.7.21 The first Local Authority Legal Planning Meeting was held at 1.30pm that day and it was decided that the threshold had been met for a Care Order application. By that time the Police Protection Powers had lapsed 13 hours earlier and the children were not under any form of legal protection. This Review has been unable to establish why there was a 3 day gap between Police Protection being instigated and the first Legal Planning Meeting, and why there was no urgency around seeking a legal device to replace the Police Protection arrangements. Telford and Wrekin Legal Services provided this Review with a report which explained their involvement, but the Author of that report was unable to discover why there was a 3 day gap between Police Protection powers being exercised on 7th September and the Legal Planning Meeting taking place on 10th September. The Legal Services report did however point out that responsibility for arranging Legal Planning

meetings rests with Children's Services, and that if there had been a need for the Local Authority to consider making an emergency application to Court, such a decision should have been considered and made by Children's Services as soon as possible within the Police Protection period.

5.7.22 Whatever the reason, the passage of 29 hours without any form of legal protection for the children is unacceptable, and it is also unacceptable for Police Protection Powers to be allowed to expire unless the child is considered by the Police Designated Officer to be no longer at risk of significant harm, a court order been obtained, or Section 20 consent to accommodate the child has been obtained. It has been established that Telford and Wrekin Legal Services has in place a streamlined system for applying for an Emergency Protection Order either within, or outside, office hours, so the problem in this case was not caused by the lack of an adequate system but rather a lack of appreciation of the urgency, an apparent failure to consider the possibility that adults, other than the mother, may attempt to remove the children from hospital, and perhaps a lack of clarity and adequate record keeping in the discussions between the Children's Services and Legal Services. It is therefore a conclusion of this Review that, albeit for a relatively short period of time, Telford and Wrekin Council failed to ensure that the law was correctly applied on Jack and Harry's behalf.

6. Conclusions and Summary of what has been learnt

6.01 The subjects of this Serious Case Review, Jack and Harry, were both very young children when they suffered serious physical injuries at the hands of their adult carers. The Review has revealed errors in communication, practice and professional judgement which led to missed opportunities to protect Jack and Harry from significant harm. The Review also identified good practice by agencies and professionals, and this Overview Report offers recommendations for action to improve the services offered to children and families.

6.02 The children were not hidden from the outside world but were both 'visible', in the sense that they were seen appropriately by many professionals including Midwives, Health Visitors, GPs, Social Workers and Police Officers. Their Mother, FP, was only a little older than a child herself. She was a vulnerable person and she had suffered abuse in a very troubled early childhood, which meant that she had complex social needs.

6.03 There is a great deal of evidence that FP was frequently a victim of domestic abuse perpetrated by older male partners, and that the children were living in an environment where there was considerable tension and stress. FP often returned to abusive relationships and on every occasion when domestic abuse took place she failed to support the Police in prosecuting the violent men which, in turn, meant that the children were not themselves protected from the abusive relationships. Children living in a violent household are as much victims of the violence as the adult. It is likely that FP was a victim of coercion and control by the abusing partners in her life thereby making it difficult for her to work with practitioners even if she had wanted to.

6.04 There were predominantly 3 violent men within the household at different times during the relevant period of this Review. In the case of two of the men they were declared to Midwives as the Fathers of Jack and Harry respectively. Each of these men had previous involvement with either Children's Services or the Police and there was information available in agency files which may have cast doubt on their suitability to be a carer of a child, or which may have indicated that they could require extra parenting support.

6.05 In the case of Jack's Father, appropriate information gathering took place by the Midwifery Team through the medium of the multi-agency Vulnerable Women's Group (VWG). When Harry was born however, the family was not discussed at the VWG and no curiosity was demonstrated about his Father. This was an error of judgement on the part of Midwives which denied them the opportunity to potentially discover that he had a history of violence towards his former partner's child.

6.06 The Review was told that it is not normal practice for Midwives to access any health records or to contact the GP of a baby's father or partner, unless they have given their express permission. Whereas it is fully accepted that the *routine* checking of all male figures is not necessary and would be overly intrusive, it is important that the threshold for acting on professional curiosity and seeking further information about all potential carers of a baby is not set too high by Midwives. It is also very important that the perceived need for 'express permission' from the father or male carer is not seen as a barrier to good information sharing, in fact Midwives can access paternal notes if necessary – with or without consent. This was clearly a family with concerning and complex social needs, and in view of the significant history of domestic abuse involving Harry's Mother, the fact that her older child had been on a Child Protection Plan, and the fact that at this time she was just 20 years old, more professional curiosity should have been shown by Midwives as to whether she had entered into another abusive relationship in respect of Harry's Father.

6.07 The Police missed an opportunity to take the case to Multi Agency Risk Assessment Conference (MARAC) and had they done so information could have been shared, regardless of FP's reluctance to engage or support in any prosecution. A MARAC meeting should have been held as it would have provided an opportunity to better inform each respective agency as they sought to provide care and support for FP and her children.

6.08 When the Mother was pregnant with Jack she moved to Worcestershire to live with his Father. There is evidence of good communication between Midwives in Telford and their counterparts in Worcestershire, as well as with Social Workers in Worcestershire. domestic abuse was highlighted and, in particular, Midwives reported to the receiving area that they felt the Mother was deceiving them by denying that she was in an abusive relationship. This information was shared with Children's Services who immediately began assessing the Family. The case was escalated after a further domestic incident and Jack was made subject to a Child Protection Plan. This was good practice by Worcestershire Children's Services and demonstrated a robust approach to Jack's safeguarding needs.

6.09 The perception of the key Social Worker is that she had insufficient social work supervision, a lack of supervision record keeping, an overload of cases, and a culture whereby she felt Social Workers were encouraged to close cases prematurely to reduce the numbers. In respect of case-load, for much of the relevant period SW1's case load was not abnormally high although there was a spike to 45 cases between June 2013 to January 2014 – of which 22 were open referrals.

6.10 The evidence provided to this Review is that the Service is now much improved and there is a new structure in place in terms of the teams, and a better supervision ratio. Telford and Wrekin Children's Services was inspected by Ofsted in 2013 and this inspection did not identify any systemic failing at the time, nor has systemic failing since been identified.

6.11 In June 2013 following a referral by a Midwife that there had been a domestic incident involving FP (who was 3 months pregnant with Jack), a Telford Social Worker conducted an Initial Assessment. This assessment was sub-standard in the sense that too much reliance was placed upon the Grandmother being a protective factor, and not enough healthy scepticism was exhibited by the Social Worker as to whether she had in fact withdrawn from her relationship with the violent Father of jack. Overall the Social Worker had too optimistic a view of the situation, and she took no further action when in fact she should have initiated a Core Assessment so that a more in-depth look at FP and her relationships could have been explored.

6.12 Just before Jack was born, having been correctly placed on a Child Protection Plan by Worcestershire Children's Services, the family moved back to Telford. There was a delay of 6 weeks before the 'receiving in' conference was held because of a breakdown, or delay, in communication between the two local authorities. When the Conference was held there was a divergence of views about the risks to Jack between Social Workers from the respective authorities. Although the Plan was initially continued by Telford Children's Services, at the first Review Conference in March 2014 the Plan was discontinued. This discontinuance was premature, and based on flawed thinking, including an over-optimistic view of FP's honesty with professionals and an over-reliance on the Grandmother as a protective factor. A period of at least 6 months should have elapsed before consideration was given to ending the Plan. There was a lack of managerial oversight of the decision to discontinue the plan.

6.13 Child Protection Conferences are crucial to the safeguarding of children, and are the best way to ensure the widest possible range of information and expertise is available to the decision makers in a case involving a real risk of significant harm to a child. All agencies must ensure that delegates representing them at conferences are well trained and confident to fully partake in the discussion and if necessary challenge decisions with which they are uncomfortable.

6.14 In fact, within days of the Plan being discontinued a further incident occurred which involved the Grandmother drunkenly ejecting Jack, his mother and a new, undeclared male partner from her house. The Local Authority failed to properly share this information within their own organisation, and had it been properly processed and considered, this new information should have been seen to completely undermine the rationale for taking Jack off the Child Protection Plan. No action was taken as a result of the incident but the correct course of action should have been for the Local Authority to instigate an immediate Section 47 investigation and for a new Initial Child Protection Conference to be convened. This was a crucial missed opportunity to provide longer term safeguarding for Jack, and ultimately an opportunity to change the outcome for both children.

6.15 The family moved to Essex where further domestic abuse took place within the household and after a few months the mother became pregnant with Harry and moved back to Telford. This constant shifting around the Country was detrimental to the children in the sense that it prevented agencies formulating a settled regime of support and it allowed professionals to 'pass the problem' onto someone else rather than take responsibility.

6.16 During the summer of 2015, a new male figure entered the household and he was another violent character who was eventually arrested on suspicion of assaulting the two children. Little was known about this man and the fact that Jack's Child Protection Plan had been discontinued several months earlier led Health Visitors to believe that there were no longer any safeguarding concerns. The Health Visiting Regime for Harry was of a high standard and it is highly unlikely that any injuries were inflicted upon the children until after the involvement of the Health Visiting Service in late July 2015.

6.17 When the children were admitted to the Emergency Department with the serious injuries there was very good practice demonstrated by both Doctors and Nurses. The injuries were promptly identified as having probably been caused by child abuse despite several attempts by the Mother to deceive Doctors as to their origin.

6.18 Although Jack and Harry were promptly and correctly safeguarded by the Police through Police Protection Powers, there was a period of time when a delay by the Local Authority in seeking the necessary legal power to succeed the Police Protection meant that the children were left in a risky situation, albeit in hospital, but with no legal order keeping them there.

7. Recommendations for Telford and Wrekin SCB

These recommendations should be read in conjunction with the Action Plan which provides detail about methods of implementation and timescales. They appear in this section simply in the same order that the relevant text appears in the Report and the list should not be considered to have any particular hierarchy of importance.

Recommendation 1

TWSCB should be concerned about a perception by midwifery staff that they cannot access relevant notes of the father of a child without 'express permission'. It is recommended that after a review of the legal position is undertaken, the Independent Chair writes to the Chief Executive of Shrewsbury and Telford Hospitals NHS Trust to seek reassurance that caregiving fathers in potentially vulnerable families will be subject to the same level of enquiry as mothers. (*5.1.12)*

Recommendation 2

The TWSCB should seek reassurance from Children's Social Care that in respect of any pre-birth child protection conference, the relevant Health Visiting Service will automatically be invited. (*5.4.17)*

Recommendation 3

The TWSCB should conduct an audit of the training provided to agency delegates who attend Child Protection Conferences. Such training needs, in the first place, to be delivered, and it must equip safeguarding professionals with adequate knowledge of their role at CP Conferences, as well as the confidence to fully engage in the decision making and challenge where necessary. (*5.4.29)*

Recommendation 4

The TWSCB should seek reassurance from Children's Social Care that supervision arrangements for Social Workers involved in child protection cases is adequate, and in particular that the minimum standard of supervision every 4 weeks is now adhered to, and that no Child Protection Plan can be discontinued without full managerial oversight. (*5.4.35)*

Recommendation 5

Safeguarding professionals are likely to encounter feigned compliance, resistance and deceit not only from parents and carers, but sometimes also from the young people themselves. TWSCB training should be reinforced to better impart information on this facet of safeguarding so that managers can ensure that their staff are equipped with the ability to recognise and counter such resistance. (*5.5.9)*

Recommendation 6

The TWSCB Safeguarding Procedures should be reviewed to ensure they are clear and specific about the process, responsibilities and information sharing requirements when Police Protection Powers are used to ensure that a child remains in hospital. (*5.7.16)*

References

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Appendix A

TERMS OF REFERENCE & PROJECT PLAN

SUBJECTS: Jack d.o.b 14.12.13

Harry d.o.b 03.04.15

1. SCOPE

The subject children, Jack and Harry, are in scope.

Time period :

06 June 2013 (referral from the midwife)
To

11 September 2015 (the children were discharged from hospital into care

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 para 10, March 2013 as updated 2015)

3. AGENCY REPORTS TO BE COMMISSIONED

1. Telford & Wrekin Children's Social Care
2. Worcestershire Children's Social Care(including health involvement)
3. Essex Children's Social Care
4. Telford & Wrekin Early Help Services, Children and Family Locality Services
5. Telford & Wrekin Legal Services
6. Health Visiting Service, Shropshire Community Health NHS Trust
7. Essex Health Visiting
8. GP services, Telford & Wrekin Clinical Commissioning Group
9. Essex GP Services
10. Shrewsbury and Telford Hospital NHS Trust (SATH)
11. Shrewsbury and Telford Hospital NHS Trust Maternity Services
12. West Mercia Police
13. National Probation Service, West Mercia
14. Community Rehabilitation Company, West Mercia
15. Youth Offending Service, West Mercia
16. Telford &Wrekin Drug and Alcohol Rehabilitation Service
17. Adult Mental Health Services, South Staffordshire and Shropshire Foundation Trust

Family members and professionals will be anonymised

4. TERMS OF REFERENCE

i. How well did assessments inform decision making and how visible were assessments?
ii. Were the children's 'voices' heard, (including an understanding of their lived experience)?
iii. How was the family history incorporated into assessments? Were assumptions made in the absence of assessments?
iv. To what extend did practitioners consider the impact of DA on children?
v. To what extent did practitioners Think Fathers/partners?
vi. How effective was the child protection planning process? Please include core group working?
vii. Please provide some analysis of the decision to step the case down.
viii. Please comment on the quality of information sharing including the making of referrals?
ix. Please comment on the appropriateness of arrangements for the children upon admission and during their stay in hospital?
x. What effect did mother's lack of engagement have in this case?
xi. Please analyse the transition arrangements between local authorities.
xii. Please Identify examples of good practice, both single and multi-agency.

5. A TEMPLATE FOR AGENCY REPORTS

Attached.

6. METHODOLOGY

6.1. This Case Review will be conducted using the Significant Incident Learning Process (SILP) methodology, which reflects on multi-agency work systemically and aims to answer the question why things happened. Importantly it recognises good practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements. The SILP learning model engages frontline practitioners and their managers in the review of the case, focussing on why those involved acted in a certain way at that time. It is a collaborative and analytical process which combines written Agency Reports with Learning Events.

6.2. This model is based on the expectation that Case Reviews are conducted in a way that recognises the complex circumstances in which professionals work together and seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight.

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

- Proportionality
- Learning from good practice
- Active engagement of practitioners
- Engagement with families
- Systems methodology

7. ENGAGEMENT WITH THE FAMILY

A key element of SILP is engagement with family members, in order that their views can be sought and integrated into the Review and the learning. TSCB has already informed the family that this Case Review is being undertaken. The independent lead reviewers will follow up by making contact with the mother, the children's' fathers and the Maternal Grandmother.

Further contact will be made to invite them to participate in the form of a home visit, interview, correspondence or telephone conversation prior to the Learning Event. Their contribution will be woven into the text of the Case Review Overview Report and they will be given feedback at the end of the process.