Serious Case Review

Child H

April 2016 – updated April 2020

Child H was a small child, with blonde curly hair and bright blue eyes. Curious about everything, Child H was very much a typical toddler, enjoying being around other children, and was generally ‘into everything’. Child H was affectionate and funny and was cared for within the ‘bustle of a large extended family'

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April 2016

(updated April 2020)

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1 The circumstances which led to a Serious Case Review (SCR)

1.1 AT was 18 years old and living with her mother, father, and three siblings, when Child H was born 10 weeks prematurely in March 2012. There were no concerns about AT's care of her baby and professionals noted she coped well with the health complications arising from the premature birth. AT agreed during her pregnancy to accept intensive support from the Family Nurse Partnership (FNP)[1] and until the last 4 months of the programme, she engaged well with the FNP practitioner (FNP1) and was viewed as a caring and committed parent, well supported by her family.

1.2 In October 2013, 4 months before the death of Child H, AT established a relationship with BF8. As this male was already known to statutory agencies because of his violent behaviour towards two previous partners, CSC undertook an Initial Assessment[2] in respect of Child H. This assessment concluded there was no role for CSC and they were satisfied that AT would take appropriate steps to keep her child safe should BF8 pose any risk to Child H. The decision for no further action by CSC was based on an understanding that when AT and BF8 did spend time together, Child H would be looked after by the maternal grandmother. BF8 had also indicated his willingness to attend a behaviour change programme.

1.3 Police attended the home of AT in November 2013, in response to an allegation of domestic violence by BF8 towards AT, however no further action was taken when AT denied that she had been subject to an assault. Sometime in January 2014, when AT was 3 months pregnant she and BF8 moved to another part of the city, where they set up home together without informing FNP1 or CSC. Shortly after the move, an anonymous caller rang police concerned at hearing a man's voice shouting abuse at a crying child. Police visited the home but did not identify any safeguarding concerns. Less than three weeks later, Child H was admitted to hospital and later died from a hypoxic brain injury[3]. AT and partner BF8 were at the time arrested on suspicion of murder.

1.4 The Independent Chair of Hull Safeguarding Children Board (HSCB) considered that the circumstances surrounding the death of Child H met the criteria for a Serious Case Review (SCR) and notified Ofsted and the National Panel of his decision on 18 June 2014. *See Appendix 1 for more details about statutory guidance.*

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[1] *The Family Nurse Partnership was a voluntary home visiting programme for first time young mums, aged 19 or under (and dads). A specially trained family nurse visits the young mum regularly, from early in pregnancy until the child is two years old.*

[2] *An Initial Assessment was a short assessment of each child referred to Children's Social Care 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. It additionally determined the nature of any services required and if a more detailed Core Assessment should be undertaken. This has since been replaced by a single assessment process.*

[3] *Hypoxic brain injury occurs when the flow of oxygen to the brain is interrupted leading to damage to the brain*

2 The approach used

2.1 In line with statutory guidance, HSCB adopted a systems methodology to undertake this SCR. Using this approach meant that those involved in the review process looked not only at what happened to Child H, but also tried to understand some of the factors that influenced why professionals acted as they did or why they may not have acted at all. An independent reviewer with experience of using a systems methodology and an internal reviewer from the HSCB were commissioned to lead the serious case review process.

2.2 A Review Team of senior professionals representing the agencies that were or had been involved with the family was also established:

Lead Reviewer	Linda Richardson	Independent Safeguarding Advisor
2nd Reviewer	Janice Forster	Professional Practice Officer, HSCB
Business Manager	Neil Colthup	HSCB
Business Coordinator	Laura Bell	HSCB
Senior Probation Officer/Victims Manager		National Probation Service
Detective Inspector		Lead for Child Protection, Humberside Police
Named Nurse for Safeguarding Children		Hull & East Yorkshire Hospital Trust
Practice Manager		Neighborhoods and Housing, Hull City
Named Nurse for Safeguarding Children		City Health Care Partnership
Designated Nurse for Safeguarding Children		NHS Hull
Principal Social Worker		Children & Families Service, Hull City Council
Project Coordinator		East Riding Voluntary Action Services
Named GP		Hull Clinical Commissioning Group, NHS Hull
Manager		Domestic Abuse Partnership (DAP)
Named Midwife		Hull and East Riding Hospital Trust
Head of Safeguarding		Yorkshire Ambulance Service

2.3 The role of the Review Team was to provide a source of high-level strategic information about their own agency and their involvement with Child H's family through their contributions to the SCR process and through the submission of an Agency Learning and Reflection Report. Together with the Lead Reviewers, the Review Team gathered and analysed data, appraised practice and agreed the content of this report.

2.4 Members of the Review Team also identified frontline practitioners and first line managers who knew or had worked with H's family. These practitioners, where they were able to participate, formed the 'Practitioner's Group' and they met on four occasions. They offered important details about the family and the work they had undertaken and provided a rich source of information about local systems and multi-agency procedures and processes. In addition, they helped the Review Team consider the extent to which the findings from this review were typical of practice elsewhere across the partnership.

2.5 The methodology adopted for the review and the opportunity to be an integral part of a multi-agency review process was new to some of the professionals involved.

Whilst some reservations may have been apparent at the outset, there was an acceptance about the opportunity it afforded to identify and understand factors that influence the nature and quality of their work with this and other families.

2.6 Data was collected through the examination of single and multi-agency records and through individual conversations with practitioners and their managers. The lead reviewers also met with Child H's mother (AT) and grandparents, so their views could be represented in this process.

2.7 The terms domestic abuse and domestic violence are used interchangeably in this report to reflect records and conversations. The preferred term in Hull is domestic abuse.

3 Scope and Terms of Reference

3.1 Taking a systems approach encourages reviewers to begin with an open enquiry rather than a pre-determined set of questions from terms of reference. This helps the data to lead the key issues to be explored as opposed to the preconceptions of managers or a review panel.

3.2 Each agency submitted a timeline of interventions at the start of the review process and this information was collated to illuminate multi-agency activity so the Review Team were clear about who knew what and when.

3.3 Tentative lines of inquiry began to emerge from early conversations; how well do agencies in Hull respond to information about males who pose a threat to women and children; the extent to which Initial Assessments undertaken by CSC are able to identify the dangers of such men living with vulnerable young women and their children and the dangers of professionals assuming that family members are willing and have capacity to act as protective factors when risks to children emerge. As the SCR progressed other lines of inquiry were identified and these are referred to later in this report. The Review Team was also mindful of the Ofsted Inspection report, which was published in February 2015.

3.4 This Serious Case Review looks at events that took place mainly between March 2012 when Child H was born, and February 2014, when Child H died.

4 Parallel Proceedings

4.1 Throughout this SCR, there were three other processes underway: the police had initiated an Independent Police Complaints Commission (IPCC) investigation in relation to the officers who attended the home of Child H in January 2014; the local authority had initiated Family Proceedings in respect of Child H's half sibling and this included a separate Finding of Fact[4] hearing in respect of the death of Child H and there was an ongoing criminal investigation by police surrounding the death of Child H.

4.2 The IPCC investigation followed a self-referral made by Humberside Police to the IPCC. Until the IPCC concluded their report the officers concerned received professional advice that to protect their position in any potential disciplinary proceedings, they should delay responding to the questions asked by the SCR team. The officers subsequently provided written responses relating to their involvement in this matter and to inform the SCR. The lead reviewers and the HSCB Business Manager were later given confidential access to the IPCC investigation report, which supported some of the findings outlined in this report. The IPCC report was published on 20th February 2020, following the conclusion of the criminal proceedings,

4.3 Following receipt of new information received in February 2015, Humberside Police advised HSCB that further enquiries were to be made into the circumstances surrounding the death of Child H. This decision had an impact on the first Practitioner's meeting as the Police advised HSCB, that due to evidential reasons Social Worker 4 (SW4) and Family Nurse Practitioner (FNP1) could not take part in the face to face meetings with other practitioners. They did, however, participate in the learning for the SCR through individual conversations with two members of the Review Team and later attended the final practitioner's meeting.

4.4 Whilst much useful work to understand and learn from a SCR can often proceed without risk of contamination of witnesses in criminal proceedings, the systems approach does pose new challenges in respect of conducting SCRs in parallel to criminal investigations because the professionals involved in the case are brought together in a multi-agency forum. Humberside Police liaised with HSCB but advised that SW4 and FNP1 should not participate in the multi-agency meetings, as there was a possibility that the integrity of these witnesses could be compromised in any future criminal proceedings.

4.5 These practitioners were however the practitioners who had the most recent involvement with AT and Child H and their absence from the practitioner meetings limited the extent to which other practitioners could learn from and make sense of key decisions and actions that had been taken. Furthermore, the anxiety and stress experienced by SW4 and FNP1 following the death of Child H was compounded by their exclusion from a reflective process, which for other practitioners had proved to be supportive and helpful.

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[4] *Where there has been the death of a child and there is an application for a care order in respect of a sibling or another child, the death may often be investigated fully, with evidence called and examined closely. After a thorough hearing the judge will make* ***findings of fact.***

There are examples in other areas of the country where SCRs involving practitioner meetings have been undertaken while criminal investigations have been underway and the guidance issued by the Association of Chief Police Officers (ACPO) and the Crown Prosecution Service (CPS) [5] acknowledges that in '*general terms it is not unusual for potential witnesses to meet whilst criminal proceedings are pending'* and 'if *carefully managed a SCR process using a systems methodology is actually a very controlled and safe environment for professional witnesses to meet'.* The Review Team would urge a meeting between Humberside Police and HSCB to explore this issue further and to consider how other authorities address and manage this challenge in a way which compromises neither criminal proceedings nor the SCR process.

4.6 The Finding of Fact Hearing concluded on the 19th May 2015 and the Review Team was given permission to refer to the findings. The Judge concluded that having considered all the evidence, AT had failed to protect Child H and that BF8 caused the death of the child by smothering.

4.7 After a lengthy and complex criminal investigation, BF8 was charged with child H's murder and AT with causing or allowing the death. Their trial commenced in October 2019 and concluded with their convictions on 26th November 2019. BF8 was sentenced to life imprisonment with a minimum term of 20 years and AT to a custodial sentence of 4 years.

5 The Family's Perspective

5.1 Family Structure (*simplified)*

Mother	AT	
Subject:	**Child H**	
Maternal Grandmother	MGM	*remarried with young family, lived locally*
Maternal Grandfather	MGF	*separated from MGM, lived with AT*
Males known to AT	BF1 – 8	

5.2 AT and her parents were keen to meet with the two reviewers to have their views represented in the SCR report and a visit took place in AT's home on 6th May 2015. This was a distressing visit for the family; the Finding of Fact hearing had concluded only a few days earlier and AT had been told by the Judge that she had 'failed to protect' her child.

5.3 Much of what the family shared was reflected in files and records seen by the reviewers and which are referred to elsewhere in this report: AT's relationships prior to and after the birth of H; the level of care AT demonstrated towards H; the support she received from her family and the circumstances which led to the break-up of her engagement with BF7, a previous partner. AT said that until she met BF8 she had not been involved in any domestic violence incidents with previous partners, although she did recall police being involved when her relationship with BF6 had ended and police were called to the house.

[5] *Working Together to Safeguard Children HM 2010, Liaison and information exchange when criminal proceedings coincide with [Serious Case reviews]. May 2014*

5.4 AT told the reviewers that she was always willing to work with social workers, as they were there to help. She praised the support she had been given by FNP1 and said she had wanted her to continue to work with her during her second pregnancy. AT said that FNP1 visited her often and it was good to have someone to talk to and she had learnt a lot about looking after children.

5.5 Much of the discussion at the visit centred upon AT's relationship with BF8. AT knew of him before their relationship began, as he was a friend of an ex-partner BF7. MGF said he knew of BF8 as someone who used a 'lot of drugs ' but AT said BF8 had told her he '*didn't do drugs anymore, just cannabis*'. AT said she had not told her mum of the relationship, as she knew she did not like him. MGM confirmed this as her view of BF8.

5.6 AT and her parents discussed the contact with SW4 between October and December 2013. According to MGM and AT, SW4 met BF8 at the first visit at AT's home but he became very angry with SW4 and left. SW4 then spoke of the risk BF8 posed to women but said she could not say more '*because of data protection'*. They were advised that BF8 should undertake a '*Strength to Change'* [6]programme, which was a service aimed at helping men learn how to change their violent behaviour. MGM said that SW4 explained that if BF8 attended this course, it could generate strong emotions and he should not have any contact with Child H until he had completed the course. MGM said she had agreed she would look after Child H, when AT and BF8 were together if he agreed to attend the course. They were asked by SW4 to tell BF8 about the programme and urge him to ring up for more information. Neither AT nor MGM could recall the discussion about a family plan, although they did acknowledge the conversation about MGM looking after Child H when BF8 was on the course. They said they were not asked to sign any paper nor did they see any paperwork following these visits, until the Finding of Fact hearing in May when their solicitor provided them with copies of the family plan.

5.7 AT and her parents insisted they were unaware of any other potential risks to Child H from BF8. When the reviewers described why children were considered to be at risk from men who assaulted partners, they said this sort of information was never explained to them and never having experienced domestic violence in their family, they did not know how they could have been aware of this. They stressed that they were never told to keep BF8 away from other children in the family. MGM said if it had been explained to her why BF8 was a risk she '*would have used this information and stopped him having access to any of the children in the family including Child H.'*

5.8 MGF wondered why neither he nor his son (AT's sibling), who was living with AT at the time, were spoken to about BF8 or asked their views as part of the assessment. AT acknowledged to the reviewers that although BF8 had a house of his own, he spent a lot of time at her house. They said they never knew whether BF8 had enquired about, or attended the Strength to Change programme and never thought to ask.

[6] *The 'Strength to Change programme is for men who are concerned about their violent and abusive behaviour in their intimate relationships. This was and remains an initiative aimed primarily at enhancing the safety of women and children whilst giving men an opportunity to change their behaviour.*

AT said this was because early in their relationship, she never considered him a risk to her child, despite what she had been told by SW4. AT said her relationship with BF8 was good at first but then when she became pregnant, he accused her of trying to trap him. By this time MGM had remarried and moved a few miles away from AT. When SW4 called for a third time to bring toys for Child H in December 2013, AT said she asked for help to move nearer to her mum but she never heard from SW4 again.

5.9 AT said that BF8 suggested, when she was about 3 months pregnant, that they make a fresh start and he found them a house at the other side of the city from where her family lived. They moved in January 2014 but BF8 did not want the authorities to know where they were. AT said once there, BF8 took her money, phone, and laptop and restricted her movements. AT claimed he also assaulted her *'a few times'*, usually when he was unable to get drugs and had threatened that if she left him he would find her and *'torch her house with Child H in it'.* AT said she thought if she stayed with BF8, she was keeping her child safe. She said she felt trapped and was frightened to tell anyone what was happening, even her mum. MGM said she had no idea what was happening but had decided that AT was an adult and had to make her own choices. She did not think she should let CSC know what was happening and AT said BF8 had not wanted her to inform CSC of their move.

5.10 Sometime in early February, MGM's husband collected Child H for a sleepover at their home. MGM noticed Child H's ear was bruised and she had a long scratch on her cheek. She telephoned AT and was told it was because of an accident with the fireguard. MGM questioned the injury and although she remarked that the bruising was clearly recent and very visible she did not question the explanation given. She wondered then what was happening to Child H but she took no action. Looking back, MGM said she wished she had intervened but she did not think to contact CSC.

5.11 AT said a few days before Child H died, BF8 brought Child H to her because the child was still and blue. BF8 told her not to panic. AT said she didn't call the doctor or seek medical advice because Child H quickly came around and was fine. She said she wondered if BF8 was responsible but she didn't take any action or ask about what happened, as she was frightened of BF8 by this time. AT said a couple of days later she found BF8 holding Child H face down on a bed but even then she didn't know what to do, although she had noticed that Child H seemed scared of BF8. On the day Child H died, BF8 brought H to her and again the child was blue and still, AT said BF8 kept repeating *'I'm sorry'*. Until the inquest, the grandparents had believed that Child H died from carbon monoxide poisoning.

6 The Family as known to agencies

Background Information

6.1 AT was 17 years old when she became pregnant with Child H, her first child. In September 2011, CSC undertook an Initial Assessment, having received information that the father of the unborn child was BF1, and he had a conviction for a sexual offence against a child. AT advised the social worker (SW1) that BF1 had ended the relationship upon learning that she was pregnant and she would not be re-establishing contact with him.

6.2 At this time, AT was living with both parents and MGM confirmed to SW1 that the relationship with BF1 had ended and said that the family understood the risks posed by him to Child H and other children. AT reassured SW1 that the family would not allow any contact with BF1 and they were able to protect unborn Child H. It was agreed that a 'letter of expectation'[7] clearly outlining the concerns of the authority would be forwarded to AT. Discussion centred on support for AT and she willingly agreed to work with a practitioner from the Family Nurse Partnership (FNP) programme. SW1 recorded that as AT was well supported by her family, was no longer in a relationship with BF1 and was aware of the risks he posed to children, there was no role for CSC.

6.3 Throughout her pregnancy, AT attended her antenatal appointments. She met and began to work co-operatively with the FNP practitioner, FNP1.

6.4 In January 2012, CSC undertook another Initial Assessment, having received information that AT was still in contact with BF1. AT denied that she had visited or was in contact with BF1 and claimed he was trying to cause trouble for her. The social worker (SW2) undertaking the Initial Assessment concluded that this was a malicious and unfounded allegation. As AT continued to live with her family and they were all aware of the risks of any contact with BF1, the SW2 recorded that there was no role for CSC. AT was reminded of the 'letter of expectation' sent in September 2011 and that she was still expected to comply with it. AT said she was aware of this.

6.5 AT's parents separated in January 2012. MGM moved to another address close by and AT and MGF remained in what had been the family home.

March 2012 – September 2014

6.6 Child H was born by caesarean section at 30 weeks gestation in March 2012. The midwives and the nurses on the Neonatal and Special Care wards observed that AT was responsive and loving towards her baby and was appropriately anxious about caring for such a small baby with some complex health needs. They were also aware from references in Child H's medical notes that CSC had previously been involved with AT following concerns about her contact with BF1. A senior nurse from the Neonatal Outreach ward contacted CSC, soon after Child H's birth and was advised there was no current involvement. However, a child's plan was forwarded on 3rd April 2012 confirming that neither BF1 nor his uncle should have any contact with Child H. The plan stated that a '*social report would follow with discharge plans*'. This document never arrived.

6.7 Child H was in intensive care for three days and remained in hospital for a further 7 weeks, until discharged into AT's care on the 4th May 2012. During Child H's time in hospital, AT and MGM visited regularly. When AT was unwell and unable to visit, MGM came to see Child H and/or they regularly telephoned the unit to keep in touch with Child H's progress.

[7] *Letters of Expectation were used at the time to specify Children's Social Care concerns and to stipulate what was expected of parents in terms of protecting their child/children*

6.8 Child H was discharged home in early May with a nasogastric tube[8] fitted and AT was responsible for ensuring the proper procedures were followed for cleaning and replacing the tube. Staff on the ward were impressed with AT's handling of this complicated procedure. After several days, the tube, on advice, was removed and Child H was given bottle feeds and a slight weight gain was noticed. AT received 12 visits from the neonatal outreach service between early May and late June 2012 and in addition, 5 telephone calls were made to offer more advice and support. There were no concerns about AT's care of her baby.

6.9 Child H had frequent bouts of sickness and diarrhoea and her weight fluctuated but AT regularly and consistently sought medical advice. Child H slowly gained weight and although continuing to suffer from a variety of infections and colds, the child was noted to be alert and reaching expected milestones. The Consultant Paediatrician confirmed that Child H's size, development, and health issues were in line with a baby born so prematurely.

6.10 Between March 2012 and September 2013, AT had several short-term relationships[9], at least three of which involved police being called out to domestic incidents which, according to police records, were mainly fuelled by all parties drinking alcohol. In March 2012, CSC together with police colleagues, carried out a s47 investigation[10] following an allegation by BF1, and in November 2012, a Core Assessment[11] was undertaken in respect of allegations by BF5 and BF6 alleging that AT was regularly drinking alcohol and leaving Child H '*with anyone'*. These assessments led to no further action by CSC but '*letters of expectation'* were issued advising AT of her responsibility to keep her child safe.

6.11 Throughout this period AT remained engaged with FNP1 who at various times met the boyfriends of AT and attempted, not always successfully, to engage with them. Family members were often present when FNP1 visited and the planned session would sometimes have to be rescheduled or delivered in the presence of family members and/or boyfriends. Workers from the Domestic Abuse Partnership (DAP) offered support to AT following domestic incidents but although AT seemed to welcome this at first, she invariably declined to pursue the help offered.

[8] *Nasogastric (NG) intubation is a procedure during which a thin, plastic tube is inserted through the nostril, down the esophagus, and into the stomach. Once an NG tube is in place, food and medicine can directly reach the stomach or remove substances from it. It is a common procedure for babies born prematurely.*

[9] *Referred to as BF 1 - 8*

[10] *Local authorities are required to make section 47 (s47) enquiries where they believe a child living in their area is, or may be, suffering from significant harm.*

[11] *A Core Assessment was 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. A Core Assessment usually started at the point at which the Initial Assessment ended. One of the main principles of a Core Assessment was that it was a multi-agency assessment, incorporating the specialist knowledge of all the professionals working with a child and their family.*

6.12 The concerns of FNP1 centred mainly around AT's vulnerability in terms of her personal relationships and her lack of understanding about the potential risks of exposing Child H to new partners. However, Child H was observed to be a happy, healthy child, meeting expected developmental milestones and with a strong attachment to AT. MGF lived with AT and Child H, and MGM and the extended family all lived close by.

These factors were a reassurance not only to FNP1 but also to the social workers responding to incidents and allegations about Child H.

October 2013 – February 2014

6.13 On 1st October 2013, FNP1 made a home visit and was introduced to BF8 as AT's new boyfriend. FNP1 recorded that she was unable to observe any interactions between Child H and BF8, as he remained at the back of room and engaged only occasionally in her conversation with AT. FNP1 recalled that although he appeared open and honest, '*something did not feel right'*. He told FNP1 that he had a son from a previous relationship who he saw regularly and gave details so she could contact the health visitor. FNP1 later tried to determine who the health visitor was for BF8's son but could find no health records relating to a child of the name given to her by BF8.

6.14 In early October 2013, the Probation service shared information with CSC about domestic violence in another family and named BF8 as the perpetrator. CSC consequently undertook an initial assessment in respect of children within that family and during that process learnt that BF8 was no longer involved with the family but had begun a relationship with AT. CSC took a decision to initiate an Initial Assessment in respect of Child H. SW4 made a home visit on 4th October 2013 and saw AT, BF8, and Child H. The Review Team was told by SW4 that she recalled BF8 being very angry when she visited and he tried to snatch her papers accusing her of '*breaching confidentiality*'. It appears he believed, mistakenly, that SW4 held papers in her hand pertaining to allegations of domestic abuse in relation to BF8 and his [previous] family. BF8 said he was angry at social workers. SW4 attempted to diffuse the situation but BF8 remained angry and left the house. SW4 continued her conversation with AT.

6.15 Child H appeared well and a positive relationship with AT was observed. AT advised that she was well supported by her parents. SW4 was told that she and Child H shared a house with her father (MGF) and her mum lived a few doors away. AT said there was nothing in BF8's behaviour which gave her concern, he did not live with her and she would end the relationship if she felt Child H was at risk in any way. SW4 explained about the risks to children from men who could be aggressive or violent and told AT about the 'Strength to Change' programme. AT said she would be pleased if BF8 agreed to attend this programme.

6.16 FNP1 was contacted by SW4 on 11th October 2013, as part of the Initial Assessment and the recent visit to the family was discussed. FNP1's records note that SW4 had said she had felt frightened when BF8 had tried to grab the papers from her. FNP1 explained her role as an FNP practitioner and confirmed she had no concerns about the care of Child H but expressed concern about AT's past and present relationships with men who were '*violent and aggressive'*. FNP1 suggested a more detailed core assessment would be needed, but SW4 said she was unsure about this.

She agreed to discuss this further with her manager. FNP1 attempted to contact SW4 a few days later to determine the outcome of that discussion but was informed she was on leave.

6.17 FNP1 undertook a home visit on 18th October 2013 with a colleague who was asked to provide play activities for Child H whilst FNP1 talked with AT. Records indicate it was difficult to discuss BF8's history of violence, as he and another male were present and several members of AT's family. AT was recorded as being concerned about social care involvement and stated that she had not been asked to sign any papers to say that BF8 should not have contact with Child H. FNP1 confirmed she would follow this up with SW4. She observed that BF8 did not interact with Child H at all. Child H was recorded as being bright and alert and engaging in imaginative play. AT said bedtime routines were a problem and this was discussed in more detail. On the 21st October 2013, FNP1 contacted CSC and in SW4's absence, spoke with a duty worker in the office who confirmed there was nothing recorded in the system to suggest that BF8 could not have contact with Child H but SW4 had not yet completed the Initial Assessment.

6.18 SW4 and a Family Practitioner (FP1), visited a second time later in October. The rationale for this joint visit was that FP1 had '*skills in engaging families'* but SW4 in later conversations acknowledged that she was also apprehensive about being in contact with BF8 again. The visit took place in the home of MGM and CSC's records indicate the plan was confirmed that MGM would look after Child H when AT and BF8 spent time together. MGM was recorded as saying that if she were concerned in any way, she would contact CSC. Information was again given about BF8 attending the 'Strength to Change' programme and AT agreed to pass on the social worker's contact details so BF8 could be given more information about the support available to him. AT said she was very happy with the support she was receiving from FNP1. It was agreed a letter and the plan would be forwarded to AT and MGM.

6.19 A few days later BF8 contacted SW4 by telephone to enquire about the 'Strength to Change' programme. SW4 recalled BF8 being calm and she shared with him the nature of their concerns. The Review Team were informed that BF8 said he would attend the programme and would agree to not having contact with Child H if it meant it would keep social workers from being involved in their lives. SW4 passed on the details and stressed the voluntary nature of the programme and that BF8 would have to make the first contact through a telephone call. SW4 advised him to attend the programme and discuss his issues with his probation officer. The Review Team was able to confirm that BF8 did not contact the programme.

6.20 SW4 contacted the Probation Officer, (PO1) on 23rd October 2013 and was informed that BF8 was in breach of a 12 month Community Order following an offence of animal cruelty. Previous offences included Public Order offences and breaching a Harassment Order. SW4 was also told about his history of violence towards two previous partners. SW4 confirmed she had been told that BF8 was not residing with AT. On the 28th October 2013, SW4 contacted FNP1 to advise she had made another visit to AT and it was agreed that BF8 would not have any contact with Child H until he had completed the 'Strength to Change' programme. SW4 was advised that the FNP programme was coming to an end and only had 7/8 sessions remaining.

6.21 On the 29th October 2013, AT's appointment with FNP1 was cancelled by a text from an unknown number. There was a 'no access' visit on 5th November 2013 and AT later contacted FNP1 to apologise saying she was unwell.

On the 19th November 2013, FNP1 visited and observed BF8 and an unknown adult male leaving AT's house. BF8 said he had been to collect his coat. FNP1 discussed the agreement with AT that BF8 should not have any contact with Child H but AT said she only saw BF8 every other day and her mum looked after Child H. She told FNP1 that she thought she was pregnant and became upset when FNP1 advised her she would have to inform CSC but she later accepted the reason for this. Child H was described as bright and alert and appropriately dressed. AT said Child H's sleeping patterns continued to be a problem so bedtime routines were discussed.

6.22 Police received an anonymous call on 23rd November 2013 about 11.00 pm alleging that BF8 had arrived at AT's home and assaulted her leaving her with a cut to the eye. The caller said that BF8 had weapons in the house and had shown other adults who were present a knife with a 6-inch blade. He then ordered everyone from the house. The female caller said she was worried for her friend (AT). According to police records, officers attended AT's address 21 hours later. AT said there had been no incident and BF8 had not been in the house as CSC had told her she was not to have contact with BF8 whilst caring for Child H. The attending officers noted that Child H was '*up and awake'* at the time. There is no reference to whether AT had any injuries to her eye as was reported by the caller. This incident was not recorded as a domestic violence incident and neither was it reported to CSC. FNP1 was unaware of this incident.

6.23 FNP1 visited on 5th December 2013 as arranged but could not gain access. A text from an unknown number said AT had forgotten about the visit. FNP1 replied to the text arranging another appointment for 17th December 2013. At this point FNP1 was still unsure about the outcome of the Initial Assessment, which she expected would have already been completed.

6.24 The Initial Assessment started at the beginning of October 2013 and was signed off by Team Manager (TM1) on 12th December 2013. SW4 concluded that there were no concerns about Child H's care and as BF8 was not living with AT and had agreed to attend a 'Strength to Change' programme, there was no role for CSC. MGM was identified as a protective factor and the assessment described that she had agreed she would care for Child H if AT were to spend time with BF8. She also confirmed that she would contact the local authority if she had any concerns. Records indicate that that all parties had agreed with this. At this time SW4 was unaware that AT was pregnant.

6.25 AT attended an antenatal check on 16th December 2013 but later rang the FNP office and left a message cancelling the visit by FNP1 for the next day, and saying her phone was not working so she was using her father's mobile. On 21st December 2013. AT took Child H to A&E with a 'burn' on her wrist and said this was caused by a hot cup of coffee. Hospital records indicate that the presenting injury was consistent with the explanation given and was recorded as an accidental injury. AT was given verbal advice about keeping young children away from hot liquids and was discharged to her GP.

6.26 AT attended an appointment for maternity care on 27th December 2013. She confirmed the father of her baby was BF8. Notes from this appointment indicate that AT told the midwife that there was no previous social work involvement and replied in the negative to questions about risks and vulnerability factors.

The Review Team were informed that as this was AT's second pregnancy and as the medical notes contained references to domestic abuse, and a 'family plan', the midwife (now retired) wanted to be sure that the details given by AT were correct, so she used a referral form to share information about AT's pregnancy and her relationship with BF8 and forwarded this to the hospital social worker,[12] (SW5) asking if the '*case was closed*'. SW5 recalled a conversation with a member of staff in the Central Duty Team. She was advised that there was no current involvement but details relating to the pregnancy were recorded on Carefirst, the recording system in CSC. According to SW5, the conversation was confirmed in an email.

6.27 At a FNP visit on 7th January 2014, AT confirmed that she was pregnant and was still in a relationship with BF8. She said they saw each other once during the week and once at the weekend and at these times MGM looked after Child H. Child H was described as playing with MGF, had lots of smiles and was playing with toys. AT said that she had stopped giving Child H special formulae milk and she was now on full fat milk. Child H's nappy rash was discussed. AT was happy for CSC to be contacted by FNP1 about her pregnancy and said she thought that the midwife would also be contacting them.

6.28 Sometime after this visit, AT and Child H, moved with BF8 to a different address in Q Street, about 5 miles away from where AT had lived previously. Neither FNP1 nor CSC was informed about this move.

6.29 FNP1 contacted CSC Central Duty Team on 9th January 2014 to express her concerns about Child H and AT, given that AT was pregnant. She was advised to put these concerns in writing and she submitted a referral to CSC on 16th January 2014 in which she stated that the '*family would benefit from a social care assessment to look at any potential risk posed by AT being in a relationship with BF8 and them becoming parents together given his history'.* FNP1 also referred to the fact that until October 2013, AT had worked well with the FNP programme but her engagement had changed significantly since she became involved with BF8. Children's social care records note that the Central Duty Team took a decision that in response to this referral, '*a further social care assessment would be undertaken*'.

6.30 On 21st January 2014, AT again cancelled a FNP visit saying she and Child H were unwell and she was making a GP appointment for later that day. The visit was rearranged for 4th February 2014.

6.31 The Police received an anonymous phone call on 25th January 2014. The caller said that they could hear a child crying and a male voice shouting and telling the child to 'shut the fuck up and go to sleep'. Police attended a house in Q Street where on arrival they spoke with a man and then, to AT. The male explained that he had been shouting at the dog as it had eaten the child's food. The attending officers observed a noisy and excited dog and accepted the explanation given. They asked to see the child and one officer was escorted upstairs by AT where, according to Police records, she was asked, out of earshot of the male, if there had been any family disagreements. AT said all was well. The police officer saw Child H asleep in a tidy room, before they left the premises.

[12] *This person is employed by Children's Social Care but is based within the hospital.*

The officers concluded there was no need to complete a Form 125[13] as no safeguarding concerns were noted. It later transpired that the male was BF8 but he had given his brother's name when asked for his identity.

6.32 There was a no access visit by FNP1 on 4th February 2014 and AT did not respond to calls or texts. On 6th February 2014, AT attended for an antenatal check by a midwife, no concerns were recorded. On 13th February 2014, Child H was taken to hospital by ambulance as she had stopped breathing. She was noted to have a bruise on her forehead and on her right cheek.

6.33 Child H died in hospital because of a hypoxic brain injury.

7 Appraisal of Practice

7.1 This section looks back at the actions and decisions of professionals working with Child H and explores why these professionals acted as they did. The 'why' questions are important as they helped the Review Team understand what systems were in place at that time to support good practice or to make it less likely. The Review Team were mindful of how much hindsight can distort judgement about the predictability of an adverse outcome[14] and that the prediction of events is not a straightforward matter; nevertheless it remains essential that SCRs examine what happened and why actions and decisions may have made sense at the time.

7.2 An important factor of a systems review is to consider whether any system vulnerabilities are still present and how and where these can be changed. The aim of using a systems model is to select and review a specific case and to use this to provide '*a window on the system*'.[15]

7.3 This review highlighted familiar dilemmas for those working with young parents where there are perceived or substantiated concerns about violent and aggressive partners and the risks these adults pose to children. It is however important to note that although AT had several boyfriends during the period under review, it was not until she began a relationship with BF8 in September/October 2013, that significant concerns began to emerge and it is this period which has produced most of the learning.

7.4 This section outlines the Review Team's views about how well professionals carried out their roles and responsibilities in working with Child H's family and provides a link to the analysis of why certain actions may have made sense at the time.[16] The examination of single and multi-agency working leading up to the death of Child H has identified several areas of learning for all agencies, together with some reflections about how judgments were applied at key points of interventions.

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[13] *Completion of Safeguarding Form 125 is required when officers have been called to a house in connection with concerns about the safety or well-being of a child.*

[14] *Munro (2011: 1.14)*

[15] *http://www.scie.org.uk/children/learningtogether*

[16] As the police officers were unable to take part in the SCR process, they provided written statements about their actions

The analysis is structured around **areas of significant practice (ASP**), which leads to the findings and identification of common thematic issues. These are listed below and further details follow.

ASP 1: The ways in which professionals communicated and worked collaboratively within a multi-agency context
ASP 2: The use of 'Letters of Expectation' and 'Family Plans' to address safeguarding concerns
ASP 3: The extent to which professionals engaged with significant males in the family
ASP 4: The response of CSC to referrals and notifications and the timeliness and quality of subsequent assessments**.**
ASP 5: The response by agencies in Hull to incidents of domestic violence and the need to keep the child in focus at all times
ASP 6: Supervision and Managerial Oversight

7.5 **ASP 1: The ways in which professionals communicated and worked collaboratively within a multi- agency context.**

The FNP practitioner and the Probation Officer highlighted concerns about BF8 and although information was gathered as part of the assessment process, the risks posed by BF8 were not analysed from a multi-agency perspective. The Review Team wanted to explore multi-agency working to discover if it took place and if not, what the barriers to effective collaboration and communication were.

7.5.1 Agencies have a collective responsibility to protect children and this demands effective communication and co-ordination of services at both strategic and operational levels. Whilst the lead agency for undertaking Initial and Core assessments[17] is CSC, that agency still relies on partner agencies to provide much of the information, which underpins their assessments. In this review, the FNP practitioner had considerable information about AT and family relationships and the police and probation officer had relevant background material but very little of this information appears in the assessments undertaken by CSC.

7.5.2 The Probation Service initially highlighted concerns about BF8, and these were responded to appropriately by CSC who undertook an assessment of risk and sought information from other agencies. The Review Team was informed that information was gathered verbally, as it is not usual practice for agencies to be asked to contribute to CSC assessments in writing and this is why not all of the background information held by other agencies appears in the assessment undertaken by CSC. However, without sight of this information it remains impossible for others to understand or review how the assessment outcomes have been reached and on what basis.

7.5.3 AT had been referred to the FNP programme by CSC following an earlier initial assessment in September 2011. This was a proactive response which engaged AT as a potentially vulnerable young parent, in a highly structured and intensive programme of support. FNP1 sent a letter to CSC in November 2011 advising them of AT's engagement and included a leaflet explaining the role and function of the FNP practitioner. FNP1 was not however kept well informed when CSC responded to allegations or domestic violence incidents and she was not sent copies of '*letters of expectations'* or '*family plans'*.

[17] *These assessments have now been replaced by a Single Assessment process.*

This meant that FNP1 was working very much in isolation and was the only professional working with a family where domestic violence had been identified. Despite this involvement, there is very little of FNP1's perspective evident in the Initial Assessment initiated in October and signed off in December 2013.

7.5.4 FNP1 was proactive in following up the progress of this assessment and eventually spoke with SW4 who advised that the assessment was still underway and a decision would be taken by her manager as to whether the case remained opened or was closed. This decision was accepted by FNP1. The practitioners exchanged information and SW4 told FNP1 about the written agreement between CSC and the family in relation to BF8. FNP1 reminded SW4 that her time working with the family was coming to an end. FNP1 accepted the information she was given by SW4 and whilst she did not question or query the possibility that the 'case' might be closed, she was nevertheless reassured that the assessment was underway and that it would identify any actual or potential risks to Child H from BF8.

7.5.5 It was acknowledged by practitioners in this review that it is not uncommon for other professionals to hold the view that social workers '*must know best'* and they suggested this is why relatively few challenges to social worker's decisions are made. During her work with the family, FNP1 had supervision several times and her concerns were discussed once in a group supervision session. She was not however advised or supported to challenge the actions or decisions of CSC at any time during her work with AT. The Review Team was informed that as FNP1 was a level 4 practitioner, she would be expected to make decisions about referrals to CSC and decide for herself when, and if, challenges were necessary. The Review Team was of the view that this expectation could leave practitioners, however well experienced, in a very isolated and vulnerable position.

7.5.6 Research [18] highlights the importance of professionals from all agencies working collaboratively, sharing knowledge and expertise. There was evidence of good team working and information sharing within the Maternity service, the Neonatal Intensive Care Unit, Outreach service, and Family Nurse Practitioner when Child H was born. It was also good practice that the FNP practitioner and SW3 undertook a joint visit following the conclusion of the Core Assessment in November 2012 but subsequently, although information was shared there was less direct collaboration between the agencies. A joint assessment or visit between CSC and FNP1 as part of the initial assessment carried out in October 2013 could have been of immense benefit given that the FNP had worked with the family for over two years. Neither professional considered this option as a possibility or were encouraged to do so by their line managers or safeguarding leads. The Review Team was informed that time and workload pressures frequently impacted on opportunities for joint working and this was especially the case when Initial Assessments were undertaken.

[18] *Social work assessment of children in need: what do we know? Messages from research DFE March 2011*

7.5.7 The value and purpose of conversations with colleagues from other agencies lie not simply in their taking place, but in the opportunities afforded to have active, reflective and robust discussions about how to best safeguard children. Although telephone conversations took place after concerns were highlighted in relation to BF8, these were limited to sharing information as opposed to developing a multi-agency plan. For example, the Review Team learnt from individual conversations with practitioners just how threatened and intimidated they felt in the presence of BF8, but there were no opportunities for these experiences to be shared and to form part of the analysis of the risks posed by BF8. A meeting between the PO1, SW4, FNP1 and Police would for example, have allowed a more detailed assessment of the concerns and offered scope for the development of a multi-agency safety plan for Child H. Such a plan could have clarified under what circumstances CSC should intervene, what information should be shared and when and this would have provided an important source of support for FNP1.

7.5.8 The Ofsted inspection of services for children in need of help and protection, children looked after and care leavers, published in February 2015, pointed to the fact that step down arrangements from CSC were still at an early stage of development in terms of their effectiveness in supporting multi-agency plans for children where there was no ongoing involvement from CSC. Agencies have made progress recently in developing a framework for such multi-agency collaboration, but the context for the work with Child H is that such arrangements were not in place and such a meeting would have been very unlikely to have taken place at that point in time.

7.5.9 The referral form sent to the hospital social worker by the midwife in December 2013, initially led the Review Team to conclude that this was a referral to CSC. In effect, the midwife had used the referral form to enquire about the status of the case. SW5 advised the review team that usually midwives would telephone her to find out information but on that day she believes she was not in the office and the midwife had just used the referral form to make enquiries. SW5 explained that the role of the hospital social worker is to provide information to midwives when asked and/or to advise them to make a referral direct to the Access and Assessment team[19], if appropriate. In response to the query on the submitted form, SW5 recalls she confirmed there was no ongoing involvement with the family and ensured that details about AT's pregnancy were recorded on the Carefirst[20] system. The information relating to BF8 was however lost in translation and consequently there was no follow up action by CSC and no link with FNP1's referral made two weeks later. The role of the hospital social worker and the pathway for referrals to CSC needs to be clarified and this has been highlighted in the single agency learning reports for CSC and Hull and East Yorkshire Hospital NHS Trust.

[19] *On 13th Jan 2014 the Central Duty Team became known as the Access and Assessment Team*

[20] *Carefirst is a case management system which was used by many local authorities across the UK and has since been replaced in Hull by Liquid Logic*

7.5.10 FNP1's referral in January 2014 provided new information about AT's pregnancy, and that since October 2013 a number of her visits to AT and Child H had been missed or cancelled by AT. In other respects, as far as any professional was aware, Child H's circumstances remained the same, and FNP1 stated in her referral that as far as she was aware AT made arrangements for her mother to care for Child H when she saw BF8.

7.5.11 The referral was rated as high priority in CSC but the required date for the assessment was listed for 19th March 2014, suggesting to the Review Team that the referral was accepted more as an alert for a pre-birth assessment for AT's unborn child rather than as an unassessed risk of immediate concern in relation to Child H. Whilst we now know that AT and Child H moved to live with BF8 sometime in January 2014, no one was aware of this at the point of referral. The CSC decision maker decided that AT's possible disengagement from FNP (which was coming to an end in March 2014 in any event), together with the new pregnancy, meant that a further CSC assessment was required in relation to Child H and the unborn child. However, the information did not suggest an immediate risk to Child H, and the assessment had not begun by the time of Child H's death five weeks later. It is likely that the context of the new pregnancy influenced this apparent delay in that practice in relation to CSC assessments of unborn children, is to delay the start of such an assessment until the 20th week of pregnancy. In the absence of any information suggesting an immediate risk to Child H the established pre-birth arrangement was followed, and this meant that the changed living arrangements for Child H did not come to light.

7.5.12 Although CSC records indicate that they were unaware of AT's pregnancy until after the Initial Assessment was completed in December 2013, FNP1 was aware that AT thought she was pregnant in November 2013 but this was not shared with SW4 until the pregnancy was confirmed in January 2014. It would have been appropriate for FNP1 to have alerted SW4 earlier that AT could be pregnant as this was a significant piece of information and may well have influenced the Initial Assessment.

7.5.13 Whilst the information about AT, BF8 and Child H living together was not known at the time and could therefore not influence decision making, it would have been good practice for there to have been a conversation between a social worker and FNP1 following the written referral in January 2014. The full extent of FNP1's concerns were not explicit in the written referral, and the practitioner conversations have established that FNP1 was hoping for more collaboration from CSC, and in making the referral was seeking assurance that the issues she was raising were understood in CSC. Had a discussion taken place, the concerns may have been clearer and the need for prompt action better understood. It is in these circumstances that effective communication and collaboration are key.

By its very nature, joint working brings together professionals with different roles and responsibilities as well as divergent professional cultures and these differences can act as barriers to effective joint working. Understanding the roles and responsibilities of colleagues from different disciplines and respecting their expertise is critical to the success of joint working. The Review Team debated whether the depth of knowledge that FNP1 had gained in her work with AT was appreciated by CSC and whether her ongoing involvement with the family acted as a reassuring factor for CSC.

The opportunity to have a conversation about the nature of her unease about the failed/missed appointments, for example, could have helped CSC understand this aspect of her concerns. FNP1 was not however prompted by any agency systems to follow up her referral to establish what action was to be taken, and CSC did not themselves initiate such a conversation with FNP1 during the period between receipt of the referral and Child H's death. The Review Team was informed that at the time, it was not common practice for follow up conversations with referring agencies as usually such conversations had taken place prior to the paperwork being submitted.

Finding 1: *There was a lack of multi-agency collaboration and challenge which left AT and Child H vulnerable to the risks posed by BF8.*

Finding 2: *When FNP Practitioners are working as the only professional in a family and there are concerns about domestic violence, other agencies can be falsely reassured by their involvement. Without a multi-agency assessment, this can leave both children and the practitioner vulnerable. This would also apply to any practitioner working as a lone professional with a family where domestic violence is known or suspected. (Patterns in multi-agency working)*

Finding 3: *If duty officers in CSC do not routinely communicate with the referring practitioner before making decisions about a referral, misunderstandings can occur and this leaves children vulnerable.*

7.6 **ASP 2: The use of 'Letters of Expectation' and 'Family Plans' to address safeguarding concerns**

According to CSC records, three 'Letters of Expectation' were forwarded to AT during the period September 2011 – May 2013. Although outside the timescale for this review, the information pertaining to the use of these 'letters/plans', was of interest to the Review Team. The first 'letter of expectation' was issued in September 2011 and AT was reminded in January and March 2012, that this letter remained in force following allegations that she was in contact with BF1. The second letter was delivered on 12th November 2012, in response to a domestic incident with a boyfriend and another was sent on the 24th May 2013 following a domestic incident with a different boyfriend. A 'family plan' was agreed with AT, MGM and BF8 in October 2013. The Review Team considered this was a significant area of practice as these 'letters or plans' could inadvertently minimise risk and actually be a barrier to multi-agency working.

7.6.1 A '*Letter of Expectation'* is a formal letter still used, at the time, by some authorities across the UK, most often in situations where domestic abuse has occurred. The 'letter' was used to formalise and give emphasis to the expectations held by social workers in respect of the parents' responsibilities to care for and protect their children. They were seen to provide clear communication to parents or carers about what action or actions they are expected to take in relation to their children. They were, in effect, a statement of the local authority's concerns and advice given to the parent or carer; they were not, however, a contract and there was no legal requirement for parents to sign to indicate their agreement.

7.6.2 The use of these letters was described as common practice in Hull at the time and they were used as a means of responding to 'lower' levels of concern including at the point of case closure, to stipulate expectations of the local authority. The Review Team considered that the use of these letters could easily slip into defensive rather than proactive practice, in other words, a practice that protects the agency more than a child. Research[21] suggests that such letters are ineffective in reducing domestic abuse incidents, may actually increase risks for some victims and in themselves do not keep children safe.

7.6.3 It is not clear whether the 'letters' sent to AT were in fact written agreements in that those documents seen by the Review Team required the signature of all parties. A document produced by CSC entitled 'Written Agreements and Letters of Expectation' was produced in November 2013. This document sought to clarify the difference between the two approaches and the circumstances in which each could be used most effectively. The guidance notes stipulate that when used, these documents must always be typed on headed notepaper using the Hull City Council logo and should always include the contact details of the social work team.

7.6.4 The Review Team was informed that in December 2013 CSC stopped using 'Letters of Expectation' and replaced them with 'Family Plans'. The Review team had sight of what appeared to be the 'Family Plan' agreed with AT and MGM in December 2013, but they struggled to determine a significant difference between it and the earlier 'letters of expectation'. This would suggest there is a need for far greater clarity in the use of these documents and perhaps more thought given to the language and definitions used. Crucially, they should always be used as a multi-agency, rather than a single agency tool. The 'family plan' presented to the lead reviewers by AT and Child H was unsigned and produced on plain paper but the Review team were informed that this would be because it had been printed off from the Carefirst system for use in the Finding of Fact process.

Finding 4: Written Agreements or Family Plans can be valid tools for helping a family to change, to solve problems and in some cases to remove the risks that would otherwise make the children unsafe at home. However, without a process by which an agreement is monitored and reviewed and shared with other agencies, these 'plans' do not in themselves keep children safe but may give the impression of doing so. (Patterns in Management of Systems)

7.7 ASP 3: The extent to which professionals engaged with significant males in the family

A factor of case reviews and audit work nationally is the repeated finding that fathers and male figures are often absent in recordings, assessments and care plans. Learning highlighted in serious case reviews has pointed towards the lack of engagement by social care and health professionals with men whose involvement with mothers is clearly evident or with those males who appear on the periphery of family life. The Review Team were of the view that when protecting and supporting children, practitioners need to proactively assess and engage with all significant men in a child's life, understanding that some may pose risks, some may be assets and some may incorporate aspects of both.

[21] *NSPCC Children and Families experiencing Domestic Abuse (2010)*

7.7.1 AT had several relationships with adult males before and during the period under review. She also shared a house with her father, yet there is very little information about any of these males in the assessments that were undertaken. Successive biennial analyses and more recent serious case reviews[22] warn that professionals too often overlook the presence of males in families. The biennial analysis from serious case reviews (2005-2007) provides a warning about fixed thinking about men, which is also evident in more recent serious case reviews and was found in this serious case review.

'…. Men were perceived in a polarised way as primarily 'good' men (good dads) or 'bad' men (bad dads). This attribution was then linked to whether fathers were thought of by professionals as reliable or unreliable and trustworthy or untrustworthy.'

7.7.2 Between March 2012 and October 2013, AT began and ended several relationships, in itself perhaps not so unusual for a young single woman. According to police records, they were contacted on five occasions during this period: twice because of threats made to AT by ex-partners and three times in relation to domestic incidents, although each of these related to a different partner.

7.7.3 There is a plethora of research to suggest that children are at greater risk from unrelated males in a household than from biological fathers[23]. Much of this research concludes that the presence of a 'non-biological' father figure in the home should be considered a significant predictor of future harm and certainly FNP1 was concerned about AT's relationships and the impact these could have on Child H. Whilst AT's increasingly complex and fluid relationships could have necessitated a broader examination of these adults and their impact on Child H, the Review Team acknowledged that until October 2013, there was very little to suggest such a course of action was necessary or that the intervention of statutory agencies should be a priority: steps had already been taken to ensure that AT did not have contact with BF1; Child H was seen regularly by FNP 1 – far more often than the usual health visiting service – the child was reaching the appropriate milestones and records from SW2, SW3 and FNP1 attested to the positive relationship and strong attachment observed between AT and her child. In addition, AT was engaging well with the FNP programme and was considered to be 'well-supported' by her family. The fact that MGF lived with AT was referred to frequently in agency records and although he remained 'unassessed', he appears to have been viewed as a protective factor in Child H's life.

7.7.4 FNP1 did try to engage with the males with whom AT established relationships and this was good practice. There was evidence of good practice where, when these males were in AT's home, FNP1 tried to include them in her discussions with AT and not only asked about their lives but advised them she would check their details with CSC.

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[22] *Hidden men: learning from case reviews: Summary of risk factors and learning for improved practice around 'hidden' men NSPCC 2015*
Add references needs adding
[23] *Handbook of Child Maltreatment. Jill E. Korbin, Richard D. Krugman, Office of National Statistics 2013*

The Review Team was concerned to note that FNP 1 did not always receive prompt information about domestic incidents and this significantly limited the opportunities for timely discussions e.g. the domestic incident, which took place on the 14th April 2013, only reached FNP 1through a police incident report on 4th June 2013.

7.7.5 The Core Assessment, which was undertaken, and the response to domestic incidents involving BF6 and MGM in May 2013, did not refer to engagement with the significant males involved. It should be noted that these males at the time, were not members of the household and therefore contact would not have been straightforward. Nevertheless, gathering information and listening to their perspective, may have contributed to a more robust analysis of family functioning, rather than just relying on accounts of incidents given by AT and MGM.

7.7.6 It is however important to explore the realities of trying to engage men in the assessment process. Research[24] indicates that, as the priority is always child safety, that means deciding to concentrate on the child's mother, because it is often she that spends most time with the children and some males are simply not around or make themselves scarce when social workers visit. When males are not living in the household this makes the effort of engaging them even more difficult and can impact upon the timescales in which assessments are completed. Whilst these practicalities need to be considered, research[25] also suggests that within the culture of safeguarding, without challenge and opportunities for reflective thinking, men can too easily be constructed as a threat or dismissed as irrelevant. There is evidence of both perspectives in this review.

7.7.7 There is extensive literature on fathering, and within that a considerable range of research findings indicating how social workers and other professionals can fall into the trap of ignoring significant males/fathers, of dismissing their contribution, or of loading responsibility onto mothers to protect children from any dangers coming from the male/father. Whilst professional vigilance is necessary to ensure that information about fathers is available whenever possible, the Review Team would suggest that similar vigilance should also be applied to all adults living in a household where there are concerns about the welfare or safety of a child.

7.7.8 The maternal grandfather was included in the widely held assumption by professionals that AT's family was a supportive one. This view appears to be based on the fact that until January 2014, he lived with AT and Child H, but there is very little information recorded upon which it can be assumed that MGF was a positive and protective influence in the family. As Child H's live-in grandfather, he was a significant adult in the child's life and it is unclear why he was not assessed as a potential or actual carer for Child H and his views and parenting capacity assessed accordingly.

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[24] *Learning from Serious Case Reviews DFE May 2010*

[25] *Ashley, C. (ed.) (2011) Working with Risky Fathers: Fathers Matter 3: Research findings on working with domestically abusive fathers and their involvement with children' social care services. London, Family Rights Group.*

There are several references to his drinking with his daughter and her boyfriends but these anecdotal descriptions are not validated or given any prominence and he remains an unknown and unassessed character in the records of the various assessments which took place. It is clear however that he had a daily presence in Child H's life.

7.7.9 Although FNP1 saw MGF quite often during her visits, there appears to have been little direct engagement with him, contrary to her involvement with AT's boyfriends. FNP1 and SW4 both recall that they were frequently told by AT that she was 'well-supported' by her family but the extent of this support was neither explored nor analysed within the context of any assessment. It is clear that the role MGF played in the life of his grandchild should have been assessed before assuming his presence equated with him being a protective factor. Had MGF been considered a risk to his grandchild, he would have been subject to a detailed risk assessment, but the fact he was regarded as a protective adult was taken for granted on the basis of his familial role and his physical presence in the home but without the benefit of any assessment to confirm that view.

7.7.10 There was one telephone conversation with BF8 at the time of the Initial Assessment in October 2013, but otherwise he was not included as part of the assessment. He was known to be a perpetrator of domestic abuse and the risk to both AT and Child H had been made explicit in a conversation with his Probation Officer. SW4 believed BF8 should not be in the home of AT when Child H was present and she made this quite clear to AT and MGM. SW4 told the Review Team that her first encounter with BF8 had been 'unnerving'. This highlights how working with hostile adults can, without support and good supervision, impact on the ability of practitioners to work confidently in families where domestic violence is a concern.

7.7.11 On the second visit, SW4 took a support worker with her and she agreed that she had been worried that BF8 might be present. This was sensible practice. Research[26] suggests that where domestic violence is known or suspected, two professionals should be present at assessments so that there is less chance of the perpetrator intimidating the practitioners or manipulating them in to a collusive relationship. However, the reason for taking a colleague on a joint visit was not recorded in the Initial Assessment signed off almost 7 weeks after this visit. This raised questions as to whether SW4 discussed what happened during the visit with her manager and if not why she was hesitant to do so, a point discussed later under 8.4.

7.7.12 Messages were conveyed to BF8 through AT and MGM about the 'Strength to Change' programme and although BF8 did make telephone contact with SW4, she was able to later reflect that perhaps more could have been done to engage with him and she could have followed up whether he did actually attend the programme. There was recognition that further engagement with BF8 could also have supported an assessment about his willingness and capacity to change his behaviour but there was sufficient evidence to reassure SW4 that AT and her extended family members were able to protect Child H and understood the potential risks. At the time, there was no evidence of any domestic abuse between BF8 and AT, and no concerns expressed by the family about BF8's interaction with Child H.

[26] *Stanley and Humphries (2006), N. Stanley, NSPCC (2010)*

7.7.13 Following the concerns raised by PO1, further enquiries do not appear to have been made to the police to determine the extent and nature of his abuse towards previous partners and his children. By CSC maintaining a perspective that BF8's aggression was linked to concerns about his [past] family, a distorted picture of AT and her family emerged in which the family were viewed, especially given their past experiences of dealing with AT's boyfriends, as being well able to cope with any risks which BF8 might pose. The risks were consequently measured against what was seen as a 'protective' family but the extent to which AT, herself, could withstand the influence of a controlling and aggressive male was not explored.

7.7.14 Within domestic abuse literature, there is frequent reference to men's use of power over women and children, but this did not appear to have been fully considered in the assessment undertaken in October 2013, despite the feelings BF8 had invoked in SW4. A meeting with the Probation Officer might have proven helpful to explore the ways in which BF8's behaviour could appear intimidating and threatening even to confident professionals. Where agencies come into contact with perpetrators, they need staff who are confident and skilled to explore violent and abusive behaviour and systems of support for this very challenging area of work. The Review Team was unable to find evidence that the need for this level of support was well understood by the managers of SW4 or FNP1, an issue further explored in ASP 6 below.

Finding 5: *When professionals are working with families where concerns have been raised, all family members and especially those living in the household should be subject to assessments, both to determine risk and to confirm and assess their ability to protect children within the family. Their active involvement in plans should be carefully monitored.*

Finding 6: *A lack of engagement with men in situations where domestic abuse is known or suspected allows a distorted picture of the family situation to emerge, but without partnership working between agencies, clearly identifiable support structures for staff and managerial oversight, any engagement with known or suspected perpetrators is less likely to be effective.*

7.8 ASP 4: The timeliness and quality of assessments undertaken by CSC.

During the period under review, there was no ongoing involvement by CSC. Five assessments were undertaken by CSC between September 2011 and October 2013, three of which took place in the period under review. The Review Team wanted to know whether the responses to concerns from partner agencies adequately assessed the risk to Child H and to what extent managerial oversight supported the decisions and actions taken.

7.8.1 In September 2011, when concerns were raised when AT became pregnant by BF1, a male with a conviction for a sexual offence against a child, CSC responded swiftly and over the course of 4 months, two Initial Assessments were undertaken in relation to those concerns. Although outside the period of review, these assessments are significant in that the Review Team considered that the findings and concluding analyses established a view of AT and her family which persisted, without challenge, over the next 30 months.

7.8.2 AT had a troubled adolescence and was viewed by professionals as a vulnerable young woman who met new partners and very early in the relationship allowed them to move into her home.

She was however, also viewed as a caring parent and despite the complications arising from a premature birth, Child H developed well and was observed to be a contented and happy child. AT was thought to be a protective factor for Child H; she claimed to understand the risks posed to her child from BF1 and reassured professionals that she was capable of seeking help should Child H be at risk in any way. The fact that AT was working with FNP1, lived with her father, and was near to her mother, led to the conclusion that this was a family who could and would protect Child H. It is interesting to note that a practitioner described MGM as a 'strong and likeable' woman and this, according to research,[27] may have influenced the view that MGM was a protective factor in the family. In effect, however, MGM's capacity to protect Child H was not assessed, despite that she had her own young family and was employed in a part time job. Practitioners acknowledged that 'liking' or being able to empathise with a parent can, without opportunities for reflective thinking, make it harder to be objective about an individual and their behaviours[28].

7.8.3 The process through which professionals work with parents to help them understand why there are concerns, what they need to do and what needs to change to keep their child safe and well, is common in work with families and is often referred to in academic terms as a 'single loop' process. There is evidence that police, health and social work professionals discussed with AT on many occasions the importance of keeping Child H safe and what as a parent, she needed to do to protect herself and her child from males who could pose a risk. Letters were used to confirm this advice. It remains clear that professionals considered that AT was able to protect both herself and Child H and the perceived closeness and support of her family strengthened that view.

7.8.4 Munro (2010)[29] argues that professionals should always take time to step back and question the assumptions which underpin their actions and decision-making, a form of reflection she describes as 'double loop' learning. The Review Team questioned some of the assumptions made by professionals in relation to how MGM could have been considered as a protective factor and AT being able and willing to distance herself from the situations in which she or Child H could be at risk. The Review Team also questioned whether later, it was realistic to expect that AT, as a vulnerable young woman, would have had the capacity to withstand the demands placed upon her by BF8, a known and aggressive perpetrator of domestic abuse.

7.8.5 Munro's research suggests that professionals need to take active steps to work against '*our human tendency to seek only the information that we wish to find*', and confirms the dangers of a tendency to '*stick to what we think we know'* and carry on with plans without question or challenge. Fish (2009) writes '*one of the most common, problematic tendencies in human cognition ... is our failure to review judgments and plans – once we have formed a view on what is going on, we often fail to notice or to dismiss evidence that challenges that picture*.'

[27] *Nauert PhD, R. (2012). Intuition and Reasoning Influence Decision-Making. Psych Central.*
[28] *Nauert PhD, R. (2012). Intuition and Reasoning Influence Decision-Making. Psych Central.*

[29] *Munro, Eileen (2010) Learning to reduce risk in child protection. British Journal of Social Work*

7.8.6 There is a sense that when assessments were undertaken, social workers looked for reassurance that all was well for Child H and so this is what they found. Research[30] tells us it is important that professionals are mindful of the dangers of making assumptions and using intuition as the only basis on which to make judgments. Confirmation bias can occur when professionals rely more on evidence that is consistent with existing views or preconceptions and place less emphasis on evidence which contradicts this view. The perception that AT and her family were strong protective factors was not in fact tested but based on conversations with family members who self-reported they were able and willing to keep Child H safe. There were no assessments undertaken in respect of either grandparent, and little to evidence that any individual visits or conversations took place with these or other members of AT's family. MGM had a young family of her own and how she would have been able to keep track of what was happening to Child H was not discussed or explored. CSC were not informed when MGM remarried and moved to a different area of the city, neither were they contacted when BF8 and AT moved to a different area and set up home together, despite the agreement that he would not have contact with Child H. There was evidence that the social workers undertaking assessments persisted in their initial judgments and were not challenged or supported to question their assumptions, or actively encouraged to seek out information that shed doubt upon them.

7.8.7 There was evidence in files which suggested that AT did drink heavily on occasions – she was admitted to hospital being intoxicated in August 2012 and police records frequently referred to adults being intoxicated when they were called out to domestic incidents at her address. There were other occasions when professionals were perhaps too ready to accept AT's version of events and where a dose of 'healthy scepticism' and 'respectful uncertainty' (Laming 2003) would have been more appropriate. In both Initial Assessments undertaken before the period under review, the allegations made by BF1 were dismissed as being malicious by AT and this was accepted without challenge. Professional curiosity might have led to further enquiries and established the possibility that AT did not always heed the advice of professionals or comply with agreements, despite giving the impression to the contrary.

7.8.8 SW4 accepted AT's assertion that BF8 did not and would not stay overnight or be in contact with Child H. However, whilst the Review Team accepted that the assurances given by MGM and AT were persuasive, further enquiries and a more sceptical stance may well have highlighted that AT would find it difficult, should she even wish to do so.

7.8.9 The 'rule of optimism' that can affect assessment and decision-making in child welfare and child protection work is well documented.[31] A likeable, seemingly co-operative parent has considerable power to disarm and distract professionals from what is happening in their family.

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[30] *Gambrill, E.D. (2005) 'Decision-making in child welfare: errors and their context', Children and youth services review, vol 27, 4, 347–352*

[31] *Humphreys C. and Stanley N. (eds) 2006. Domestic violence and child protection. Ofsted 2011. Ages of concern: learning lessons from serious case reviews: A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011*

Professionals clearly warmed to both AT and her mother and accepted that they would not allow Child H to come to any danger. Whilst the risks were explored with the family, it is possible that the extent of BF8's capacity to exert power and control was not appreciated by the family or indeed by the professionals working with AT.

7.8.10 There is considerable research[32] which suggests that without the use of tools to assess risk, professional judgment can too often be flawed, with some assessments being '*only slightly better than guessing*'. The assessments undertaken by CSC did not reference the use of any specific assessment tools in relation to domestic abuse, such as the DASH[33] assessment which may have informed the analysis of risk to AT and Child H. More direct collaboration with the Probation Service would also have enabled reference to the assessment of risk carried out by that agency in relation to BF8, and a clearer understanding of the implications for arrangements to safeguard Child H. The challenge for professionals of course is to know which tools to use and when. The Review Team was informed that the practitioners working with AT had not attended any training in the use of the DASH assessment tool.

7.8.11 The dilemma of how to work to a strengths-based approach, whilst also maintaining a critically evaluative focus on whether parental avoidance is happening, is found in research[34] and suggests that professionals often place too much reliance on what parents say and fail to consider that families can be resistant to contact from professionals and able to develop skillful strategies for keeping them at arm's length. The possibility that this could be the case with AT, MGM and MGF was not considered at all in any of the assessments undertaken and again highlights the importance of good reflective supervision, which asks professionals to explore other possibilities and perspectives.

7.8.12 Critical and analytical thinking encourages practitioners to process information rigorously and methodically and to question the reliability of both sources and content. Building reflection into practice allows for regular review of assumptions and formulations in the light of existing and new information. In this review the absence of healthy scepticism in relation to the relationship between AT and BF8 and the lack of understanding about the risks BF8 posed underpinned the lack of challenge to MGM's belief that the family could protect Child H.

Finding 7: *There were some common thinking errors in this review - untested assumptions and a lack of healthy scepticism about what was being reported by the family - these were not picked up through current case management processes at the time.*

[32] *Child Abuse and Neglect: Caseworker assessments of risk for recurrent maltreatment association with case-specific risk factors and re-reports March 2008*

[33] *Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) is a checklist for identifying and assessing risk used by police and partner agencies across the UK.*

[34] *Ofsted, 2008, Evaluation of 50 SCRs*

7.9 **ASP 5: The response by agencies in Hull to incidents of domestic violence and the need to keep the child in focus at all times.**

Multi-agency working is central to current policy and practice approaches to safeguarding children and domestic abuse work[35]*. Its rationale lies in an understanding that the needs of children and families are inter-linked and multi-dimensional and meeting these needs requires joint working and collaboration. The Review Team considered that in relation to Child H, individual agencies were working independently of each other and missed opportunities to work collaboratively to assess risk from BF8.*

7.9.1 Evidence from serious case reviews continues to highlight domestic abuse as a characteristic in families where children die or are subject to a serious incident.[36] The risks to children under the age of 5 are also well documented.

7.9.2 According to the police chronology, AT had contact with police officers on eight occasions between March 2012 and February 2014, following domestic incidents. Police records were generally not robust in terms of stating whether Child H was seen and under what circumstances. As the front-line service intervening with children and families experiencing domestic violence, police officers attending incidents need to be aware of any children in the home, their immediate circumstances and ensure that details relating to their care and well-being are carefully recorded and referred on.

7.9.3 An anonymous call was made in November 2013, alleging that AT had been assaulted by BF8 and he had a weapon, police called at the given address within 20 minutes but there was no response. The Review Team was told that Police were 'distracted' by wanting to find BF8 as he was wanted on a warrant and they spent time looking for him in the community and called at previous known addresses. The incident was then logged as a 'job' for the following morning but AT was not seen until late that evening making it 21 hours since the original call had been made. The Review Team was informed that, by that stage, the focus was primarily on finding BF8 rather than responding to a domestic abuse incident, so there was no evidence that the officers recorded/checked out whether or not AT had an injury consistent with the original referral and neither did they complete a DV report. At this time, CSC was already undertaking an Initial Assessment and this information would have been significant.

7.9.4 There is a wealth of research which highlights that domestic violence cases are distinguished by a high rate of denial by victims and this can place police officers, in their front line response role, in a very difficult position. The fact that the officers did not submit the required paperwork following the November 2013 call out suggested they did not consider that they were dealing with a domestic abuse situation even though the Command Centre had graded the incident as medium risk[37].

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[35] *HM Government 2010: Call to End Violence to Women and Girls*

[36]*Lessons from Serious Case Brandon et al., 2008.*

[37] *All calls for service in relation to Domestic Violence incidents are graded by the Forces Command Centre before being passed to the attending police officers*

In January 2014 when Police responded to a further anonymous call, they accepted the explanation given by both adults, and were given false details by BF8 so were unaware to whom they were speaking. AT assured them that all was well. They saw Child H asleep in bed and left concluding this was not a domestic incident. It is perhaps understandable why this may have made sense to the officers at the time, although established procedures are that a Form 125 (Safeguarding) should have been completed to highlight that a child had been involved in the alleged incident.

7.9.5 The Review Team was unable to explore these questions further as the officers in question were not available for individual conversations and although, some information was provided in relation to the call out in January 2014, the Review Team was unable to confirm why the required paperwork was not submitted.

7.9.6 In 2013, the Home Secretary commissioned an investigation into how police forces across England were responding to domestic violence incidents. The HMIC report relating to Humberside Police was published in 2014 and included 7 recommendations, which led to major changes in the force. Significantly, the recommendations included the need for frontline officers to be more aware of domestic violence incidents, the need to develop better reporting and recording arrangements in the force and the need to improve services offered to those families where risks were graded as standard or medium. The Review Team were of the view that HSCB needs to maintain robust and rigorous scrutiny of the action plans to ensure changes in practice can be evidenced.

7.9.7 Hester (2011)[38] uses the term 'planets' to describe the very different and separate professional and practice worlds of those involved in domestic abuse work. SW4 indicated that this family was like many others with whom she had worked and this may have lessened her concerns. FNP1 considered that the shift in AT's engagement was significant and her concerns were heightened by this fact. In conversation with the Probation Officer, the Review Team was provided not so much with information, but rather with 'intelligence' which had it been shared with other agencies might have led to a different appraisal of risk.

7.9.8 Different agencies may all have different priorities shaping their work with families. Moreover the number of agencies involved requires careful co-ordination and joined up working to ensure that children's needs are being met and risks are being identified and addressed. This was particularly important in this review where the perpetrator was clearly manipulative towards professionals. Agencies should have understood the implications of BF8's history and the fact that he had been listed at MARAC with previous victims. There was no evidence to suggest this was considered in the assessment undertaken in October 2013.

7.9.9 The monitoring of known high risk domestic abuse perpetrators, if they have a history of perpetrating domestic abuse in more than one intimate relationship, is extremely important in terms of understanding previous behaviour and how this can impact on current risk factors.

[38] *British Journal of Social Work Volume 41 Issue 5.*

7.9.10 Effective multi-agency working is a significant challenge - just because it is a good idea does not make it happen naturally, it is time-consuming and can lead to conflict. However, putting together different parts of the jigsaw and sharing the right information constructively is essential. The need for close collaboration and joined up work with families where domestic violence is known or suspected is well-documented, but in this review each agency had their own source of information relating to BF8 and AT and there was insufficient collaboration so information was not shared in a purposeful way and plans were left to a single agency to formulate.

7.9.11 Given the prevalence of domestic abuse in the Hull area, it is likely that one of the largest cohorts of children requiring early help will be those experiencing and witnessing domestic abuse. The Munro recommendations strengthen the role and remit of LSCBs to include ensuring the effectiveness of early help for children. The prevalence of domestic violence locally raises fundamental questions about the causes of such high levels, including poverty and deprivation, and how it might be tackled

Finding 8*: This review sheds light on how some families where there is known or suspected domestic abuse can be regarded as 'low risk' and consequently may not be assessed within a multi-agency framework. This can leave some children vulnerable and with ineffective help.*

7.10 **ASP 6: Supervision and Managerial oversight**

Robust managerial practice, which supports reflective supervision, is central to supporting critical thinking and good assessments in multi-agency work. Supervision, regularly delivered, is key to providing good support for professionals working with families and especially those where domestic abuse is known or suspected. The Review Team were concerned to note that managerial oversight in both health and care settings appeared to be absent in relation to delay in the completion of the Initial Assessment undertaken in October 2013 and the referral submitted in January 2014.

7.10.1 SW4 informed the Review Team that as an experienced worker, she believed she was expected to 'get on with the job'. Caseloads were very high and the team was extremely busy. In addition the team was in the midst of a restructure. SW4 said she was confident in working with families where men like BF8 were present, she had worked with many similar families and whilst she had not felt the need to discuss what happened with a line manager neither was she confident about the support she would receive given other pressures in the team at the time. SW4 described that at the time, supervision when it occurred, was more about signing off work than reflecting on current issues with families. This view was also shared by SW2 and SW3, one of whom felt it was seen as her responsibility to seek out supervision when needed.

7.10.2 FNP1 was also an experienced practitioner and demonstrated some very good practice, tenaciously following up progress with CSC on the earlier assessments and checking up on details to ensure Child H was kept safe.

FNP1 appears to have had six supervision sessions during the period under review plus a consultation with the CHCP Safeguarding Team in October 2013, although this would appear to fall well short of the supervisory arrangements referred to in the CHCP Agency Learning Report. There is little to evidence any managerial intervention or escalation towards the latter part of 2013 when FNP1's concerns were heightened. This left FNP1, despite her experience and supervisory position, in an isolated position with no recourse to a multi -agency plan.

7.10.3 In line with procedures, and following a telephone call with the CSC duty officer, FNP1 submitted a referral and put her concerns in writing. She also forwarded a copy of the written referral to CHCP Safeguarding Children's team. The named professionals in the CHCP Safeguarding Children team provide a statutory role for their employing organisations and are expected to provide support and guidance to operational staff, including FNP Supervisors.[39] Whilst CSC have a responsibility to ensure referrals are dealt with promptly and referring professionals are kept informed about decisions and actions taken, it also the responsibility of referring agencies to follow up their referrals and monitor progress. This did not happen in respect of the referral made by FNP1 in January 2014. There was no explanation for this oversight but the Review Team was informed it was usual practice to follow up referrals. The Review Team queried the role of the CHCP Safeguarding Team in that, although they had received a copy of the referral made in January 2014, no action was taken to review the content, analyse it in light of the information that could have been accessed within their organisations and use their expertise to ensure safe practice and procedural compliance.

7.10.4 The Review Team was informed that FNP Supervisors are not subject to the same level of support or monitoring that would be expected for some other health professionals. Whilst this is acknowledged, it nevertheless would be expected when a FNP supervisor is raising concerns about a child with whom she is working, the line manager and/or the Named Nurse[40] in the Safeguarding Team would support and advise on the actions to be taken. It is not acceptable that any practitioner, however qualified or experienced, is left to make key decisions without an opportunity to discuss these in supervision.

'Effective professional supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support professionals to reflect critically on the impact of their decisions on the child and their family. Any professional working with vulnerable children should always have access to a manager to talk through their concerns and judgements affecting the welfare of the child. (Working Together to Safeguarding Children, HM Government 2013).

The Lead Reviewers were concerned to note that there would appear to be no system within the CHCP Safeguarding team for recording and tracking referrals into CSC.

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[39] *Intercollegiate Guidance /Safeguarding Children Roles and Competences for Healthcare Staff pdf*

[40] *The Named Nurse ensures effective safeguarding children practice for the organisation as stipulated in primary legislation and underpinned in Government strategy and national, regional, and local guidance, procedures and standards.*

If the remit of the team is to offer advice and guidance on safeguarding matters, it would seem prudent to have a system whereby records are kept to ensure that where referrals are advised, the progress and ensuing outcomes are recorded.

7.10.5 The Review Team was informed that the volume of contacts with CSC remains very high and a high number of these relate to families where domestic abuse is known or suspected. One of the main impacts of dealing with such a high volume of work must relate not only to the capacity of professionals to respond effectively to the needs of children, but also to the managers who need to effectively oversee the progress of children's cases and prevent drift and delay.

7.10.6 It is inevitable whatever the state of their work environment, that frontline workers must constantly make assessments and judgements while working on their own. However supervision sessions are vital - and perhaps even more so in time of organisational change - to support and challenge practitioners helping them to reflect and consider different perspectives. Supervision and management oversight are well-established positive systems to provide further safeguards for the identification of risks to children and families in single and multi-agency settings. In the current climate financial and organisational pressures are likely to be pressing and will impact upon allocation of resources including time spent supervising practitioners.

Finding 9: *Working with families where domestic violence is known or suspected makes a range of practical and emotional demands on practitioners and managerial oversight and access to good reflective supervision is essential. A lack of managerial oversight can undermine attempts to work across agency and professional boundaries, leaving practitioners unsupported and unsafe decisions not challenged.*

8 Context in which professionals were working

8.1 The police and social workers were clearly working under a great deal of pressure, both in respect of increased workloads and competing demands for time. The practitioners involved in the review process spoke about the impact of both, discussing that high caseloads can easily encourage professionals to focus more on their own individual responsibilities because multi-agency working can appear to take more time and maintenance.

8.2 Information from the Practitioners Group and the Review Team suggests that in this authority like others, there are diminishing budgets and competing priorities.

Research by Brandon et al (2008)[41] suggests that these factors along with pressures of work can lead to raised thresholds for access to services, although there was no evidence of this in the SCR and the Ofsted inspection in 2014 indicated that the application of thresholds in Hull was appropriate. The Review Team was told by practitioners, however that the growing number of referrals to the police and CSC raised significant challenges for services and these were not without impact on frontline practitioners. Munro (2011) argues that practitioners can break 'rules' for good reason as the range of decision scenarios with which they are confronted is varied so that, at times, the rules of accepted good practice do not apply. When there are constraints of time and resources in systems, professionals have to make pragmatic decisions about what to prioritise. It is unfortunate that the Review Team could not hear from the police officers themselves why the decisions they took in relation to this case seemed to make sense at the time. The findings from the HMIC report however clearly highlighted some of the challenges facing the Police and these were evidenced in this review.

8.3 In Humberside, at the time, domestic abuse accounted for 12% of all calls to the police for assistance - well over 6,000 in Hull each year – and, of these, around 15% were from repeat victims. During 2013/14, Hull DAP received 2272 referrals for support. Within these referrals, there were 1,835 victims with 2,130 children affected by Domestic Abuse and of these 38% were aged between 0-4 years. Given these figures, it is likely that one of the largest cohorts of children requiring early help will be those experiencing and witnessing domestic abuse. It is here where early help coordinated across and between agencies is essential.

8.4 The complexity of social workers' decision-making is increased by the fact that many decisions have to be made through the course of a single day and there is a danger that this engenders exhaustion or 'decision fatigue'. Strong support and constructive challenge of front line practitioners will not be possible if the agency context is one of overwhelming workloads with a limited capacity, or lack of opportunities, to invest in relationship building or critical reflection.

8.5 The Review Team were told by agency partners that the challenges for services and the need for good quality support for practitioners was acknowledged by all agency partners in Hull and were currently being further explored through a review of the Hull Domestic Violence Strategy.

[41] Brandon, M et al :(2008) *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What Can We Learn? A biennial analysis of serious case reviews 2003-2005*. Research Report DCSF-RR023. University of East Anglia.

9. Developments in agencies since 2014

See separate addendum report

10. Concluding Comments

10.1 AT was advised by SW4 of the risk posed to her child by BF8 and she was offered advice about the precautions she should take to keep her child safe. Neither she nor her parents fully understood or accepted the risks posed by BF8, although they clearly had a genuine desire to keep Child H safe. The death of their child will remain with them for the rest of their lives.

10.2 Whilst this review has highlighted the need for professionals to be persistent, curious, and child-centred when pursuing concerns about the welfare of children, the death of Child H cannot and must not be attributed to any failings on the part of professionals who knew the family. This review is a stark reminder for all agencies of the need for robust assessments and dogged challenges to parents and professional colleagues but also emphasises the dangers to children and vulnerable adults from males known to have a violent history.

11. The Findings

1. There was a lack of multi-agency collaboration and challenge which left AT and Child H vulnerable to the risks posed by BF8. (*Patterns in multi-agency working)*

2. When FNP Practitioners are working as the only professional in a family and there are concerns about domestic violence, other agencies can be falsely reassured by their involvement. Without a multi-agency assessment, this can leave both children and the practitioner vulnerable. This would also apply to any practitioner working as a lone professional with a family where domestic violence is known or suspected*. (Patterns in multi-agency working*)

3. If duty officers in CSC do not routinely communicate with the referring practitioner before making decisions about a referral, misunderstandings can occur and this leaves children vulnerable.

4. Written Agreements or Family Plans can be valid tools for helping a family to change, to solve problems and in some cases to remove the risks that would otherwise make the children unsafe at home. However, without a process by which an agreement is monitored and reviewed and shared with other agencies, these ‘plans’ do not in themselves keep children safe but may give the impression of doing so. *(Patterns in Management of Systems)*

5. When professionals are working with families where concerns have been raised, all family members and especially those living in the household should be subject to assessments, both to determine risk and to confirm and assess their ability to protect children in the family. Their active involvement in plans should be carefully monitored. (Patterns in the use of Tools).

6. A lack of engagement with men in situations where domestic abuse is known or suspected allows a distorted picture of the family situation to emerge, but without partnership working between agencies, clearly identifiable support structures for staff and managerial oversight, any engagement with known or suspected perpetrators is less likely to be effective.

7. There were some common thinking errors in this review - untested assumptions and a lack of healthy scepticism about what was being reported by the family - these were not picked up through current case management processes at the time.

8. This review sheds light on how some families where there is known or suspected domestic abuse can be regarded as ‘low risk’ and consequently may not be assessed within a multi-agency framework. This can leave some children vulnerable and with ineffective help.

9. Working with families where domestic violence is known or suspected makes a range of practical and emotional demands on practitioners and managerial oversight and access to good reflective supervision is essential. A lack of managerial oversight can undermine attempts to work across agencies and professional boundaries, leaving practitioners unsupported and unsafe decisions not challenged. *(Patterns of Management Systems)*

Finding 1

There was a lack of multi-agency collaboration and challenge which left AT and Child H vulnerable to the risks posed by BF8.
(Patterns of Multi-agency Working)

How was this manifest in this review?

Individuals and agencies often worked independently of each other. Although there was evidence of some multi agency working and information sharing in the earlier part of the review period, there was little to suggest any multi-agency collaboration from October 2013 and much to suggest that professionals were working in 'silos'. Whilst some information about what was happening may have been gathered as part of the Initial Assessment, it was not shared or analysed from a multi-agency perspective and this left professionals unaware of what was happening in the family. A clearer framework for collaboration would have enabled better opportunities for sharing concerns, working supportively of each other and understanding each other's roles, obtaining a better oversight of the whole family and reduced the chance of misunderstanding each other's focus and concerns, especially regarding any risk factors.

Is this an underlying issue in Hull or unique to this particular review?

- *This finding was recognised by the Practitioners and the Review Team as not being unique to this particular review. However, the view was also expressed that there are many examples of where multi-agency collaboration works well and is effective. Challenging decisions made by CSC was considered to be more problematic.*

Issues for the Board to consider

1. How can management systems ensure and encourage recourse to multi-agency processes, especially where there are concerns about domestic violence?

2. Is the Board confident that the new structures in Children's services and the current developments in Early Help better support multi-agency working?

3. To what extent can HSCB be confident that professionals in all agencies are aware of the Board's Escalation Policy and use the process appropriately?

Finding 2

When FNP Practitioners are working as the only professional in a family and there are concerns about domestic violence, other agencies can be falsely reassured by their involvement. Without a multi-agency assessment, this can leave both children and the practitioner vulnerable**.** This would also apply to any practitioner working as a lone professional with a family where domestic violence is known or suspected.
(Patterns in multi-agency working)

How was this manifest in this review?

Assessments undertaken by CSC concluded that no further action was required and social workers were clearly reassured by the regular involvement of the FNP practitioner. Even when BF8's background became known and the risks to Child H were more evident, FNP1 remained the sole professional working with a family where concerns about a violent and aggressive male had been identified. When this practitioner raised her concerns about potential risks to Child H, these were not given due prominence, possibly indicating that the FNP role was not clearly understood across other agencies. Where professionals are working as the key professional in a family (in this case the FNP practitioner), especially as part of a specialist project, it is important that managers and front line professionals in the wider system of early help and safeguarding understand the role, what the focus is and how and where they can offer support. This will ensure that assumptions are not made about the nature of the involvement. A multi-agency assessment would mitigate this risk significantly and ensure the clarity of role described above and in Finding 1.

Is this an underlying issue in Hull or unique to this particular review?

- The Review Team were told that where a child was made subject to a child protection or child in need plan, FNP practitioners would often work alongside a social worker. It was unusual for a FNP practitioner to be the sole professional when domestic violence was known to statutory agencies.

Issues for the Board to consider

1. In what way does HSCB promote the FNP programme and ensure that the role and remit of FNP practitioners is well understood across all partner agencies?

   See also Finding 1(1)

Finding 3

If duty officers in CSC do not routinely communicate with the referring practitioner before making decisions about a referral, misunderstandings can occur and this leaves children vulnerable

How was this manifest in this review?

The referrals made to CSC in December 2013 and January 2014 did not specify in enough detail why the practitioners were concerned, although the referral from FNP1 clearly expressed her concerns about domestic violence in the family. Once received, children's social care did not contact the referring practitioners to discuss and clarify the referral. Consequently a misunderstanding occurred and a pre-birth assessment was arranged instead of an urgent assessment to determine risk to a live child from a male known to be violent. Current systems are designed to ensure that the referral is talked through between the referrer and an experienced social worker. However, not all written referrals from professionals are followed up with a telephone conversation to clarify the referral and, in this case, this contributed to misunderstanding the nature of the referral.

Is this an underlying issue in Hull or unique to this particular review?

- *The Review Team was informed that it is not common practice for referring agencies to be contacted to discuss their referral. Whilst it does occur on occasions, the Review Team were told that often referring agencies do not know what is happening and are not always informed about outcomes.*

Issues for the Board to consider

1. How is the Board to ensure that the newly designed referral form is leading to better quality referrals, which clearly identify the risks and needs of a child?
2. Practitioners advised the Review Team that duty officers do not routinely contact them to discuss their referrals. In what way does the Board quality assure the response by CSC to referrals received from external agencies?
3. Referring agencies need to be confident that their referrals will be robustly and promptly addressed. They also need to be aware that it is their responsibility to chase up a referral if there is no communication from CSC in response to their referral. How can the Board ensure greater awareness across agencies about their responsibilities to chase up referrals?

Finding 4

Written Agreements or Family Plans can be valid tools for helping a family to change, to solve problems and in some cases to remove the risks that would otherwise make the children unsafe at home. However, without a process by which an agreement is monitored and reviewed and shared with other agencies, these 'plans' do not in themselves keep children safe but may give the impression of doing so.
(Patterns in Management of Systems)

How was this manifest in this review?

The practice of sending letters or 'family plans' to parents where domestic abuse is known or suspected appears to have been used as an alternative to service provision and in this review were used to support case closure. It was unclear who would be sent a copy, which would monitor compliance and when and how the 'expectations' would be reviewed. Written agreements and family plans do not in themselves keep children safe or effect change in families. They may be helpful when they are well understood by families and reflect the purpose of any direct work with professionals to enable any necessary change to happen, and in these circumstances effective reviewing and monitoring is then needed.

Is this an underlying issue in Hull or unique to this particular review?

- *The newly developed Early Help Safeguarding Hub has been charged with the task of ensuring that more robust systems are applied to the review of all child/family plans.*

Issues for the Board to consider

1. The use of 'family plans' by CSC would benefit from review to ensure their purpose and function is clear and they are used as part of agreed multi-agency interventions rather than a single agency tool.
2. Where family plans are introduced to support safety measures for a child, how can the board be assured that these plans are appropriately signed off by managers and shared/negotiated with other agencies?

Finding 5

When professionals are working with families where concerns have been raised, all family members and especially those living in the household, should be subject to assessments, both to determine risk and to confirm and clarify their ability to protect children in the family. Their active involvement in plans should be carefully monitored**.**
(Patterns in the use of Tools)

How was this manifest in this review?

The maternal grandfather was living with this young mother for most of the period under review. However, he was not included in any assessments and his views and opinions were not sought. Professionals did not undertake comprehensive and robust risk assessments of the extended family and this left Child H vulnerable. Professionals working with families where concerns have been raised need to take account of everyone in the household and work to ensure their full engagement and participation in an holistic assessment. This is particularly the case where there are potential risks to children and requires clear and purposeful engagement which makes explicit the concerns and works positively to strengthen protective factors within the household and build trust, honesty and confidence between professionals and the family.

Is this an underlying issue in Hull or unique to this particular review?

- *The Review Team were unable to determine if this was a regular issue in assessments but were told there would be an expectation that assessments would involve all family members living at the child's address but only where there was a clear need to do so would these assessments extend to a wider family network.*

Issues for the Board to consider

1. How does the Board audit single and multi-agency assessments?

2. What specific multi agency assessment tools does the Board commend?

3. Is the Board confident that training programmes equip professionals with opportunities to acquire, develop and practice skills in assessment work?

Finding 6

A lack of engagement with men in situations where domestic abuse is known or suspected allows a distorted picture of the family situation to emerge, but without partnership working between agencies, clearly identifiable support structures for staff and managerial oversight, any engagement with known or suspected perpetrators is less likely to be effective.

How was this manifest in this review?

Whilst there was engagement with some males who lived with AT, there was no engagement with BF8 known to be a perpetrator of domestic abuse and who presented as an intimidating male. Despite this, an assessment was signed off with no further action, with a somewhat unrealistic requirement that the young mother did not see her 'boyfriend' when her child was present. Engagement with men in households and men who are significant but not living in households is essential. Without this, only a partial perspective of the daily life and functioning of a family and the familial network emerges. More fundamentally, work is needed to appreciate the capacity of men as carers and as a protective factor to mitigate risk. The lack of visibility of men in assessment of households and wider networks can also mean that risk is not sufficiently understood, shared or mitigated. However, the challenges for practitioners in working to engage with some individuals who may be hostile or aggressive, as in this review, should not be underestimated.

Is this an underlying issue in Hull or unique to this particular review?

- *This finding was recognised by the Practitioners and the Review Team as not being unique to this particular review*
- *This finding replicates a finding from a previous SCR child F in 2011.*

Issues for the Board to consider

1. This is a significant issue, well evidenced and researched. How does the Board ensure that assessments and work with families and children fully engage significant males in the family in those processes?
2. What support structures and training opportunities are in place to support practitioners working in families where there are known perpetrators of domestic violence?
3. How can the Board ensure that professionals become more curious and questioning about 'new' males involved in the lives of children with whom they are working?

Finding 7

There were some common thinking errors in this review - untested assumptions and a lack of healthy scepticism about what was being reported by the family - these were not picked up through current case management processes at the time.

How was this manifest in this review?

A view emerged and was sustained during the period under review that AT was 'well supported' by her family. This assumption was never tested despite evidence that familial relationships had not always been strong and MGM had remarried and had young children of her own. Professionals clearly warmed to AT and to MGM and did not challenge or test their assertions that they would and could prevent BF8 having any contact with Child H.

Is this an underlying issue in Hull or unique to this particular review?

- *This finding was recognised by the Practitioners and the Review Team as not being unique to this particular review*

Issues for the Board to consider

1. How is the Board assured that partner agencies support the provision of good quality and regular supervision, which encourages reflection and critical thinking?
2. Has the Board considered how it might make better use of workers from other agencies to enrich multi-agency learning and thinking on general and case specific issues relating to work with vulnerable women and violent males?

Finding 8

This review sheds light on the way in which some families where there is evidence of domestic violence may be considered 'lower risk' and therefore may not be assessed within a multi-agency framework. This can leave some children vulnerable and with ineffective help.
(Patterns in Reasoning)

How was this manifest in this review?

There was no multi-agency collaboration when it became known that AT was in a relationship with BF8. The protective factors were considered to outweigh any risk to Child H, but had agencies shared their respective intelligence and 'soft data', the need for a more robust safety plan for Child H may have been identified. The review highlights the need for multi-agency collaboration across the whole continuum of early help and safeguarding. This will ensure an holistic assessment of 'family' and provide for better information-sharing and enhanced management oversight, professional's individual concerns can then be more readily shared and risks more effectively mitigated.

Is this an underlying issue in Hull or unique to this particular review?

- *This finding was recognised by the Practitioners [and the Review Team] as not being unique to this particular review*
- *This finding replicates finding from a previous SCR child F in 2011.*

Issues for the Board to consider

1. How does the Board shape and influence the whole system approach to Domestic Violence?
2. Was the Board aware of the systemic difficulties in terms of reporting and tracking in Humberside Police, if not why not?
3. Has the board considered in sufficient detail the link between alcohol misuse and domestic violence and the subsequent outcomes for children living in these families?
4. Given the growing numbers of domestic violence incidents, is the Board taking any action to raise these issues beyond the safeguarding community?
5. Is the strategy for meeting the needs of children living in families where domestic violence occurs, but which fail to meet the threshold for statutory intervention, robust and effective?

Finding 9:

Working with families where domestic violence is known or suspected makes a range of practical and emotional demands on practitioners and managerial oversight and access to good reflective supervision is essential. A lack of managerial oversight can undermine attempts to work across agencies and professional boundaries, leaving practitioners unsupported and unsafe decisions not challenged.
(Patterns of Management systems)

How was this manifest in this review?

There was evidence across all agencies that managerial oversight of practice and decision-making was poor or absent. The Police systems did not pick up difficulties with tracking and monitoring DV incidents, the Family Nurse Practitioner was not supported or encouraged by her line manager to challenge decisions she felt were unsafe and the supervision experienced by social workers appeared to be mechanistic rather than reflective so assumptions and biases were not challenged. Whilst informal supervision and access to management advice is important, especially in busy teams, across the continuum of early help and safeguarding, it is not a substitute for structured, reflective and routine formal supervision, which is a key mechanism for sustaining both management oversight and support to front line staff.

Is this an underlying issue in Hull or unique to this particular review?

- *This finding was recognised by some of the Practitioners and the Review Team as not being unique to this particular review*

Issues for the Board to consider

- Is the Board confident in the way in which it audits and quality assures managerial performance across agencies in terms of safeguarding?
- Does the Board have a system to analyse how safeguarding decisions are made, other than within SCR processes? [42]

[42] See *DFE: Clinical Judgement and Decision-Making in Children's Social Work: An analysis of the 'front door' system. Research reports April 2014. Elspeth Kirkman and Karen Melrose - The Behavioural Insights Team*

Working Together to Safeguard Children 2015

Statutory Guidance

a. A Serious Case Review is one where: 'a) abuse or neglect of a Child is known or suspected: and b) either – (i) the Child Has died; or (ii) the Child Has been seriously harmed and there is cause for concern as to the way in which the Authority, their Board partners or other relevant persons have worked together to safeguard the child.' Regulation 5 of the Local Safeguarding Children Boards (SSCB) Regulations 2006 require LSCBs to undertake reviews of serious cases in these specified circumstances and to 'advise the Authority and their Board partners on lessons to be learnt'

b. Statutory guidance requires SCRs to be conducted in a way that:

- 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.

c. The guidance also stipulates that when undertaking reviews, LSCBs should ensure that frontline practitioners are fully involved in the process and are invited to contribute their perspectives without fear of being blamed for actions, which they took in good faith. Boards are also expected to consider ways of involving family members and sensitively and appropriately managing their expectations.

d. The guidance requires that reports should be written in plain English and in a way that can easily be understood by professionals and the public alike.

Appendix 2

Actions arising from Single Agency Learning

City Health Care Partnership CIC (FNP)

1. Raise the profile and ensure that other agencies are aware of the Family Nurse Partnership model
2. Safeguarding Children team to review CHCP CIC internal referral process to ensure quality of referrals and that professionals know how and when to escalate concerns relating to professional disagreements
3. Safeguarding Children team to review quality of supervision

City Health Care Partnership CIC Named GP

1. To raise awareness of the risk factors of teenage pregnancy with the GPs
2. To raise awareness of the importance of documenting who a minor is accompanied by with the GPs and enquiring about the family relationship to the child
3. Flag up in the notes in a easily noticeable place that there is a history of domestic violence in the family (i.e. on the home page)
4. Consider referring to DAP for further support if there is evidence or suspicion of domestic violence

Domestic Abuse Project (DAP)

1. Raise awareness with victims and professionals of the Domestic Violence Disclosure Scheme 'Right to know and 'Right to ask'
2. The DAP trainers will develop a training course to enable professionals to identify and respond to 'new' male partners so risk management and interventions can be more effective.

Hull Children & Families Service

1. Working group considered approach to use of family plans and provided revised guidance to social care practitioners in December 2013.
2. Agreement reached within the partnership for the development of an Early Help Safeguarding Hub, and appointments have been made to key Social Care role within the Hub.
3. The introduction of the systemic model of social work practice, with an emphasis on family relationships, has highlighted this issue and brought about improvements in practice.
4. Senior Leadership Team have discussed the role of individual supervision in the context of systemic leadership training. Training session has been identified for use with the wider Systemic Leadership team.

Hull & East Yorkshire Hospital NHS Trust

1. Clearer process identified for when child misses appointment
2. Review of processes to ensure that women receive their postnatal assessments within 24 hours of the expected assessment date.
3. Pathway for referral to CSC has been reinforced within the organisation
4. Senior Midwife identified to support capacity for staff within the maternity service to support SCR process.

Humberside Police

1. The policy in the way DV forms should be completed was amended in early 2015 and the way in which information is shared with CSC was further updated in July 2015. Incidents which do not meet a safeguarding threshold but which require intervention will be forwarded to the Early help team.
2. Although the forms used (F913) are currently being reviewed, developments are taking place to allow data to be transferred from a mobile directly onto the DV form.
3. Learning from this SCR has been incorporated into training programmes with effect from February 2015.

National Probation Service

1. Offender managers to pass on external documents for inclusion in the case management system
2. Licence condition in respect of developing relationships for domestic abuse cases.
3. Disseminate information about the role and responsibilities of Family Nurse practitioner programme.

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