Lancashire Safeguarding Children Board

Serious Case Review

Overview Report

Child LC

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1 INTRODUCTION

Child LC was an immobile baby below the age of 12 months when he died in October 2015.

1.1 Incident Leading to the Review

On 1st October 2015 an ambulance was called to the home address of Child LC by their father who was looking after Child LC. On arrival the ambulance crew found Child LC to be unresponsive. It was noted by police at the scene that Father was suspected of being under the influence of Cannabis.

Child LC was transported by emergency ambulance to the local hospital where cardio pulmonary resuscitation (CPR) was attempted. After 21 minutes without response CPR was ceased and Child LC was pronounced deceased.

In a statement to police Father said that he had fallen asleep in front of the television with Child LC on his lap. He said that when he awoke he found Child LC to be unresponsive and called an emergency ambulance.

1.2 Confidentiality

Child LC's specific age is not referred to in this report. Child LC's gender is not referred to in this report. Child LC's mother will be known as Mother and father will be known as Father.

Professionals involved in the case are referred to by role.

1.3 Period under review

The period under review is July 2014 to October 2015. Relevant background information is summarised below.

1.4 Conduct of the Review

This serious case review (SCR) was commissioned by the Lancashire Safeguarding Children Board following the death of Child LC. The review commenced in March 2016.

Regulation 5 of the Local Safeguarding Children Board (LSCB) Regulation 2006[1] sets out the functions for LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances.

Regulation 5(1) (e) and (2) sets out an LSCB's function in relation to serious case reviews, namely:

5. (1) (e) Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:

(a) Abuse or neglect of a child is known or suspected; and

[1] http://www.legislation.gov.uk/uksi/2006/90/contents/made

(b) Either (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The methodology used to conduct the review was the Child Practice Review process (Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012)[2].

A review panel consisting of senior representatives from key agencies was convened to oversee the review. A SCR chair/author was appointed in line with guidance. The review panel met on three occasions.

Brief chronologies containing key contacts and events were obtained from agencies who had been involved with the family. An integrated chronology was compiled from which the panel identified significant events for analysis.

A practitioner learning event was held in May 2016 which was attended by 7 practitioners who had had contact with the family. At the event there was no representation from Children's Social Care (CSC), Police or General Practice. These agencies were followed up by the LSCB and the Chair/Author to ensure that information and the views of practitioners from these agencies were included in the review.

The practitioner event provided an opportunity for professionals involved in the case to critically analyse their own practice and that of other agencies. Practitioners were asked to reflect on the case based on the information that was available to them at the time and to identify key learning.

To enable the review to assess the involvement of Children's Social Care in working with the family, the panel considered conducting a separate interview with the social worker who had subsequently left the employment of the authority. However, due to the Social Worker being a key witness for the prosecution in criminal proceedings they were not interviewed as part of the SCR. Information about the social worker's involvement in the case was taken from agency records and from a police statement made by the social worker. The social work manager was also interviewed; they reported that they had very little involvement in the case.

Following sentencing in the criminal case the Review Chair conducted a telephone interview with the Social Worker. Information gathered during this conversation is included where relevant throughout this report.

The Senior Investigating Officer (SIO) responsible for the criminal case met with the Chair/Author and LSCB Business Co-ordinator to ensure that the SCR and the criminal proceedings were aligned. The SIO provided information in relation to aspects of the criminal case and the Chair/Author had sight of some evidential material however this is not included in this report or analysis.

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[2] http://www.sewsc.org.uk/fileadmin/sewsc/documents/Published_SCR_CPR/Child_Practice_Review_Guidance_-_Welsh_Government.pdf

The practice learning event identified that further information was required regarding father's involvement with police as an adolescent. To this end enquiries were made with the police in father's home area and they provided a chronology of events relating to their contacts.

1.5 Criminal Proceedings

Both parents were charged with offences related to Child LC's death; Father was charged with the murder of LC and Mother was charged with causing or allowing a child to be harmed.

Mother entered a plea of guilty of causing or allowing a child to be harmed and received a custodial sentence. Father entered a plea of not guilty to murder and was tried by jury. A verdict of guilty to the charge was returned and father received a custodial sentence. At the time of writing this report father has appealed his conviction. On that basis the Review was advised not to seek his involvement so as not to compromise evidence required in the appeal.

1.6 Post Mortem

The review requested details of the post mortem findings from the Coroner who advised that this information could not be shared due to the ongoing criminal proceedings.

The review then requested this information from the SIO who provided an overview of Child LC's injuries at death which included a number of internal mouth injuries, bruising to the genitals, faint finger mark bruising around the upper neck and jawline.

1.7 Coronial Matters

Following Father's conviction for the murder of Child LC there will be no inquest.

1.8 Family Involvement

Child LC's parents were informed in writing that a SCR was taking place.

To ensure that the criminal case could progress without interference Lancashire Constabulary requested that neither of LC's parents, nor any family member or professional who may be called as a material witness in the case be approached to participate in the review until the criminal proceedings had concluded.

Following sentence contact was made with mother who agreed to contribute to the review. Her views are incorporated into the body of the report and are shown in italics. The accounts given by mother are her views only and not those of any member of the Review Panel.

As stated above it has not been possible to interview father due to the appeal process.

1.9 Background to Child LC

Child LC was born by normal delivery in good condition. Child LC's parents were young parents and LC was their only child. Child LC showed normal development and was seen by professionals in line with the universal Healthy Child Programme.[3]

1.10. Background to Mother and Father

Mother had contact with mental health services in her adolescence (at the time she was assessed by adult Mental Health Services due to her age and the local arrangements for transitional services). At that time Mother had presented with a brief history of low mood and self-harming. She had taken what she described as an impulsive overdose which she said she regretted. She was assessed as not having mental health needs or requiring interventions from mental health services and was discharged to the care of her GP. *In conversation with the Lead Reviewer mother said that she had low self-esteem when she was younger; she said she was self-conscious and a little shy and didn't really go out with boys until she met Child LC's father. She said she wasn't experienced at all in relationships but that they hit it off straight away and she was really happy with him at first.*

Child LC's father was not originally from the local area having moved some time ago to live with his grandmother (Child LC's great-grandmother). Father's parents had separated when he was a child; he had lived with both parents and their new partners, however neither arrangement had been successful. Father became known to Children's Social Care at this time and went to live with his grandmother when arrangements to live with his mother and her new partner broke down. Father had said that he was subject to bullying by his mother and her new partner.

The review established that Father had experienced some difficulties as a child. In his early childhood his mother had consulted her GP with concerns that he was displaying inappropriate sexualised behaviours. She told the GP that he had been exposed to internet pornography by an older male in his family. Police records also show that a report had been made that Father was subjected to indecent assault by an adult neighbour as a young child.

Police in Father's home area provided information that Father had been involved in anti-social behaviour as a young person. This was largely related to theft and criminal damage. Father had gone missing from home on two occasions which he said was due to not getting on with his mother. Police noted that Father was dyslexic and that a custody risk assessment showed that he had previously self-harmed (cutting his arms).

Whilst Father was living with his father and step-mother in 2012 police were called to a domestic incident where Father he had been verbally abusive and aggressive towards his step-mother and had then barricaded himself in his room.

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[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

Following this incident Father moved to live with his grandmother in the area where he met Mother.

2. SIGNIFICANT EVENTS AND PROFESSIONAL CONTACTS

Child LC's parents met when Father became employed as a labourer in maternal grandfather's business. Professionals reported that Mother's parents were not pleased about the relationship but could not stop it from continuing. *Child LC's mother told the review that she became very stressed when she got pregnant but that she definitely wanted to have the baby. The relationship was still good but father was using Cannabis frequently which she didn't like.*

Mother and Father moved into a flat together for which mother was the tenant, the flat was very close to Mother's family home. *Child LC's mother said that she hated living in the flat with father and that things began to deteriorate in terms of their relationship. She had lost her friendships and said that her self-esteem at this time was really low.* Professionals reported that Mother probably saw her family on a daily basis and that the family were very involved in Mother's life.

When she became pregnant Mother presented to her GP and was referred to maternity services. She attended a booking appointment which confirmed that she was eight weeks pregnant.

Because of her age Mother was referred to the teenage pregnancy (Young Mums) service however she did not engage well with the service. *Mother said that this was because she was shy and didn't really want to join a group, she said there were no other reasons not to join. Although she was aware of some peer pressure not to engage with Social Care services she had not experienced any pressure not to engage with midwifery services. Mother confirmed that father had never tried to prevent her from attending the teenage pregnancy service.* Professionals noted that Mother was well supported by her family during her pregnancy and attended routine ante-natal appointments. She was appropriately asked about her previous low mood/mental health issues and reported that she was now well and was not experiencing any mental health problems.

Although Mother missed some of her ante-natal appointments professionals had no concerns about her wellbeing or that of the baby during pregnancy. Father attended some appointments with her and he was noted to be supportive however little information about Father was sought or recorded by maternity services.

Child LC was born in good condition by normal delivery. Mother had decided to breastfeed the baby and was confident in caring for LC. The day after birth LC and Mother were discharged home and were seen the following day by a community midwife. No concerns were observed, Mother reported to professionals that she was emotionally well and LC was alert (although slightly jaundiced). Safer sleeping was discussed in line with the local safe sleeping policy.[4]

[4] http://www.lancashiresafeguarding.org.uk/media/10131/SAFER-SLEEPING-GUIDELINES-final-2015.pdf

Mother told the review that she was really happy when LC was born; she loved being a mum and was very proud of the baby. She loved showing the baby off and spent lots of time with LC. She said that father spent far less time with the baby and although he shared some tasks it was mostly mother who looked after Child LC. In the first few weeks after Child LC's birth the relationship between mother and father became more strained and mother focused all her energy on the baby whilst father began to resume some of his old friendships and began using drugs more frequently. She said that father began to steal money from her to buy drugs but she didn't tell anyone about this. She said she wasn't afraid of father but didn't want to make things any worse in the relationship. She also said that she didn't want to fail in the relationship and she felt she had a responsibility to look after father because of his background.

Mother chose not to engage with some services however she was visible to professionals; she was well supported by her family; Child LC was observed to be well cared for and Mother did take up universal HV services.

Father was less visible to professionals and it was noted that he was self-interested and not very involved in the care of Child LC. Father was suspected by some professionals to be a user of Cannabis although he reported that he had cut down following the birth of Child LC. Police information indicated that Father was in fact a frequent/heavy user of Cannabis.

It was not until the domestic abuse incident which took place in July 2015 that professionals became aware of potential risk factors in the relationship between Mother and Father.

An incident took place in July 2015 in which Father assaulted Mother at their home address. The circumstances of the incident were that on the day of the assault Mother and Father had been drinking alcohol, a friend was also present at the address. An argument began and Mother asked Father to leave. Father became aggressive and was reported by the friend to have pinned Mother up against the wall and put his hands around her throat. *Mother said that at this time she was afraid of father although he had never done anything like this before.*

Later that day Mother returned to the address and noted that the locks were broken. It transpired that Father was hiding inside a cupboard and jumped out on Mother who threatened to call the police. Father assaulted Mother by jumping on her foot and spitting in her face. Father was holding Child LC during the incident and handled him roughly. Police were called and arrested Father who was subsequently charged with criminal damage and Section 39 assault. Police graded the incident as high risk for a vulnerable child, medium risk domestic abuse. Father was bailed with conditions that he did not make contact with Mother or enter the home address.

As a result of this incident Children's Social Care became involved with the family. The referral was made via the MASH[5] as a CAF[6] assessment, there was no S47 discussion as the case did

[5] Multi-Agency Safeguarding Hub – a local multi-agency safeguarding system for assessing and referring cases
[6] Common Assessment Framework
http://webarchive.nationalarchives.gov.uk/20130401151715/https:/www.education.gov.uk/publications/eOrderingDownload/Framework%20for%20the%20assessment%20of%20children%20in%20need%20and%20their%20families.pdf

not meet the threshold for Child Protection. A social worker was assigned to the family and conducted a home visit to Mother and Child LC. A written agreement was discussed as a means of safeguarding Child LC, the agreement was signed by Mother. The agreement stated that Mother would ensure that Father had no direct or unsupervised contact with Child LC until CSC had completed their assessments and that Mother should notify CSC if Father attempted to make contact. *Mother said that she felt that the written agreement wasn't fair to her and that it made her responsible for protecting Child LC from father. At this time even though she was told that she shouldn't be in contact with father she said that they were in touch with each other. She felt that it wasn't realistic to expect her to keep him away and that at that time there was still some possibility of the relationship being repaired.* Within the review the Social Worker reflected on the practice of using written agreements in cases of domestic abuse and felt that this needs to be reviewed as it is unlikely to succeed given the power dynamics within such relationships.

The case was then allocated to a duty social worker who undertook a joint home visit with HV at the end of July. Caseloads were high at the time and cases were being 'stacked' and allocated as soon as a social worker became available.

At the Home Visit the Social Worker noted that Mother interacted well with Child LC and that they appeared to have a good bond. The Social Worker noted that mother appeared to be minimising the domestic abuse incident and mother said that although she was concerned about father smoking cannabis for the last three months he was cutting down. Mother said there were some financial difficulties but that she was coping. *Mother said that she didn't relate well to the Social Worker as she felt that she was being criticised rather than having a constructive relationship.*

The Social Worker spoke to father about his Cannabis use, he said that he used Cannabis less when he was with mother and that ultimately he wanted them all to live together as a family. The Social Worker was familiar with local drug services and was aware that it would be unlikely that he would meet the criteria for referral to drug services, however she did provide advice and information to father regarding his drug use.

3 KEY THEMES AND ANALYSIS

The review has highlighted a number of key themes which form the basis for learning and recommendations. These are set out below with an analysis of their significance in the case.

3.1 Parental Engagement with Services

Mother chose not to engage with some services although she was visible to professionals; she was well supported by her family; Child LC was observed to be well cared for and Mother did take up universal HV services under the Child Health Programme.

Whilst Mother did not attend the Teenage Pregnancy (Young Mum's Service) it is noted that attendance at the service is voluntary. Practitioners told the review that young mothers are generally reluctant to attend the service because of concerns that they will come to the attention of Children's Social Care and that they 'may have their children removed'.

This reluctance is attributed by practitioners to some young women using social media to share information about services and to discourage participation. Practitioners are aware that messages are posted on social media by young pregnant women which say that attendance at services such as the Young Mum's service will draw them to the attention of Children's Social Care and that this results in closer scrutiny and children being removed.

Professionals expressed their concern about the impact of social media in this context but said they feel unable to counter the influence of social media. The review makes a recommendation regarding the positive use of social media by agencies.

Father was less visible to professionals; it was known that was he was not a local person and that he had lived with his grandmother since moving to the area. He was noted as being supportive during Mother's pregnancy however he did not appear to take an active role in caring for Child LC.

Maternity services knew little about Father although this is not unusual in the service. It was recognised by practitioners that asking too many questions about fathers can be a disincentive to engagement and that a balance needs to be achieved between gaining information about the dynamics of the relationship between parents and ensuring that the mothers feel confident in using the service[7]. It was felt by professionals that this is a matter of professional judgment and noted that there are tools and guidance available to support practitioners in assessment and escalation of concerns.

Professionals who met Father after the birth of Child LC observed that he was more interested in his own needs than those of the child (i.e. getting money for cigarettes). It was suspected by professionals that he may use drugs (cannabis) but they did not feel there was any firm evidence for this having not received information contained in police records. Further enquiry regarding suspicions of drug use could have been made and the review would encourage professional curiosity and action in this regard.

The social worker saw Mother on several occasions. The Social Worker noted that Mother was supported by her family. They also attempted to see father on more than one occasion, and eventually spoke with him individually regarding compliance with the written agreement.

Father's childhood experiences i.e. exposure to sexualised behaviour/abuse by adults; cannabis use and anti-social behaviour were not known to health or social care services.

Professional engagement with Father was minimal. Practitioners made attempts to engage father however these were inconsistent and not sustained. It is important that practitioners understand the need to engage fathers, particularly where there may be additional risk factors (i.e. drugs, alcohol, domestic abuse).

The panel concluded that it would be useful to develop practice in relation to exploring the bond between the new born and father and that professionals could encourage fathers to talk about the developing relationship with their child.

[7] https://www.rcm.org.uk/sites/default/files/Father's%20Guides%20A4_3_0.pdf

3.2 Domestic Abuse

The domestic abuse incident that took place in July 2015 involved elements that are often seen in high risk cases (e.g. the perpetrator hiding and making a surprise attack, the use of strangulation)[8]. The incident also involved Father roughly handling Child LC whilst the assault was taking place. Despite the incident being rated as high risk for a vulnerable child (and medium risk for domestic abuse) there was no consideration of a strategy meeting taking place, either by police or by CSC. This was a missed opportunity to initiate a S47 and bring relevant information together.

The nature of the domestic abuse incident was such that it should have been rated high risk; the victim was young and vulnerable with a young baby[9] (the latest data from Safe-lives indicates that as many as 50% of high risk cases involve female victims below the age of 18, many of whom are pregnant or have recently had a baby).

Mother had refused to undertake a CAADA DASH[10] risk assessment however there were sufficient indicators of risk to warrant a high risk rating which would have resulted in referral to MARAC.

Mother was referred to the Independent Domestic Violence Advocacy (IDVA) service. The service attempted to engage with Mother on several occasions but she did not want to engage with them. Victims of domestic abuse often minimise incidents and it is not unusual for victims to refuse services; it should be borne in mind that engagement with this type of service is entirely voluntary on the part of the victim.

3.3 Use of a Written Agreement

Children's Social Care became involved with the family following notification of the domestic abuse incident. It was noted that Child LC had been present at the incident and had been roughly handled by Father during the incident. It was noted that Father had used strangulation in the assault on Mother.

Children's Social Care received only a partial picture from the Multi-Agency Safeguarding Hub (MASH) following the domestic abuse incident. Information held by the MASH was that Father was a regular drug user and that he had come to the attention of the police in another area on numerous occasions; this information was not shared with Children's Social Care.

The use of a written agreement in this case was considered by the panel to be inappropriate. Lancashire's Policy[11] on written agreements gives clear guidelines on how and when to use them to best effect.

The written agreement was not well documented in the case records, the conditions of it were unclear and there was no detail regarding how and when it would be reviewed. The

[8] http://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL.pdf
[9] http://www.caada.org.uk/practice-support/resources-frontline-domestic-abuse-workers-and-idvas/resources-ypvas/latest-young
[10] http://www.caada.org.uk/practice-support/resources-identifying-risk-victims-face
[11] http://lancashirecsc.proceduresonline.com/chapters/g_written_agree.html

written agreement placed sole responsibility on Mother for the safeguarding of Child LC and did not take Mother's vulnerabilities into account.

The panel concluded that it was unlikely that either Mother or Father would have been willing to comply with the written agreement despite the social worker asking questions about compliance. Both Mother and Father stated that they had not decided whether the relationship would continue although this did not alert the social worker to the possibility that Mother and Father may have been in contact during the period of the written agreement.

Monitoring such agreements is a time consuming task however the value of putting an agreement in place without sufficient monitoring of compliance is questionable. The panel has made a recommendation regarding the use of written agreements in cases such as this.

Consideration should have been given to the use of a Domestic Violence Protection Order (DVPO)[12]. Although Father was not a serial offender the use of the DVPO takes into account the ongoing risk factors for the victim of domestic abuse and thereby any related safety issues for the child.

3.4 Information sharing and effectiveness of MASH

Police held information regarding Father's history of exposure to sexual abuse and previous contact with police in another Force area. Police also appear to have had confirmation that Father was a 'frequent' drug user.

Following the domestic abuse incident it was indicated to CSC that the detail of this information would be shared with them, however this did not take place. This in turn led to the Health Visiting service being unaware of Father's background.

4. KEY LEARNING POINTS FROM THE REVIEW

4.1 The MASH system should include all relevant background information to the case, even if these appear to be historic. In this case relevant information about father's childhood was not shared with agencies.

4.2 Maternity services found it difficult to engage Mother despite being tailored to the needs of young mothers. The use of social media to exert peer pressure and deter engagement in services is difficult to counteract and requires creative and innovative thinking.

4.3 Father did not engage with maternity services although he did attend some appointments with mother. Professionals recognise the importance of engaging fathers and would welcome focused initiatives to develop improved practice in this area of work.

4.4 Father continued to use drugs throughout the period under review although he told professionals that he had stopped/cut down his use of cannabis. Professionals need to be

[12] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/506148/2016-03-08_DVPO_report_for_publication.pdf

equipped with sufficient knowledge and understanding of dependent drug use to enable them to make sound judgments regarding the impact of drug use on the family, and to know when to refer to specialist services.

4.5 Domestic abuse was a feature of the relationship between Mother and Father. Mother minimised domestic abuse and did not engage with IDVA services when these were offered. There is scope within this case for exploring new models of risk assessment and response to domestic abuse that are specific to young victims and perpetrators.

4.6 If written agreements are to be used to manage safeguarding issues they must include specific conditions that are achievable and measurable. Agreements should be monitored as to their effectiveness and practitioners responsible for overseeing agreements need to receive regular supervision and guidance from managers. The use of written agreements in domestic abuse cases is questionable as it places the onus on the victim to manage perpetrator behaviour.

4.7 Some professionals felt they were not sighted on mother's mental health history. A professionals meeting following the MASH referral would have enabled more information to be brought together to inform joint working with the family.

5. RECOMMENDATIONS

5.1 Recommendation 1

The LSCB should be assured that the system within the MASH for collating chronologies and sharing information is robust and takes into account relevant background information.

The LSCB should be assured that wider information sharing in relation to risk factors is quality assured by individual agencies and that there is a mechanism for checking the content and accuracy of information received from MASH.

5.2 Recommendation 2

The LSCB should be assured that all practitioners exercise appropriate professional curiosity in relation to the role of fathers (including specific focus on young fathers with additional risk factors) and that suitable training is available to support practitioners in this regard.

5.3 Recommendation 3

The LSCB should be assured that the local guidance and practice in relation to Written Agreements is updated to reflect the learning from this review.

5.4 Recommendation 4

The LSCB should be assured that responses to domestic abuse incidents involving young victims are appropriately risk rated, taking into account specific vulnerabilities and in line with national learning. This should include assurance that tools such as the DVPO are used when appropriate.

5.5 Recommendation 5

The LSCB should explore adopting new models of Multi-Agency Risk Assessment Conferencing (MARAC) for young people (i.e. below age 18).

5.6 Recommendation 6

The LSCB should be assured that professionals understand and are able to respond to the influence of social media on young people's engagement with services.

5.7 Recommendation 7

The LSCB should be assured that local Safe Sleeping guidance is up to date and makes specific reference to the role played by fathers.

5.8 Recommendation 8

The LSCB should be assured that professional knowledge in relation to dependent drug use is up to date.