Serious Case Review

Overview Report

Child LI

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Date: April 2018

Publication Date: 31st July 2018

Part 1

Introduction

1. The subject of this serious case review (hereafter, referred to as an SCR) is Child LI who was born in April 2016. LI was seriously injured in August 2016, aged four months, whilst in the care of their mother (MLI) and male partner (PMLI). Child LI has a twin (S2LI) and an older half-sibling (S1LI) who was born in June 2014 and is the child of MLI and PMLI. The latter is not the father of the twins.

2. Following admission to a local hospital at the end of August, LI was examined and found to have sustained life threatening injuries with lifelong consequences for their health and development. LI was transferred to an out of area hospital for specialist care and further tests.

3. The injuries were deemed by examining doctors to be non-accidental and a joint enquiry was undertaken by Lancashire Children's Social Care and Lancashire Constabulary. Child LI and the two siblings were removed from the care of MLI and PMLI and became looked after by the local authority who started care proceedings.

4. Lancashire Constabulary arrested the two adults and started a criminal investigation into the circumstances of LI's injuries.

5. The Lancashire Safeguarding Children Board considered the circumstances of LI's injuries and decided on the 04.10.16 to hold a SCR.

Part 2

Aims, Terms of Reference and SCR Process Issues

Aims

6. The overall purpose of this SCR is set out in Government Guidance[1], namely to undertake a rigorous, objective analysis that will;

- "Look at what happened in this case, and why, and what action needs to be taken to learn from the Review findings.
- Action results in the lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm.
- There is transparency about the issues arising from this case and actions which the organisations are taking in response to them.
- Including sharing the overview report with the public"

(Working Together, 2015, 72)

Terms of Reference (ToR)

7. This SCR and the overview report have been undertaken in relation to the following terms of reference, namely;

1. Critically examine and evaluate the effectiveness, or otherwise, of agency/multi-agency attempts to safeguard LI and her siblings in relation to the identification, assessment and management of the risk from harm and domestic abuse.

[1] Working Together to Safeguard Children (2015): HM Government/Department for Education

2. Comment critically on the effectiveness, or otherwise, of agency and multi-agency interventions-including early help and support for the carers- regarding planning, implementation and review that sought to safeguard and protect LI and her siblings from harm, including domestic abuse.

3. Examine the effectiveness, or otherwise, of inter/intra-agency working, including information sharing and case handovers/transfers, both within and without Lancashire in relation to safeguarding LI and her siblings.

4. Examine the efficacy, or otherwise, of decisions made and actions taken to safeguard LI (including pre-birth) and her siblings. How child focused were they and did they comply with agencies' policies and procedures and those of the Lancashire Safeguarding Children Board?

5. Examine the involvement of other significant wider family members in the life of Child LI and her siblings including a consideration of the potential for caring for the children.

6. Examine to what extent safe handling advice and support was provided to the carers.

Scope of SCR

8. The time-frame under examination by this SCR was from September 2014 to the end of August 2016. This covers the period from the first Police Protection of Vulnerable Person (PVP) referral on MLI to when the local authority started care proceedings on LI and the two siblings following the discovery of non-accidental injury on the 26. 08.16.

9. The SCR was undertaken under the ' Working Together' 2015 statutory guidance as it was commissioned by the Lancashire Safeguarding Children Board (LSCB) in October 2016.

Methodology

10. At the behest of the Lancashire Safeguarding Children Board the ' Welsh Model'[2] format was used to undertake this SCR[3].

11. The following documents, meetings and events underpinned the SCR;

- Time-line of Significant Events/Analysis.
- Discussion and analysis at four panel meetings.
- Learning event involving front line practitioners and managers: February 2018
- Conversations with family members (to be done)
- Reference to the six ToRs
- Liaison with the Lancashire Police Senior Investigation Officer (SIO) and Crown Prosecution Service (CPS)
- Sight of all relevant documents
- A visit by the lead reviewer in June 2017 to the Multi-Agency Safeguarding Hub (MASH) and conversation with the Children's Social Care MASH manager.

[2] ' Protecting Children in Wales: Guidance for Arrangements for Multi-Agency Child Practice Reviews (2012); Welsh Government
[3] Albeit, within the overall framework of Government guidance, ' Working Together' 2015, Chapter 4.

- The adoption of a broadly,' Systemic', approach to the understanding and analysis of the case within an organisational context of professionals' actions and decision making at the time.
- A focus on learning and not blame

12. There was a delay in progressing the SCR because of the need to wait for permission from the Police SIO and CPS before holding the practitioner's event in February 2018. A final decision was made by the CPS in March 2018 not to proceed with a prosecution of MLI and PMLI. Additional delays were caused by the need to wait until the care proceedings were concluded in August 2017.

13. Mindful of the delays and the need to identify learning and make changes to practice and policy in a timely manner, a draft report was provided to the panel in July 2017. This contained some early learning which was communicated to the panel and the LSCB and resulted in changes to the operation of the Lancashire Multi-Agency Safeguarding Hub (MASH).

The Panel

14. The Panel comprised of senior representatives from the following agencies;

SCR Panel Chair	Mrs. Louise Burton, NHS Chorley and South Ribble, CCG, NHS Greater Preston CCG and NHS West Lancashire CCG
Service Manager	CAFCASS
Named Nurse for Safeguarding Children and Adults	Blackpool Teaching Hospitals
Service Manager	Fylde Coast Women's Aid
Deputy Designated Lead Nurse; Safeguarding Children	NHS Fylde and Wyre CCG
Fylde District Team Leader	Lancashire Children and Family Well-being Service
Detective Inspector	Lancashire Constabulary
Team Manager	Lancashire Children's Social Care
Named Nurse for Safeguarding	Lancashire Teaching Hospital Trust
Business Support Officer	LSCB (non member)
Business Co-ordinator	LSCB (non member)

15. The independent lead reviewer was Mr. Paul Sharkey (MPA)[4]. He had no previous connection with either the LSCB or any partner agencies, including those involved in the SCR. He has a professional background in statutory and third sector safeguarding of over thirty years at senior

[4] Master's in Public Administration (2007) from Warwick University Business School.

management level. He has authored/chaired more than fifteen SCRs since 2002 and has attended several DfE/NSPCC courses on improving the quality of SCRs over recent years.

Confidentiality

16. In compliance with Government guidance this SCR has respected the right to anonymity of Child LI, their family and the professionals involved in the case.

17. **Family Involvement**

MLI and PMLI declined to be interviewed by the lead reviewer for the purposes of this SCR. However, LI's aunt (ALI) did and her views are included here. She advised that the family were very supportive to MLI, particularly during the initial separation between her and PMLI. Following the separation MLI spent a lot of time with the family; this drifted when she reconciled back with PMLI. ALI cared for the children following the birth of the twins during MLI's hospital stays and again following Child LI sustaining her injuries. ALI did not have significant contact with agencies/services involved with the family but what contact she had she reported to be good. ALI reported the PMLI stayed in the background at family events and following the birth of the twins MLI moved area closer to PMLI's family and contact was limited. MLI did not share information with her family. ALI would like to be informed when the report is published.

Race, Religion, Language and Culture

18. Child LI and family are English speakers of white British heritage.

Parallel Proceedings

19. As mentioned previously, the care proceedings on LI and the two siblings finished in August 2017. The CPS decided in March 2018 not to proceed with a prosecution of MLI and PMLI.

Dissemination of Learning

20. To be done by LSCB and Panel members

Part 3

Background and Overview

21. PMLI had a history of coercive control[5] of female partners prior to starting a relationship with MLI in early 2013. She soon started to experience coercive control from PMLI and left in early 2014 but returned to him shortly after. S1LI was born in June 2014. MLI left her partner again in the autumn of 2014 and went to live with her sister who supported her in finding accommodation. There were two incidents in late 2014 which involved the Police making Protection of Vulnerable Persons (PVP) referrals to the Lancashire MASH.

22. MLI applied for and obtained from the Family Court a one year non-molestation order[6] against PMLI in September 2014[7] which, in October of that year was varied to a ten year order. MLI received support from the health visiting service and the Independent Domestic Violence Adviser (IDVA), consequent to two multi-agency risk assessment conferences (MARACs) in late 2014 and early 2015. Support from a local Children' Centre was offered to MLI who declined. A third PVP was made by the Police in January 2015.The Family Court, following a recommendation from CAFCASS (Child

[5] Defined by Evan Stark (2009) as, 'A strategic course of self-interested behaviour designed to secure and expand gender-based privilege by establishing a regime of domination in personal life…….the oppression is ongoing rather than episodic (a course of conduct) and resulting harms cumulative, that is, multi-faceted, and that involves rational, instrumental behaviour'.)

[6] Under the Family Law Act 1996.

[7] Heard before a District Law Judge.

and Family Court Advisory Service), made S1LI the subject of a child arrangement order in February 2015 with a provision for regular contact with PMLI.

23. MLI and S2LI remained living away from PMLI for most of 2015 but the couple resumed their relationship in early 2016. By this time MLI was pregnant with LI and the twin, S2LI. The children were born in April 2016. A referral was made by the local hospital staff to Lancashire MASH (Children's Social Care) a few days after the births regarding concerns around domestic abuse. A DASH assessment was undertaken by the IDVA service.

24. Lancashire CSC, on the basis of information received from the IDVA and the health visitor -who in turn, based their assessments on what they had been told by MLI- concluded that the risk level did not meet the Continuum of Need (CoN) threshold for child protection or child in need intervention.

25. A fourth PVP, following an incident between MLI and PMLI, was made by the Police in late July 2016 and assessed as standard risk, thus not reaching the threshold for CSC intervention. It was later established by the Police enquiry that LI had sustained two bruises to their face on or around the 02.08.16 whilst in the care of their mother and PMLI. The evidence was captured on MLI's phone which was seized by the police in the course of their enquiry. There was no reference made to the bruising (assuming it was visible)[8] by the health visitor (HV2) who saw LI and the twin on the 04.08.16.

26. The twins received their immunisations at the GP surgery on the 25.08.16. That night, LI was taken by ambulance, with their mother, to the Accident and Emergency department of the local hospital. On examination, LI was found to have suffered serious injuries which were thought to be non-accidental in nature and transferred to the out of area hospital.

27. All three children were taken into the care of the local authority and a police investigation was started. The care proceedings finished in August 2017 with all three children being made the subject of care orders to Lancashire County Council. The family proceedings court found either one or both of the adults caring for her, were, on the balance of probabilities, responsible for LI's injuries. It could not say who, in fact, had specifically caused the injuries.

28. On the 26.03.18, the SCR was informed by Lancashire Constabulary that a decision had been made by the CPS that there were insufficient grounds for a realistic prospect of a conviction of either MLI or PMLI.

Part 4

Agency Involvement and Case Narrative

2013/14

29. Child LI's mother (MLI) started a relationship in March 2013 with PMLI which led to her moving in with the partner and his mother later that year. MLI became pregnant with S1LI in late 2013 but left PMLI in early 2014 because of his controlling and coercive behaviour. The couple reunited in the Spring of 2014 and S1LI was born that summer. A health visitor (HV1) was allocated and proceeded with the 'Universal' offer.[9]

[8] Although the picture of LI's bruising was taken on the 02.08.16 its age was not known and could have originated before the date given. There was a possibility that the bruises had disappeared by the 04.08.16. The lead reviewer was not able to speak to the health visitor (HV2) to ascertain whether she noticed the bruising or not as this was beyond the control of the SCR.

[9] This consists of every new mother and baby having access to a health visitor, receiving development checks at just after birth, 6-8 weeks, 9-12 months and 2-21/2 years; and being given good information about health start issues such as parenting and immunisation.

30. Following continuation of his controlling behaviour, MLI and S1LI left PMLI for the second time and went to live with her sister (S1) in the early autumn of 2014. The move resulted in the allocation of a new health visitor (HV2).

31. S1 reported domestic (mental) abuse of her sister by PMLI on the 10.09.14 to the Lancashire Police who made a Protection of a Vulnerable Person (PVP) referral, graded at 'Medium' to the MASH that day.The MASH assessed MLI as being in an emotionally abusive and controlling relationship with PMLI. Information was shared with the National Probation Service, health agencies and the Independent Domestic Violence Advisor (IDVA) service. The social work assessment within the MASH graded the PVP, against the Continuum of Need (CON) at Level 3 (not needing a referral to CSC) and recommended a step down to a Children's Centre.

32. MLI was assigned an IDVA, advised to seek legal advice regarding child contact with S1LI's father and offered family support from a local Children's Centre (CC1). No criminal offence was identified.

33. A one year non-molestation order, under section 42 of the Family Law Act 1996, with conditions, was made in MLI's favour on the 22.09.14. PMLI was served notice of the order on the 24.09.14 and a copy lodged on the same day at Blackpool Police Station.

34. A second PVP was made by the Police to the MASH on the 04.10.14 following a complaint made by MLI regarding a 'Revenge porn' incident initiated by PMLI. The MASH assessment of medium risk determined that the incident did not breach the conditions of the non-molestation order or give grounds for a harassment offence.[10]

35. MLI and her baby received support from HV2 and IDVA1during late 2014 but declined intervention from the Children's Centre. The Family Court granted a ten-year non-molestation order on the 17.11.14, made a finding of fact on the issue of domestic abuse and ordered that CAFCASS provide a Section 7 report for a February 2015 hearing. It granted twice weekly daytime contact for S1LI's father (PMLI).

36. MLI told IDVA1 that the abuse had started in September 2013, shortly before becoming pregnant with S1LI. She described a very controlling relationship with PMLI frequently checking her phone, not allowing her on Facebook, deleting all the numbers in her book, controlling what she wore, her money, access to her family and not allowing her out on her own.

37. IDVA1 undertook a CAADA-DASH[11] risk assessment on the 20.11.14, scoring 14, thus indicating 'High Risk' ; and made a referral to the MARAC, in addition to placing a DV marker on the property with the Police.

38. CAFCASS received a request from the Family Court on the 10.12.14 for a section 7[12] report to be submitted by the 18.02.15. An updated safeguarding letter had been sent to the Court by a Family Court Adviser (FCA1) on the 20.11.14 confirming that enhanced information (from the Local authority and the Police) had not raised any additional safeguarding concerns or need for immediate action regarding S1LI.The case was re-allocated to FCA2 on the 15.12.14 who triaged it as 'Low

[10] (Arguably, it did; NB came before the legislation, section 33 of the Criminal Justice and Courts Act 2015 (which came into force in April 2015) which makes it an offence in England and Wales to disclose private sexual photographs and films without the consent of the individual depicted and with the intent to cause distress. There is a maximum sentence of two years imprisonment.

[11] Co-ordinated action against domestic abuse-Domestic Abuse, Stalking and Honour based Violence risk assessment and management model (2009)

[12] Of the Children Act, 1989.

risk' based on the available information. A transcript of the Finding of Fact hearing of the 26.09.14 was requested on the 19.12.14 for FCA2 to assess any risks.

39. The MARAC held on the 18.12.14 deemed MLI to be at very *High Risk* and noted her to be engaging with services. It agreed;

- IDVA1 to advise MLI to carry non-molestation order to present when necessary.
- IDVA1 to request vulnerable marker when MLI moved.
- IDVA1, victim update.
- Police to re-check PNC with previous name provided, before it was changed by deed poll (this referred to PMLI).
- IDVA1, Children's Centre and HV2 to refer to Children's Social Care if any concerns about S1LI.

2015

40. Lancashire Police made a third domestic abuse PVP to the MASH on the 06.01.15, having done a DASH and classified the incident at Medium Risk, consequent to MLI's complaint about feeling intimidated by PMLI at a handover of S1LI a few days earlier. MLI referred to the non-molestation order and attendant conditions but despite the recent MARAC (and the order having been lodged at Blackpool Police Station on the 24.09.14), these details were not on the PNC. She was advised to obtain it from her solicitor.

41. The PVP referral remained in the Police queue until the 16.01.15 and was reviewed on the 17.01.15 (a Saturday) as a single agency by the police sergeant who, because of the presence of S1LI, raised the referral to High risk and referred to the MASH. S1LI was identified at risk of being used as a tool between the parents. The MASH social worker considered the episode and concluded that it was Level 3 on the Continuum of Need , which indicated a, ' Step down' , to a Children Centre, thus not getting onto CSC's ' radar'. The PVP was finalised on the Monday 19.01.15.

42. PMLI was not arrested for breaching the terms of the non-molestation order despite a referral being made to the MARAC for breach of the order. PMLI was advised by the Police by telephone not to have any further unnecessary contact with MLI.

43. On the same day, FCA3 (CAFCASS) was contacted by MLI's solicitor and told of the incident and PMLI 'bombarding' her with Facebook posts and texts. FCA3 sent a s16a[13] e-mail update to the Court outlining recent events concerning PMLI's behaviour and requested an urgent court review, which in the event, did not happen. It was noted by CAFCASS that the e mail did not address the risks to S1LI were he to have continuing contact with his father.

44. MLI and her baby moved into their own accommodation in January 2015. IDVA1, on the 14.01.15, asked the Police to place a DV marker on the new address as per the MARAC of the 18.12.14.

45. MLI was seen by FCA3 on the 11.02.15 and 16.02.15 regarding the forthcoming Child Assessment Order hearing in the family court scheduled for the 24.02.15. FCA3 noted that MLI was, 'Still very much afraid of her ex-partner ', and felt intimated at hand-overs of S1LI. She

[13] This is a risk assessment required of CAFCASS under section 16 of the Children Act 1989-see section 2 of the CAFCASS child protection policy 2014.

was DASH assessed by FCA3 as ‘High risk’, with reference to serious findings having been made against PMLI in the previous Finding of Fact hearing. PMLI was seen on the 16.02.15 and 18.02.15 by FCA3.

46. A second MARAC was held on the 12.02.15. Resulting actions were,
    - Victim update by IDVA1.
    - IDVA1, joint visit with Police.
    - IDVA1 to speak to victim regarding non-molestation order conditions being varied.
    - Police to re-check PNC information.
    - Children’s Centre to check engagement with victim.
    - BTHFT, CSC and Children’s Centre to check records for any additional children.

47. The S.7 report was filed with the Family Court on the 18.02.15. It recommended a child arrangement order to PMLI that included the existing contact arrangements. Any move to overnight contact should only occur following PMLI’s attendance on a Domestic Violence Perpetrators Programme (DVPP), a Separated Parents Information Programme (SPIP) and a GP referred ‘Anger management’ course.

48. A final order was made on the 24.02.15 by the Family Court that followed the recommendations of the S.7 CAFCASS (FCA3) report. No further mention was made of the DVPP/SPIP programmes and there was no court requirement for CAFCASS to monitor PMLI’s attendance at these.

49. IDVA1 and PC1 (Police officer) visited MLI in early March and discussed the MARAC plan. A copy of the ten year non-molestation order was e-mailed to the Police who agreed to update the Police National Computer (PNC).

50. PMLI, via his GP attended the first session of an ‘Anxiety’ workshop in March 2015 but had dropped out of the programme by April having attended only one meeting. The workshop did not cover anger management as recommended by FCA3 for the family court.

51. IDVA1, at MLI’s request finished her involvement and closed the case in early May. MLI and SLI continued to attend clinic in May/June for routine weighing. There were no further recorded incidents of intimidation or abuse between MLI and her ex-partner during 2015.

52. MLI attended her GP in late September when her pregnancy was confirmed. A twin birth LI and S2LI) with an expected delivery date of early May 2016 was established. She booked in with the local Trust midwifery service in early October and was duly seen by a community midwife (CMW2). MLI mentioned that she had been subject to domestic abuse by her previous partner, who was not the father of the twins. She continued to engage well with the midwifery service for the rest of the year with no safeguarding concerns identified.

2016

53. In early January, MLI was seen by a doctor at the local hospital for reduced foetal movements. On examination to MLI a small laceration was identified, in addition to foetal heart beats. She was asked to stay for further treatment but left without telling staff. A message was left on her phone requesting that she attend the next week for a scan. There was no documentation as to whether any questions about the lacerations had been followed up, which would have been expected practice.

54. MLI did attend for an ante-natal appointment on the 08.02.16 and arrangements were made to see her in four weeks. S1LI was admitted the next day, by ambulance, to the local hospital 2, Accident and Emergency with a prolonged seizure. MLI, along with the other parent (not documented, but thought to be PMLI) was present.

55. S1LI was admitted to the children's ward where they received appropriate treatment and remained for two days. It was noted that the baby had some scarring due to a cannula to the right hand which was treated. There were no concerns recorded about the parental interaction whilst on the ward.

56. S1LI was again seen on the 13.02.16 in the local hospital 2 due to concerns that the scarring to the hand was not healing. There were no concerns from the plastic surgeon who deemed that the hand was healing well and S1LI was discharged home.

57. MLI attended ante-natal appointments and the early pregnancy unit in March with some anxieties about the growth of the unborn children. She was admitted overnight to the local hospital 1 on the 21.03.16 and transferred to an out of area hospital 2 because of threatened pre-term labour. It was noted that PMLI was at home caring for S1LI. This was the first documented reference that the couple were together despite the 10 year non-molestation order. MLI was unaccompanied and upset at having no family visitors whilst at out of area hospital 2. Following obstetric tests, she was assessed as fit to discharge and left the hospital on the 24.03.16 with an appointment to attend local hospital 1 on the 29.03.16. Treatment information was shared with local hospital 1.

58. MLI self-referred to local hospital 1 maternity triage on the 27.03.16 for severe itching, previously diagnosed as obstetric cholestasis. It was noted that her abdomen appeared to be bruised. There was no evidence of any routine enquiry regarding the bruising. She left the unit saying she could not stay as her 'Husband' (PMLI) needed to go to work. She attended the midwife delivery unit at the local hospital 2 on the 29.03.16 for 'Bloods'.

59. The twins, LI and S2LI were born on the 14.04.16 at 35 weeks gestation. LI was transferred to the neonatal unit due to hypoglycaemia (low blood sugars). The birth notification was received by the health visitor (HV2) on the 15.04.16.

60. 32. MLI and PMLI were heard arguing by SCBU[14] staff on the 16.04.16. PMLI was wanting MLI to self-discharge as she was 'neglecting' S1LI. Domestic abuse and appropriate services were discussed. Expected practice would have been for staff to have discussed comments made about S1LI by PMLI with the Paediatric Liaison Nurse (PLN). MLI was noted on the 17.04.16 to be attending to all of the twins' needs and she also had a visit from her family. Neither PMLI nor S1LI visited. MLI told ward staff that PMLI was not the twins' father which appeared to be the first time they became aware of this fact.

61. SCBU staff reported PMLI's aggressive behaviour to themselves and MLI to the PLN1 on the 19.04.16. The health visitor team reported to PLN1 that there had been significant domestic abuse between the two resulting in a MARAC, police markers on the property and a ten year non-molestation order against PMLI. A referral was made by ward staff to the IDVA service and both safeguarding and the named midwife were informed of the situation by PLN1.

[14] Special Care Baby Unit.

62. MLI was seen by IDVA1 on the 21.04.16 who carried out a DASH risk assessment which scored 6, based upon the information given. MLI said that she did not want any support from FCWA (IDVA service) but would contact if she needed any future support. IDVA1 said she was going to make a referral to CSC and also spoke with the health visitor about the situation. MLI and the twins were discharged home. The named midwife completed a referral to CSC.

63. CSC received the named midwife safeguarding referral on the 22.04.16 regarding the three children and was processed by SW1 on the 27.04.16. The referral reported a high risk of domestic abuse and reference was made to the February 2015 MARAC.

64. The current information from the health visitor HV2, who had discussed the situation with MLI was that there were no safeguarding concerns at that time. The MASH (police) was contacted by CSC who recorded that the last domestic abuse incident was in December 2014; this being a verbal argument over contact with S1LI. It was recorded that the PNC was checked regarding this incident and there was no order out against PMLI in relation to MLI. IDVA1 had seen MLI and had assessed the (DASH) risk as low. On this basis, CSC did not make a child protection referral and closed the case due to a lack of evidence that MLI was at current risk of being a victim of domestic abuse. It noted that the professionals involved with MLI and the children were aware of the situation and were monitoring and giving support. Any further concerns regarding S1LI would result in consideration 'To be given re C and F at that time'. (Children and Family assessment).

65. MLI received two midwife visits on the 22 and 24 April with no documented enquiry into the relationship with PMLI or domestic abuse. HV2 made the first home visit on the 25.04.16 under the Universal service offer. MLI spoke about the previous domestic abuse from PMLI who was not present. She said that her children were her priority and understood the importance of keeping them safe. She did not show any indication of a low mood to HV2. Expected practice would have been to record any history of post-natal depression (PHQ9 tool) and enquire about the relationship with PMLI.

66. MLI was admitted to the medical ward at local hospital 1 on the 27.04.16 for itching (cholestasis) and other ailments and received appropriate treatment. She self-discharged three days later.

67. The health visitor (HV2) was contacted by a social worker (SW1) on the 27.04.16 regarding the referral from the SCBU concerning PMLI's aggressive behaviour. HV2 saw LI on a home visit on the 28.04.16. She was seen again on the 04.05.16 in the care of MLI's sister (the aunt to LI and S2LI) and PMLI. PMLI was said by maternal family members to have been an excellent support whilst MLI was in hospital. The midwife visited for the last time on the 05.05.16 when nothing of any significance was noted. MLI and the children were discharged into the care of the health visitor (HV2) and GP.

68. MLI was admitted to LOCAL HOSPITAL 1 with sepsis on the 06.05.16 when some bruising to her legs was noticed by the nurse. Enquiries were made regarding domestic abuse. MLI said that PMLI had been staying with her since the twins' birth. She was discharged on the 09.05.16.

69. On the 09.05.16 S1LI (nearly two) was seen by the GP for a 1cm laceration to the roof of his mouth. 'Dad' had reportedly given the child calpol for the pain. Nothing abnormal was discovered; reassurance and advice were given.

70. HV2 visited MLI and the children on the 11.05.16 for routine baby checks. MLI had not heard from CSC. HV2 checked later and found that CSC had closed the case, MLI was informed of this by HV2. No routine enquiry was documented by the health visitor into MLI's relationship with PMLI.

71. On the 16.05.16 the GP referred S1LI for a paediatric appointment regarding the reported change in the child's behaviour (angry), waking in the night screaming and weight loss. The GP felt it might be 'Night terrors' but wanted a second opinion.

72. It was recorded that MLI did not turn up on the 23.05.16 for a surgical clinic appointment. She was normally good with attendance.

73. On the 05.06.16 MLI made allegations to the Lancashire Police that she and her new partner (thought to be PMLI) had been receiving malicious Facebook messages for the last two months from an ex-partner. A PVP domestic abuse referral was made to the MASH at standard risk and a crime report completed for a criminal offence of harassment. MLI said that the ex-partner was an alcoholic and she was happy for him to be given a warning in the first instance. The information was shared with HV2 on the 17.06.16.

74. The twins were seen by the GP and HV2 on 08.06.16 for the 6-8 week review. A routine visit by HV2 took place on the 20.06.16 when the PVP referral was discussed. Intervention was nominally at 'Universal' level but the frequency of contact was above this. MLI consented to investigations into her bilestones.

75. On the 22.06.16 the GP recorded that LI did not attend a hip ultrasound scheduled at LOCAL HOSPITAL 1.

76. On the afternoon of the 04.07.16, PMLI contacted NHS 111 regarding a laceration to S1LI's lip; the second time he had sustained an injury. PMLI said that S1LI's lip had got trapped in a DVD case. He was advised to see the GP. MLI then contacted the GP and was advised to attend the GP or primary care. There was no evidence that the parents and S1LI attended for medical attention.

77. The twins were notified by HV2 on the 25.07.16 as having received their first childhood immunisations.

78. On the 26.07.16 MLI contacted NHS 111 with concerns about S2LI having a fever, pain and inconsolable crying. A GP triage call was requested (FCMS) and a GP tried three times to contact with no answer. There was no follow up.

79. No access was reported by HV2 on a planned visit on the 29.07.16.

80. On the 30.07.16 (a key date**)** the Police attended a domestic incident at PMLI's address involving MLI who said that the two had recently re-united despite the existence of a ten year non-molestation order. MLI said that there had been a 'massive blowout' that night over the twins. A finding of fact from the later care proceedings stated that on this date the three children were exposed to aggressive behaviours between MLI and PMLI that led to the Police being called. MLI had left the house with LI who had been grabbed with excessive force by PMLI. [15]She returned to her own address but PMLI had S1LI and S2LI and was refusing to hand himS2LI over to her.

81. Consequent to the Police presence PMLI handed over the other twin but S1LI remained with him, despite the previous MARACs and the ten year non-molestation order. All three children were deemed to be 'Safe and well' by the officers who submitted a PVP domestic abuse referral to the MASH at standard risk. The information was shared with IDVA, CSC, Health and Probation.

82. The Court (care proceedings on the three children) finding of fact based upon the findings of the Police investigation, found that on 02.08.16 LI had two bruises to her face, one on each cheek. [16]The injuries were as a result of trauma and were inflicted by MLI and/or PMLI on or before the 02.08.16. Both adults failed to seek appropriate or any medical attention for LI's injuries.

83. S1LI was seen on the 03.08.16 by a paediatrician following the GP referral. MLI reported that his behaviour had improved and he was less angry; eating and sleeping better. The doctor thought that the child's behaviour might have been related to being ill and in hospital.The child was still complaining of a painful right hand where the cannula had tissued.The child was to be seen in six months if the parents felt that the behaviour had not improved.

84. HV2 was informed on the 04.08.16 of the recent domestic abuse incident. She visited MLI at her address who appeared to minimise the incident, despite the existence of the ten year non-molestation order. MLI said she was happy with PMLI; the incident was due to problems with his mother who had moved away. She described her emotional well-being as 'Very happy, feels good'; good family support was noted. The twins were meeting their developmental milestones.

85. S1LI attended the Accident and Emergency department at the LOCAL HOSPITAL 1 on the 24.08.16 with a head injury (a 4cm haematoma). This was the third time the child had presented with an injury since 09.05.16 but the first time at A/E. Both parents were present and explained that the S1LI had tripped over the dog and hit their head on the bannister.The injuries matched the story given and the child was discharged home.

86. The twins attended GP surgery on the 25.08.16 at 5pm for their immunisations. Nothing untoward was noted.

87. On the same day at 20.47 hours, MLI made a 999 call regarding LI who was unresponsive, lifeless and floppy. The child was taken by ambulance to the LOCAL HOSPITAL 1, arriving at approximately 10pm, with their mother. Two bruises were noted above the umbilicus (abdomen) and the left upper thigh. A CT scan at LOCAL HOSPITAL 1 showed sub-dural

[15] According to the Court Finding of Fact.

[16] This was evidenced from the Police examination of MLI's mobile phone during the later criminal enquiry.

haemorrhages (bleeding on the brain). Lancashire Emergency Duty Team (EDT) was contacted who liaised with the Lancashire Police. LI was transferred to the out of area hospital. No suitable explanation was given by MLI for the cause of the injuries.

88. An investigation was started by Lancashire Police into the non-accidental injuries sustained by LI. Both parents were arrested by Merseyside Police on suspicion of S.18 assault and child neglect and were subsequently given police bail, pending further enquiries. EDT and Lancashire Police did a home visit to find the other two siblings in the care of their maternal grandfather. The children became cared for by their maternal aunt. EDT noticed a bump on S1LI's forehead which the grandfather said was caused by the child falling over a dog. There was no reference documented as to whether the family members had been considered as being possible perpetrators or the potential risk to the children.

89. A strategy meeting was held on the 26.08.16 at the out of area hospital with the Police, Health and CSC. A S.47 enquiry was started. LI had an MRI brain-scan on the 27.08.16, whilst in the PICU (paediatric intensive care unit). This showed, acute-bilateral sub-dural haemorrhages, evidence of diffuse axonal injury (brain damage), and extensive retinal haemorrhages. The subsequent Court finding of fact (based on the later Police enquiry) found that the some of the injuries had most likely been sustained within fifteen days of the 26.08.16 and probably far less. Other injuries were up to seven and eleven days old respectively.

90. The finding of fact established that the injuries to LI's head and eyes were inflicted by MLI or PMLI forcefully shaking LI, with or without an impact with a semi-yielding object, at or after 6p.m. on the 25.08.16. Furthermore, it would have been obvious to whoever shook LI that inappropriate force had been used and that urgent medical attention should have been sought for her. The adult who had witnessed the other shaking LI or was aware that the child had been shaken by or had been inappropriately handled by the other on the 25.08.16 had concealed the same from professionals and had failed to seek timely and appropriate medical attention for her.

91. The Court also established that LI had sustained bruising injuries to their abdomen and thigh, inflicted on more than one occasion, on the 23 and/or 24.08.16 by MLI and/or PMLI as a result of excessive rough handling. Depending on who was responsible for the injuries, the other adult had failed to protect LI and their siblings by permitting the assailant to remain in the same household. Moreover, both adults had failed to seek any medical attention for LI's injuries.

92. Neither adult had as of the date of the final hearing (01.09.17), been open and honest about the circumstances in which the injuries were inflicted to LI by one or both of them, on or before the 02.08.16, on 23 or 24.08.16, or on the 25.08.16.

93. Care proceedings were started on the children on the 31.08.16 and completed on the 01.09.17 when all three children were made the subjects of care orders to the local authority.

94. The CPS decided in late March 2018 that there were insufficient grounds to mount a realistic prospect of a conviction of MLI and PMLI.

Part 5

Analysis of Practice with regard to the Terms of Reference

1. Critically examine and evaluate the effectiveness, or other wise, of single/multi-agency attempts to safeguard LI and siblings in relation to the identification, assessment and management of the risk from harm and domestic abuse.

95.There were ten occasions, during the time frame in question when professional considerations regarding potential harm and domestic abuse were given to the welfare and safety of LI and her two siblings. These were,

- The four PVPs of the 10.09.14, 04.10.14, 06.01.15 and 30.07.16 made to the MASH.
- The two MARAC's held on the 18.12.14 and 12.02.15.
- The CAFCASS section 7 report provided for the Family Court hearing of the 24.02.15.
- The DASH assessment made by IDVA1 on the 21.04.16
- The child protection referral made by the named midwife for safeguarding to the CSC received on the 22.04.16, a few days after the birth of LI and the twin.
- The s.47 joint investigation conducted by Lancashire CSC and Lancashire Police following the serious injuries to LI sustained on the 25.08.16.

96. S1LI was involved on all ten occasions, with LI and her brother being involved in the four episodes after their birth, namely the IDVA1 DASH assessment, the CSC assessment, the final PVP and the joint S.47 investigation.

The Lancashire Multi-Agency Safeguarding Hub (MASH)[17]

The Lancashire County MASH[18] was set up in April 2013 originally on the basis of Police only referrals. Its vision is,

' *To identify and make safe all vulnerable people in our communities at the earliest opportunity by sharing information and making referrals into pathways across the safeguarding partnership.' (LSCB MASH-Diagnostic July 2016)*

97. The MASH operating manual defines the MASH thus,

' The Lancashire MASH will allow participating agencies to share information in a timely and secure manner and enable agencies to decide on appropriate referral pathways into services for vulnerable people.' (LSCB MASH-Diagnostic July 2016)

98. The MASH consists of the following agencies,

[17] The Lancashire MASH has changed considerably in the last 12 months (April 2018, at the time of writing). See Lancashire MASH Operational Manual (Version 9, Update, February 2018) for an update on developments and current arrangements

[18] Blackpool and Blackburn and Darwen have their own separate MASHs.

- Local authority, Customer Access Service, Children's Social Care, Adult Services, YOT, Education workers, Early Response Team, LADO.
- Police
- Health
- Probation; National Probation Service
- Fire and Rescue

99. Originally set up in Leyland, the MASH relocated to Accrington in June 2014. The LSCB completed a 'Diagnostic ', in 2016 and made a number of recommendations. Since then a multi-agency strategic board and operational group have been established and a systems review of process has been completed. Closer links have been developed with the Police and social care localities.[19] CSC merged the workers in the Contact and Referral Team (CART-the 'Front Door' team) and MASH together and managed both police referrals and referrals from other agencies such as, health and education. The Social Care team within the MASH manages all non-Police referrals but not Protection of Vulnerable People (PVP) referrals which include domestic abuse referrals. These are processed by the Police. Where children are involved levels of contact/intervention are assessed against the Lancashire ' Continuum of Need (CON) and Threshold Guidance'[20] by a social worker within the team who will recommend the following outcomes,

- Close and No Further Action
- Step down to Early Help
- Step up (Child in Need or Section 47 child protection) to a district team for a statutory Child and Families assessment.

The outcome will be ratified and decided upon by the CART manager.

<u>The Four PVP Referrals</u>

100. Following a DASH assessment, all PVP domestic abuse referrals to the MASH are graded at three levels by the attending police officer, depending on the degree and likelihood of harm to the potential victim. These levels are,

- Standard
- Medium
- High

101. The first two PVPs of September and October 2014 (so called 'Revenge Porn') on MLI were both graded at Medium Risk by the attending police officer. The MASH, as per procedure, reassessed the risk assessment and on both occasions agreed with the original medium risk grade. Appropriate safeguarding measures were taken (see paragraphs 32/33 above) to protect MLI by way of mitigating future risk.

102. All medium and high risk PVPs were passed onto the CART who on both occasions, in relation to S1LI, identified the Level of Need, according to the Continuum of Need/ Threshold

[19] The single site MASH (as of June 2017 when this section of the report was written) has since been devolved into localities which has improved local inter-agency links and contacts. (See later section for more details)

[20] This was refreshed in May 2016.

guidance framework, at Levels 3 and 2 respectively. At that time, this meant a 'Step down' to a children's centre. There was no involvement with CSC as the Level of Need did not warrant this. Consequently, there were no entries made of these PVPs on the recording system (Liquid Logic). This meant that they did not show up in the later CSC assessment of the 22.04.16 following the birth of LI and her twin, consequent to the referral from the LOCAL HOSPITAL 1 staff who had concerns about domestic abuse towards MLI from PMLI.

103. By the time of the third PVP in early January 2015, MLI had obtained a ten year molestation order (with conditions) from the Family Court. She had also been subject to an IDVA DASH assessment and MARAC which had raised her situation to that of High Risk.

104. Given the previous IDVA1 DASH and MARAC high risk classification the MASH, on this occasion came to the same conclusion of High Risk. Despite the ten year non-molestation order having been granted in September 2014, and having been lodged at Blackpool Police Station on the 24 September, the details (conditions) were not on the PNC. This meant that the Police could not confirm if there was a power of arrest attached to it. In the event there was, as evidenced by the non-molestation order being noted (in the Police/MASH documentation of this PVP), on the 16.01.15, to be on the PNC with a conditional power of arrest. Arguably, it would have been a reasonable decision to have arrested PMLI for breach of the order, given that he had contravened the conditions of the Court.

105. It is not known why the full details of the non-molestation order, including the powers of arrest, were not entered in a timely way onto the PNC, especially as the order from the Family Court had been lodged at Blackpool Police Station in the previous September. This omission would have implications for later actions taken by CSC regarding the referrals made by the IDVA and the LOCAL HOSPITAL 1 staff on the 22.04.16. (See below at paragraphs 145 to 148)

106. Notwithstanding the High Risk PVP grading, the Continuum of Need (CON) recommendation by the MASH social worker (MSW1) concluded that S1LI and his mother's situation met Level Three, namely a step down to children's centre services. Whilst recognising that there was a risk that S1LI was being used as a tool between the couple, SWM1's recommendation was accepted by the MASH Police sergeant and ratified by the CSC MASH team leader. The actions were that a referral was made to the MARAC and children's centre services were to ascertain that all necessary supports were in place for S1LI and mother. In fact, MLI had declined early support from the local children's centre in the previous November.

Comment

107. In all the circumstances of the time, it would seem that the MASH social worker (MSW1) made a defensible decision to designate the PVP referral at Level 3. However, this meant that the PVP referral did not go to CSC at -statutory intervention- Level 4 , namely Children in Need and/or Section 47 child protection services and was therefore not entered onto that agency's electronic case recording system (Liquid Logic). A consequence of this was that the PVP incident did not show up at the later child protection referral to CSC of April 2016.

108. The final PVP referral made on the 30.07.16 was submitted by the attending police officer to the MASH at Standard Risk, which, at that time, were not passed onto CSC; and hence, was not recorded. Therefore concerns about the children were not passed to the social worker in the

MASH for assessment against the CON.The incident never registered on the CSC recording system and the referral was closed by the MASH.

109. Given the existing ten year non-molestation order, the circumstances of the incident, ' A massive blow out over the twins', the previous three PVPs and the two MARACs at 'High Risk', there is a strong case for this PVP to have been submitted at the very least as a Medium Risk. It may have been that the attending officers were not in full possession of the relevant information, notwithstanding that the non-molestation order, should at that time, have been recorded on the PNC.

110. In any event, MASH Police staff could have challenged the Standard Risk grade and elevated it to medium or even high. Had this been done, the referral would have been considered by the MASH social worker, graded against the CON at Level 4 [21]and possibly resulted in a strategy discussion and/or further intervention from CSC.

Comment

111. In summary, none of the first three PVPs warranted a referral to CSC as they did not meet the Level 4 statutory intervention/assessment threshold. The final PVP was not considered by the MASH social worker (MSW1) because of its, arguably incorrect, Standard Risk designation. Therefore, the existing MASH processes had resulted in a systemic outcome whereby any concerns for the children would need to reach Level Four of the CON in order to trigger a statutory response (i.e a potential Child in Need/Child Protection intervention) from CSC and the opening of a case record. Consequently, at no time during the period in question were LI or the two siblings ever an open case to the CSC. Of significance, nor was there any record available that would give the bigger, historical picture of the children's experiences whilst in the care of their mother and the attendant implications of potential risk from the two adults. In essence, the children were never on CSC's radar.

112. A key lesson emerging from the above analysis would suggest that consideration should be given to entering a 'Flag and Tag' on CSC and Police electronic recording systems (' Liquid Logic') of all-including ' Standard- PVPs involving children. This would enable the MASH social worker, CSC and the Police to have access to a fuller historical context of a referral involving a child and lead to a more informed and better understanding of potential risk to children, especially within the context (as in this case) of perpetrator coercive and controlling behaviour.

113. ' Flag and tag', of all PVPs by CSC and the Police would also alert CAFCASS to possible child protection concerns when doing early safeguarding checks in private law family proceedings (see below in section dealing with the CAFCASS section 7 report).

The Two MARACs

114. There was a social worker present at both of the MARACs in December 2014 and February 2015. MLI's situation was deemed to be High Risk. It was noted at the second MARAC that an action for the Police was to re-check PNC information in regard to the10 year non-molestation order. Appropriate actions were taken to mitigate the risk to MLI and S1LI from PMLI, including the IDVA having sent an e-mail on the 06.03.15 to the Police regarding amending the PNC in relation to the 10 year non-molestation order.

[21] At the time Level 4 was split into CoN 4A (Child in Need) and CoN 4B (Child Protection)

115. It is not known whether CSC had(s) facilities to cross reference electronic recording systems (Liquid Logic) with MARAC meetings and minutes that could have informed social work assessments of need and risk for children. However, it is the case that the social worker at the MARAC would record any information onto the LCS (Liquid Logic recording system) if the case was already open to CSC. This did not happen with MLI and S1LI as CSC did not open a case subsequent to the two MARACs, presumably because the level of risk and need to the child did not meet the Level 4 (CON) statutory intervention threshold. The lead reviewer and panel took the view that this arrangement was not child focussed.

116. The learning from this would suggest that, in a similar way to PVPs (see above), CSC should arrange for all MARACs involving children to be, ' Flagged and Tagged up', on its electronic recording system, irrespective of the threshold level of need (CON).

CAFCASS Section 7 Report

117. CAFCASS received MLI's application for a Child Arrangements Order sometime shortly after the first Family Court hearing of the 26.09.14, through a 'Work to First Hearing', notification. The Family Court Adviser (FCA1) had previously recommended that consideration be given to a judge-led conciliation meeting and for the parties to attend a Separated Parenting Information Programme (SPIP) to assist them in understanding the impact of parental conflict on S1LI.

118. As per standard procedure, safeguarding checks were conducted with the Police and the Local Authority into the adults and any known risks to S1LI. It is not known whether the two PVPs logged by the Police were notified to FCA1 although both associated incidents were known to the Family Court hearing of the 17.11.14. A safeguarding letter was filed on the 20.11.14 notifying the Family Court that the enhanced information did not raise any concerns or require any immediate action.

119. However, FCA1 would not have been aware at that time of either the IDVA1 DASH High Risk assessment made on the 20.11.14 or the subsequent MARAC of the 18.12 14 (High Risk) which came after the filing of the letter. The Court had ordered on the 17.1.14 that CAFCASS file a Section 7 Report by the 18.02.15 for the hearing scheduled for the 24.02.15.

120. The Family Court judge, on the basis of the evidence presented at the hearing of the 17.11.14, varied the non-molestation order from one to ten years in duration. This was done on the grounds of PMLI's previous record of domestic abuse and his current behaviour towards MLI, especially in relation to his uploading of a video of sexual imagery of her onto the internet (the so called 'Revenge Porn' episode). Moreover, he instructed that a copy of the judgement transcript be placed upon the Children Act file for consideration by the judge at the hearing of the 24.02.15.

121. Of significance to this Review, the judge also indicated that the transcript evidence be used by CAFCASS to consider whether or not to undertake a risk assessment of PMLI in the light of the findings made regarding the issue of PMLI's continued contact with S1LI. The court's concerns were specifically in relation to the sexual imagery (of MLI) that he had distributed onto the internet and the implications for S1LI's welfare.

122. The judge was also of the opinion that the uploading of the video of MLI constituted firstly, harassment under paragraph three of his previous order of the 22.09.14 and secondly, posting of a derogatory statement relating to the applicant (MLI). He was happy for MLI to refer the matter to

the Police and CPS to consider whether to prosecute for breach of the order. There was no evidence that she did this.

Comment

123. In summary, serious findings were made against PMLI by the Family Court. The significant extension of the non-molestation order reflected the seriousness of PMLI's coercive control and abusive behaviour towards MLI and the concerns of the court in this regard. Moreover, the court had concerns about the safety and welfare of S1LI in relation to the matter of continued contact with his father and any potential risk emanating from the 'Revenge Porn' episode.

124. It is of some concern that FCA3 did not address the risks to S1LI, from continuing contact with his father, in the updated Section 16 (a) risk assessment of the 06.01.15. This states that,

> *' If … an officer of the Service … is given cause to suspect that the child concerned is at risk of harm, he must a) make a risk assessment in relation to that child and b) provide the risk assessment to the court.' (CAFCASS Child Protection Policy 2014, page1)*

Comment

125. By the time of the updating to the court, there had been an IDVA DASH assessment (made on the 20.11.14) graded as High Risk and a MARAC held on the 18.12.14 that deemed MLI to be at High Risk from PMLI. The Review questioned why there had been no communication between FCA3 and the IDVA or MARAC about their involvement, as, arguably, the information sharing could have made for a more informed and accurate risk assessment had this been done.

126. The Review learnt from CAFCASS that the reason why this was not done was because of the Family Proceedings Rule 2010 (FPR 2010)[22] which prohibits the dissemination of information relating to family proceedings without leave of the court, save in exceptional circumstances. IDVAs by virtue of r.2.3 FPR 2010 are not included in the tightly defined category of professionals, ' Acting in furtherance of the protection of children'. Moreover, MARACs; understood as a diffuse collection of individuals and not a legal corporate entity, are not included in the category of professionals.

127. CAFCASS, therefore can not share information with professionals who fall outside the Rules without leave of the court. It can however, where there are legitimate safeguarding concerns, share information with an, 'Officer of the local authority exercising child protection functions'. This, in essence, is what permits a CAFCASS officer to make a section 47 referral to the local authority.

128. In this case the CAFCASS officer (FCA3) was unaware of the two MARACs and therefore did not make contact with the MARAC chair to request the sharing of information. Although there would have been a CSC representative at the two MARACs no information was entered onto that agencies' electronic recording system because the case did not reach Level 4; the statutory intervention threshold. In short, the two PVPs and two MARACs did not provide grounds for CSC to open a case on S1LI.

129. However, the ongoing family proceedings were known to the IDVA so it could have been possible for her to have contacted- with MLI's permission- the CAFCASS officer with a view to have shared information. Had this been done, it could possibly have triggered a section 16a

[22] See the document , 'MARACs and disclosure into court proceedings', produced by the Working Party of the Family Justice Council (Family Justice Council/CAADA); December 2011. Also, ' MARACs and Disclosure From Family Court Proceedings', (CAFCASS)

assessment coupled with a request for the court's leave to disclose to the IDVA and members of the MARAC, relevant information from the family proceedings.

130. The Review learnt from the CAFCASS panel member that in some areas the local MARAC will ask a routine question where children are involved, whether there are court proceedings and CAFCASS involvement. This affords the opportunity for the MARAC chair to consider whether any relevant information should be shared with CAFCASS and passed onto the family court.

131. A key piece of learning indicates the need, in circumstances where children are involved in domestic abuse, for the IDVA service and the wider MARAC system- including CSC and the Police- to develop communication links with the family court and CAFCASS.

132. It is not known why FCA3 did not produce a risk assessment of S1LI's situation or why this was not picked up by the manager. There appeared to be no management oversight and sign-off. Arguably, it would have been helpful if FCA3 had had sight of the transcript of the Hearing of the 17.11.14 and the finding of serious risk in relation to PMLI, although this was not requested until the 19.12.14 by FCA3. In this regard it is of some concern that CAFCASS did not receive the transcript until the 11.02.15. Ideally, the findings judgement should have been sent to CAFCASS at the time that the Section 7 hearing was ordered, namely on the 17.11.14.

133. The learning point from this practice episode suggests that the Family Court needs to send findings, judgements and transcripts in a timely way to CAFCASS in order for it to provide accurate and full reports; and appropriate recommendations to later hearings.

134. By the time of the completion of the S.7 report on the 18.02.15, the CAFCASS family court adviser had interviewed both parents and seen the transcript of the earlier hearing containing the findings and concerns of the judge regarding S1LI's continuing contact with his father. The family court adviser undertook a DASH assessment and concluded the risk to be high. There was no evidence that he was aware of the High Risk DASH assessment of the IDVA and the actions of the two MARACs. It is not known whether MLI mentioned her ongoing involvement with IDVA1 and the MARAC.

135. The report made no mention of the 10 year non-molestation order but did note that PMLI did not accept the Court's findings in full, in particular the ' Revenge porn' finding and concluded that,

> ' *The impact of this in relation to the request of the Court and the risks that PMLI poses to MLI and the impact upon S1LIin the long term is significant.'*

136. The family court officer (FCA2) identified that PMLI had a lack of understanding about the impact of his abusive behaviour towards MLI on his son regarding emotional harm and the longer term implications of domestic violence on children, being immense.

137. Notwithstanding the High Risk assessment and PMLI's lack of insight of his behaviour on S1LI and his mother, the report recommended a Child Arrangements Order being made on S1LI, to include a plan for the child to spend time with their father. Whilst recognising the risks to S1LI, the plan could proceed to overnight stays,

> ' *Following completion of the SPIP (Separated Parents Information Programme) course*[23] *and referral to the DVPP (Domestic Violence Perpetrators Programme) course…….(and) PMLI to continue with seeking assistance from his GP re anger management.'*

[23] To include MLI.

138. It was noted that a DVPP referral would be made on condition that PMLI was able to fully accept the findings of the Court, which needed to be,

> ' *Fully explored by the Court. The Court needs to be assured that PMLI fully accepts and takes responsibility the findings made against him by the Court.'*

139. The report noted that attendance on the aforementioned programmes would alleviate,

> *' Some of the risks and fears that MLI has in respect of coming to terms with the contact moving forward and leading onto S1LI having overnight with his father.'*

Comment

140. Clearly then, FCA2 was very aware of the significant risks to S1LI from his father and had recommended to the court that any progress on contact should be conditional on PMLI's full acceptance of the court's previous findings regarding his abusive and controlling behaviour and attendance on the SPIP and DVPP programmes. In this regard, FCA2's Section 7 report and risk assessment was the only example of an agency seeking to safeguard both MLI and, in this case, S1LI.

141. It is not known how thoroughly the Court fully explored the analysis, conclusions and recommendations of FCA2's section 7 report. In the event, the requirements for PMLI to attend the SPIP and DVPP programmes prior to increased contact with his son were not implemented, despite the risks set out by FCA2. It is not known why the court chose this course of action. Arguably, it would have been in S1LI's interests for the court to have followed the recommendations of FCA2 and asked for a progress report at a later date, before considering whether to proceed to overnight contact. Given FCA2's concerns about potential risk from PMLI it was open to the court to order the local authority to undertake a section 37 (Children Act, 1989) assessment.

142. In any event, CAFCASS's involvement with the family finished with the conclusion of the final hearing of the Family Court on the 24.02.15, albeit there was an unexplained delay in closing the case on the 06.05.15.

<u>The IDVA DASH Assessment of 21.04.16</u>

143. IDVA1 assessed the risk as 'Low' giving a DASH/Safelives score of six based upon the replies from MLI. She told IDVA1 that she was not living with PMLI although this was challenged by the health visitor who had seen him. There is a suggestion that MLI tended to minimise her responses to IDVA1who in completing the DASH/Safelives assessment would have considered the implications of pregnancy, babies and young children in the family.

> *' The presence of children increases the risk of domestic violence for women (Walby and Allen,2004)……...There is a significant association between risk and the number of children in the household, the greater the number the higher the risk……The presence of step children in particular increases the risk to both the child and the woman……Clearly, young children are extremely vulnerable in situations of domestic abuse and consideration must be given both to the risks that they face and the risks to the mother.'* (Safelives, 2014, 6-7)

Comment

144. MLI declined any IDVA support and said that she was able to recognise any signs of controlling or abusive behaviour from PMLI and would contact the Police if necessary. Given the

information provided by her and the refusal of support it is difficult to see what else IDVA1 could have done to protect MLI and the three children. In the event she correctly ensured with the midwife that a safeguarding referral was made to CSC.

The Safeguarding Referral to CSC of the 22.04.16

145. CSC's decision of no further action was based upon, firstly, the information from the health visiting team that suggested the couple were not residing together, albeit that their relationship was unclear. No concerns were raised about MLI's care of the children; she was aware of her responsibility to safeguard them. She said that they were her priority above that of PMLI. She also reportedly had support from her family who lived close by. Secondly, there had been no concerning incidents since December 2014 when MLI had contacted the Police to report PMLI. This had involved a verbal argument over contact with S1LI. Thirdly, checks with the MASH established that there was no outstanding order against PMLI, despite the ten year non-molestation order being extant an on the Police PNC. Fourthly, the IDVA had recently completed a DASH assessment which concluded that the risk to MLI was low at six points.

146. On the information provided by other agencies and MLI herself, the assessing social worker and the manager concluded that there was no evidence of any current safeguarding concerns regarding the children, or that MLI was the victim of any current domestic abuse or any risk of domestic abuse. The situation was being monitored and supported by the health visiting service who would refer back to CSC in the event of any further domestic abuse concerns.

Comment

147. It would seem that the decision not to proceed to a Children and Family assessment was predicated upon incomplete information. Firstly, there had been three PVPs and two MARAC's prior to the referral, which, with the exception of the December 2014 MARAC, were not evident to CSC, because of the CoN threshold issue and absence of an open case on the children, noted above. The December MARAC had actually resulted in a 'High risk' designation (partly due to the ' Revenge porn' episode) which was not mentioned in the CSC assessment. Moreover, the third PVP in January 2015 had not been picked up, as had, very significantly, the matter of the ten year non-molestation order which should have been on the Police PNC since January 2015. In the opinion of the Review it would also have been good practice to have spoken directly with the IDVA regarding her assessment.

Comment

148. Had the three PVPs and the two MARACs been flagged up on CSC's Liquid Logic as mentioned above and the ten year molestation order been known about, in addition to a conversation with the IDVA, this may have resulted in the CSC undertaking a Child and Family assessment. This, in turn, may have provided a fuller and more accurate assessment of the needs of the children and the potential risks-particularly in the context of coercive control; albeit that the concept was not widely appreciated at the time- they faced whilst in the care of their mother and PMLI. That said, there could have been several possible CSC intervention outcomes, ranging from, no further action, through to children centre/early help, Children in Need and statutory child protection action.

The injuries to LI of the 02.08.16 and the health visitor's 3-4 month maternal and infant health assessment of the 04.08.16

149. Regarding the bruising to LI's cheeks identified by the Police investigation and established as a finding of fact in the later care proceedings on the three children. The lead reviewer was not able to speak to HV2 as this was outside of the control of the Serious Case Review. It was documented that on the 04.08.16, HV2 completed a health assessment on LI and the twin and concluded that they were, ' Meeting their developmental milestones'. Assuming that the bruising was visible, there was no evidence that any questions had been asked by HV2 about its causation and the implications for LI and her siblings. Alternatively, it may have been that the bruising had faded and was no longer visible to HV2 at her visit, as it was not known when the bruising was caused. Although it was photographed by MLI on the 02.08.16 it may have been sustained some time before.

Comment

150. There are thus two possibilities, firstly, that the bruising was visible at HV2's visit and she did not see them. Secondly, that they had faded and were no longer visible.

The Child Protection Enquiry of the 25.08.16

151. From the evidence provided the multi-agency child protection enquiry into the injuries sustained by LI was well conducted and in accordance with LSCB policy and procedures.

152. It is not known how and why the decision was made to leave LI's siblings in the care of family members without there having been a risk assessment into their safety and well-being.

153. Enquiries were made by the review of the North West Ambulance Service (NWAS) into why there was a 42 minute delay from the telephone call being made to the arrival of the ambulance. NWAS reported that the 999 call from MLI was graded as Red 2 which is classed as potentially life threatening and commands an 8 minute response (75% of the time), this being a national standard. The emergency medical dispatcher continually searched for a nearer resource to allocate to the call. The delay was caused by the high volume of 999 calls at that time and protracted handover times at the local hospital 1.

ToR 2

Comment critically on the effectiveness, or otherwise, of agency and multi-agency interventions- including early help and support for the carers- regarding planning, implementation and review that sought to safeguard and protect LI and her siblings from harm, including domestic abuse.

PVPs and MARACs

154. Following the two PVPs made in September and October 2014, MLI obtained a ten year non-molestation order, with conditions, against PLMI. The judge made the lengthy order because of the compromising video that had been made by PMLI who subsequently posted it on the internet. As previously noted, the order was lodged on the 24.09.14 at the local Police Station.

155. Based on the MASH assessments and the IDVA1's ' High Risk' DASH assessment made in November 2014 (see paragraphs 32-35 above) and the first MARAC of the 18.12.14, a protective plan as set out in paragraph 11 above, was initiated for MLI.This included her and S1LI being referred to a children's centre. By this point she was living with a sister and awaiting her own accommodation. The second MARAC of mid-February (following the third PVP of 06.01.15) updated the original set of protective actions and included a joint visit from IDVA1 and a police officer (PC1) in early March. MLI choose not to engage with the children's centre which precluded her from receiving any early help and support. She had taken appropriate action in leaving PMLI, obtaining the ten year non-molestation order and applying for her own accommodation, in addition to being supported by her own family.

Comment

156. There was therefore effective intervention taken through the Family Court and MARAC process to protect MLI and S1LI from PMLI. Regarding formal child protection measures for S1LI, there were none taken because none of the three PVPs resulted in Children's Services within the MASH deciding on statutory intervention by undertaking a Level 4 Child and Family assessment. As previously mentioned this was because MLI's circumstances did not reach the prescribed threshold, as per the Continuum of Need (CoN) operating at that time. The reasons for this are set out above at paragraphs 107 to 111.

CAFCASS and the Child Arrangement Order

157.Despite FCA2 producing a very sound Section 7 report based upon an effective and comprehensive risk assessment the Family Court decided not to implement the underpinning recommendations to the child arrangement order (see above at paragraph 141).

Comment

158. Given the independence of the Family Court[24] it has not been possible to ascertain why directions were not made in accordance with FCA2's recommendations. As previously noted at paragraph 103, given the documented risks from PMLI to S1LI it was open to the court to have ordered the local authority to undertake a section 37 (Children Act, 1989) assessment. There was therefore no protection planning or review emanating from the child arrangement order.

The IDVA DASH Assessment of 21.04.16

Comment

159. As previously mentioned and for reasons set out above (at paragraphs 143-144) the IDVA DASH assessment did not result in a referral to the MARAC and a resultant protection plan.

[24] See, ' President's guidance: Judicial Cooperation with Serious Case Reviews', issued by Sir James Munby, President of the Family Division on 2 May 2017.

The Safeguarding Referral on the 22.04.16 to CSC from the Midwife

Comment

160. As noted above the referral resulted in no further action and hence no resultant child protection plan. The reasons for this outcome are set out at paragraphs 145-147 above

The Child Protection Enquiry of the 25.08.16

Comment

161. This was conducted in an effective manner resulting in a sound child protection plan. It was well implemented and subject to review which protected LI and her siblings from further abuse. There was good information sharing both between Lancashire agencies and also with the out of area police force and hospital. Decisions were made by the Lancashire local authority that were child focussed and promoted the safety and well-being of the children. Indeed, they became subjects of care orders in August 2017 and are now being well cared for as children looked after by Lancashire County Council. Decisions were compliant with the policies and procedures of the Lancashire Safeguarding Children Board.

ToRs 3 and 4

Examine the effectiveness, or otherwise, of inter/intra-agency working, including information sharing and case handovers/transfers, both within and without Lancashire in relation to safeguarding LI and her siblings.

Examine the efficacy, or otherwise, of decisions made and actions taken to safeguard LI (including pre-birth) and her siblings. How child focused were they and did they comply with agencies' policies and procedures and those of the Lancashire Safeguarding Children Board?

163. There was effective information sharing and inter-agency working between the Police and the IDVA service regarding the first three PVPs in late January 2015 resulting in the MARAC considering the case and a sound plan that mitigated the risks to MLI and S1LI. The CSC at the MASH assessed the PVP at Level 3 and stepped down the referral to children's centre support services which was the appropriate decision given the CoN framework of the time. As was noted above, MLI declined the offer of early support from the children's centre.

164. The omission by the police to enter the ten year non-molestation order, with the conditions, on to the police national computer at the point of notification by the family court in September 2014, fell short of expected practice and was not compliant with procedure. It is not known why this was not done sooner that March 2015. Had this information been known at the time of the third PVP in January 2015, arguably, PMLI would have been arrested for breaching the conditions of the non-molestation order.

165. Communications issues between CAFCASS and the local MARAC (including the IDVA service) in respect of the Family Proceedings Rule 2010 have previously been addressed above in paragraphs 111-116.

Comment

166. This SCR has learnt that CAFCASS produced a, 'Practice Pathway', in May 2016 setting out a structured approach to risk assessment in domestic abuse. The guidance is mindful of the impact of domestic abuse on children in private law applications and makes reference to the need, where appropriate and with the Court's leave, for a referral to be made to the local MARAC. A key piece of learning is the need for local MARACs to routinely enquire whether there is any CAFCASS involvement in domestic abuse cases involving children.

167. As was noted above, FCA2 produced a very good section 7 report for the child arrangement application which appropriately recommended several conditions including attendance by PMLI at a SPIP and a court referral for him take part in a DVPP. This was good practice by the FCA and it was unfortunate that the Court, for reasons unknown, did not agree to this as a court ordered activity (COA). Doing so would, self-evidently have been in accordance with the paramount , ' Welfare principle', of the child as per section 1(1) of the Children Act 1989 and in the interests of S1LI.

Comment

168. Notwithstanding the independence of the judiciary, a lesson from this episode suggests that, unless there are compelling reasons not to do so, the recommendations of the FCA should ordinarily be followed if they are demonstrably consistent with the paramount welfare of the child as per section 1 of the Children Act 1989.

169. Analysis of inter-agency practice and decision making in relation to the IDVA DASH assessment and midwifery safeguarding referral to CSC in April 2016 can be found above at paragraphs 143-147.

170. Analysis of inter-agency practice and decision making regarding the child protection enquiry and resulting child protection plan for the three children can be found above at paragraph 151-153.

ToR 5

<u>Examine the involvement of other significant wider family members in the life of Child LI and her siblings including a consideration of the potential for caring for the children.</u>

171. There was significant wider family involvement with MLI and the children, especially in late 2014 and 2015 when MLI had separated from PMLI and received support from one of her sisters. MLI moved around her family network and at different times was supported by her father and other siblings. This may have caused difficulties for professionals to stay in contact. However, it seemed that professionals' involvement with the wider family was limited, albeit adequate to the circumstances.

172. The ToR will be augmented following visits to the wider family.

ToR 6

Examine to what extent safe handling advice and support was provided to the carers.

173. The SCR learnt that within the Lancashire midwifery service all parents are offered the baby steps programme, which includes safe handling. However, in this case it was not documented whether the programme was offered to MLI and if it was, whether she took it up. The lead reviewer learnt that the health visitor (HV2) had covered safe handling with MLI.

Part 6
Findings and Conclusions

ToR 1

174. Effective actions were taken to protect MLI and S1LI from domestic abuse and harm following the three PVPs and two MARACs of 2014 and 2015.

175. The CAFCASS section 7 report provided a sound risk assessment for the Family Court's consideration in regard to S1LI and the potential for harm from his father. Unfortunately, the Court choose to ignore the risk mitigating conditions set out by FCA2 prior to granting PMLI increased (overnight) contact with S1LI and was not in the child's best interests.

176. The IDVA DASH risk assessment of April 2016 was dependent on the information given by MLI which indicated a low risk, albeit there was a suggestion that she was minimising. Given the circumstances of the time, the low risk outcome was, in the opinion of the lead reviewer, a reasonable and defensible decision.

177. The CSC assessment of April 2016 was based upon incomplete and inaccurate information as set out in the above paragraphs (120-122). The result was a partial understanding of the situation which tended to minimise the potential risks to the children and their mother. There was a tendency to see the various episodes of domestic abuse as isolated events and not as part of a bigger picture of a pattern of control and coercion of MLI by PMLI.

178. In this sense, the CSC assessment was ineffective as it did not lead to a fuller Children and Family assessment. However, even if there had been such an assessment this would not necessarily have resulted in a formal child protection outcome, as arguably, the circumstances would not have met the threshold for Level 4 (statutory) intervention. However, the family, including LI and her two siblings would have been an opened case and therefore entered on the CSC electronic recording system (Liquid Logic); in short they would have been on CSC's 'radar'.

179.The fourth PVP at the end of July 2016 was sent in as, 'Standard', risk and therefore did not proceed to a MARAC or lead to a consideration by CART of the potential safeguarding issues for the three children. This should have been re-assessed by the MASH as, at least, 'Medium'. Had this happened, MLI might have been protected by a MARAC and the children's potential risk environment assessed.

180. None of the first three PVPs warranted a referral to CSC as they did not meet the Level 4 child protection threshold. The final PVP was not considered by the MASH social worker because of its, arguably incorrect, Standard Risk designation. Therefore, the existing MASH processes had

resulted in a systemic outcome whereby any concerns for the children would need to reach Level Four of the CON, to trigger a child protection response from the CSC and the opening of a case record.

181. Consequently, at no time during the period in question were LI or the two siblings ever an open case to the CSC. Of significance, this meant that there was never any record available that would give the bigger, historical picture of the children's experiences whilst in the care of their mother and the attendant implications of potential risk from PMLI. In essence, the children were never on CSC's radar.

182. A key issue for contemporary practice is the need to locate the domestic abuse suffered by MLI during the time-frame in question within the context of ' Coercive control', albeit that the legislative framework and accompanying guidance[25] **(**the Serious Crime Act 2015, section 76) was not implemented until December 2015.

183. It is suggested that MLI's experiences of domestic abuse and the implications for the children of risk from PMLI would now better be understood by agencies within the context of coercive control.

184. Therefore a core piece of learning from this Review suggests that current and future multi-agency policy and practice should understand and locate the risk assessment and management of children who experience domestic abuse within the wider context of coercive control. It is noted that there is no reference to coercive control in the current (2009) Lancashire County Council/ Lancashire Constabulary, 'Domestic Abuse Guidance and Protocol. It is suggested that this should be updated to include coercive control.

ToR 2

185. Given that MLI and S1LI were not living with PMLI in early 2015, the existence of the ten year non-molestation order and the support she was getting from her own family, it can be concluded that the MARAC plan and IDVA intervention were effective in protecting MLI and S1LI from domestic abuse and harm from PMLI at that time.

186. There was also effective liaison and communication between the IDVA and the Police in implementing the MARAC multi-agency plan.

187. The decision to review and end her involvement with MLI by IDVA1 in May 2016 was appropriate given that the known circumstances and risk factors did not warrant any further intervention. Moreover, MLI was not requiring any continuing support.

188. The child arrangement order did not did not protect S1LI from potential abuse from his father because there was no mandated court ordered activities in relation to SPIPs and DVPPs.

[25] See Home Office guidance , ' Controlling or Coercive Behaviour in an Intimate or Family Relationship' (December 2015)

ToRs 3 and 4

189. Information sharing and inter-agency working between the Police and the IDVA service was effective regarding the initial three PVPs in late 2014 and January 2015. The two MARACs provided for a sound plan that managed the risk from PMLI to MLI and S1LI.

190. There was sub-standard practice by the Police in not entering the ten year non-molestation order, with accompanying conditions, on to the PNC in October 2014 in compliance with the court's expectation. Had this been done in a timely way it is likely that PMLI would have been arrested in January 2015 for breach of the order.

191. A key piece of learning indicates the need, in circumstances where children are involved in domestic abuse, for the IDVA service and the wider MARAC system- including CSC and the Police- to develop communication links with the family court and CAFCASS. Consideration should be given for local MARACs to routinely enquire whether there is any CAFCASS involvement in domestic abuse cases involving children.

ToRs 5 and 6

192. MLI received good support from her wider family when asked for.

193. Safe handling was included the midwifery service, ' Offer', and addressed by the health visitor with MLI.

Part 7
Key Learning Points and Improvements

194. The Lancashire Safeguarding Children Board and its partners are challenged by this SCR to consider what actions are needed to translate and implement the following key learning points and suggested improvements.

- The need to consider, 'Flagging and tagging', all domestic abuse PVPs (including Standard) involving children onto CSC's Liquid Logic and Police electronic recording systems in order to get the 'Big picture' of the historical extent of domestic abuse and whether coercive control is a factor. This should include all children irrespective of whether or not they are an open case to CSC.
- The need to consider ', Flagging and tagging', all MARACs involving children onto CSC's Liquid Logic and the Police case recording systems, irrespective of whether or not they are an open case to CSC.
- The need for the local MARAC to routinely enquire whether there is any CAFCASS involvement with a child where their carer is subject to a MARAC plan.
- The need for Lancashire Police to ensure that non-molestation orders and their accompanying conditions are placed, in a timely manner, on appropriate information platforms (e.g. the PNC)
- The need for family courts to consider following the recommendations of CAFCASS FCAs in regard to mandating appropriate court ordered actions (CAO) such as SPIPs and DVPPs.
- The need for family courts to be given the outcomes of CAOs so as to inform decisions about children in accordance with the paramountcy principle.
- The need to raise awareness, understanding and the use of the legislation and practice around coercive control amongst professionals and agencies.

- The need for coercive control to be included in local multi-agency guidance and strategic planning.

Part 8: Glossary of Terms

Family

LI	Subject Child
MLI	Mother of LI
S1LI	Older (half) sibling to LI
S2LI	Twin to LI
PMLI	Partner to MLI and father to S1LI
S1	Sister to MLI

Professionals

FCA1	Family Court Adviser 1
FCA2	Family Court Adviser 2
HV1	Health Visitor 1
HV2	Health Visitor 2
HV3	Health Visitor 3
IDVA 1	Independent Domestic Violence Advisor 1
MSW1	MASH social worker 1
PLN	Paediatric Liaison Nurse
PO1	Police Officer 1

Terms

A and E Dept.	Accident and Emergency
CAADA-DASH	Co-ordinated Action Against Domestic Abuse-Domestic Abuse, Stalking and Honour Based Violence risk assessment
CAFCASS	Child and Family Court Advisory Service
CC1	Children's Centre
CMW	Community Midwife
COA	Court Ordered Activity
CoN	Continuum of Need
CSC	Children's Social Care
CPS	Crown Prosecution Service
DfE	Department of Education
DVPP	Domestic Violence Perpetrators Programme (Lancashire)
EDT	Emergency Duty Team (Lancashire Social Care)

FPR	Family Proceedings Rule
GP	General Practitioner
IDVA	Independent Domestic Violence Adviser
LADO	Local Authority Designated Officer
LSCB	Lancashire Safeguarding Children Board
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
NSPCC	National Society for the Protection of Children
NWAS	North West Ambulance Service
PNC	Police National Computer
PVP referral	Protection of Vulnerable Person
SIO Police	Senior Investigation Officer
PICU	Paediatric Intensive Care Unit
SCBU	Special Care Baby Unit
SCR	Serious Case Review
SPIP	Separated Parents Information Programme
ToRs	Terms of Reference
YOT	Youth Offending Team

References

1. CAFCASS Child Protection Policy; 2014
2. Evan Stark; 2009
3. Family Law Act;1996
4. Home Office Guidance, ' Controlling or Controlling Behaviour in and Intimate of Family Relationship'; December 2015
5. Lancashire MASH Operational Manual (Version 9, Update) February 2018)
6. LSCB MASH-Diagnostic ; July 2016
7. Lancashire Continuum of Need and Threshold Guidance LSCB; Refreshed May 2016
8. Protecting Children in Wales; Guidance for Arrangements for Multi-Agency Child Practice Reviews, 2012: Welsh Government

9. President's Guidance, Justice J Munby;President of the Family Division; 2 May 2017: 'Judicial Cooperation with SCRs'

10. Working Together to Safeguard Children 2015, HM Government/Department for Education

11. Working Party of the Family Justice Council, 2011; MARACS and Disclosure into Court Procedures; Family Justice Council/CAADA