Lancashire Safeguarding Children Board

SERIOUS CASE REVIEW

CHILD O

Date of Serious Incident: August 2014

In order to protect the identity of individuals this report has been anonymised. The subject of this review is herein referred to as Child O.

Independent Reviewer: Sian Griffiths

Independent Chair: Jane Booth

Date: March 2016

This report has been commissioned by:

Lancashire Safeguarding Children Board

Chair's foreword

This Serious Case Review has considered the complex circumstances around Child O's life and death. The Lancashire Safeguarding Children Board has taken responsibility for the completion of the review as the death took place in Lancashire but neither the child nor the mother were known to agencies in this area. The child had previously lived in a number of areas and we have worked with four other Safeguarding Children Boards – Devon, Hampshire, Norfolk and Southampton – in order to complete this review. The findings and issues for consideration from the review have been endorsed by Lancashire Safeguarding Children Board and have been forwarded to the four other Boards for their endorsement. Child O died at the hands of their mother who also committed suicide. She had taken great steps to hide Child O and herself from public and professional view. Experience and research both tell us that the circumstances around Child O's death are extremely rare. This child's death was a tragedy and our sympathies go out to Child O's father and extended family.

The review has enabled agencies and professionals to look at their actions to see if there was anything that could be done in future to further improve working between agencies and safeguarding for children. It has identified some areas where agency practice can be improved. It is acknowledged that, whilst different actions might have resulted in Child O being traced earlier, there is a real possibility that this would have resulted in another move and ultimately the same outcome.

Regretfully one of the agencies involved, Cafcass, has indicated that it does not feel able to endorse the overview report. This is the first time that Cafcass has not endorsed a Serious Case Review overview report and the first time the Lancashire Safeguarding Children Board has been unable to secure unanimous sign off a Serious Case Review by all agencies. Considerable efforts have been made to reach an agreed position and Cafcass has not taken this decision lightly. Cafcass has however drawn on the findings from their own internal review in to the circumstances of this tragedy and has identified an action which addresses supervision arrangements.

Family members have contributed to the review and been kept informed of its progress. Their contribution has helped inform the learning from this review. Lancashire Safeguarding Children Board and the independent reviewer would like to thank them for their contribution which we know has not been easy due to their loss.

Jane Booth, Independent Chair of the review

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1. INTRODUCTION

1.1 The circumstances that led to this Review

1.1.1 In the summer of 2014 twenty-two month old Child O and mother were found dead in the garage of a house in Lancashire after concerns about them had been raised by neighbours. The post mortem report concluded that both mother and child had died from carbon monoxide poisoning. Neither the mother nor Child O were known to any statutory or other agencies within Lancashire. Child O had been reported to Devon and Cornwall police as missing in October 2013, had been located but had then moved again. The mother was using an assumed name and the only person who appeared to be aware of where they were living was Child O's maternal grandfather.

1.1.2 The subsequent inquest, which took place during the course of this review, concluded that Child O's death was an unlawful killing, in that Child O's mother had poisoned her child with carbon monoxide. The inquest also ruled that Child O's mother had taken her own life by self-administering carbon monoxide. The inquest, which heard comprehensive evidence from both professionals and family members, saw written information suggesting that the mother had been fleeing domestic violence from the father of Child O and also heard similar allegations from the maternal grandfather. However, the Coroner concluded that there was no substance to the mother's belief that she was being pursued by the father. Nor did the coroner find that Child O's father had manipulated the Police, Family Court System or Children's Services, but indeed that he had acted appropriately throughout.

1.1.3 The case of Child O was referred to the Lancashire Safeguarding Children Board on 14th August 2014. Due to the involvement of several Safeguarding Children's Boards and following discussion with the Department for Education, the Independent Chair of Lancashire Safeguarding Children Board formally made a decision to undertake a Serious Case Review on 26th November. Child O's case had met the criteria for a Serious Case Review as identified in Working Together to Safeguard Children 2013[1], in that there was information that:

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

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

1.1.4 The initial completion date for the Review was to have been the end of May 2015. However, due to the complexities of establishing which

[1] Working Together: HM Govt 2013

agencies in which parts of the country had been involved with Child O and their family, it became clear that it would not be possible to meet this date. The Review was therefore completed by September 2015.

1.1.5 A Police investigation had been undertaken on behalf of the Coroner.

1.2 Family Composition

The family members referred to in this review are as follows:

- Subject – Child O
- Father
- Paternal grandfather
- Paternal grandmother
- Mother
- Maternal grandfather
- Maternal grandmother

1.3 Methodology

1.3.1. Statutory guidance within Working Together requires Local Safeguarding Children Boards to have in place a framework for learning and improvement, which includes the completion of Serious Case Reviews. The guidance establishes the purpose as follows:

> *Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children. (Working Together, 2013:66)*

1.3.2. The statutory guidance requires reviews to consider: "*what happened in a case, and why, and what action will be taken*". In particular, case reviews should be conducted in a way which:

- *recognises the complex circumstances in which professionals work together to safeguard children;*
- *seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;*
- *is transparent about the way data is collected and analysed; and*

- *makes use of relevant research and case evidence to inform the findings.*

1.3.3. From the outset of this Review it was established that that there would be limitations regarding information gathering. In particular the Review Team were aware that this could have an impact on achieving an understanding of why things took place, rather than simply what happened. Child O and mother lived in a number of different locations around the country, ultimately moving to Lancashire where they had no contact with any social care or health agencies. Four other Safeguarding Children Boards needed to be involved in the Review as a result:

- Devon Safeguarding Children Board
- Hampshire Safeguarding Children Board
- Norfolk Safeguarding Children Board
- Southampton Safeguarding Children Board.

Staff and services in the different authorities, which are geographically very widely spread, generally had very short periods of contact with the family, and most of that contact took place in 2013. As a result the capacity of the practitioners involved to add anything significant to this Review in addition to their written records was very limited.

1.3.4. The methodology used for this Review was however underpinned by the principles outlined in Working Together, including the need to use a systems approach. The author of this report is familiar with a systems based methodology. In particular this approach recognises the limitations inherent in simply identifying what may have gone wrong and who might be 'to blame'. Instead it is intended to identify which factors in the wider work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely. A central purpose therefore is to move beyond the individual case to a greater understanding of safeguarding practice more widely.

1.3.5. The Review was chaired by Jane Booth, who is also the Independent Chair of Lancashire Safeguarding Board. Ms Booth met the criteria of independence given that Child O was never known to services in Lancashire. The Author of the Review is Sian Griffiths who has significant experience in undertaking Serious Case Reviews and is an Accredited SCIE Learning Together Reviewer[2]. The author is independent of all the agencies involved.

1.3.6. The chair and author worked with a core Review Team from relevant agencies in Lancashire. The four other Safeguarding Boards were asked to consider sending a representative to the Review Team meetings, but predominantly felt unable to do so, given the limited nature of their involvement with the family and the resource implications of travelling to Lancashire for meetings. Contact with the four Boards was

[2] This Review has not been undertaken as a SCIE Learning Together Review

undertaken by the Chair of the Review and opportunities for comment and reflection on the draft report were built in.

1.3.7. Attendance at the Review team was made up of Senior Safeguarding representatives from the following agencies:

- Cafcass
- NHS Chorley and South Ribble Clinical Commissioning Group
- Lancashire Constabulary
- Lancashire Children's Social Care
- Northern, Eastern and Western Devon Clinical Commissioning Group (Designated Doctor)

The Norfolk Safeguarding Children Board Manager also attended on one occasion.

1.3.8. The review process included

- Consideration of chronologies and learning summaries produced by 14 key agencies.
- 4 meetings of the Review team.
- Meetings with the family of Child O.
- Access to the Lancashire Police investigation file
- Attendance by Lancashire SCB representative at the Inquest for Child O and mother
- Access to the Family Court files

1.3.9. The following agencies provided chronologies and Agency Reflection and Learning Reports:

- Cafcass
- Devon Family Solutions (Mediation)
- Devon GP (Teign Estuary Medical Group)
- Devon Virgin Care (health visiting services)
- Devon and Cornwall Constabulary
- Devon Children's Social Work
- Southampton City Primary Care Trust and North Hampshire Primary Care Trust
- Hampshire Hospitals NHS Foundation Trust
- University Hospital Southampton NHS Foundation Trust
- Hampshire Constabulary
- Southampton City Council Children and Family Services
- Hampshire Children's Services
- Norfolk Children's Services
- Norfolk Constabulary

1.3.10. The **timeframe** under consideration for this Review was:

14th February 2012 – 13th August 2014

The starting point was chosen as this was the point that the mother informed the father that she was pregnant with Child O. The date of Child O's death marks the end point.

1.3.11. The Terms of Reference identified four key issues for consideration within the Review, however these were not intended to limit any other learning that might emerge:

1. What knowledge or information did agencies have about the family, including any that indicated mother might be a risk to Child O?

2. What services were offered to mother, father and Child O and were they accessible and sympathetic?

3. What information did family and friends have that might have indicated mother was a risk to Child O?

4. What learning is there for agencies in this case?

1.4 Contribution of family members

1.4.1. The involvement of key family members in a Review can provide particularly helpful insights into the experience of receiving or seeking services. The Independent Author met with the father and his family as well as with the maternal grandparents early in the process of undertaking the Review. Their main concerns are summarised here, but also where relevant to the purpose of this Review more detailed contributions are woven into the report.

1.4.2. **Child O's father and extended family**: Child O's father and partner, his paternal grandparents and paternal aunt contributed significantly to this review, both in providing written information and in meeting with the author. The first meeting took place with all the family, a second meeting just with Child O's father and his partner.

1.4.3. Child O's father and his family feel significantly let down by a system which they felt should have recognised that Child O might be at risk, not necessarily of such a tragic outcome, but at least of the possibility of emotional harm. They considered that there were points at which individual agencies should have been more concerned about the mother's behaviour and could have responded more effectively. For the father and his family there were three particularly significant concerns:

- the apparent lack of urgency during the Family Court Process.

- the response of Devon and Cornwall Police when Child O was reported as missing.
- failings of communication between the various agencies.

A strong thread throughout their concerns was their sense that the significance of Child O's father's role was inadequately recognised and the allegations made by the mother were too easily accepted. As such they felt there was an inherent bias towards him as a father.

1.4.4. The impact on Child O's father and his family has been profound. Child O's father had not seen his child since he was 5 months old and had no knowledge of his whereabouts for the remainder of his life. The mother of Child O would not allow any contact with the father's family, meaning that they never met their first grandchild and nephew. Child O's father was also faced with serious allegations from Child O's mother which could have been life-changing, but these were ultimately identified by the police as unfounded.

1.4.5. **Child O's maternal grandfather**: Child O's grandfather met with the author on one occasion. The grandfather's main focus of concern was his belief at the time that his daughter was fleeing serious domestic abuse and that her life was at risk. He described this need to believe what his daughter told him as taking priority over any other requirements, including court orders, and he confirmed his continued belief that he was justified in his actions.

1.4.6. Child O's grandfather did not raise particular issues about the responses of the various agencies other than in relation to Devon and Cornwall Police. He was highly critical of the police for what he considers to be their failure to respond to his daughter's allegations of domestic abuse. He also questioned the degree to which the police's actions in July 2014 impacted on his daughter's state of mind.

1.4.7. **Child O's maternal grandmother:** Child O's grandmother, accompanied by a friend, met with the author on one occasion. Child O's grandmother's level of distress throughout the meeting was acute and despite her desire to contribute it was evident that this would be difficult for her to achieve. Child O's grandmother provided background information about her daughter's early life. However, as she had never met her grandchild, nor had any contact with her daughter during Child O's lifetime, she was not in a position to comment on the services provided to them.

1.4.8. **Child O**: Whilst it is Child O who is at the heart of this review, there are few sources of information to draw on in order to gain a detailed picture of their personality, or experience of their own life. Child O was only known to professionals in the very early months of their life and that contact was of a routine nature. Child O was not able to have any contact with their father after the age of 5 months, so for Child O's paternal family their knowledge of Child O for much of Child O's life has

been limited to a few photos and videos provided by the maternal grandfather following Child O's death. Maternal grandfather described Child O as absolutely normal and adorable, and said that the child was learning to talk and running around. The available information about Child O's care by his mother would suggest nothing other than a thriving child who was physically well cared for. It is evident however that Child O's world was limited to relationships with mother and maternal grandfather. While this would have been likely to lead to concerns about Child O's development as they grew older, given Child O's age it is fair to assume that this had yet to have a significant impact.

2 SUMMARY OF THE CASE AND AGENCIES' INVOLVEMENT WITH THE FAMILY

The following is a chronological summary of what is now known about the family and their involvement with agencies. The summary will identify what was or was not known to the relevant agencies at the time the events were taking place.

2.1. **Ante-natal period:** The parents of Child O met in early 2012 in Southampton. Neither, at that point, had any previous involvement with safeguarding services. The mother of Child O had at some point prior to their meeting changed her name, but this was not then known to the father. The mother's initial description to the father of her own family was that she had been brought up by her grandmother and had no contact with her parents for most of her life, which is now known not to be the case.

2.2. The couple had only been in a relationship for a period of months when the mother told the father she was pregnant. This was not only an unplanned pregnancy, but unexpected, as the father states that he had been told by the mother that she was unable to conceive. The first relevant contact with services was when the mother visited her GP in Southampton in February 2012 and confirmed that she was pregnant. She booked with the midwife for her ante-natal care shortly afterwards. During the booking appointment, which she attended alone, the mother spoke of general anxiety but declined any help from health services. She did not raise any issues about domestic abuse, nor were there any safeguarding concerns identified.

2.3. During her pregnancy the mother attended at her GP's with a range of symptoms and in June 2012 she was referred by her GP to IAPT (Increased Access to Psychological Therapies[3]) for stress related problems. No record has been provided as to whether the mother accessed this service. The couple moved to Basingstoke in August 2012

[3] IAPT: NHS programme of psychological therapy treatments for people suffering from depression or anxiety disorders.

and mother registered with a new GP the following month. Again the mother made no reference to domestic abuse.

2.4. **October 2012 Birth of Child O**. Child O was born at North Hampshire Hospital in October 2012. There was no information of concern identified in the hospital records. Although the staff in the hospital noted that there was some evidence of maternal low mood, this was not highlighted as being unusual. However, the father's experience gave him greater cause for concern, including the mother's quite insistent refusal to allow anyone else to touch the baby. He was also concerned at the mother's insistence on discharging herself the day she had given birth due to her dislike of hospitals but contrary to medical advice. Child O became ill with congenital pneumonia necessitating a return to hospital the following day and care in the neo-natal unit for a number of days.

2.5. A few days after their return home, the midwife recorded that the mother was feeling stressed and '*needed time alone with Child O to bond following disruptive beginnings'*. The Health Visitor (HV1) also noted that the atmosphere in the home was very tense and that the mother talked about stress, although she did not expand on this. The father, who was visibly upset, told HV1 that the problem was the mother's relationship with his parents to whom he was close. The mother reported having no family of her own and would not allow father's family to visit new-born Child O. HV1 noted that she would follow the family up for a Mood Assessment at 6 weeks, rather than waiting for the more standard next visit in 8 weeks.

2.6. The following day HV1 spoke to the GP because of her concerns including that the father had visited her at her office, again very upset. He stated that he increasingly felt he did not really know the mother and that she had been dishonest about a number of things, including her relationship with her family. The Health Visitor sought advice from the GP and they noted a joint concern about the possibility of the mother having mental health problems. Information from the father was that the relationship was now breaking down and he was becoming increasingly worried about the mother's extreme over-protectiveness of Child O, which effectively excluded him from having any meaningful care of the child, as well as worries about whether she had been lying to him about her personal history and family.

2.7. A couple of days after the father's visit to HV1, Mother contacted the health visiting service to cancel her next appointment as she was planning to leave the area. HV1 was on annual leave but the duty Health Visitor (HV2) recognised the significance of this given the recorded concerns regarding mental health and arranged to meet her later that day. HV2 noted that the mother's mood was low, but she had no concerns about her care of Child O. The mother presented as distressed about the ending of the relationship with the father, but stated that he was not abusive or controlling, simply that he did not understand how she felt. HV2 encouraged her to see her GP and consider medication to

help her stabilise her mood, which she did the following day and was duly prescribed with a low dose anti-depressant. Follow up appointments with both GP and HV2 were planned for the following week.

2.8. In mid-November the mother phoned the police following what she described as a '*heated argument'* with the father, who had then left the house. Police attended, spoke to both parents and recorded no offences. It was agreed that the parents would stay in separate rooms until Mother was able to move out in the next couple of days. A DASH risk assessment[4] was undertaken and concluded there was a standard risk, the details were passed to Victim Support and a Child at Risk form was sent to Children's Social Care as a matter of routine.

2.9. **November 2012: Mother and Child O move to Devon** The following day the father made a referral to Hampshire Children Services, raising concerns about mother's mental health. Children's Services made enquiries with HV1 and recorded that mother had post-natal depression, had been abandoned by her father as a child, but had '*good family support'* in place. A duty Social Worker telephoned the mother who stated she would be moving to Devon the next day and did not want the father to know her new address. When both the father and maternal grandmother subsequently contacted Children's Services they were informed that the mother had moved to Devon and that they would need to contact Devon Children's Services if they had further concerns. The father also contacted HV1 who explained that she would provide a verbal handover to the new Health Visitor and GP once the mother and Child O were registered. Both Children's Services and HV1 advised him to seek legal advice.

2.10. Hampshire Children's Services informed Devon Children's Services by fax that the mother and Child O had moved to Devon and that the mother did not want her new address disclosed to Child O's father. It was further stated that there had been no concerns raised by the Health Visitor and the only referral they had received was from the father who was concerned about the mother's mental health and wanted this to be checked. The manager reviewing the referral concluded that there was no reason for further action as the issues described by the father did not reach the threshold for Safeguarding concerns and information from Hampshire Children's Services were '*clear that there were no concerns held by health in the originating area*'. The mother later phoned Devon Children's Services unhappy that they had become involved and stating that the father had been abusive to her.

2.11. HV2 from Hampshire telephoned the mother to check if she had registered with a GP, and confirmed that Child O was registered with Teignmouth Medical Centre. HV2 also spoke to the new Health Visitor, who had already sent out an appointment. The Devon Health Visitor

[4] CAADA-DASH RIC : Nationally used risk assessment for domestic abuse.

recorded that there were concerns around post-natal anxiety and conflict in the parental relationship.

2.12. **Period living in Devon, November 2012 to Summer 2013:** Child O and his mother remained in Devon until some point in the summer or early autumn of 2013. Her address there was known both to the father, who was aware of it from information that the mother had left behind, and to primary health services. At this time Child O and his mother were living with maternal grandfather in a property owned by him. The mother was registered with the same GP as Child O and stated that she had left her previous address because the father had been abusive. She denied having post-natal depression.

2.13. A similar conversation took place with the Devon Health Visitor (DHV), who noted that the mother had '*fled*' domestic abuse but had also said that this had never been physical. A referral was made by the DHV to unspecified 'domestic violence services'. Child O's mother again denied any post-natal depression and stated she was not on any medication. Nevertheless, information that the mother was prescribed with anti-depressants whilst in Hampshire was recorded within the Devon health visiting records. Child O was subsequently seen by the GP for the routine 8 week baby check and routine vaccinations. He was initially identified as Universal Partnership Plus by the Health Visitor, meaning that the family would have some extra support, though this was soon afterwards reduced to the Universal service provided to all children. Child O was seen on 11 occasions by the health visiting team.

2.14. Child O's father made contact with the mother in Devon and it was agreed that he could have contact with Child O supervised by the mother in a restaurant in Devon. This proved unsuccessful and as a result in April 2013 the father arranged for them to take part in mediation at Devon Family Solutions. Two mediation sessions took place but were unsuccessful in achieving any agreement. The father had suggested a contact centre which would provide supervision, but the mother was unwilling to agree. Although the Mother requested that they remain in separate rooms during the second mediation appointment, there was no information recorded that suggested any concern about risks to the mother. Instead this was understood by the mediation service to be because the mother felt more comfortable being in a separate room.

2.15. Following the failed attempt at mediation Child O's father made an application to the Family Court under private law to resolve the dispute between them. During this period the mother contacted her GP asking for Child O's name to be changed by removing the father's surname. It would appear that this was actioned by the GP.

2.16. Whilst living in Devon, Child O's mother contacted the police on 3 occasions with allegations about the father. On the first occasion she stated that he had called her pretending to be from a doctor's surgery in order to obtain information. She also said he had contacted the surgery

claiming to be from the hospital. There was no evidence to support this allegation. This was recorded by the police as a 'non crime domestic incident' and a DASH assessment undertaken, which identified it as 'standard risk'. On the second occasion she reported receiving an abusive letter from his parents. The Police Officer did review the letter and did not consider the letter to be threatening or offensive and again recorded this as a non-crime domestic incident on the basis of what the mother had told them. Lastly in April 2013 the mother reported that during a contact meeting the father had made a threat to her life and had also sent her a sympathy card. Again this was recorded as a non-crime domestic incident, but given that the mother appeared to be very frightened, the DASH risk assessment on this occasion was recorded as medium. The Police Officer spoke to the father who was noted to be polite and understanding, but denied the allegations. The father reported to this Review that the officer had told him he had not actually seen the sympathy card and felt frustrated at what therefore appeared to him to be an unquestioning acceptance of the mother's allegations.

2.17. **Summer 2013: Father's application to the Family Court:** In late summer of 2013 father applied to the Family Proceedings Court in Torquay under private law proceedings[5]. He had not had any contact with Child O since March 2013. The application was forwarded to Cafcass who, in line with their normal practice, undertook safeguarding checks with Children's Services and checks with the police regarding any criminal convictions, which confirmed that neither party had convictions. A Cafcass officer in the team responsible for undertaking the initial pre-court checks, spoke to the father by telephone, and was informed of his concerns, including that the mother had changed her name in the past. In the absence of a phone number for mother Cafcass e-mailed her to ask her to make contact with them, but she did not do so.

2.18. During the same period and in response to a request from the father, the Devon Health Visitor was advised by her Child Protection Supervisor that she should pass on information to him about Child O's progress as it was understood he had parental responsibility, though not to disclose the mother's address. Child O's mother was unhappy that the GP had disclosed which town she lived in, although, this was in fact already known to the father. Child O's mother stated that she would now move away '*to maintain her and Child O's safety'*.

2.19. The first Family Court hearing was in late September 2013. Cafcass had forwarded the outcome of their safeguarding checks to the court. The father attended the hearing, but the mother did not. The mother did not attend any of the subsequent hearings at the Family Court. Another court date was set for November when the further necessary safeguarding checks would be produced by Cafcass.

[5] Applications to Family Court regarding parental disputes over children under the Children Act 1989

2.20. At the end of October 2013 Child O's father contacted Devon Police to report that Child O and mother were missing. This followed the return of court papers, sent to the mother, which had been marked that she was no longer at that address. The father had also been concerned as a result of previous comments that the mother had made suggesting she might move to Spain. During the autumn the mother missed appointments with the Health Visitor, including taking Child O for their 1st year assessment in November 2013.

2.21. The Police immediately initiated a Missing Person enquiry in relation to Child O and mother, assessing the case as Medium Risk. They spoke to maternal grandfather who said that he had not seen his daughter and grandchild for two months since they moved to Spain, but did provide an e-mail address. Mother subsequently contacted them to state that she and the child were safe and well, but she refused to tell them where they were living. There is no independent information to suggest that they had in fact moved to Spain. In early December Devon police identified that Child O and Mother were living at an address in Norfolk. Contact was made by Devon with Norfolk Police who agreed to visit in order to undertake a '*safe and well'* check, which took place first thing the following morning. Two officers attended, they saw both Child O and mother and concluded that there were no immediate concerns regarding Child O's welfare. Child O was described as clean, cheerful and engaging and the home environment was immaculate. Child O's mother was very unhappy about having been traced and was not willing to provide any details in order for a Risk Assessment to be undertaken nor to provide a contact phone number. She was advised that she should inform maternal grandfather or her solicitor if she intended to leave the country.

2.22. The information was fed back to Devon and Cornwall police. The Norfolk officers completed a Domestic Incident Report, which was recorded as medium risk, and the information was shared with Norfolk Children's Social Care Multi-Agency Safeguarding Hub (MASH) in line with normal practice. Later that day maternal grandfather contacted Devon and Cornwall police asking for a further visit from the police in Norfolk as Mother wished to make a statement regarding a history of sexual and physical abuse and attempts to kill.

2.23. A Police Officer from the MASH visited Child O's mother 4 days later and spent several hours with her. The mother made serious allegations of domestic violence and rape against father. She also alleged that he had in the past told her of a sexual relationship with a young person which, because of the nature of his employment, would need to be investigated by the local authority in Southampton. This investigation is commonly known as a LADO investigation, as it is undertaken by a Local Authority Designated Officer. The mother also said that she was in fear of her life as the father had threatened to kill her if she '*took Child O from him'*. Mother was not willing to make a formal statement in relation to any of

the allegations, but agreed that she could be referred to the IDVA (Independent Domestic Violence Advisor).

2.24. The Police Officer referred the relevant allegations to the Norfolk LADO officer who telephoned her equivalent in Southampton with the information. Norfolk Police also e-mailed the information to Devon and Cornwall, so that they could inform Hampshire Police. However, no LADO investigation was initiated in Southampton. This will be explored further in Section 3. The Police Officer followed up her visit by e-mailing the mother on two occasions to ask if she had thought further about making a formal complaint, but got no response. The IDVA contacted the mother twice offering support but also gained no response. Whilst it was not known to the agencies at the time, the mother and Child O left this address some time in January 2014 and moved to a house owned by her father's family in Lancashire where she and Child O remained until their deaths.

2.25. A total of 11 Family Court hearings took place between September 2013 and Child O's death as summarised in the table below. The mother did not attend any of these hearings.

24.07.13	Application to the Family Court for contact by Father.
23.09.13	Family Proceedings Court, first hearing. Mother did not attend, adjourned for further safeguarding checks and listed for a Review Hearing in November.
01.10.13	Proceedings transferred to Plymouth County Court.
04.11.13	Family Court Hearing (County Court): Court informed that Child O now registered as missing. Prohibited Steps Order made to prevent the mother leaving the Country. Order for DWP[6] to provide the mother's address.
26.11.13	Family Court Hearing (County Court): The mother did not attend and a further hearing listed for January.
21.01.14	Family Court Hearing. (County Court): An address for the mother had been provided by the DWP. Section 7[7] report ordered from Cafcass. The address provided was her address in Devon, at which she was no longer living.
14.04.14	Cafcass file the Section 7 report with the Court. Attempts to contact Mother had been unsuccessful.
29.04.14	Family Court (County Court): Child O made a Party to proceedings and the Cafcass officer appointed as the Children's Guardian.[8] Case adjourned to be heard by a Circuit Judge on 30.04.14

[6] DWP: Department of Work and Pensions

[7] Section 7 Report. A report required under Section 7 of The Children Act 1989, regarding the welfare of the child and making recommendations.

[8] A Child can be made a party to private Family Court Proceedings in their own right under Rule 16.4 of the Family Proceedings Rules 2010. A CAFCASS officer is appointed as Guardian within the proceedings and the Child will be legally represented through the Children's Guardian.

30.04.14	Family Court hearing (Circuit Judge): Parental Responsibility Order made to Father. Various orders made to trace Mother and a Penal notice attached[9].
22.05.15	Family Court hearing (Circuit Judge): New Order for disclosure of information re whereabouts of Child O from CSA. Case transferred to High Court.
16.07.14	Hearing in the High Court. Order to Child Support Agency (CSA) to disclose all information regarding mother by 18/07/15 or CSA director would be ordered to attend court. Location order made.
25.07.14	Hearing in the High Court. Adjourned due to Mother not having been served with Order
31.07.14	Hearing in the High Court. Adjourned to be listed before the same judge, the first week in September

2.26. Various unsuccessful attempts were made during the Family Court process to locate Child O and mother, including contacting the Department for Work and Pensions and the Child Support Agency. A court order made in April 2014 was intended to include an order to the police to disclose Child O's whereabouts. The court order however was wrongly drafted and had to be redrafted in May 2014. It is not clear why the order was not served on the police after that point but it was not, and information therefore not identified about the mother's address in Norfolk.

2.27. In July 2014 Child O's case was transferred to the High Court which then enabled a Location Order[10] to be put in place. This Order, which has powers of entry and arrest, is executed by a Court Officer, known as the Tipstaff, who acts either in person, or requests the police to act on their behalf. The Tipstaff contacted Devon and Cornwall police in mid July 2014 in order to locate and serve the court order on the mother, on the basis of her original Devon address, which had been provided both by the CSA and the DWP. Devon Police visited the address and subsequently informed Tipstaff that mother was not there and this was maternal grandfather's address. On 8th August 2014 Tipstaff requested that the police visit maternal grandfather's address twice daily in an effort to make contact with him. On two occasions maternal grandfather was spoken to by phone and gave dates when he would be available to be seen, but due to internal errors the police did not attend on those dates.

2.28. On 13th August 2014 Child O and mother were found in the garage of the house in Lancashire.

2.29. As a result of Lancashire Police's investigation regarding the deaths, it was identified that the original LADO referral in December 2013 had not led to an investigation. This was taken up with the Southampton LADO.

[9] A Penal Notice can be attached to a family court order, meaning that failure to comply with the order can result in a period of imprisonment.

[10] Location Order is an order under the child Abduction and Custody Act 1985

However given the comprehensive nature of Lancashire Police's investigation with its clear conclusions that there was no evidence to support Mother's allegations against Father and conversely that there was evidence corroborating the view that Mother had lied on a number of significant occasions, it was agreed that there was no evidence to justify initiating a LADO investigation.

3 APPRAISAL OF PRACTICE AND ANALYSIS

3.1 Introduction

3.1.1. This Section will consider the principal areas for learning which have emerged during the Review and in the course of doing so will also appraise significant episodes of practice that have been identified both by the Review team and by family members. It begins with two areas for learning which help contribute to our understanding of what is the most central issue for the Review: the capacity of systems to identify and respond to potential risk to the child.

3.1.2. Individual agencies have acknowledged that there were some, largely minor, mistakes made during their contact with Child O and his family and have responded to these appropriately. Where these have no significant bearing on the outcome for Child O and do not contribute to wider learning, these have not been re-examined within this analysis. With hindsight however, we can also see aspects of practice across a number of agencies that would benefit from a re-evaluation, irrespective of the impact they are likely to have had on the outcome for Child O. The key findings from this Review are therefore predominantly about wider cross agency culture and practice.

3.1.3. It is not the remit of this Review to analyse in detail the practice of the Family Courts, however, the analysis does reflect on the relationship between the Family Court and the multi-agency safeguarding system. The information contained within this Review is of relevance to the Family court and could provide valuable learning within that arena. A recommendation has therefore been made to ensure the Review is shared with the family court. (Recommendation 6).

3.1.4. The analysis will conclude by considering whether the risk to Child O could have been anticipated and what implications this has for future practice.

3.2 Working with fathers

"despite recognition of the benefits of father inclusive health and family services, services are still heavily weighted in favour of mothers, and appear slow to change."[11]

3.2.1. The role that the father was able to play in his child's life was manipulated by the mother, who, we can see with hindsight, worked over an extended period to exclude him from Child O's life. That she was able to do this so effectively appears, to some degree, to have been unwittingly supported by professional assumptions and attitudes about the father's role and it appears that her actions were rarely actively challenged. Given the limitations on this Review our understanding of the professionals' response to the father is based predominantly on written records combined with what we know about engagement with fathers from research. It is important to note that the Review has not identified explicit, confirmed evidence of individual bias or negative views towards the father by professionals. However, the routine practices and culture within agencies often did not appear to support an active engagement with fathers.

3.2.2. The father describes a level of controlling behaviour by the mother, beginning during pregnancy, which prevented Child O from having a normal relationship with their father and with the extended paternal family. Much of this described behaviour took place within the family setting and was not visible to health or other agencies. The father describes this behaviour taking place in the hospital immediately following Child O's birth. Nevertheless, the mother's actions are not identified in professional records or memories as having been a particular cause for concern. This is not to say that the father was wrong in his view; some of the behaviour that he has described to this Review is certainly concerning. However, given the information available it is not possible to judge now whether the fact that this has not been noted by professionals represents a failure to recognise the impact on the relationship between father and child, or was a reasonable response at the time in a busy maternity unit familiar with anxious parents.

3.2.3. What is apparent from their records is that when the father raised his concerns with the Health Visitors, they took his concerns seriously and identified the possibility of Post-natal depression. The health visiting service shared their concerns with the GP which led to the mother being prescribed a low dose of anti-depressants. During the short period of their involvement with the family, the health visitors demonstrated that they were involving and listening to both parents.

3.2.4. At other points in Child O's life there is some evidence that processes and routine practice tended to assume that the mother, who had immediate care of Child O, was '*the parent*'. Examples of this include the acceptance by the GP of the Mother's decision to remove the

[11] The Burdett Report June 2014:

father's surname from Child O's surname. A parent can only change a child's name legally with the agreement of everyone with parental responsibility or with a court order. The implications of removing the father's name did not appear to be recognised and there is no evidence that this was questioned or challenged. After the move to Devon, there is no evidence of attempts being made by the health visiting service to actively contact or involve the father. The need for training and support of Health Visitors in this regard has been identified nationally as an area for development. Evidence from research supports the view that improvements to practice can be achieved.[12] Also, in February 2014 in response to a solicitor's letter the GP surgery were only willing to confirm that Child O was registered with them and the date they had seen the child, as the mother had requested that no information should be given about the child to Child O's father. Child O's father had Parental Responsibility and this had been confirmed by the Health Visitor, which raises a question as to why he was not considered to be entitled to full information about his child.

3.2.5. The father felt that he and his family were frequently not taken seriously enough by professionals and believes this was a result of his role as a father. In particular he described a poor experience of Cafcass' involvement. He did not feel listened to or properly consulted, for example he specifically told the Children's Guardian that Mother was not at the address in Devon, and was left highly frustrated that letters continued to be sent to this address, which, it appears, was the only address held by the court, and therefore by Cafcass, at that time. He felt the Children's Guardian was at times dismissive of his concerns and that he was given minimal opportunity to speak to the officer either before or during court hearings, including not receiving responses to his phone messages. The Children's Guardian has been interviewed by Cafcass as part of this Review and *"believes … was sympathetic to the situation and was clear with the father about their role".* The degree of the mismatch between the father's description of his experience and the Cafcass officer's perception is striking, but ultimately it is not something about which this report can make a judgement.

3.2.6. What is undisputed is that the Children's Guardian made a decision not to interview the father while undertaking the Section 7 report for the Court and it is evident that this has impacted significantly not least on the perception of fairness, irrespective of the rationale. The Children's Guardian began the enquiries by trying to speak to the mother and meet the child, sending three letters, the last by recorded delivery and visiting the address on the day of the court hearing. On failing to make contact with the mother the Children's Guardian decided not to meet the father, instead undertaking a short telephone interview. The Review has been told that one reason for this was because of the distance that the father would have had to travel to a meeting, although this does not appear to have been offered to him as a choice. The Children's Guardian also

[12] Osborne, M (2014)

decided not to look at the file of papers when the father asked for these to be viewed. Cafcass considers that this was a reasonable decision as the father was in a position to place this information with the court. The Review questions this. It cannot be concluded that if there had been a meeting with the father it would have changed the outcome for Child O, but it might have shifted the perception of the case and, for example, led to a stronger advice to the court about the need for an urgent response.

3.2.7. Cafcass have acknowledged that a more 'cautious' approach would have been to meet the father earlier in the process. Cafcass practice standards do not define whether or how parties should be interviewed, this is a matter for professional judgement. The Cafcass report identifies that the Children's Guardian had developed a mindset about Child O's case, as one of a '*mother not seeking to be found as she did not want her child to have a relationship with their father'.* It concludes that she had not been robust enough in her planning. Cafcass has assured this Review that there was no suggestion in discussion with the practitioner that the Children's Guardian's thinking had been influenced by assumptions about the different roles of mothers and fathers.

3.2.8. In response to questions about whether there might be anything further to learn about the organisation's approach to working with fathers, Cafcass has provided information from two National Audits of practice (April 2013 and November 2014) and the Ofsted National Inspection (April 2014). This latter report concluded that Cafcass '*consistently worked well with families to ensure children are safe'.* None of these audits identified poor practice in relation to working with fathers and Cafcass as a result feels satisfied that attitudes to fathers are not a cause of concern within their practice nationally. This Review has therefore sought further information about the specific context in which the Children's Guardian was working in order to better understand how such practice decisions are made. However, the information provided was unable to answer the key question as to *why* the Children's Guardian adopted a particular approach. On this basis the Review cannot share Cafcass' confidence that it can exclude the possibility that an individual or cultural response to fathers' roles may have impacted on the management of this case.

3.2.9. The application of supervision and support available to the individual practitioner is of concern in this case. There is now a strong body of knowledge within social care[13] that errors in human thinking are an inevitable feature of complex assessment. '*Critical challenge by others is needed to help social workers catch … biases and correct them – hence the importance of supervision*.'[14] In the case of Child O there is no evidence that reflective supervision or other systems which might

[13] Munro 2011 (and others.)
[14] Munro 2011 (p93)

have challenged a particular mindset, and acted as a safeguard, took place.

3.2.10. The Cafcass Operating Framework identifies that individual performance management and reflective supervision take place within quarterly 'performance *and learning review meetings*' whose focus is '*based around how learning has been applied and embedded in work from one quarter to the next'.* Supervision in relation to current work with individual children and families, is based on a model of '*situational supervision'* which takes place '*at the point of need'.* The frequency of this supervision is flexible and reliant on the individual practitioner or manager identifying the need for individual case supervision. The Cafcass Operating Framework states in relation to Rule 16.4 cases (where a child is made a party to the proceedings in their own right), such as Child O: '*Case review/case consultation/management oversight should occur at appropriate intervals to ensure the case is on track and not drifting*[15]*.* However, there is no evidence of any agreement as to what the '*appropriate interval'* would have been in this case, and no supervision is recorded as having taken place. No information has been provided to this review evidencing that this was unique to this case or that there is a system in place to avoid this happening again.

3.2.11. It is the judgement of the author and the Review team (with the exception of Cafcass) that this highlights a gap in the Cafcass approach to case supervision. Cafcass states that it *'aims to be in line with the direction of travel set out in Eileen Munro's Review of Child Protection''.* A significant theme of the Munro review was to reverse a trend whereby social workers had become deskilled by an excessively bureaucratic approach, overly focussed on process and regulation. This aspiration is reflected in Cafcass' approach to professional development which is based on the concept of '*self-regulation'*. However, what is also clearly identified by Munro is the crucial role played by employing organisations, as well as by individual practitioners, relating to supervision and reflection in order to ensure safe practice. Munro identifies that effective safeguarding practice requires a proactive approach by services and includes '*arrangements for frequent case supervision for practitioners to reflect on service effectiveness and case decision-making, separate from arrangements for individual pastoral care and professional development*[16]*.* The most recent OFSTED inspection, which was based on 7 of Cafcass' 17 Service Areas, judged that *'quality assurance is effective in most cases'.* Nevertheless, in the absence of more robust processes regarding the supervision of individual cases, Cafcass cannot be fully assured that it has fulfilled its obligation to support and challenge practice in order to ensure the best outcomes for children. An agency specific recommendation is therefore made as follows:

[15] CAFCASS (para 4.32)
[16] Munro (p111)

Recommendation 1: That Cafcass consider how it can ensure that its supervision systems are sufficiently comprehensive in order to identify those cases where there may be an unrecognised safeguarding risk to the child.

Following the completion of this Overview Report, CAFCASS forwarded an alternative recommendation which has been included in Appendix B.

3.2.12. The role of fathers is an all too familiar an issue in SCRs[17], frequently in relation to fathers who seem to be 'invisible' or may be threatening or dangerous. SCRs and research more widely have also highlighted the failure to recognise that fathers can bring positive resources to their children's lives. Child O's separation from their father was fundamentally a result of the actions of their mother and maternal grandfather. However, what Child O's experience again reflects is the often subtle mindset within health and social care which can view the mother, who is generally the day to day carer, as having more 'rights' and significance in the child's life and involvement with the father as 'optional or undesirable'[18]

3.2.13. Changing the approach of agencies and professionals to fathers is a complex task that requires not simply new policies or procedures, but a shift in skills and culture and the development of a 'father inclusive service'. Five Safeguarding Children Boards have played a part in this review; within each of these Boards and their partner agencies there is likely to be a wide spectrum of practice and culture in working with fathers. Whilst there are plenty of training courses and other tools that this Review could highlight, these will only be of value in the context of a positive organisational culture towards the role of fathers.

3.2.14. It is the conclusion of this report that there is evidence to suggest organisational weaknesses in the approach to working constructively and proactively with fathers. The recommendation of this report therefore is:

Recommendation 2: The Safeguarding Boards to satisfy themselves that they and their partner agencies have in place a proactive strategic approach to working with fathers and a means to assess the impact on the outcomes for children.

3.3 Domestic abuse – disclosure or allegation?

3.3.1. Child O's mother made a number of allegations of domestic abuse to a range of services, initially asserting that there were no issues of domestic abuse, later describing low level conflict and emotional abuse

[17] OFSTED The voice of the child: learning lessons from serious case reviews, 2011
[18] Osborn, M (July 2014)

and specifically stating that the abuse was never physical, but developing over time into very serious allegations. The evidence in this case is that professionals generally worked to established practice guidelines regarding listening to, respecting, recording and offering support when approached by the mother. Health services routinely asked the mother about domestic abuse and followed up any information the mother supplied which might suggest cause for concern. Advice and information was provided to the mother about support services.

3.3.2. Maternal grandfather has been very critical of the response of Devon and Cornwall police to his daughter's contact with them. However, given the nature of the allegations, as outlined in Section 2, this Review has concluded that the response of Devon and Cornwall Police was within expected standards. Officers used the national Risk Assessment tool and applied appropriate professional judgement in reaching the decision that the risk was 'standard', which is defined as "*current evidence does not indicate a likelihood of causing serious harm".* There is no reason to consider that this was anything other than a reasonable conclusion, based on the available information and the use of well-established tools supporting professional judgement.

3.3.3. When very serious allegations of domestic abuse, both physical and sexual were made to Police in Norfolk, the Police Officer, who was trained and experienced in sexual abuse and domestic abuse, worked hard to gain the mother's trust. She was not restricted by resources and referred the mother to appropriate support. Without the mother being willing to make any formal complaint regarding historical allegations, the police could not reasonably be expected to take any further action. What is of concern however, is the multi-agency management of the LADO referral and this will be considered separately in 3.5.

3.3.4. The primary focus of learning for this Review is not about improving practice relating to agencies' work with women who have experienced domestic abuse. Instead, what is of concern here is services' capacity to recognise those much smaller number of occasions[19] when what is being revealed is an unevidenced allegation, possibly a false allegation made tactically to manage the response of professionals and court proceedings. That there are a small group of women who are willing to make false allegations about domestic abuse, is not an unknown phenomenon, particularly in the family courts. However, it is not an issue that receives frequent attention in the wider health and social care world; it is little accounted for in service and individual practice and can be an unfamiliar, even uncomfortable, concept for many professionals. For the family, the impression was given, whether or not it reflected what professionals actually thought, that father had already been

[19] See for example, CPS 2013

judged. What resulted was a perception of bias, in the words of Child O's paternal grandmother:

> *'they just put him in this box: he was a man, he had to be violent and he was none of those things."*

3.3.5. Although the father's distress at being contacted by the police about false allegations is entirely understandable, reasonable judgements were made about the absence of criminal offences and no action was taken other than '*giving words of advice'*, which in itself understandably added to the father's sense of frustration. Nevertheless, it is difficult to avoid the conclusion that services had not given serious consideration to the possibility that the allegations might be malicious and therefore whether this might lead them to take different actions or consider the potential implications for Child O. Illustrative examples include:

- The language of agency records effectively shifts from allegation to presumed fact, such as recordings that the mother has '*fled*' domestic abuse.
- The use of the words 'disclosures', rather than 'allegations' in many records, which subtly reflects an acceptance of what the service has been told.
- Decisions by health and social care services not to pass on information about Child O in response to the mother's wishes.

3.3.6. One particular example of the way current systems to assess domestic abuse can have unintended consequences and could impact unhelpfully on professionals' judgement is the use of risk assessment tools. Police officers appropriately used the CAADA DASH RIC, a tool which is used nationally to identify risk in relation to domestic abuse. The risk factors that form the basis of the assessment are statistically evidentially sound. However, what the assessment does not explicitly recognise is that the actual information provided to the assessor may not itself be based on objective evidence. On one occasion the risk assessment identified 9 high risk factors, moving the risk assessment from standard to medium risk. However, each one of those risk factors was totally reliant on self-reporting by the mother and therefore open to manipulation.

3.3.7. Given what is known about the often hidden nature of domestic abuse and the difficulty in obtaining evidence, the use of this tool is both legitimate and highly valuable. Seven women a month are killed by a current or former partner and on average high-risk victims live with domestic abuse for 2.6 years before getting help.[20] The consequences of not taking domestic abuse allegations seriously can therefore be extremely dangerous. However, what this case highlights is that there are always limitations to any risk assessment tool when considering

[20] http://www.safelives.org.uk

individual cases. These limitations can go unrecognised and the proper focus on identifying genuine domestic abuse may not always be adequately balanced alongside professional curiosity about absent or contradictory information. This review does not seek to argue that tools such as the CAADA-DASH RIC should not be used, but that they should be considered within the full context of the case. What is needed is a proper awareness of the evidential base of the assessment and consideration of the need for any further investigation before judgements or decisions are made in relation to the alleged perpetrator.

3.3.8. The allegations against the father did however remain exactly that: allegations which had not been proven. There is no actual evidence that the allegations in themselves led directly to Services preventing him from having contact with Child O, which was throughout Child O's life within the control of the mother. It is the case however that decisions not to disclose the mother's address, had the result of preventing the father from knowing the whereabouts of his child. Some of the professionals however, rightly advised the father to seek legal advice which he subsequently did, leading him to his application through the family court system.

3.3.9. From the outset of the Family Court Proceedings it was known that the father denied there had been domestic abuse and told Cafcass and the court that the mother had made false allegations about him. There is no direct evidence that the Children's Guardian's decision making was a result of believing the mother rather than the father. Up until the point that the case was transferred to the High Court, the approach taken both by Cafcass and the court followed a course whereby the allegations of domestic abuse and the failure of the mother to attend the proceedings were the main focus of actions. As such, it could again be argued that the mother's perspective effectively determined the actions of professionals. The mother was absent and yet completely in control up until the very final weeks of Child O's life.

3.3.10. Managing intransigent behaviour of either or both parents is commonplace in Private Law Proceedings, and it is well recognised that the actions of one parent can significantly frustrate the attempts of the Court to achieve the best outcome for the child. Whilst there can be no easy assumption that it would have changed the outcome, Child O's father could have provided information about the pattern of the mother's behaviour, which might have painted a different picture, than that being created by the mother. The request for a Section 7 report presented an opportunity to begin gathering information from the father rather than simply waiting until the mother was located, with the implication that her views were more important. Irrespective of any impact that might reasonably have been expected in this case, this offers important learning for future work.

3.3.11. The paradox highlighted by Child O's case is that whilst there is evidence that agencies generally met required standards in responding

to domestic abuse, what appeared to be missing was a recognition that in certain circumstances allegations can be used as a weapon to deny a child a relationship with a father and to create a smokescreen with professionals. We are therefore left with a question about the unintended consequences of the major shift in understanding and policy regarding domestic abuse that has taken place in recent years and its overwhelming focus on believing the woman's reporting of what has happened.

3.3.12. It is therefore the conclusion of this review that there is an identified need for professionals to be encouraged and supported to balance respect for women who talk to them about domestic abuse, with appropriate scepticism and curiosity where allegations are denied. This is particularly important where there is no independent evidence and where a child is at the centre of a parental dispute. The following recommendation is made as a result:

Recommendation 3: The Safeguarding Boards to assure themselves that their Domestic Abuse strategies and practice supports services and staff to respond effectively to the needs of victims whilst remaining aware of the possibility of false allegations in a minority of cases.

3.4 Recognition of potential risk to the child

3.4.1. What is striking at a number of points during the involvement of agencies was the lack of explicit focus on how Child O might be experiencing their circumstances and whether those circumstances might raise safeguarding concerns. It has been difficult to identify evidence that agencies reflected on whether Child O's circumstances following the parents' separation might in themselves be an indicator of a safeguarding concern. In May 2014, the County Court judge did ask the Cafcass officer to alert Torbay Children's Services of the Court proceedings, but it would appear that this was, albeit a perfectly sensible sharing of information, not in itself a safeguarding alert.

3.4.2. Child O was referred to Children's Services within the first two weeks of their life, by father. The response was that the referral would not reach the threshold for a safeguarding assessment, and this is not in itself being challenged. Referrals to Children's Services continue to be very high and the initial process of establishing whether a referral should trigger a fuller assessment is by necessity based on the immediate seriousness of the issues being raised. Children's Services did make contact with the Health Visitor, reviewed the police report, which gave no cause for concern and spoke to the father in person, but at this point the mother moved to Devon. As such normal standards of practice were followed by Hampshire Children's services in forwarding the information to Devon.

3.4.3. The information having been received by Devon Children's Services, led to a similar conclusion which was recorded as being that the concerns did not reach safeguarding thresholds, which again is a justifiable position. What is of some concern is that the rationale as fed back to the Mother was that '*the concerns had not been substantiated*'. In the absence of an assessment it is not clear how such a conclusion could have been reached. It is also of concern that information faxed by Hampshire Children's Services to Devon, stated that there had been no interventions or concerns raised by the health visiting service. As a result Devon recorded that '*it is clear there were no concerns held by health in the originating area'.* Whilst the possibility of post-natal depression without other features of concern could not be expected to trigger a safeguarding assessment, this was nevertheless a relevant piece of information that should have been given to Devon and recorded for future reference.

3.4.4. On receiving the application to the Family Court, Cafcass' standard process is to undertake basic safeguarding checks including telephone contact with each parent. These checks did not identify anything of immediate safeguarding concern for Child O. The next point for Cafcass at which an assessment of any risk to the child would be considered was the request for a Section 7 report and comment has already been made about the gap in this assessment of not speaking to the father. The Cafcass officer has acknowledged that the possibility of a safeguarding concern was never part of their thinking and this did not change throughout the court proceedings, even when the decision was made that the child should be separately represented and therefore take a more central role in the proceedings. Information provided by Cafcass also stated that the father "*had not raised significant safeguarding concerns, although he did express anxiety about Mother's mental health or possible post-natal depression"*. It is important to recognise that a concern about mental health does not in itself indicate that there will be safeguarding risks to a child. However, any parental mental health problem, particularly depression, should be considered in relation to a child's welfare, not least in the context of a child of this age whose whereabouts were unknown.

3.4.5. Although Child O was reported as missing to Devon and Cornwall Police by their father, this appeared to have limited subsequent impact on professional perceptions regarding any safeguarding risk to him. Child O was not brought to their first year health review and in the absence of any explanation, this should have caused greater concern. The health visiting response was to write to the Mother but take no further action, assuming that the mother was happy with Child O's development and inviting her to make contact if she had any concerns. The health visiting service has acknowledged that there should have been a more pro-active attempt to identify whether mother and child had left the area and consideration of a national safeguarding alert. This has led to an individual agency recommendation.

3.4.6. Devon and Cornwall police have analysed in some detail their response to Child O being reported as missing. While the investigation was immediately initiated and ultimately succeeded in locating Child O and mother, it is also acknowledged by the police that there was a period of a few days when the investigation drifted. The father's experience was that he had to push for an active response, for example by using the local press. Nevertheless within a fortnight the police had reason to believe that Child O and mother might be in Norfolk and this information was passed to the Norfolk Police. Within 5 weeks her location was identified. Although Father has some very understandable concerns regarding the categorisation of Child O on being missing as medium risk, on the basis of the information the police had this could not be considered an inappropriate categorisation. Medium risk '*requires an active and measured response by police and other agencies*' and there is clear evidence of proper activity by the police during the investigation. The categories relating to risk are clearly defined with High Risk being defined as follows: "*risk posed is immediate and there are substantial grounds for believing that the subject is in danger*"[21]. This is reflected in national statistics which identify that only 13% of cases are assessed as High Risk[22]. No child that is reported missing can be graded as standard risk. On receiving the information from Devon about Child O and mother's whereabouts, Norfolk police responded immediately, succeeding in meeting with them both the following morning.

3.4.7. What however did represent a failure in the multi-agency approach, including the role of the Family Court, is that the information about the mother's Norfolk address was never shared with any other agencies because of the mother's apparent concern about being discovered by the father. The Family Court was made aware in January 2014 that the police had located mother (although by this point it is likely that she had already moved and was therefore now missing again). In late April the Court made an order to seek the information from the police, although this order could not be served as it had been badly drafted. It was subsequently redrafted, although it is unclear why a further attempt was not made to serve it, nor why it was not actively pursued by any of the professionals involved, including the Children's Guardian who had taken the view that it was the court's role to '*manage the situation'*. The role of the Family Court itself is not for this Review to analyse, but from a multi-agency safeguarding perspective this was effectively a lost opportunity to identify that Child O and mother were missing again and to re-open a police missing person investigation

3.4.8. From a problem solving perspective there was a significant period once Child O and mother were registered as missing, when the actions available to agencies were inevitably focussed on the adults. What is difficult to identify, prior to the move to the High Court, is evidence of a conscious recognition that this was not just a parental dispute, but a

[21] ACOP Guidance on the Management, Recording and Investigation of Missing Persons, 2010

[22] UK Missing Persons Bureau: Missing Persons Data and Analysis 2012/13

missing child who had not, as far as anyone was aware, been seen by any independent professional for a significant period. Viewed from a safeguarding perspective the pace of the Family Court proceedings with its repeated attempts to gain the mother's attendance, lacked apparent urgency prior to the transfer to the High Court. The requirement for Cafcass to undertake a Section 7 report unavoidably takes a period of several weeks, however it is of concern that in the absence of any response by the mother over a two month period no urgent action was taken to contact the court and therefore minimise further delay.

3.4.9. Family Courts, particularly the High Court, are very familiar with the concept of Child Abduction. However the definition and received understanding of child abduction assumes a child abducted, often by a non-resident parent and taken abroad. What appears to be much rarer is a resident parent going missing with the child in this country, and as a result, there is no tailored, established process to ensure an urgent response in such circumstances. One feature of particular concern that has been identified is the very limited budget available via public funding to the Children's Guardian to appoint investigators to trace a child. The father's income meant that he had no access to legal representation and he was also asked to contribute to the costs of appointing investigators. Whilst this father had some limited funds available, this was experienced by him as highly insensitive and unjust and again failed to take into account that his child was in fact missing. It is not within the power of this Review to require a change to Government policy in relation to Legal Aid funding, however, there is no doubt that the absence of financial support to the non-resident parent in these circumstances could have a significant impact on the outcome for a child.

3.4.10. The issue of Mother's mental health remains unresolved and it is not the role of this report to take a view on whether she was suffering from any mental health condition or personality disorder. Maternal grandmother has asked whether the point at which her daughter changed her name might have marked a fundamental personality change, but it is impossible to comment on this. Medical information has provided some evidence of historical emotional vulnerability, including a referral to psychology services, although this information would not have been available to Cafcass or Children's Services at the time. There is no previous history of any mental ill health problems and neither of the mother's parents' identified mental health concerns during her childhood or adolescence.

3.4.11. There was nevertheless information which was available about potential post-natal depression and the possibility of emotional or personality problems. This included substantial information held by the father, some of which was supported in health records, regarding over-protectiveness, as well as contradictory information provided by the mother about her own background and family relationships which

impacted on her view of Child O's paternal family. This included quite extreme behaviour such as an unwillingness to allow the father's family or friends to have any information about the pregnancy or Child O's birth. Given that the mother was understood to be happy about the pregnancy and to welcome the father's commitment to their relationship and child, this might suggest something more complex and worrying was in fact taking place.

3.4.12. All the information available to agencies was that the mother's physical care of Child O was very good. Child O's father never raised concerns in this regard and when professionals saw the child there was a consistent picture of a visibly well cared for child. The Norfolk Police Officer who met with the mother in December 2013 following her allegations described the home as "*immaculate*" and that Child O "*seemed loved and well cared for*". Although she also noted some concern about the longer term impact on Child O of such a reclusive lifestyle. On the information available to professionals it would have been a significant leap to conclude that Child O met the threshold for emotional abuse which is defined in Working Together as :

> "*The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects of the child's emotional development*."[23]

3.4.13. Child O's case however does pose a question regarding the state of our current knowledge about the potential for emotional harm to children where physical abuse or neglect are not apparent. Whilst there was very limited information available and no serious criticism of individuals intended here, at what point should professionals consider that issues such as maternal over-protectiveness, control and exclusion of the father and inconsistent engagement with primary services such as health, might be safeguarding issues?

3.4.14. Child O's father has raised a question as to whether there should be a greater degree of contact by statutory agencies with pre-school age children, to provide better protection in such circumstances. Whilst this is a legitimate question given the experience of this family, universal services for children are designed to balance the legitimate need for safeguarding with the equally legitimate requirement for minimal unnecessary intervention by the state in family life. It is also the case that increasing routine contact with statutory services, for example more frequent health contacts, would be unlikely to impact on a parent determined on a particular course of action. This is a question that was considered seriously by the Review team and has been considered in other Serious Case Reviews, but as identified in the SCR regarding Hamzah Khan: '*it is realistically impossible to guarantee that a child will not remain hidden from universal or specialist services ….under current statutory arrangements'*[24]

[23] Working Together 2015 (p92)

[24] Bradford Safeguarding Children Board, Nov 2013

3.4.15. It is not the contention of this Review that given the limited involvement of individual professionals, and particularly the lack of access to the mother and Child O, professionals could have anticipated that the concerns outlined above were indicators of such a significant risk. Identifying the nature of the risk that is now known the mother posed to Child O, would have been extremely difficult if not impossible. However, greater knowledge about child killings (filicide) in the context of parental conflict could only have helped the agencies and professionals involved with Child O to better understand what risks he might face. Recent research by O'Hagan has identified that the exercise, and then loss, of parental control is a significant feature of filicide[25]. Even with the gaps in our knowledge about the mother's motivation, what is absolutely clear is that she was determined to maintain control over her care of Child O even if this meant taking extreme steps, the most extreme when it may have appeared to her that she might be about to lose that control.

3.4.16. The numbers of parents who kill their children in the context of parental separation are very low, an average of 4 taking place each year[26]. A review of information held by Cafcass has identified that on average there are 2 such incidences a year where the family is known to that agency and that predominantly the perpetrator is male. The limited data about this type of homicide means that it is extremely difficult for agencies and practitioners to identify whether a particular individual presents as a serious risk.

3.4.17. The numbers of children who die in these circumstances are small both in total and as a proportion of the number of child deaths arising from abuse or neglect.[27] However the numbers also remain stubbornly consistent from year to year and statistically any one of the 5 Board areas could be faced with a child death of this nature within the foreseeable future. It is therefore the finding of this review that whilst recognising the difficulties in identifying which children might be at risk, nevertheless the repeating nature of such deaths requires an active response by agencies. Two recommendations are therefore made:

Recommendation 4: The Safeguarding Boards to consider a plan of work designed to develop knowledge and awareness amongst partner agencies of the nature of homicide in the context of parental conflict.

Recommendation 5: That Lancashire SCB, as lead for this SCR, request a thematic review of SCRs relating to homicide and suicide held in the NSPCC repository.

[25] O'Hagan (2014 p194)

[26] O'Hagan

[27] There is no single source which identifies the number of child killings. However, information from the NSPCC and Ofsted would suggest that this is between 50 and 200 annually. See NSPCC March 2014

3.5 Communication across agencies and geographical borders

3.5.1. On a number of occasions there were problems with the way that agencies communicated information, particularly when this involved agencies in different geographical locations. This included the information from the original health visitor in Hampshire being missed for reasons that remain unclear and therefore not being passed on either to Children's Services or to Cafcass. It should however be noted that the Hampshire Health Visiting service did meet practice standards in passing on information to their counterparts in Devon and following up with the mother to check that she had registered with a GP. Small gaps in information sharing are commonly a feature of Serious Case Reviews[28], particularly across geographical boundaries, and can have an impact on the course of a case disproportionate to the original error. The broad issue of achieving consistent, effective communication across complex systems and multiple agencies, is well recognised as a continuing difficulty within safeguarding and as such is not subject to a recommendation in this Review.

3.5.2. There is one gap in communication that could potentially have impacted on subsequent professional actions and requires more detailed appraisal. When particular allegations were made by the mother to Norfolk Police these were referred to the Norfolk LADO for further action. These were serious allegations about inappropriate relationships with young people in the father's professional life. As has been noted in Section 2, this was not actioned in Southampton until after Child O's death. Two factors led to this significant failing.

3.5.3. Firstly the Southampton LADO did not record the telephone conversation she had received from Norfolk, a conversation which from memory she believes took place on her personal mobile phone on Christmas Eve. She also believes she had been expecting written information from the police. Southampton Family Services have acknowledged that this was a significant mistake, but identified that it took place in the context of organisational problems which meant that the LADO was also working as a Conference Chair, in effect undertaking two roles which impacted on her capacity to cover all the work. There is a clear lesson here for Southampton Family Services regarding the importance of ensuring that adequate resources are given to the LADO role, given the potentially serious consequences of not pursuing an investigation

3.5.4. The second problem was that the information held by the police was not passed on to the Southampton LADO. Norfolk Police made a decision to pass their information to Devon and Cornwall Police, given the mother's apparent belief that someone in Hampshire Police might inform the father of her whereabouts. The intention was that Devon

[28] Brandon et al, 2011 (p30)

and Cornwall would pass it on to Hampshire, thereby 'cloaking' the original source of the information. However, Devon and Cornwall Police did not agree to this course of action and the information was never transferred. Both police forces evidently believed that they had fulfilled their duties in sharing the information but the outcome belied that belief. As a result, Devon Police and Norfolk Constabulary have each responded with an individual agency recommendation.

3.5.5. The significance of this failure to effectively share information is that an investigation into serious allegations did not take place. For Child O, the initiating of the LADO investigation in December 2013 might have been able to contribute further information to the collective understanding of the mother's actions and the implications for Child O. The father's view is that this could have had a significant impact and in his words

> "*it would have been a hideous way to get there, but I wish they had done it…if they had investigated then they could have found out it was false and Child O might still be alive".*

Whether or not a LADO investigation would have affected the outcome, the impact on the family of knowing that this did not take place, when it should have done, has added to their sense of trauma. That the investigation did not take place in a timely way fell crucially short of good agency practice.

4 CONCLUDING COMMENTS

4.1. The purpose of a Serious Case Review is to learn from the case in order that improvements to practice can be put in place so as to help families in the future. The learning from this case does not lend itself to simple solutions, nor is the learning particularly specific to one authority.

4.2. It should be acknowledged that it is possible, though would not have been easily achieved, that different actions could have resulted in Child O being traced earlier. However, given all that we know about the mother's determination not to be found, and her access to the financial and practical support that allowed her to stay hidden, there is a real possibility that this would have resulted in another move and ultimately the same outcome.

4.3. As has already been noted, both Lancashire Police and the Coroner concluded that there was no evidence to support the allegations of domestic violence made against Child O's father. Conversely there was evidence that Child O's mother and maternal grandfather provided misleading information to the statutory services in order to conceal Child O and the mother's whereabouts. The information provided to this Review is entirely consistent with the Coroner and Police's conclusions.

Child O's mother left a suicide note stating that her intent was to prevent Child O being harmed by someone who was hunting them down. What is clear from all the information available is that no-one, other than her own father, knew where she was living until after her death and there was no information at the time of her death to suggest that the father had located her.

4.4. The death of Child O and mother took place in circumstances which both experience and research would tell us are extremely rare[29]. Whilst the explanation given by the grandfather and the mother in the notes she left was that this was a response to fear of the father, such a fear appears to be highly irrational, or possibly not a genuinely held fear. The suicide note's strangely calm tone and reference to their pending deaths being *"the only way I can keep my child happy and safe*" indicates a disturbing logic that mother believed Child O's death by her hand was acceptable, in stark contrast to the harm she suggests others intended. The deaths of Child O and their mother were carefully planned, rather than impulsive, underlining a sense that the mother was controlling all aspects of Child O's existence.

4.5. Current knowledge, and therefore capacity to identify the risk of homicide and suicide following separation is still comparatively limited. The most well-known model used to explain this phenomenon, developed by Philip Resnick in 1969, has for many years been used to provide explanations for motivation in these cases. Currently, it is to some degree being reviewed and there also is recognition that there is a lack of knowledge about mothers who kill in these circumstances. The most recent research from O'Hagan acknowledges that it is extremely difficult to provide useful information to practitioners to help with the recognition of risk. However, given the repeat nature of the resulting child deaths it is incumbent on services to improve their knowledge and better prepare professionals in the future. Improving collective understanding of the degree of control and planning that is often identified after these events is particularly important, given what we know about Child O's experience and the message from research that "*most….are wholly dependent upon an exceptionally high degree of premeditation on the part of the perpetrator*.[30]

5 RECOMMENDATIONS FOR THE BOARDS

a. This Serious Case Review was undertaken following the tragic death of Child O in a very unusual set of circumstances which themselves only increased the trauma for Child O's remaining parent. In examining the involvement of the various agencies it has been possible to identify points of practice where mistakes have been made or where practice

[29] See Berry et al

[30] O'Hagan, (p100)

could be improved, although these largely do not lend themselves to simple recommendations with SMART outcomes. More significantly it has highlighted some vulnerable aspects of safeguarding practice that apply to a larger or greater extent across agencies and cannot be considered unique to particular individuals or agencies. There is the potential for significant learning to be gained from Child O's death, irrespective of the extent or quality of agency involvement in this individual case. Lancashire Safeguarding Children Board, which had no involvement with Child O during their life, has already acknowledged that there will be learning for safeguarding agencies within Lancashire.

b. As a result the recommendations are not specific to groups of agencies or individual boards. It is also hoped Child O and their family's experience will contribute to the national body of knowledge particularly regarding the death of children in such circumstances.

c. A number of the contributing agencies identified learning specific to their agency and their resulting recommendations are attached as Appendix A.

d. The multi-agency recommendations are as follows:

Recommendation 1: That Cafcass consider how it can ensure that its supervision systems are sufficiently comprehensive in order to identify those cases where there may be an unrecognised safeguarding risk to the child.

NB: Cafcass have not accepted this recommendation and therefore not provided an action plan

Recommendation 2: The Safeguarding Boards to satisfy themselves that they and their partner agencies have in place a proactive strategic approach to working with fathers and a means to assess the impact on the outcomes for children

Recommendation 3: The Safeguarding Boards to assure themselves that their Domestic Abuse strategies and practice supports services and staff to respond effectively to the needs of victims whilst remaining aware of the possibility of false allegations in a minority of cases.

Recommendation 4: The Safeguarding Boards to consider a plan of work designed to develop knowledge and awareness amongst partner agencies of the nature of homicide in the context of parental conflict.

Recommendation 5: That Lancashire Safeguarding Children Board ensure that this report is shared with the Family Court and discussions take place with the judiciary as to how learning from SCRs relevant to the Family courts can be shared.

APPENDIX A: LSCB ACTIONS

Devon Safeguarding Children Board Action Plan

Recommendation 2: The Safeguarding Boards to satisfy themselves that they and their partner agencies have in place a proactive strategic approach to working with fathers and a means to assess the impact on the outcomes for children.								
	Lessons learned	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Target date by which actions will be completed**	**Actual completion date**	**RAG status**
	Embed the participation and involvement of fathers in all stages of the assessment and planning and review process	Single and Multi-Agency Case audit to be undertaken to evaluate participation and involvement of fathers and the Think Family protocol	Evidence of the following within case files: Use of genograms Evidence of father's views within assessments Fathers being invited to attend at meetings Evidence of assessed exclusion to also be evidenced	All practitioners to evidence that they have contacted the father and facilitated his participation in their work with the family unless it has been assessed that it is unsafe to do so. In such cases the reasons for exclusion should be clearly given and recorded.	Safeguarding Leads	May 2016		

Recommendation 3: The Safeguarding Boards to assure themselves that their Domestic Abuse strategies and practice supports services and staff to respond effectively to the needs of victims whilst remaining aware of the possibility of false allegations in a minority of cases.								
	Assumptions regarding Domestic Abuse should not be made Professional challenge and curiosity should be maintained Careful use of language when an allegation remains as such (allegation vs disclosure)	To use this case in training and disseminate learning through the DSCB "magazine" and on the DSCB website	Inclusion in training packages (Domestic Abuse, learning from Serious Case Reviews) Attendance at training Supervision records Case audit (MACA)	Accurate and non-prejudicial case management. All practitioners should be aware of the complexities of domestic violence/abuse and the potential for it to be used as a smokescreen. All practitioners should consider their use of language particularly avoiding escalation of terms in the absence of confirmation/evidence of behaviours. Maintain "respectful disbelief/professional scepticism/professional curiosity" To understand that Filicide is rare but	Workforce Development Lead for the DSCB	January 2016 (subject to SCR being published)		

				more common in conflict situations				
		For Domestic Abuse Strategy to be in place		For Domestic Abuse Strategy to support services and staff to respond effectively to the needs of victims whilst remaining aware of the possibility of false allegations in a minority of cases	Director of Public Health	April 2016		
Recommendation 4: The Safeguarding Boards to consider a plan of work designed to develop knowledge and awareness amongst partner agencies of the nature of homicide in the context of parental conflict.								
	Filicide is rare but more common in conflict situations	Use this case as an example to promote understanding of Filicide. Disseminate learning through the "magazine" and on LSCB website	Filicide to be included in LSCB training programme	Increase understanding and knowledge of filicide amongst practitioners using this case as an example. For there to be no further cases of preventable Filicide	Workforce Development Lead for the DSCB	January 2016 (depending on publication date)		

	Recognising the range of carer's behaviours which may ultimately lead to harm or compromise a child's development	Use case in training to illustrate the risks of "overprotective" behaviours/disguised compliance and how this links to emotional abuse.	Training packages Supervision records	For Practitioners to recognise behaviours which may ultimately lead to harm or compromise a child's development.	Workforce Development Lead for the DSCB	January 2016 for current Domestic Abuse training (depending on publication date) April 2016 (for new training)		

Hampshire Safeguarding Children Board:

	Lessons learned	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Target date by which actions will be completed**	**Actual completion date**	**RAG status**
1	Recommendation 2 – to ensure that agencies / professionals have a proactive approach to engaging with and working with Fathers.	HSCB to review its multi-agency training to ensure that professionals know how to, and the benefit of, engaging fathers and male carers in case work and discussions.	Training courses include how to engage fathers / carers and why it is important to hear from everyone who can help them understand the needs of a child.	Professionals will be able to - identify important males in children's lives - understand the roles that fathers / men play in the lives of at-risk children - make accurate assessments of risk and	Workforce Development Group	March 2016		

		HSCB and SSCB to work with Pan-Hampshire colleagues to update the relevant 4LSCB policies to highlight the importance of engaging fathers / male carers.	Policies will be updated and published online.	challenge any inappropriate behaviour if necessary - support men in strengthening the positive contribution they can make to the child's well-being.	4LSCB Procedures Group	March 2016		
2	Recommendation 3- Domestic Abuse strategies enable staff to respond effectively to the needs of victims whilst remaining aware of potential false allegations	HSCB and SSCB will oversee the review and update of the 'Joint Working Protocol' which outlines how professionals will respond to issues relating to domestic abuse, and ensure that it includes information relating to the potential for false allegations.	The protocol will be updated and relaunched to include the learning from the Child O review	Professionals will be able to support victims of domestic abuse but will also be able to consider the possibility for false allegations which may mask real risk factors for vulnerable children.	Hampshire County Council Mental Health Commissioning Manager	Review in progress and due to be completed by March 2016.		
3		HSCB to include the key points from this recommendation in the next cohort of 'Lessons Learnt' briefings for professionals across the county.	Relevant points to be worked into case studies used in workshops to highlight potential risk factors to front line staff		Workforce Development Group	March 2016		

4	Recommendation 4 – to improve awareness of the nature of homicide in the context of parental conflict.	HSCB to include the key points from this recommendation in the next cohort of 'Lessons Learnt' briefings for professionals across the county.	Relevant points to be worked into case studies used in workshops to highlight potential risk factors to front line staff	Professionals understand that in some - extreme and on-going – cases of parental conflict there can be an increased risk of homicide or serious harm to children.	Workforce Development Group	March 2016		
5		HSCB to review its multi-agency training to ensure that professionals are aware of the risk of homicide in cases involving parental conflict.	WDG will explore how training courses can be updated to include the potential, and extreme, risk of homicide in ongoing parental conflict.		Workforce Development Group	March 2016		

Lancashire Safeguarding Children Board Action Plan

	Lessons learned	Key Actions	Evidence	Key Outcome	Lead Officer	Target date by which actions will be completed	Actual completion date	RAG status
1	Recommendation 2 – to ensure that agencies / professionals have a proactive approach to engaging with and working with Fathers.	LSCB to review its multi-agency training to ensure that professionals know how to, and the benefit of, engaging fathers and male carers in case work and discussions.	Training courses include how to engage fathers / carers and why it is important to hear from everyone who can help them understand the needs of a child.	Professionals will be able to - identify important males in children's lives - understand the roles that fathers / men play in the lives of at-risk children - make accurate assessments of risk	Learning and Development Sub Group	March 2016		
2	Recommendation 3- Domestic Abuse strategies enable staff to respond effectively to the needs of victims whilst remaining aware of potential false allegations	LSCB to include the key points from this recommendation in the Child O learning brief	Relevant points to be worked into case studies used in workshops to highlight potential risk factors to front line staff	Professionals will be able to support victims of domestic abuse but will also be able to consider the possibility for false allegations which may mask real risk factors for vulnerable children.	Learning & Development sub group	March 2016		

3	Recommendation 4 – to improve awareness of the nature of homicide in the context of parental conflict.	LSCB to include the key points from this recommendation in the Child O learning brief	Relevant points to be worked into case studies used in workshops to highlight potential risk factors to front line staff	Professionals understand that in some - extreme and on-going – cases of parental conflict there can be an increased risk of homicide or serious harm to children.	Learning & Development sub group	March 2016		
4		LSCB to review its multi-agency training to ensure that professionals are aware of the risk of homicide in cases involving parental conflict.	L&D Sub group will explore how training courses can be updated to include the potential, and extreme, risk of homicide in ongoing parental conflict.		Learning & Development sub group	July 2016		

Southampton LSCB Action Plan

	Lessons learned	Key Actions	Evidence	Key Outcome	Lead Officer	Target date by which actions will be completed	Actual completion date	RAG status
1	The Safeguarding Boards to satisfy themselves that they and their partner agencies have in place a proactive strategic approach to working with fathers and a means to assess the impact on the outcomes for children.	*LSCB Team to arrange a Wednesday Workshop on 'Working with Fathers'.* *LSCB and HSCB to work with Pan-Hampshire colleagues to update the relevant 4LSCB policies to highlight the importance of engaging fathers / male carers.*	Workshop takes place Policies will be updated and published online.	Increase professional knowledge on this issue	LSCB Team 4LSCB Procedures Group	April 16 April 2016		
2	The Safeguarding Boards to assure themselves that their Domestic Abuse strategies and practice	*LSCB and HSCB will oversee the review and update of the*	The protocol will be updated and relaunched to include the learning	Professionals will be able to support victims of domestic abuse but will also be able to consider	4LSCB Procedures Group	April 2016		

	supports services and staff to respond effectively to the needs of victims whilst remaining aware of the possibility of false allegations in a minority of cases.	*'Joint Working Protocol' which outlines how professionals will respond to issues relating to domestic abuse, and ensure that it includes information relating to the potential for false allegations.* *Raise awareness of existing Domestic Abuse training for professionals* *Learning and Development Group to ensure that training is available on responding effectively to the needs of victims of Domestic Abuse which acknowledges*	from the Child O review Featured in LSCB Communications Training on this issue will be identified	the possibility for false allegations which may mask real risk factors for vulnerable children. An increase in the take up of DV training Professionals will feel confident in responding to and working with victims of Domestic Abuse and know where they can receive training on this issue.	 LSCB Team Chair of Learning and Development Group LSCB	 March 2016 February 2016		

		the possibility of false allegations within existing training.						
3	The Safeguarding Boards to consider a plan of work designed to develop knowledge and awareness amongst partner agencies of the nature of homicide in the context of parental conflict.	*Learning and Development Group to review training opportunities with regard to homicide in parent conflict.*	Training on this issue will be identified or developed	Professionals will have a greater understanding and awareness of the nature of homicide in the context of parental conflict.	Chair of Learning and Development Group LSCB	April 2016		
4	Identified by the Southampton LSCB	Practice and Policy Group to ensure that agencies have a clear response and process when they are no longer able to track families.	Practice and Policy Group assurance documented in minutes.	All agencies and the LSCB will be clear on the process for tracking 'lost families'	Chair of Practice and Policy Group LSCB	April 2016		
		Southampton LSCB to seek assurance of CAFCASS processes via Section 11 reports	Section 11 forms and feedback Regular data and reports from CAFCASS to LSCB	Southampton LSCB to be assured of CAFCASS processes and systems to Safeguard Children	Chair of Monitoring and Evaluation Group LSCB Chair of LSCB	December 2015		Green

Southampton Children and Families Service

	Lessons learned	Key Actions	Evidence	Key Outcome	Lead Officer	Target date by which actions will be completed	Actual completion date	RAG status
4	It is important that the LADO is clear as to the source of the referral or contact and that there is a narrative thread that runs through the recording. This has already been implemented. All referrals that relate to another authority should be noted for audit purposes.	All referrals to LADO are recorded, even if it is a misdirection for another authority. All conversations are recoded on the LADAO database	Audit of LADO data base	All communications to and from LADO are recorded	Principle Social Worker	September 2015	June 2015	

Southampton CCG/NHS England (Wessex Local Area Team) - Southampton Primary Care Team

	Lessons learned	Key Actions	Evidence	Key Outcome	Lead Officer	Target date by which actions will be completed	Actual completion date	RAG status
5	Within a GP practice, where there are known risks and vulnerabilities associated with an individual patient, it is fundamental that this information is shared utilising uniform READ codes (RCGP 2009) as stipulated by the DES (2006)	Include a question on the use of the agreed READ codes in annual audit (RCGP template) Review and analyse audit post return (Oct 2015) Escalate poor compliance with READ codes to Local Area Team and performance teams	Annual Southampton GP audit includes question on READ code use within practice Analysis of audit provides areas of poor compliance which when escalated, results in joint action by LAT and lead professionals with further monitoring as part of agree action planning	Ascertain the level of READ code usage within individual Southampton GP practices to ensure that identified adult risk and vulnerability factors are shared	Named GP / Designated Nurse / LAT	Dec 2015		Green
6	During all engagements with individuals who present with mental health issue,	"Spot check" of READ codes to be undertaken with individual GP practices	Further audit of READ codes to identify adult risk / vulnerabilities is documented within	Monitor the use of read codes/patient records to ensure that READ code for adult risk and vulnerability	Named GP / Designated Nurse / LAT	May 2016		Amber

	emotional distress, learning disabilities, or a drugs and alcohol misuse, assessment should be made with regard to parenting capacity Potential parental risk (JWP) factors need to be READ coded in children's notes to increase awareness of the potential risk	"Spot check" to include review of parental notes for evidence of further enquiry and / or assessment of parenting consideration "Spot check" to include review of children's notes for translation of appropriate READ codes associated with parental risks / vulnerabilities	individual patient record Consideration of parental role and where applicable, risk / vulnerabilities are transferred to READ codes on child's (children's) record	factors is documented and associated READ codes assigned to Child (ren) record				
7	People who experience domestic violence and abuse must be offered evidenced-based treatment and support	IRIS referrals made by Southampton GPs are monitored and analysed against the known demographics and reporting of DVA	Monthly reporting by IRIS provides details of GP referrals per month comparable to referrals from other services within the multi-agency	Patients who attend a consultation with their GP and disclose information / provide indicators of domestic abuse, are referred to a specialist service for support and advice	All GPs / Named GP / Designated Nurse	Sept 2015	Sept 2015	Green

8	All pregnant females attending GP consultations in Southampton should be seen alone and specifically asked about mental illness and domestic violence and abuse.	An audit of antenatal referral forms by Southampton GPs will be audited for review timely and appropriate sharing of information specifically related to mental health and domestic abuse	Antenatal audit identifies percentage of antenatal forms which include information of mental health / domestic abuse Audit identifies GP practices where information of mental health / domestic abuse has not been shared with midwifery service via the antenatal form	Frontline practitioners must ensure they are able to recognise and respond to the indicators of domestic abuse and understand how it impacts upon parenting / caring capacity (babies, children and young people)	Safeguarding Lead Midwifery / Named GP / Designated Nurse	May 2016		Amber

University Hospital Southampton Midwifery Services Action Plan Updated 24.8.15

	Lessons learned	Key Actions	Evidence	Key Outcome	Lead Officer	Target date by which actions will be completed	Actual completion date	RAG status
9	When a mother changes her booking from PAH it is important that records of A/N care are retained by the hospital. It is also important for the mother to take her A/N handheld records with her to her new provider to share her A/N care thus far . The maternity records guideline does not reflect this and needs to be reviewed	Review Maternity Records Guideline Raise awareness When a woman changes maternity services provider she should be given a copy of her handheld maternity records to take with to her new location, a copy of the handheld records should also be retained with her maternity records at PAH	Maternity Records Guidelines updated to reflect learning from SCR child O	Maternity records will be available for future reference	Quality Assurance Manager	October 2015 November 2015 December 2015	October 2015	First action is Green 2 actions are Amber
10	When pregnant women leave the area this fact needs to be recorded centrally on the Electronic Documents (E Docs) system and the	Raise awareness Midwives should inform HICSS Maternity Manager by E mail of the details when a pregnant woman	Maternity Records Guidelines updated to reflect learning from SCR child O	Electronic records will be kept up to date	HICSS Maternity Manger	October 2015	January 2016	Green

	pregnancy suspended on the hospital computer system. (the pregnancy cannot be ended on the system until the outcome is known)	moves area this E mail can then be saved to the E Docs system and the pregnancy can be suspended.						

APPENDIX B: INDIVIDUAL AGENCY ACTIONS and RECOMMENDATIONS

This section contains recommendations made by agencies in response to their internal reviews.

Cafcass

A recommendation will be made to the Head of Service, for individual coaching to be commissioned from the National Improvement Service to ensure that the learning from this review is fully embedded for the individual FCA involved.

The following additional recommendation was forwarded to the LSCB after completion of the Overview Report:

In private law cases Work after First Hearing, if one party or more is persistently not engaging with the FCA/court process, situational supervision should be sought to determine what actions need to be taken to safeguard the child and/or ensure the court is informed.

Integrated Children's Services

1) Good Record keeping and analysis of concerns will be monitored through management and safeguarding supervision and audited both by internal annual VCL records audit / ICS annual safeguarding audit and external Multi-agency case audit ensuring quality assurance is in place. Analysis training will be rolled out across ICS to all service areas, this is currently in an action plan for a local SCR. Retention period for clinic sheets will be reviewed by the Public Health Nursing service with advice from the Information Governance team to ensure data is retained and stored as per DOH guidance. This will be monitored through audit and internal service inspection.

2) GP and Health Visitor liaison is now firmly embedded in practice, each GP practice has a link Health Visitor who meets regularly with the GPs. Consideration needs to be given to how information shared at these meetings is recorded and fed back to the named Health Visitor for the family by the Public Health Nursing Service for ICS.

3) A systems review of the process where families have left the area or are believed to be missing, including a review of ICS DNA Policy, to be completed by the Public Health Nursing Service to ensure guidance is current and will result in a prompt response with safeguarding concerns fully explored. This process is to be monitored through supervision and case file audit.

4) A review of the process for issuing missing child alerts to take place between the Named Nurses for ICS and the designated professionals for safeguarding children in Devon CCG to ensure a robust system is in place.

Devon and Cornwall Police

Recommendation 1: This review and others has highlighted the requirement for this agency to consider the current levels of knowledge and understanding among front line staff including supervisors around the DASH risk assessment process. Women's Aid has been commissioned to carry out a gap analysis in respect of training requirements. Findings from this work will inform the development and commissioning of DASH training for police officers. Progress on this recommendation will be monitored through the force domestic abuse improvement plan and is currently captured in Covalent (Recommendation 2014DHRC02-01) which is the tracking system used by this force to monitor recommendations arising from Serious Case Review and Domestic Homicide Review. It is recommended that audits are conducted across the force area post implementation to identify any weaknesses in practice and ensure these are redressed through supervision and monitoring. The force may also wish to consider Peer review as an effective mechanism to review and audit practice.

Recommendation 2: The review of the use of COMPACT shows a number of uncompleted tasks, which have in some cases been completed but incorrectly recorded on the narrative. This has caused issues in the review and management of the enquiry and has detrimentally impacted upon the expediency and efficiency of the investigation. It is recommended that supervisors intrusively monitor investigations to ensure the system is utilised as intended and actions are generated and resulted correctly within the tasking system. Findings from this review should be disseminated to portfolio lead and Missing Persons Intervention Managers.

Recommendation 3: Enquiries conducted through this review indicates that significant information has not been shared across all relevant police forces. This agency should consider regular refresher training for staff working in specialist Public Protection roles to ensure they have a good operational understanding of their responsibilities in recording and disseminating information.

Norfolk Constabulary

Ensure significant information is shared across relevant police forces in a timely manner and the fact that the information shared is recorded on relevant systems

Southampton and Hampshire PCTs

1. Include monitoring of the agreed READ codes in annual audit (RCGP template) and escalate poor compliance to LAT and performance teams (Responsibility Designated and Named professionals)

2. READ coding of risks and vulnerabilities in adults to be spot checked after self-reporting with annual safeguarding audit. Spot checks supported by LAT / performance teams. (Responsibility Designated and Named professionals with support LAT) to include if enquiry and / or

assessment of parenting consideration evident in parent's notes and associated risks / vulnerabilities translated to appropriate READ codes in children's noes.

3. The number of referrals of IRIS team in Southampton is monitored and analysed against the known demographics and reporting of DVA. The antenatal referral forms will be audited to review timely and appropriate sharing of information.

4. In Hampshire where women can self-refer for antenatal care (not see GP first) an audit and assurance process needs to be undertaken to ensure booking assessment covers all aspect of the NICE guidance (Designated professionals).

Southampton City Council Children and Families Service

It is important that the LADO is clear as to the source of the referral or contact and that there is a narrative thread that runs through the recording. This has already been implemented. All referrals that relate to another authority should be noted for audit purposes.

University Hospitals Southampton NHS Foundation Trust

1. When a mother changes her booking from PAH it is important that records of A/N care are retained by the hospital.
   It is also important for the mother to take her A/N handheld records with her to her new provider to share her A/N care thus far.
   The maternity records guideline does not reflect this and needs to be reviewed

2. When pregnant women leave the area this fact needs to be recorded centrally on the Electronic Documents (E Docs) system and the pregnancy suspended on the hospital computer system.
   (the pregnancy cannot be ended on the system until the outcome is known)

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