SERIOUS CASE REVIEW
OVERVIEW REPORT

In Respect Of

Child J

Overview report prepared by:-

Sian Griffiths, Independent Author

Signature:-_____

Overview Report Endorsed by:-

Mike Tarver, Independent Chair, BSCB

Signature:-_____

Contents

GLOSSARY

FAMILY

Child J	Subject
Child K	Sibling of Child J
Child L	Sibling of Child J (unborn at time of events)
Adult P	Mother of Child J
Adult Q	Mother's Partner at time of Child J's death
Adult R	Maternal Grandmother
Adult S	Maternal Step Grandfather
Child M	Maternal Uncle

SIGNIFICANT OTHERS

An anonymised list of other family members and friends can be found at the end of this report.

RELEVANT ADDRESSES

An anonymised list of relevant addresses can be found at the end of this report.

Other Acronyms:

A&E	Accident and Emergency
ACPO	Association of Chief Police Officers
BSCB	Bolton Safeguarding Children Board
CAF	Common Assessment Framework
CAM	Child Action Meeting
CAFCASS	Children and Family Court Advisory and Support Service
CPS	Crown Prosecution Service
FWIN	Force Wide Incident Notice (Police record of incident)
GP	General Practitioner
IMR	Independent Management Review
LSCB	Local Safeguarding Children Board
MARAC	Multi-Agency Risk Assessment Conference
NWAS	North West Ambulance Service
OFSTED	Office for Standards in Education
PCT	Primary Care Trust
PPIU	Police Public Protection Investigation Unit
PPU	Prisoner Processing Unit
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SCRP	Serious Case Review Panel
TOR	Terms of Reference

1. INTRODUCTION

This Serious Case Review has been prepared in relation to Child J who died as a consequence of non-accidental injuries. The purpose of the Serious Case Review is to identify whether agencies which provided services to Child J and family have acted appropriately and whether lessons can be learned from Child J's experience.

1.1 Circumstances that led to this Review

1.1.1 Child J was born in Bolton and lived with Adult P with frequent contact with the older sibling Child K, who had lived with the maternal grandmother, Adult R since infancy. Child J's father is not known to this Review and was not identified on the birth certificate. Child J's mother was in a relationship with Adult Q who was caring for Child J at the time of death. It is not believed that the couple were living together.

1.1.2 Child J and family had contact with a range of services. Four referrals had been made by different agencies to Children's Social Work[1] during Child J's life, none of which led to child protection or other legal procedures being instigated. The last referral was made by the police approximately a month before Child J's death following an incident of domestic abuse and led to an Initial Assessment by Childrens Social Work. The case was closed prior to Child J's death.

1.1.3 On the day of Child J's death, a 999 call was made by Adult P who said that Child J had fallen an hour previously. A rapid response vehicle attended within 7 minutes followed by an ambulance and by a second rapid response vehicle staffed by an advanced paramedic. As the first paramedic arrived, two police officers were attending a nearby address and they accompanied the paramedic into the house. The paramedic performed CPR and Child J was then transferred to hospital. Child J was formally pronounced dead later that day.

1.1.4 Adult Q was arrested for the murder of Child J and subsequently convicted of murder.

1.1.5 A notification was made by Greater Manchester Police to the Bolton Safeguarding Children Board following the death of Child J. OFSTED was informed of Child J's death on the same day. The Chair of the Board considered that given the information provided at the outset, the criteria for a Serious Case Review were likely to have been met. On this basis an Independent Chair and Author were identified in

[1] The term Children's Social Work is used in this report to refer to the social work teams within the Staying Safe Division of Children's Services responsible for assessing children's needs. Children's Services is the overarching Division of Bolton Council which has responsibility for all the authority's services to children, including children's social work and children's centres.

order to be involved with the process from the earliest possible point, but on the understanding that the formal decision would be taken at a subsequent Serious Case Review Panel.

1.1.6 The Initial Serious Case Review Panel met within the one month timescale, with the Independent Chair and Author in attendance. The Panel were unanimous in their decision that the criteria for undertaking a Serious Case Review had been met and formally made this recommendation to the Chair of the Board who approved the decision the same day.

1.1.7 OFSTED and the Department for Education were informed of the decision to undertake a Serious Case Review.

1.1.8 The Independent Chair and the Independent Author for this Overview Report were formally appointed at the meeting and the Serious Case Review Panel (SCRP) was at that point established to manage the process with representation from the relevant agencies.

1.2 The Terms of Reference of the Review

1.2.1 The Terms of Reference for the Serious Case Review, which fully set out the scope and context of the Review, are attached as Appendix A. A summary of the Terms of Reference is as follows:

1.2.2 The Terms of Reference were established in line with the requirements of Working Together 2010, which states that a Serious Case Review must:

- Establish what lessons are to be learned from the case about the way in which local practitioners and organisations work individually and together to safeguard and promote the welfare of children
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Improve intra and inter agency working and better safeguard and promote the welfare of children

1.2.3 The Terms of Reference highlighted that:

The prime purpose of a Serious Case Review (SCR) is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. The lessons learned should be disseminated effectively, and the recommendations should be implemented in a timely manner so that the changes required result, wherever possible, in children being protected from suffering or being likely to suffer harm in the future. It is essential, to maximise the quality of learning, that the child's daily life experiences and an understanding of his or her

welfare, wishes and feelings are at the centre of the SCR, irrespective of whether the child died or was seriously harmed.

1.2.4 In addition to the overall Terms of Reference the following Key Lines of Enquiry were identified for specific consideration by the Individual Management Reviews (IMRs):

Key Lines of Enquiry

Recognition

a. To what extent were any vulnerabilities or needs of mother recognised and taken into account in terms of any potential risks they posed for her child; to comment in particular on any action taken to ascertain whether there were any issues of learning or other disability relevant to agency involvement

b. Was sufficient recognition given to the incidents of domestic abuse and how was this used in considering the implications for the safety and well-being of the child

c. Was enough information sought about the relationship between mother and Adult Q or previous partners during the time frame for the review and the implications for the children?

d. What information was sought or known about in regard to the mental health and use of alcohol or drugs by any of the adults who were in or a visitor to the household

e. Was there sufficient recognition and consideration of how well Adult P was able to provide a safe environment; including judgements about suitable carers, boundaries and routines etc?

Assessment & Decision Making

a. How and to what extent was the relationship between Adult Q and the children assessed?

b. The quality and timeliness of any assessments and the extent to which they took account of relevant family or personal history, the cultural, ethnic and religious identity of the family, the needs of Child J and the capacity of the mother to meet the needs of her children; this should include comment about any extended family or others and their role and impact in promoting the safety and well being of Child J and siblings

c. Comment on the quality of judgments and decision making and the extent to which it reflected a focus on the needs of Child J and siblings (including the unborn sibling) and represented appropriate professional standards and a competent understanding of any relevant guidance, research, theoretical and/or legal frameworks; particular attention should be given to how evidence of domestic violence was collated and analysed.

d. *How and to what extent was consideration given to Child K not being cared for by Adult P and the circumstances around this decision? How did this impact on the assessment of Adult P's ability to provide care for Child J?*

Using and Sharing Information

a. *Identify whether information in respect of the family was shared among agencies to the best effect so as to inform appropriate interventions; in particular to identify when practitioners in contact with Child J or siblings saw either child and sought their views, wishes and feelings especially in regard to visitors to their home, the incidents of verbal and physical violence and the different partners*

b. *To comment on the quality of reports and information provided for interagency enquiries and analysis including information provided in Child Action Meetings*

Planning and Interventions

a. *Identify whether agencies and members of the Child Action Meetings and MARAC[2] in contact with Child J's immediate family worked together effectively to provide services that safeguarded and promoted the welfare of the children*

Practice Support and Supervision

a. *Consider whether all relevant single agency and multi-agency procedures were followed and the extent to which they facilitated or hindered sharing and analysis of information and informing action by the different services*

b. *Consider whether the policy, procedural, management and resource infrastructure that surrounded each agency's involvement with Child J and the family promoted appropriate decision making; this should include evaluating the training, knowledge and experience of people working with Child J and the family, their workloads and the organisational stability; comment should also be made about whether any shortfall in resources were an impediment at any time during the period of the review*

c. *Consider whether professionals working had sufficient and appropriate supervision commensurate with their role and responsibilities, and the extent to which the case was subject to*

[2] Multi Agency Risk Assessment Conference (convened in relation to referrals regarding Domestic Abuse).

appropriate and effective managerial oversight and promoted critical reflection

Learning from SCRs and other review processes

a. *Consider previous or concurrent serious case reviews conducted by the Bolton or other local safeguarding children boards. Take into account any common themes and actions arising from those SCRs that are relevant to the circumstances of this case and comment on what impact they had in this case*

b. *Consider previous reviews of single agency practice. Take into account any common themes and actions arising from those reviews that are relevant to the circumstances of this case and comment on what impact they had in this case*

The terms of reference for the Health Overview Report

The health overview report should provide an overview of the information and analysis provided by all health services for the serious case review. In particular it should address the following:

a. *Comment on the quality of information and analysis and identify significant themes and areas for learning*

b. *Provide comment on the extent to which evidence about domestic abuse and violence, substance misuse and was identified and acted upon by various health services*

c. *Comment on the extent to which the reports provided by health services have identified appropriate learning and have provided sufficiently informed analysis*

d. *Give particular regard to any implications for the likely reform of health arrangements in Bolton identified through the review*

e. *The quality of recommendations proposed by health services*

f. *Identify any further themes to be explored within the overview report*

g. *Make any recommendations necessary to ensure appropriate implementation of learning across the health service in Bolton*

The terms of reference for the Overview Report

In conducting a serious case review BSCB will ensure that a multi-agency overview report is produced in accordance with the national guidance in Working Together to Safeguard Children (2010). In addition to the requirements of Working Together to Safeguard Children (2010) and taking into account the specific issues identified above, the overview report author should:

a. *Comment on whether the individual management reviews have addressed the terms of reference and all relevant issues*

b. *Comment on the conduct of the serious case review by BSCB and whether there are lessons for BSCB for the future conduct of SCRs taking account of impending revised government guidance*

c. *Examine the inter agency working and communication between all involved agencies*

d. *Determine whether services which were provided, actions taken and decisions made were in accordance with current policies, procedures and government guidance*

e. *Consider, using the benefit of hindsight, whether different decisions or actions may have led to a different course of events and outcomes for Child J*

f. *Provide comment and analysis within the context of relevant research and national evaluations of services and serious case reviews and its application in this case*

g. *Identify whether there are any areas of learning that have implications for national policy or guidance*

h. *Provide an executive summary for publication on behalf of BSCB*

1.2.5 The Terms of Reference identified that the time period for consideration by the Serious Case Review should begin with the ante-natal period for Child J and conclude on the date of Child J's death. The Panel reviewed the time period during the SCR process to ensure that it was still considered fit for purpose in the light of emerging information. The Panel agreed that the time period remained relevant and appropriate.

1.2.6 The agreed timescale was therefore:

Pre-birth to date of death

1.2.7 The time period was identified in order to obtain a full understanding of the significant events in relation to Child J and carers. IMR authors were required to consider contextual historical information that was available to them and include this as appropriate in summary form and also to contribute to the analysis of the service that had been provided.

1.3 Membership of the Serious Case Review Panel

The Serious Case Review Panel was made up as follows:

Agency or Organisation	Role
Peter Maddocks	Independent Chair
Bolton Children's Services	District Manager
Greater Manchester Police	Detective Inspector, Safeguarding Vulnerable Persons Unit
Greater Manchester Probation Trust	Probation Operations Manager
Adult and Community Services	Commissioning Manager, Drugs and Alcohol.
Bolton PCT	Associate Director Safeguarding - Designated Nurse
Bolton NHS Foundation Trust	Consultant Paediatrician - Designated Doctor
Bolton Council's community Housing Services	Head of Community and Private sector Housing

Also in attendance at the Panel meetings were the following:

- Sian Griffiths, Independent Overview Author
- Senior Solicitor, Legal Services, Bolton Council
- Bolton Safeguarding Children Board Officer
- Senior Administrator, Bolton Safeguarding Children Board

Peter Maddocks has over thirty-five years' experience of social care services the majority of which has been concerned with services for children and families. He has experience of working as a practitioner and senior manager in local and national government services and the voluntary sector. He has a professional social work qualification and MA and is registered with the General Social Care Council now superseded by the Health and Social Professions Council (HSPC). He undertakes work throughout the United Kingdom as an independent consultant and trainer and has led or contributed to several service reviews and inspections in relation to safeguarding children. He has undertaken agency reviews and provided overview reports to several LSCBs in England and Wales and worked on domestic homicide reviews. He has undertaken training in regard to systems learning and its application to serious case reviews.

Sian Griffiths is the Independent Author of the Overview Report. Ms Griffiths works as an Independent Social Worker. She is not employed by any Local Authority or Agency other than for commissioned pieces of work of an independent nature. Ms Griffiths has been a qualified social worker since 1987, working both in the Probation Service as a practitioner and manager and later as a Family Court Advisor in CAFCASS. Ms Griffiths is registered with the General Social Care Council (now transferring to the HSPC). She has previously authored Overview Reports for Serious Case Reviews for other Safeguarding Boards and is trained in undertaking reviews adopting a systems learning approach.

1.4 Timescale for undertaking the Review

1.4.1 Bolton Safeguarding Children Board, in line with Working Together 2010[3], required that the Overview Report be completed and submitted to OFSTED and the Department of Education within 6 months.

1.4.2 During the course of this Review the criminal trial was scheduled for completion. Given the close proximity to the original submission date, the SCR Panel recommended a short extension to the timescale in order that the Overview Report could take into account the outcome and any relevant findings from the criminal trial. This recommendation was accepted by the Independent Chair of the Board and a revised submission date was established. The Department of Education were informed, OFSTED, no longer having a role in evaluating individual reports.

1.4.3 The Review was presented to and endorsed by Bolton Safeguarding Children Board and completed within the revised timescale.

1.5 Methodology of the Review

1.5.1 This Serious Case Review was conducted in line with the requirements of Working Together 2010. The Review Panel was aware of the ongoing redrafting of Working Together and the development of a systems model for undertaking SCRs developed by the Social Care Institute for Excellence (SCIE). Nevertheless the Review was undertaken, as required, in line with existing statutory guidelines.

1.5.2 The SCR Panel agreed that the framework for the Review should be that required by Working Together. However, the underlying principles adopted as far as practicable reflected the SCIE systems thinking model as outlined in the recently published Munro Report.[4] In particular IMR authors were encouraged to reflect with practitioners

[3] HM Government (2010) Working Together to Safeguard Children, Chapter 8
[4] Munro (2011)

on the context of their decision making in order to maximise the learning from this review.

1.5.3 The Panel agreed that in line with the new approach to Serious Case Reviews developed by SCIE, the Overview Report would provide Key Challenges for the Board to consider, rather than producing SMART recommendations. The intention being to ensure that responsibility for the decision making about how to respond to the lessons being identified was taken at Board level. This approach is intended to encourage more meaningful ownership of the outcomes by partner agencies and increase the relevance and effectiveness of subsequent actions.

1.5.4 The Panel was also explicit in its view that any early lessons identified during the Review should be responded to in practice without delay where this was possible and that the Panel and the Board should receive updates with an 'Early Learning and Lessons from SCR Report'.

1.5.5 The Panel requested and received Individual Management Reviews from the following agencies:

- Greater Manchester Police
- Bolton Children's Services
- Bolton NHS Foundation Trust
- Bolton PCT (General Practitioner Services)
- Bolton at Home (Housing)
- Greater Manchester Probation Trust
- Action for Children

1.5.6 Information was sought from the following agencies who confirmed that they had no relevant knowledge of the family:

- Education
- Greater Manchester West Mental Health NHS Foundation Trust
- CAFCASS
- Bolton Drug and Alcohol Services

1.5.7 The following agencies who had some contact with Child J and the family, but not of a nature to warrant a full IMR, were asked to provide brief reports:

- Affinity Sutton Housing
- North West Ambulance Service
- Greater Manchester Fire and Rescue Service
- Area 2 Children's Social Care
- Area 2 Youth Offending Team

1.5.8 Towards the end of the Review period, North West Ambulance Service (NWAS) provided more information than was originally anticipated and suggested that with hindsight they could have produced an IMR. A representative of the Service was invited to attend the SCR Panel meeting in September 2012, to discuss any further learning directly with the panel. This provided useful further information regarding developments in relevant NWAS procedures. The Panel, were however satisfied that there was no need to seek a full IMR from NWAS.

1.5.9 As it was identified that Adult Q had previously lived in Area 2, the Area 2 Safeguarding Children Board was asked to make enquiries with their constituent members as to whether he was known to any of the agencies in that area. Information was provided by Children's Services and the Youth Offending Team. Specific enquiries were made with Area 2 mental health and substance misuse services, who confirmed that they had had no involvement with Adult Q during the timeframe of this Review.

1.5.10 The Overview Author was also provided with copies of the notes from 5 Child Action Meetings.

1.5.11 A Health Overview Report was commissioned from Bolton NHS Primary Care Trust to encompass the IMRs of the two NHS providers listed above. The report was authored by the Designated Doctor and Designated Nurse who were also members of the Serious Case Review Panel.

1.5.12 The Serious Case Review Panel met on seven occasions over the review period six of these were half day sessions and one, the meeting with IMR authors was a full day. All of the IMR authors were invited to a meeting with the Panel to take part in a discussion about the emerging themes and receive feedback in general terms. IMR authors were also provided with individual feedback on their reports.

1.5.13 A structured meeting was also held to brief IMR authors on their role. Authors had access to ongoing advice and support from Panel members and the Independent Chair and Author. As a result all the IMRs were resubmitted following first drafts and several of the resubmitted IMRs provided a subsequently improved depth of learning.

1.6 Parallel Processes

1.6.1 As a result of the injuries received by Child J, Adult Q was charged on with the murder of Child J. He was subsequently convicted following a trial and sentenced to life imprisonment. Adult P was charged with Causing/allowing the death of Child J, contrary to Section 5(1) and (7) of the Domestic Violence, Crime and Victims Act 2004 and was found guilty following a trial.

1.6.2 The Coroner was informed that a Serious Case Review would be taking place. The inquest into the death of Child J was opened on and adjourned pending the outcome of the criminal trial.

1.6.3 Immediately following the death of Child J, an internal police review took place regarding the allegations of assault by Adult Q on Adult P. Greater Manchester Police (GMP) subsequently referred the matter to the Independent Police Complaints Commission (IPCC) who opened an investigation which is ongoing at the time of writing this report.

1.6.4 Proceedings were initiated in the Family Court regarding the long term care of Child K and Child L, both of whom were made subject to Interim Care Orders. These proceedings were still ongoing at the time of completion of this report.

1.7 Family Contribution to the Review

1.7.1 In line with the expectations of Working Together (March 2010) early consideration was given by the Panel to seeking a contribution to the Review by key family members. The panel agreed that the family members who should be invited to contribute should be Child J's mother (Adult P) and maternal grandmother (Adult R). The panel made concerted efforts to establish whether the father of Child J could be identified, but without success.

1.7.2 Given the ongoing criminal investigation and in line with guidance provided by ACPO and the CPS in April 2011, the Chair of the SCR Panel sought the advice of Greater Manchester Police's Senior Investigating Officer (SIO) and the views of the CPS with regard to meeting the family, so as to ensure that any subsequent proceedings would not be compromised. The advice was that as Adult P had been charged in relation to Child J's death, and criminal proceedings were pending, it could potentially compromise those proceedings to meet with her. However, the advice in relation to Adult R was that a structured meeting could take place. As Adult R was likely to be a witness in the criminal proceedings this advice was on the clear understanding that a record of the meeting would be produced and shared with Greater Manchester Police. Advice was also provided by the SIO regarding appropriate questions given the careful balance that was required between meeting the SCR's remit and the role of Adult R as a potential witness.

1.7.3 The Panel agreed that following the completion of the court proceedings, further consideration would be given to contacting Child J's mother, Adult P, to see if she would be willing to make a contribution to the Review. It was agreed that if in doing so new information was provided which could lead to further learning, the Panel would reconvene to consider how to best ensure such learning was taken forward, including the possibility of an addendum to the Overview Report. Contact was made but no response was received from Adult P at this time. The Chair of the Panel wrote to the

identified family members to explain the advice received regarding their involvement and to keep them informed of the progress of the Serious Case Review.

1.7.4 The meeting with Adult R had to observe constraints agreed with the police and prosecuting counsel. For this reason the discussion was probably more limited than Adult R or the panel would have wanted. Adult R was also very distressed by the death of Child J. Adult R had been aware of the contact that different services had with Child J and Adult P.

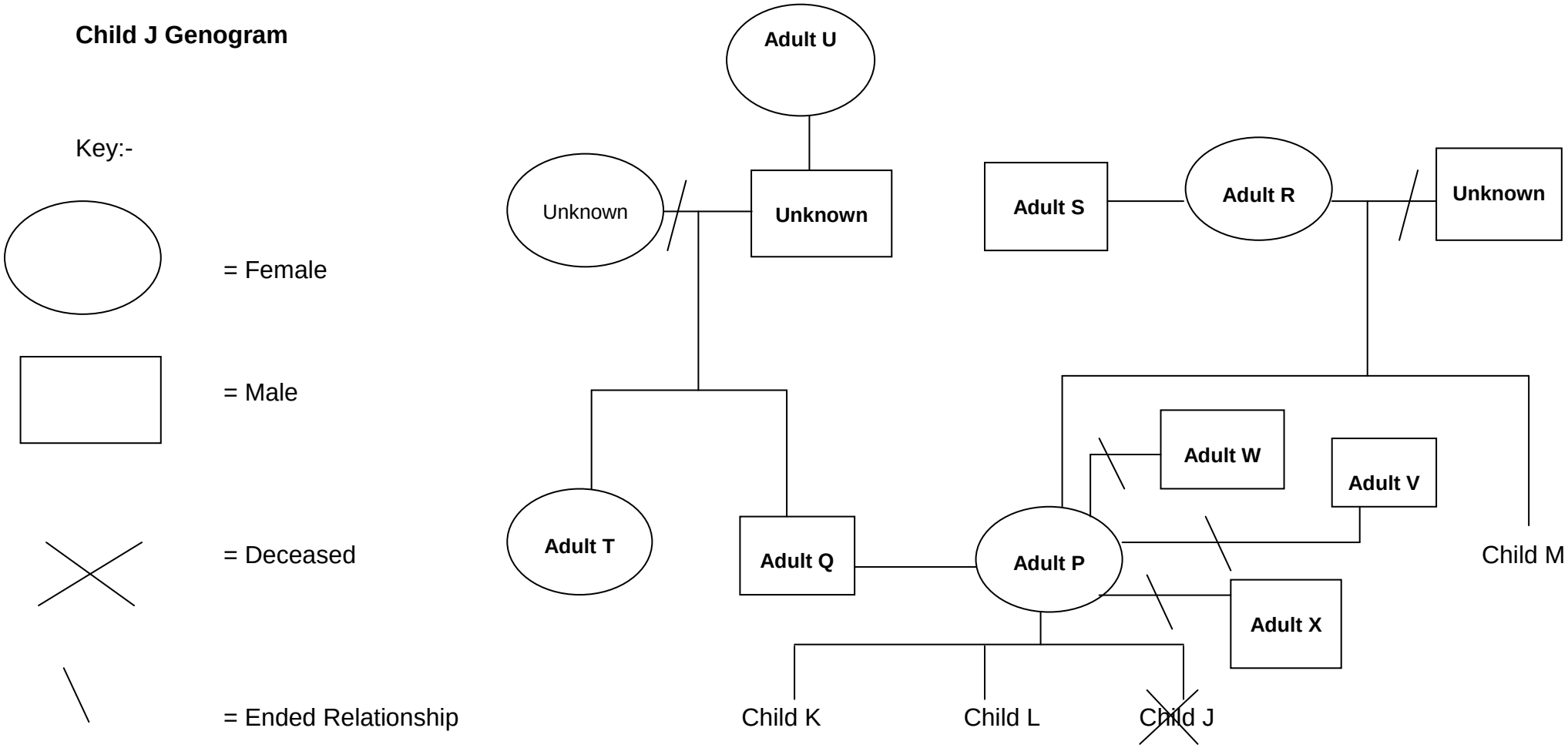
1.7.5 Adult R made four particular observations about those services. Firstly she raised questions as to why services had not intervened more with Adult P's care of Child J following the fire in the house. Secondly she identified the difficulty that family members experience in understanding their legal rights when caring for a child for whom they do not have parental responsibility. Thirdly she identified that it was difficult to know which of the services to go to when a family member had concerns. Fourthly she suggested that clearer information should be provided as to where to go for advice or help outside office hours. Her concerns have been considered within the body of this report and will be summarised at the end of the critical analysis.

1.7.6 Following endorsement by Bolton Safeguarding Children Board and in preparation for publication further engagement was undertaken with the family. Adult P and Adult R had the opportunity to read the report in full before publication. In response to their feedback it was agreed with Bolton Safeguarding Children Board Independent Chair that all dates, as well as gender references relating to the children would be removed from the report. It was agreed this did not detract from the learning.

2. GENERAL FACTUAL INFORMATION

2.1 Genogram

Child J Genogram



2.2 Combined Chronology of Significant Events

A full chronology of significant events was prepared to inform this review. Each individual agency provided a chronology as part of their IMRs and also provided brief historical information which whilst outside the timeline provided relevant contextual information for the Review.

2.3 Relevant Ethnic, Cultural Or Other Equalities Issues

2.3.1 In line with the requirements of Working Together (2010), IMR authors and the author of both the Health Overview and this Serious Case Review Overview Report were directed specifically to consider any particular issues of race, culture, language, religious identity or disability of significance to the family.

2.3.2 All the agencies, with the exception of GMP, which has not provided specific information, recorded Child J, the family and Adult Q as being of white British origin and noted that no barriers to communication were identified. Adult P was recognised as a single parent, who was viewed by many of the agencies as being 'vulnerable', the significance of which will be explored in greater detail subsequently. Child J and Adult P lived close to the maternal grandmother and half sibling, Child K and to varying degrees this wider family unit was known to the agencies and recognised as being a significant part of Child J's life.

2.3.3 Several of the agencies recognised that the family, which was reliant on state benefits, were living under financial pressure in a community where financial and social disadvantage was widespread. The GP IMR summarised the community in which the family lived as follows: *"a largely white ward with higher levels of deprivation than Bolton as a whole. Compared to Bolton, its population is younger, with more single parent families and lower levels of education"*

2.3.4 The fact that Child J's father was unknown, and different putative fathers were identified at different times does not appear to have been viewed as particularly significant by the agencies at the time and may suggest it was simply accepted as a cultural norm. This issue will be discussed further in the critical analysis of this review.

2.3.5 No information was provided to agencies in relation to disability, although Adult P disclosed to Bolton at Home that she had experienced depression. Adult P's GP who had known her for many years stated that there was no information to suggest that she had specific needs or vulnerabilities. There is no information to suggest that religion was a significant factor in Child J's family life.

2.3.6 Few of the agencies within Bolton had any information regarding the existence of Adult Q within the family until he was charged with assault on Adult P a few weeks before Child J's death. The information

regarding him has therefore largely been provided to this Review by agencies within Area 2 where he lived.

2.4 Relevant Historical Information

2.4.1 Some limited information regarding the family's lives and background prior to the timescale within the Terms of Reference has been gained from a number of the agencies that have contributed to this Review, as well as from Adult R.

2.4.2 Bolton Children's Social Work had contact with Adult P and her family on 3 occasions prior to Child J's birth. The first arose when Adult P was 14 years old, and a referral was made to Children's Social Work by an agency concerned that Adult P and another girl might have been vulnerable as a result of adult males apparently seeking relationships with them. Following some discussion with her school and family, and given that no further concerns were reported Children's Social Work closed their involvement.

2.4.3 The family had been known to health services following the birth of Child K. Child K had some additional health needs, which required extra health appointments post natally including 3 monthly reviews with the Paediatrician. The Health Visitor made a referral to Children's Social Work due to concerns about Adult P's failure to take Child K to a number of health appointments and general concerns about her parenting. The health visitor recorded a joint visit taking place with a social worker and produced a CAF (assessment under the Common Assessment Framework) as a referral to Children's Social Work. The health visitor subsequently organised a Child Action Meeting, which was also attended by Children's Social Work. Both the CAF and the Child Action Meeting, as well as referral to any consequent services, require the consent of the child's carers as these fall within the multi-agency procedures below the threshold for the statutory involvement of Children's Social Work. Little information has been provided by Children's Services regarding this period of involvement.

2.4.4 The parenting concerns were not initially identified as being specifically in relation to Child K's additional health needs, but rather to Adult P's inability to put the child's needs before her own. Adult R reported her understanding that she had been asked by Children's Social Work to look after Child K. An arrangement was then reached within the family that Child K would be cared for by Adult R and other than providing legal advice about family court proceedings, no further action was deemed necessary. Child K continued to live primarily with grandmother, although cared for at times by Adult P. Children's Social Work is recorded as taking no further action.

2.4.5 The only other information known to services regarding Adult P was that there had been complaints about anti-social behaviour by

neighbours after she had taken up her first housing tenancy in 2008. These issues continued to be live during some of the time covered by this review and will therefore be considered in more detail subsequently.

2.4.6 Adult Q was not known to any agencies in Bolton, prior to his arrest in March 2012 for assaulting Adult P. Adult Q was raised and lived in Area 2 and it is known that as an older teenager he lived for significant periods with his grandmother. When he was 14 years old, Area 2 Children's Services received a referral from the Domestic Abuse unit following an incident when his father was alleged to have punched him to the head arising out of an argument about Adult Q using drugs. This did not lead to any formal action being taken.

2.4.7 In late 2004, when he was 15 years old, Adult Q was referred to the Education Welfare Service and the Connexions service and was at times involved with the Youth Offending Team (YOT). Adult Q appeared at times to be effectively homeless, moving between addresses, including a caravan, an uncle's home and his grandmother's home. He was known to be using cannabis as well as other drugs and was referred to the Drugs and Alcohol team in November 2005, although it is noted that his drug use continued, including leading to an overdose in September 2006. His father is reported as himself having a drug problem and is understood to have spent periods in prison. Adult Q described both of his parents as alcoholics, said that he had a very poor relationship with them and that Children's Services had involvement with another member of the family at one time. This has been confirmed by Area 2 Children's Social Care.

2.4.8 Adult Q had a number of criminal convictions beginning when he was 13 years old, including common assaults. He was sentenced to a referral order in 2006 supervised by the YOT and during his time under supervision took part in a range of group sessions including anger management; something which he had acknowledged was a problem for him.

3 INFORMATION KNOWN TO AGENCIES

A comprehensive chronology was prepared from the information provided by each of the agencies, detailing the relevant contact episodes between Child J, siblings, their carers and each agency. Each IMR and the Health Overview Report was required to include a full detailed chronology and narrative containing all the information regarding the agency's involvement with the children. The purpose of this section is therefore to focus on summarising and highlighting the key events and contacts with the family. Section 4 will critically analyse these events and contacts.

3.1. Child J Ante-Natal Period

3.1.1 Prior to the beginning of the timeframe under consideration by this Review, Adult P had the sole tenancy of a flat with Bolton at Home. The records stated that she had a child, Child K, who was living at another address, although there was a discrepancy in Bolton at Home's records, as on another occasion Child K was recorded as living with Adult P in the flat.

3.1.2 A CAF was produced by Health Visitor 2 in relation to Child K. A Child Action Meeting was then arranged and chaired by Health Visitor 2, and also attended by Social Worker 7, from the Advice and Assessment team, Adult P and Adult R. The meeting was called due to:

- Inconsistent input into Child K's care by the mother and its potential impact on Child K's emotional and social development
- Adult P removing Child K from Adult R's care for several days in response to having been refused money by Adult R, using Child K to manipulate Adult R
- Concerns by Adult R about conditions in the home and reported poor management of Child K's behaviour. Allegations that Adult P smacked Child K
- Financial pressures on Adult R who does not receive the child benefit for Child K
- Child K vulnerable due to her health needs
- Adult P pregnant (denied by Adult P)

3.1.3 Actions were identified including a referral to be made to Family Support as well as day-care for Child K. A review meeting took place, attended only by Health Visitors 1 & 2 and Adult R; apologies were received from Social Worker 7. The meeting noted that Adult P had not engaged with services and that Adult R would contact Children's Social Work personally about her concerns. No further review was planned and no information is available from Children's Social Work about their involvement in this episode.

3.1.4 Adult P was also having ongoing involvement with Bolton at Home Tenancy Sustainment Service due to a number of complaints by neighbours about anti-social behaviour. In February the Tenancy Sustainment Officer recorded an intention to contact the health visitor and Social Services to ask for help for Adult P who said that she was struggling with the care of Child K. There is no evidence that such a contact took place.

3.1.5 However, this did lead in March of that year to a referral to the Young Person's Housing Officer, within Bolton at Home's Anti-social behaviour team. The Young Person's Housing Officer's role was specifically designed to work with young tenants in order to help

reduce anti-social behaviour and support them to maintain their tenancies.

3.1.6 The identified concerns included:

- large numbers of visitors
- noise late at night
- littering in the communal areas

On one occasion there was contact from the police regarding a young male visitor to the house, but no further information is available. Over the next four months several unsuccessful attempts were made to meet with Adult P; however the Young Persons Housing Officer was eventually able to gain access. At this point Adult P informed her that the problems had now ceased as she had separated from her boyfriend, Adult AF. Adult P also told the housing officer that she was spending significant periods at her mother's address, and that Child K was spending 3 or 4 nights a week with her.

3.1.7 In early 2009 GP records note that Adult P sought advice about a possible pregnancy. The GP subsequently referred her for ante-natal care, however, Adult P did not book for her ante natal care until three months later, and by which time she would have been 22-24 weeks pregnant. The following month a friend of Adult P called the emergency services on her behalf in with concerns about bleeding and she was taken to hospital. There is no information provided by Bolton NHS Foundation Trust as to her treatment at the hospital.

3.1.8 Midwife 4 was concerned at the late booking of the pregnancy which she discussed with Health Visitor 1 and she completed a CAF assessment. Adult R had also informed Health Visitor 1 that she would not be willing to look after the new baby as well as Child K. A Child Action Meeting took place attended by Midwife 4, Health Visitor 1, Social Worker 3, Adult P and Adult R. Bolton at Home was also invited, but did not attend although Tenancy Sustainment Officer 2 refers to making contact with the Health Visitor. There is no record that this occurred. The Child Action Meeting was chaired by Midwife 4 and it was recorded that the concerns were in relation to the parenting ability of Adult P and lack of contact with services.

3.1.9 The actions planned as a result of this meeting included:

- Adult P to access all appointments for herself, Child K and the unborn Child J
- Health Visitor 1 to assess parenting skills regarding Child K
- Midwife 1 to assess newborn parenting skills
- Adult P to be introduced to the Children's Centre (part of Bolton Children's Services Staying Safe division) and available activities

3.1.10 A copy of the CAF was sent by Midwife 1 to the Children's Centre; it would appear that the Children's Centre that was to undertake family support work with Adult P. Children's Social Work recorded that an intense package of support including parenting skills would be in place from the midwifery service and that there was no role for Children's Social Work. An Initial Assessment was undertaken by Social Worker 3 and the case closed from the Referral and Assessment team's perspective.

3.1.11 In mid-2009 a 999 call was made from Adult P stating that Child K had had a rash on the legs and chest for several days. When the ambulance arrived at the house Child K was found to be quite distressed and had untreated sunburn. The crew were concerned that Child K had not been taken to see the GP and submitted a vulnerable child form: that is an internal safeguarding child referral, which is forwarded to Children's Social Work. It is not recorded whether Child K was taken to hospital or what treatment was advised. There is no further explicit information in either the Health or the Children's Services IMRs as to this incident. Midwife 1 visited, but there is no recording of her seeing Child K or discussing the issue. The Health Visitor records state she left a message for Social Worker 2 regarding the emergency call out. A visit by Health Visitor 1 and Midwife 1 did take place the following day and it is recorded that they "*discussed safety issues when Child K stays overnight*". Adult P was also encouraged to attend all appointments and to engage with the family worker.

3.1.12 During this same period, Bolton at Home's work on anti-social behaviour was closed due to their being no recent repetition of the problems.

3.2 Child J Post-Natal Period - First Four Months of Child J's Life

3.2.1. Child J was born healthy and with no concerns. It is noted that Adult P did not attend for the post natal examination and a comment is recorded from the midwife that Adult P had been advised to rest as she had been out walking a long distance the day after delivery. The Midwife noted that she would discuss this with the Social Worker and it is noted that she does so in the Child Action Meeting.

3.2.2. The next day, following a discussion with Health Visitor 1 the midwife spoke to Bolton at Home who disclosed information about anti-social behaviour at Adult P's address. The midwife recorded that housing should be invited to the next CAM and that she informed Social Worker 2 of the issue. There is no record of this from Children's Social Work. The Health Visitor undertook the primary visit as required and recorded that there were no concerns about Child J. Adult R and Child K were also present. Adult P told the health visitor

that Child J's father, named as Adult AG had visited them, but no further information is recorded.

3.2.3. A Family Support Worker (Family Worker 1) from the Children's Centre had attempted unsuccessfully on a number of occasions to arrange a home visit to Adult P and finally succeeded when she attended with a colleague, Family Worker 2. Adult P was present with Child K, newborn Child J, Adult R and a friend. The family workers' focus was introducing the programme for the Children's Centres. The next visit took place when Adult P, Child K, Child J and Child Q (the child of a friend) were present. The family worker completed a work agreement with Adult P. Family Worker 1 commented that the home was clean and tidy, that Child J was asleep and that Child K actively engaged with Adult R, bringing toys and talking about them.

3.2.4. Family Worker 1 attempted to arrange further appointments over the following weeks, but was successful on one occasion only, although no detail is recorded in relation to this home visit.

3.2.5. A review Child Action Meeting took place attended by Adult P, Child J, Child K, Family Worker 1, Tenancy Sustainment Officer 2, Midwife 1, Health Visitor 1 and a representative of a day nursery. Some improvements were noted, although concerns were raised about Adult P's engagement with Bolton at Home. A referral was made for Child K to the Speech and Language Therapy Team. A CAF was produced as part of the CAM process but never formally completed as the Health Visitor was unable to get Adult P to sign it or give verbal consent.

3.2.6. Following the primary Health visit there were a number of occasions when Adult P did not keep arranged home visits with the Health Visitor or other medical appointments. However access was gained Visitor and Adult P, Adult R and both the children were seen but no detailed information recorded.

3.2.7. During the period between health visitor contacts a 999 call was made by a friend of Adult P who said that Child J had vomited and was turning blue. The caller also stated that Adult P had panicked as this was her first child. An ambulance attended and described Child J as being a good colour with clear airways. Adult P was strongly advised to go in the ambulance to hospital with Child J for a check-up, but she refused to do so.

3.2.8. At 11.30pm the following night, a Sunday, a further emergency call was made due to a fire at Adult P's home. Child J was said to be suffering smoke inhalation. The Fire Service and police both attended and the fire which had been on a cooker in the kitchen was put out. Adult P was not in the house, having gone out to a wedding at 4.30pm that afternoon and two babysitters, a 15 year old and Adult P's 13 year old sibling had been looking after Child J. The ambulance crew who had attended previous incidents at the property completed

another internal Vulnerable Child Referral citing neglect and parental incapacity.

3.2.9. Child J was taken to hospital in the company of Adult R where it was assessed that the smoke had not affected the child's health. Adult P arrived at the hospital later and said that she had been at a wedding and drunk 5 cans of lager. Child J was discharged the next day and the GP informed in writing of the admission and that there was no follow up required.

3.2.10. A strategy meeting took place the following day, attended by a team manager from Children's Social Work, Team Manager 1, a police officer from the Public Protection Investigation Unit, PPIU Officer 1, and Social Worker 2. The meeting agreed that a joint visit between Children's Social Work and police should take place to "*discuss appropriate babysitting arrangements and concerns about incidents at the address."*

3.2.11. This home visit took place within two working days of the incident. Child J was seen and appeared to be being cared for appropriately and mother and child presented as having a good attachment. Adult P said that this was the first time she had gone out since Child J was born and that she had been at a family celebration. It was Adult P's intention to stay with her mother until the minor repairs at her flat had been repaired. She was advised about not leaving Child J with minors and that any future incidents would lead to action by the police. It was noted that Adult R agreed to act as babysitter when needed in future and she reinforced the professionals' comments. However, it was "*unclear how far this was accepted by Adult P".*

3.2.12. The police noted that no further action was taken. The Social Worker completed an Initial Assessment and, given there were some concerns about Child J, agreed to take part in the Child Action Meeting arranged for later that month.

3.2.13. The review Child Action meeting took place and was attended by a health visitor, Social Worker 2 and Adult R. There was no representation by Bolton at Home and no reference to the meeting in their records. Adult P also did not attend, the given reason being that she needed urgent dental treatment. It was reported that despite not having a functioning cooker, Adult P had returned to the flat, with Adult R taking food to her. Concerns about lack of engagement with services were noted.

3.2.14. Social Worker 1 recommended that there was no further role for Referral and Assessment as, although the fire had placed Child J at risk, Adult P's response was appropriate and Adult R was considered a supportive and a protective factor. It was agreed that the Health Visitor and Children's Centre Family Worker would continue to work with Adult P and Child J and refer back to Children's Social Work if necessary. A follow up meeting by the Health Visitor and Social Worker to reinforce the advice took place the following week.

3.2.15. Adult P took Child J for a 6 week evaluation in this period and also for routine immunisations and all was well. Advice was also given to Adult P about long acting contraception.

3.2.16. Throughout the autumn Family Worker 1 continued to undertake home visits and attempted to engage Adult P, but had little success, with Adult P rarely being available. Eventually after three months the Family Worker closed the case due to the lack of engagement.

3.2.17. The first contact between services in Area 2 and Adult Q during the timeframe of this SCR took place when he was referred for mandatory drug testing after an offence of assault. Adult Q did not agree to a referral to the drugs service.

3.2.18. Another call was made by Adult P to the Emergency Service due to Child J being said to have breathing problems. Adult P had earlier that night called the GP Out-of-Hours Service who had offered an appointment but she declined and said she would call 999 which she did an hour later. Child J was taken by ambulance to hospital and described by medics as "*generally unwell*" and discharged home. The hospital subsequently wrote to the GP regarding this admission and suggesting follow up.

3.2.19. Two weeks later Adult P made another call to the 999 service, again regarding Child J having breathing problems having had a viral infection for 2 weeks. Again Child J was taken to hospital and shortly afterwards discharged home. Two days later Adult P took Child J to the GP with similar symptoms and was sent to the Accident and Emergency Department, where again Child J was seen and discharged home the same day. The hospital informed the GP of the attendance due to bronchiolitis and noted that no follow up was required.

3.2.20. Bolton at Home received further complaints regarding littering. Adult P failed to keep an appointment that was sent and received a final warning to improve her conduct or legal proceedings would be started to end her tenancy. The Tenancy Sustainment Officer 2 attempted to meet with her during early 2010 but without success. She eventually closed the case as there had been no further incidents and the original complainant had not responded to attempts at further contact.

3.2.21. A formal decision by Children's Social Work to close the family's case was taken four months after the referral was received. The records noted that "*the care of the children has been satisfactory and a Family Worker from the Children's Centre has been requested to assist Adult P with family routines and to apply for rehousing. Health Visitor 1 continues to be actively involved with Adult P".* The Family Support Work had been closed by this point, but there is no evidence that this had been checked by the Social Worker or manager in the assessment team.

3.3 Review Period 1

3.3.1 In early 2010 Health Visitor 1 was contacted by Adult R who said she was concerned that she had not had much contact with Adult P recently. Health Visitor 2 visited the family the following week, but other than noting that she saw Child J, Child K and Adult P, there is no information provided about the children's presentation, wellbeing, the content of the visit or why Adult R had been concerned. The next visit by the Health Visitor was two months later, two previous attempts to visit having been unsuccessful. On this visit Child J was identified as having a squint and referred for an appointment with the orthoptist. This appointment took place in at the end of 2010 when it was concluded that it had been a 'false squint' and no further action was required. It is not clear why there was a delay with this appointment, although it appears that it was at least in part due to Adult P not attending earlier appointments.

3.3.2 In this period Child J was taken by Adult P to the GP with a sticky eye and a recent history of a cough and cold. Child J is described by the GP as "*alert, happy"* and prescribed with eye drops. At a visit to the GP the following month, Child J was also diagnosed with infantile eczema, and Adult P subsequently attended at the NHS Walk-In Centre for a further concern relating to Child J.

3.3.3 Throughout the early summer, the Tenancy Sustainment Officer made a number of attempts to meet with Adult P again with limited success.

3.3.4 During this same timeframe Adult Q was sentenced at Area 2 Magistrates Court to a Community Order with unpaid work for an offence of vehicle interference. Normal practice on sentencing would be for the Probation Service to undertake a risk assessment but this does not appear to have taken place. Adult Q began his unpaid work, however his attendance was poor and he was breached by the Probation Service and resentenced, when he received a Breach Activity Requirement, with his order to continue. Nevertheless his attendance remained poor and he was returned to court for breach again in October and sentenced to further hours. He finally completed his Order 15 months later.

3.3.5 During these months Adult Q attended the Probation Office on an unplanned basis on a number of occasions to explain his absences. Adult Q was living with his grandmother and told his Offender Manager that he had done so since he was 5 years old. At one point he said that he had been told to leave by his grandmother. He disclosed that he used drugs, described being low in mood and having problems with his relationships with both his grandmother and partner who also lived in Area 2. He also spoke of wanting to go to prison. Referrals were made by his Offender Manager to a drugs service in Area 2 although Adult Q did not engage with the service, and to a specialist ETE (Employment Training Education) worker.

There was no information to suggest that Adult Q was in a relationship with Adult P at any point.

3.3.6 During this period Adult Q also visited his GP on three occasions and said that he was suffering from significant irritability and anger and was smoking skunk (a form of cannabis). A patient health questionnaire was undertaken by the GP on the first occasion but fell below the score for significant depression. On the second occasion he was identified as being depressed and was prescribed with a limited supply of anti-depressants to ensure that the GP could review him regularly, which he did. He was also given contact details for the drug misuse service and crisis team.

3.4 Review Period 2

3.4.1 Health Visitor 1 attempted to see Child J and Adult P for an arranged visit, but without success. She therefore visited the home of Adult R who told her that Adult P was staying with a friend. Adult R also told the health visitor that Adult V, who she stated was Child J's father, had recently been released from prison following a sentence for abduction and assault relating to a different partner. She is said to have had concerns about him. The police have confirmed that Adult V was released from prison at this time to an address in Bolton. The Probation Service also informed Children's Social Work of Adult V's release.

3.4.2 The Health Visitor phoned Adult P immediately and arranged to see her the following day. Adult P said that she was frightened for her safety. Health Visitor 1 and Social Worker 4 undertook a joint home visit to Adult P and Child J. Adult P said that she had not experienced violence from Adult V when they were in a relationship, although he had been aggressive. She now said that she was not frightened of him, the concerns were her mother's rather than hers. She also stated that she would not resume a relationship with Adult V although she would remain friends with him. Adult V's Offender Manager subsequently informed the Social Worker that Adult V did not believe that he was Child J's father and did not wish to have any contact with Child J without a DNA test.

3.4.3 The professionals discussed safety and risk with Adult P, and she agreed that she would contact the police if there were any problems. The Social Worker also strongly advised her to seek legal advice before considering agreeing to Adult V having parental responsibility for Child J, which is what she said she was planning to do.

3.4.4 Social Worker 4 undertook an Initial Assessment, recording that the Offender Manager for Adult V and Health Visitor 1 would monitor the situation and re-refer to Children's Social Work if concerns escalated or if there was information that Adult V was having unsupervised contact with Child J. The Social Worker told both Adult R and Adult P

that Children's Social Work would not want there to be any unsupervised contact between Adult V and Child J. Adult R agreed she would ensure this did not happen and that she would support Adult P. Adult P also assured the Social Worker that she had not received any threats from Adult V and did not want to be referred to MARAC. She promised that if there were any concerns she would tell Health Visitor 1. The Assessment concluded that there would be no further involvement for Children's Social Work.

3.4.5 Adult P had agreed to bring Child J to the Children's Centre a couple of days later, but did not do so. The Health Visitor saw Child J and Adult P again 3 months later. There was no information about any further contact between Children's Social Work and Adult V's Offender Manager.

3.4.6 During this period Adult Q was reviewed by his GP for depression and again advised to have contact with substance misuse services for disclosed cannabis use. The following month he was arrested for an offence of Possession of an offensive weapon and cultivation of cannabis. Again he spoke to his Offender Manager about having arguments with his grandmother and being stressed. On one occasion he was verbally abusive in the Probation Office, although he later phoned to apologise.

3.4.7 There was a further concern about littering outside Adult P's property raised in this period. Tenancy Sustainment Officer 2 visited and discussed this with her. Adult P said she wanted to move and said that she had a re-housing application form outstanding, but Tenancy Sustainment Officer 2 checked to find this was not the case and informed Adult P accordingly. Adult P registered a re-housing application. Further complaints were made by a neighbour about Adult P allowing someone into the flats who had a history of domestic abuse against another resident. Adult P was advised about this and given an appointment in December to discuss her visitors.

3.4.8 Child J was seen on two occasions by the GP with vomiting in this timeframe. Adult P was advised about fluid intake and given a prescription for paracetamol and rehydration medicine.

3.4.9 Health Visitor 1 was re-contacted by Adult R worried about risks posed by Adult V. Health Visitor 1 visited the home in response to this contact and saw Adult P, Child J and Child K. She described Adult P as demonstrating warmth to both children. Adult P stated she was concerned about the positioning of Child J's foot and the Health Visitor subsequently made a paediatric referral. Two appointments were offered in a three month period neither of which was attended.

3.4.10 Adult P said that she was being harassed by Adult V who had moved into the same street and she was advised to contact the Police. Adult P said she wanted to be rehoused as a result. The Health Visitor also said that she would speak to Bolton at Home which she did. Bolton at Home opened the case within their Domestic Abuse service as a result and recorded that there had been previous domestic abuse

from Adult V to Adult P. The Health Visitor informed Adult P that she had an appointment with Domestic Officer a few days after the initial contact.

3.4.11 At the same time as the appointment with the Domestic Abuse Officer was being offered, a letter was sent to Adult P by Bolton at Home advising that legal action would be taken if there continued to be anti-social behaviour as a result of her visitors. On the same day Adult P contacted Domestic Abuse Officer 1 saying that Adult V was causing problems for her. She was advised to attend the planned appointment on the next day which she did. Adult P said that Adult V was visiting Child J. It was agreed that Adult P would change her phone number, but it is not clear if she would be continuing to allow Adult V to visit Child J.

3.4.12 After the meeting Domestic Abuse Officer 1 contacted the Probation Service who said that Adult V was no longer subject to supervision by the Probation Service and that Adult P was not known to them. Domestic Abuse Officer 1 also made a formal request to the police for information with regard to Adult V. No response to this request is recorded. Several attempts were made to contact Adult P both by the Tenancy Sustainment Officer and the Domestic Abuse Officer during the month but without success.

3.5 Review Period 3

3.5.1 In the early New Year 2011 the police attended at Adult P's flat after she had reported a group of youths were causing a disturbance and trying to assault Child M. The police gave Adult P advice and no further action was considered necessary. Within a few days further complaints were received by Bolton at Home from neighbours of anti-social behaviour and the police were called to a report that 20 youths were drinking and taking drugs at Adult P's address. The report also referred to the children being at the address, although in line with standard practice, the children were not identified. The police dispersed the youths and the 'occupants of the house', presumably Adult P, were advised about behaviour. No further action was taken.

3.5.2 Tenancy Sustainment Officer 2 attempted to meet with Adult P to discuss the problems but she did not respond. Bolton at Home re-opened the case to the Anti-Social Behaviour Team, who after unsuccessful attempts to visit did meet Adult P. She was advised that she was in breach of her tenancy and that Bolton at Home and the police, who had received several separate complaints from neighbours, would be monitoring the situation together. The complaints related to multiple visitors, loud music, parties, rubbish and cannabis use.

3.5.3 Adult P agreed that she would stop Child M, from visiting the flat and would clear up rubbish. After the visit Tenancy Sustainment Officer 2

advised Domestic Abuse Officer 1 that she had seen Adult P and there had been no mention of any concerns in relation to Adult V. Child J was present during her visit, asleep in a basket. In the following weeks there were further unsuccessful attempts to meet with Adult P and further complaints of anti-social behaviour.

3.5.4 Adult R also contacted Bolton at Home and the Health Visitor again stating that Adult P had financial problems and was asking her for money. She said she was concerned about Child J because of the activities at the address. Health Visitor 1 again attempted to visit, but without success. The next record of her visiting is six weeks after the contact from Adult R. Bolton at Home's Neighbourhood Safety Officer and Health Visitor 1 arranged a joint visit, although this was subsequently cancelled, possibly due to sickness.

3.5.5 Adult P contacted the GP out of hours' service with Child J who was unwell with a high temperature. Child J was referred to the hospital where it was noted to have reduced appetite and diarrhoea and was then discharged. A couple of days later Adult P took Child J to the GP who diagnosed impetigo and provided antibiotic cream. Adult P had raised concerns about swelling, something which she had raised with health professionals previously, but on examination there was no cause for concern.

3.5.6 Adult Q's Offender Manager made a referral for him to attend the Area 2 Drugs Intervention Project, which he did in March 2011. It is stated that he disclosed using £40 of cannabis a day as well as 12 grammes of cocaine.

3.5.7 A Senior Neighbourhood Safety Manager at Bolton at Home contacted Children's Social Work (Team Manager 1) regarding concerns that a child known to Children's Social Work who was also known to be abusive to members of his own family was staying at Adult P's flat. This child (Child P) was a friend of Adult P's sibling, Child M. Action was taken by the agencies in relation to Child P. The following week, the Neighbourhood Safety Officer spoke to the Health Visitor and made another referral to Children's Social Work, concerned that:

- Child J had no cot and was sleeping with Adult P
- Anti-social behaviour was continuing and Adult P was at risk of eviction
- There were complaints of parties and drug taking whilst Child J was present
- Adult R was reporting ongoing concerns about Adult P's lack of money

3.5.8 A joint visit took place later that day with Neighbourhood Safety Officer 1 and a Student Social Worker, (Social Worker 5). Child J and Adult P were both seen and the concerns outlined. The Social Worker noted:

- Burns on the carpet, which "*looked like cannabis burns*"

- Child J was inappropriately dressed given that the flat was cold and the windows open
- Child J did not have a cot; Adult P explained this was because Child J would not sleep in it
- Whilst the bedroom was tidy there were bags of rubbish in the bedroom and empty beer bottles
- There was no food in the fridge or cupboards. Adult P saying that Child J had had beans on toast for breakfast and she was about to go shopping

3.5.9 Adult P said that she had been trying to stop people coming to the flat and needed to be rehoused because she could not manage it any more. She was advised that she did not have to allow visitors in the building and that she should contact police if youths would not leave. Child J was described as "*mobile and smiling*". Adult P said that she had just been getting Child J dressed and this was the reason for this presentation.

3.5.10 A referral to the Family Intervention Project for outreach support was agreed and an Initial Assessment was undertaken. Adult R and Child K were seen as part of the assessment and Adult R stated that she did not intend to allow Child K to return to Adult P. She said she knew Adult P had been having problems at the flat but thought it had been resolved. She also said that Adult P cared for Child J well and had bonded; unlike she had with Child K. The Social Worker also spoke to the Health Visitor.

3.5.11 The Neighbourhood Safety Officer as agreed made a referral to Action for Children seeking family intervention. The referral was received on the day after the joint visit with the social worker. The primary reason as recorded by Action for Children was due to "*the threat of eviction relating to anti-social behaviour with Adult P unable to keep Child M and friends away from her property."* The referral provided information about the family members including Child K, allegations of drug and alcohol misuse, previous domestic abuse and violence from Child M, and described Adult P as "*a young single mum. Needs support. Doesn't get out much and admits to being lonely*."

3.5.12 At the same time Adult P visited her GP, with a possible pregnancy which she said was unplanned and she would wish to terminate if it proved to be positive. The pregnancy later proved to be positive and Adult P had a termination.

3.5.13 An initial Home Visit was made by Action for Children Senior Project Worker 1 and Neighbourhood Safety Officer 1 to Adult P and Child J. Adult P told them that she was being threatened by an adolescent and that the police had been involved. The police crime report noted that Adult P had reported the theft of a television and cash box from outside her address. The police report further refers to a child being at the address and appearing distressed. A few days later an

anonymous caller called Children's Social Work stating that Adult P was selling drugs to children. Contact was made with the police who said that they had been told Adult P was dealing drugs, but that they did not consider this to be true. The allegations were therefore noted by Social Worker 1 as not substantiated.

3.5.14 The Senior Project Worker noted receiving a call from the Social Worker stating that a Child Action Meeting would be taking place over the next week. No further information was found regarding this proposed meeting in the Action for Children records and there is no reference to it in the Children's Services information. The same day Social Worker 5 made an unannounced visit to Adult P, who was not at home, however she met her in the local park with Child K and Child J, both of whom are described as well presented. Adult P explained she was spending time with Child K after school, but Child K would be going back to Adult R. Adult P described herself as feeling better and getting out more.

3.5.15 Health Visitor 1 also met with Adult P that day. She noted that Child J was appropriately dressed, the room was tidy and there was good interaction between Adult P and Child J. Adult P spoke to her of being harassed by Child P and was advised to contact the police.

3.5.16 The Senior Project Worker at Action for Children met with Adult P and Child J, to begin their assessment. Adult P identified difficulties in managing her tenancy and managing money. She spoke of a previous violent partner and was invited to attend the Freedom Programme the following day. This was a course designed for young women to help them understand more about domestic abuse. Adult P however did not attend and left a message to say that she could not get childcare.

3.5.17 The following day Adult P told the Senior Project Worker that she had been threatened by Adult V who was living nearby with another woman and her children. The Senior Project Worker informed Children's Social Work and advised Adult P to call the police. Staff from the police attempted to contact Adult P and offered her 2 appointments to formally make a complaint, but she did not attend. The police subsequently closed the case which they noted as a malicious or nuisance allegation.

3.5.18 Concurrently Adult P told Social Worker 5 that she was being threatened by a local woman and again was advised to call the police. There is no recording to suggest that she did.

3.5.19 In this period Adult P contacted the GP Out-of-Hours Service describing Child J as wheezy and unwell, on their advice she attended the Accident and Emergency department. Child J was subsequently discharged home with a diagnosed chest infection and prescribed with antibiotics. The GP was informed.

3.5.20 In early summer the Senior Project Worker at Action for Children made various attempts to contact Adult P and invite her to come into the project, which she did a few days later. The assessment was

completed and Adult P was referred to a Triple P Parenting Course[5], although this did not have a start date. The project worker also talked to Adult P about enrolling at college in September. Child J was present during this meeting. Social Worker 5 contacted Adult P the next day. Adult P spoke of feeling a lot better, she said that Child J now had a new bed and now had a bedtime routine that she was working with the Family Intervention Project and would be going to college in September. The social worker then spoke to the senior project worker, who outlined the planned work including:

- Managing money
- provision of food parcels
- support to register with a dentist
- Support to attend taster sessions at Bolton College in order to access a course in September
- Attendance at Triple P parenting course

3.5.21 Adult P later attended the Action for Children project seeking help with an electricity account and the Senior Project worker visited her at home and provided practical help with the electricity, chasing up repairs with housing and organising help to provide carpets and furnishings. Child J was present during this visit, and in summary recordings Senior Project Worker 1 described Child J as responsive, appropriately dressed, appearing confident and interacting appropriately on the couple of occasions that she had seen the child. She described Child J as confident with Adult P and older sibling. Also that Adult P was affectionate towards, and responded to, Child J when the child sought her attention in play. Detailed assessments were produced by the Senior Project Worker outlining identified outcomes for parent and child.

3.5.22 At another visit to Adult P and Child J, the Senior Project Worker confirmed that the arranged furniture had now arrived, she had liaised with a phone company about a debt and Adult P was happy with the developments.

3.5.23 The Social Worker followed this up with a home visit. She noted improved home conditions, that Child J was said to be in a better routine, Adult P was feeling much better and was not having constant visitors causing trouble. The Social Worker confirmed that she would be closing the case, given that Adult P was engaging well with the Family Intervention Project and there had been no recent complaints from housing. The case was formally closed.

[5] A research based programme designed to provide effective parenting strategies to parents

3.6 Review Period 4

3.6.1 There was a change in health visitor, with Health Visitor 3 taking over and undertaking a first visit. During this visit Adult P was seen with Child J who was described as clean and dressed. The health visitor records that behaviour management was discussed, although there is no further explanation as to what this entailed. Health Visitor 3 noted that her next visit would be in 4-6 weeks.

3.6.2 During this time the Senior Project Worker made a number of unsuccessful attempts to contact Adult P and attempted to deliver food parcels to her. Adult P eventually came to the project to collect a food parcel. There are contradictory recordings of a phone conversation between Senior Project Worker 1 and Neighbourhood Safety Officer 1. The former stated that the intention was to close the Action for Children involvement with Adult P if she did not engage. The latter records that Adult P had engaged well.

3.6.3 The Senior Project Worker made further attempts to contact Adult P during the following month without success. Action for Children wrote to Adult P closing the case at the end of the month, although it was not formally closed until two months later.

3.6.4 Adult P had raised concerns on a number of occasions with the GP and others about a medical condition. A paediatric appointment was arranged, but was not attended. Also in the same month the Bolton at Home Domestic Abuse case relating to Child V, was closed. An exit interview was offered to Adult P but she did not attend.

3.6.5 Adult Q was arrested in this period for the theft of a motor vehicle and tested negative for drugs (opiates and cocaine). The Probation Service also noted that he had been accepted on a college course in Area 2. He again attended at the GP's, on this occasion with his partner. He was described as low in mood, with some suicidal ideas although he said he would not pursue this out of care for this grandmother. He was again provided with information about the crisis team as his partner said she was afraid he would relapse into drug use. A review took place with the GP the following month when counselling was again advised, although there was a noticeable improvement in symptoms and a corresponding decrease in the Patient Health Questionnaire score, a tool used to screen for depression.

3.6.6 During summer an emergency call was made by Adult P regarding Child J who was said to be vomiting. The ambulance crew noted that Child J was said to have had a cough and cold since the previous week, had a high temperature and was slightly lethargic. Child J was taken to hospital by ambulance and later discharged home.

3.6.7 Health Visitor 3 undertook Child J's statutory health review. Adult P again raised concerns about the medical condition and inward turning feet, leading to another referral to the Paediatrician. The Paediatrician

subsequently wrote to the GP, health visitor and to Adult P regarding previous non-attendance at the previous appointment. The health visitor also noted that Child J had delayed speech and would need to be reviewed in 6 months.

3.6.8 Over the summer there were further complaints to Bolton at Home about Adult P and an appointment made for early autumn, which Adult P did not keep. It was decided to monitor the situation for 2 weeks and close the case if no further complaints made.

3.6.9 Health Visitor 3 saw Adult P and Child J two months after the statutory health review. She raised the fact of missed appointments with the paediatrician and Adult P promised to attend on the next occasion. Adult P stated that Adult R had "*applied for custody*" of Child K, which Adult P did not support. The health visitor advised her to see a solicitor.

3.6.10 Toward the end of this review period, Police attended at the home of Adult R following a dispute between Adult R, her partner and Adult P in relation to the care arrangements for Child K. Adult P was said to have assaulted Adult R. The attending officer reported that Child K was safe and well and no criminal offences were considered to have taken place. The incident was recorded as a domestic abuse incident and a PPIU/CAADA-DASH RIC[6] risk assessment was completed, assessed as "standard risk level". There was no history of previous offences and the parties were advised to take legal advice regarding Child K. Referral to Children's Social Work was considered but it was decided the criteria had not been met and there was no need for intervention from the Domestic Abuse unit.

3.7 Review Period 5

3.7.1 It is understood from information obtained by the police that Adult Q and Adult P started their relationship sometime in the early part of this period. However this was not known to agencies at the time.

3.7.2 Adult Q also returned to his GP for a review in this time period, accompanied by his partner (not Adult P) who he is described as living with. The reviews continued on a monthly basis. Adult Q describes his mood as improved, but still feeling low, although with no suicidal thoughts. Medication was prescribed, and it is noted that Adult Q now intended to try counselling. Adult Q said that his suicidal thoughts were usually triggered by thoughts which he did not want to talk about, and that his partner (not Adult P) was a protective factor.

3.7.3 Adult P tested positive for pregnancy. The following month she obtained a new tenancy with Affinity Sutton, who sought reference

[6] CAADA-DASH RIC : national risk assessment tool of Co-ordinated Action Against Domestic Abuse

checks from Bolton at Home. Adult P took up the new tenancy. As a result of her change of address there was a change of Health Visitor to Health Visitor 4.

3.7.4 An emergency call was made by Adult P in relation to Child J who she described as constantly vomiting. She said Child J had been ill for a week. When examined Child J was found to be alert, with a normal temperature and no other symptoms. Child J was transported to hospital and later discharged home with advice.

3.7.5 Health Visitor 3 visited Child J and Adult P to review speech and development. Child J was observed to be playing with toys appropriately and more speech was evident but noted to be unclear at times. A referral was made to Speech and Language therapy. Adult P did not contact the service to arrange an appointment and Child J was therefore discharged. It was noted that the health issues requiring paediatric involvement had resolved. A week later Midwife 4 informed Health Visitor 3 that Adult P was 12 weeks pregnant. It was said that Adult P was not in a relationship with the father. Adult P booked for ante-natal care approximately six weeks after confirming the pregnancy.

3.7.6 Within a month of taking up the new tenancy, Adult P was noted by Affinity Sutton to have rent arrears, although this was later resolved as being due to problems with Housing Benefit. She also reported one of her neighbours for possible drug use, to Bolton at Home.

3.8 Review Period 6

3.8.1 Four months after the beginning of her relationship, Adult P disclosed to Midwife 4 that she had been assaulted by Adult Q both on the previous day and also a week previously. She disclosed being hit in the face and pushed to the ground. Adult P was given details of the Domestic Abuse Unit and taken to the hospital by Midwife 4, although she later left without being treated. A referral was made to Children's Social Work.

3.8.2 A week after the disclosure the midwife contacted the police on behalf of Adult P who then herself formally reported the incident to the police the same day. Adult P explained that she had decided to report the assaults at this point because Adult Q, who she described as her partner, was threatening her. She said that he had kicked her to the face on one occasion and on the second occasion pushed her head into a door and headbutted her. She then described him as following her into the street, threatening her further and punching her again, before asking for money. An initial PPIU/CAADA-DASH risk assessment was undertaken by the police officer and recorded as medium risk.

3.8.3 Adult Q was arrested for assault by the police the following day. He was released on police bail with the following conditions:

- Not to contact/communicate with Adult P by way of letters, text or voicemail, phone or social networking sites such as Facebook except through solicitors
- Not to use or threaten violence, intimidate, harass or pester Adult P
- Not to contact or communicate with the family of Adult P by way of letters, text or voicemail, phone or social networking sites such as (Facebook) except through solicitors
- Not to go to (Adult P's address) or any other address where the victim is likely to be
- Not to instruct, encourage or in any way suggest to another person to use/threaten violence, intimidate, harass, pester, contact or communicate with the victim or victim's family

3.8.4 The same day, the police e-mailed a referral form to Children's Social Work and to the health visitor, the referral being classed as non-urgent. The reasons for the referral were:

- Victim is known to be pregnant
- The seriousness of the incident

Social Worker 6 who was on duty at the time attempted to visit Adult P at home, but was not able to gain access. The Social Worker was then on annual leave for a week, but attempted another visit on the first day back in work when she met with Adult R and saw Child K and Child J, Adult P being in hospital at the time. Adult P later phoned the social worker and told her that she was going to tell the police to drop the charges against Adult Q.

3.8.5 The midwifery service liaised with Health Visitor 4 and it was agreed that Midwife 2 would complete the MARAC assessment, which she commenced at Adult R's home. The assessment was completed on four days later and achieved a score of 13. A score of 14 marks the standard threshold for a referral to MARAC, but the midwife referred the case to MARAC in any event on the basis of her professional judgement. The risk assessment was classified as High.

3.8.6 A few days after the arrest of Adult Q, PPIU Domestic Abuse Investigator 2 contacted Adult P and arranged to meet her at home. At the same time the Independent Domestic Violence Advocate (IDVA) accessed the database and assigned the case to herself to offer support to Adult P. She phoned Adult P and discussed the MARAC meeting that had now been arranged. She gained the impression that Adult P wanted to access the IDVA service, but was subsequently unable to contact Adult P despite making several attempts.

3.8.7 During this time Adult Q contacted the police in Area 2 to report that Adult P had sent him 250 texts and also tried to phone him on 186 occasions. Adult Q was frustrated that he was unable to respond because of his bail conditions. The police officer confirmed that the texts and calls existed, but advised Adult Q not to respond until the police investigation was over. Although Adult Q did not consider this was harassment, it was recorded as a domestic dispute between adults and as such necessitated a risk assessment, which in turn triggered a referral to Area 2 PPIU and from there a referral to Area 2 Children's Services. Area 2 PPIU also informed Bolton PPIU, but there was no direct referral to Bolton Children's Social Work.

3.8.8 Adult P also contacted the police and stated that she wanted to withdraw her complaint of assault. A few days later she was visited by PPIU Domestic Abuse Investigator 3 who took a statement from her. Adult P repeated that her original statement regarding the assaults was accurate, but that she did not want to proceed with charges against Adult Q and would not be willing to give evidence at court. She said that she was saying this without any pressure from Adult Q but because the pressure was affecting her health and pregnancy. PPIU Domestic Abuse Investigator 3 immediately e-mailed the case officer, Prisoner Processing Unit Officer 1, with this information and stated:

The aggravating factors in this case are that Adult P was 4 months pregnant at the time of the assault and her other child, Child J was in the vicinity whilst the assault was going on. Adult P states that she is estranged from Adult Q and in the short term, has no intentions of reconciling with him. I doubt that this is the case I would recommend, given the severity of the assault on a pregnant woman, that CPS take positive action and consider summonsing Adult P to court, despite her retraction"

3.8.9 Two days after the retraction statement Social Worker 6 visited Adult P when she also saw Child J. The Social Worker discussed the domestic abuse with Adult P and explained that a referral had been made to Children's Social Work by the police. Adult P said that Adult Q had apologised immediately, she said she did not intend to resume her relationship with him, but she was pregnant with his child and so it would be difficult not to have any contact with him. The Social Worker advised her that she must contact Children's Social Work if she had contact with Adult Q. Adult P said that the Health Visitor had completed the MARAC form with her and that she had a good relationship with the Health Visitor.

3.8.10 The Social Worker observed Child J to be clean and well; speech was difficult to understand but presentation was generally a happy child. The property was sparsely furnished, but Child J had a clean bed which was nicely decorated. She did however warn Adult P about the risk of exposed gripper rods on the stairs.

3.8.11 The Social Worker discussed the case with Team Manager 1. It was described as a "*worrying situation with a nasty assault'*. It was noted that Adult P said she was not in a relationship with Adult Q but might be in the future. It was recorded that the Health Visitor and midwife would monitor if Adult Q returned and refer back if need be. The conclusion was reached that there was no role for Children's Social Work and the case was closed.

3.8.12 The MARAC meeting took place. Two actions were recorded for the police:

1. To meet with Adult P and risk assess, if necessary refer to agencies
2. To monitor Adult Q bail situation and if appropriate discuss safety issues with Adult P

3.8.13 A week after the MARAC meeting and two weeks after the retraction statement by Adult P, a meeting took place between Prisoner Processing Unit Officer 1 and Prisoner Processing Unit Supervisor 1 to consider how to progress the criminal investigation. The supervisor concluded that the allegation should not be referred to the CPS for consideration. As a result when Adult Q returned to the police station to answer his bail as arranged, he was told that no further action would be taken and therefore he was no longer subject to any bail conditions.

3.8.14 The same day Adult P attended an ante-natal appointment with Health Visitor 4. Child J was not with her on this occasion.

3.8.15 Two days later an emergency call was made by Adult P. She said that Child J was not moving, had fallen downstairs and sustained a head injury. A Rapid Response vehicle arrived at the scene in 6 minutes, followed quickly by an ambulance and an advanced paramedic. Resuscitation attempts were commenced and Child J was transferred to hospital where death was formally pronounced.

4 CRITICAL ANALYSIS

4.1 Introduction

4.1.1. This analysis is based on the individual Agency contributions to the Review, discussions held within the SCR Panel and the author's own contributions. IMR authors were required to structure their reports using the Key Lines of Enquiry as established within the Terms of Reference. The IMRs contain a high level of detail and analysis regarding the actions of individual agencies. This level of detail will not be routinely replicated here, but issues will be considered where the learning is particularly significant either from a multi-agency or

single agency perspective. Where there appear to be gaps in individual agency learning these will be identified.

4.1.2. The IMRs have identified a number of issues arising out of their reviews which although not identified within the Overview Report as key issues within the overall analysis, nevertheless have led to learning for the individual agencies. All the agency recommendations are included in Section 5 of this report.

4.1.3. This critical analysis has considered all of the Terms of Reference, including the Key Lines of Enquiry which provided the working hypotheses for this Review as well as the Specific Terms of Reference which were identified for the Overview Report (see Para 2.8)

4.1.4. This Critical Analysis has been structured around an examination of two key episodes over time:

i. The response of services to the family between June 2009 and March 2012 within the established Framework for Action

ii. The response of services to the family following the incident of domestic abuse in March 2012

It will then go on to consider two particular issues that have been identified as being of significance before considering in summary:

- Could Child J's death have been predicted or prevented?
- What does Child J's case tell us about the effectiveness of Bolton's Framework for Action?

4.1.5. Child J was the second child of Adult P, a young white British woman in her early 20s, who had her first child, Child K, when she was 18 years old. Child J and the extended family lived in a community with high levels of social deprivation and it is known that Adult P experienced financial difficulties and was caught up in low level anti-social behaviour. Whilst Adult P was brought up in the community in which she lived and had support from her mother who lived locally, the extent and strength of her personal support networks are unknown.

4.1.6. At the time of Child J's death, Adult P was expecting her third child. Adult P's first child, Child K, was cared for by the maternal grandmother, it would appear as a result of concerns about Adult P's lack of consistent parenting and, possibly, ambivalent attachment to Child K. Child K had some health problems at birth, which may have had an impact on the relationship between mother and child. However, Child K's health problems were not of the nature in themselves which could adequately explain the decision for her to be cared for by the grandmother. There is information that suggests Adult P may have had mixed feelings about all of her pregnancies. The fathers of Child J and siblings do not appear to have been significantly involved in the children's care and their paternity remains unknown at the time of writing.

4.1.7. The Review was keen to know as much as possible about Child J's developing personality, likes and dislikes, relationships and experiences. The project worker at Action for Children was able to provide the most distinctive picture in her description. The project experienced Child J as chatty but not overfamiliar with workers and describing how Child J would take toys to Adult P who would respond and engage. A not dissimilar picture is provided by health professionals who would have had the greatest degree of contact with Child J. Health records speak of a quiet and contented child, who was quite shy when first meeting professionals but who enjoyed playing with toys and would engage in play after a while. The records further described Child J as having a warm relationship with Adult P. Child J had some delay in speech, and as such verbal communication would have been limited. Because speech delay in children is not uncommon, it is difficult to know what significance, if any, this might have had.

4.1.8. Both Child J and siblings were receiving universal services, in particular from health. Each of the children were also recognised by professionals on separate occasions as having additional needs as a result of which Common Assessment Framework (CAF) assessments were undertaken by health professionals. These in turn led to Child Action Meetings and the provision of additional targeted support. Child Action Meetings are a part of Bolton's early help provision for families who need support at Level 2 of the multi-agency framework and require the agreement of the child's carers (Level 4 signifying children at risk of significant harm and in need of protection.)

4.1.9. Children's Social Work took part in the Child Action Meetings and undertook 5 Initial Assessments in relation to the two children over a period of 6 years. On only one occasion was the involvement of Children's Social Work a result of a direct Child Protection concern, this being following the fire in Adult P's flat when Child J was being cared for by a 15 year old babysitter. On each occasion the conclusion was reached that the children's needs were being met at the appropriate level, with the support of agencies and there was no further role for Children's Social Work.

4.1.10. Adult P had the tenancy of a flat managed by Bolton at Home during this period and lived near to her own mother and Child K. Child K was known to spend periods of time staying overnight with Adult P. There is some evidence to suggest that Child K was a child with behavioural problems, the cause and degree of which are not specifically identified. A very unclear picture has emerged of the level of involvement of Adult P with Child K, but it seems that the arrangements for routine care were at best fluid and at worst unsettled, possibly even damaging to Child K's stability and development.

4.1.11. A feature of this case is therefore; both the quality of care received by Child K, but also the degree to which Adult P's parenting of Child K was understood as relevant to her parenting of Child J. The

arrangements for Child K's care were made within the family when Child K was an infant. Other than providing advice to the family there was no ongoing involvement by Children's Social Work with Child K. The actual arrangements for Child K's care and the amount of time spent with Adult P and grandmother is not entirely clear. Different agencies at different times had slightly different understandings, but Child K certainly appears to have, at times, spent several days a week with Adult P.

4.1.12. Agencies within Bolton had no knowledge of Adult Q until the disclosure of domestic abuse and he was charged with an assault on Adult P. There was therefore a period of approximately 6 weeks between Child J's death and the point at which Adult Q became known to services as having a relationship with Adult P. Adult Q lived in Area 2 and was subject to Probation supervision, which was prior to his relationship with Adult P.

4.1.13. The issue of whether Child J should have been seen as a Child in Need within the statutory framework will be considered in more detail subsequently. Prior to when Adult P was assaulted by Adult Q, there was evidence to suggest that both Child K and Child J's developmental needs may not have been adequately met .With hindsight what emerges more clearly is an underlying pattern of neglect that would not have been so easily identified at the time.

4.2 KEY EPISODE: Services provided within the Framework for Action

In 2007, Bolton Safeguarding Children Board introduced an agreed multi-agency approach for working with children and families; the Framework for Action. This Framework built on the previous Child Concern model in Bolton and provides guidance on how to:

- Identify, assess and respond to the 4 different levels of need
- Access additional services to address children's needs
- Seek advice and guidance
- What to do when there are child protection issues

Child J was specifically identified in the ante-natal period as a child with additional needs, resulting in a multi-agency response within the framework's outline. At other times there is evidence of increased professional activity, for example in relation to addressing anti-social behaviour, and apparently higher levels of health visiting, but not reaching the point at which a CAF or further CAMs were considered necessary.

4.2.1. Prior to the identified timeline for this review Child K had also been identified as having extra support needs and Child Action Meetings were triggered by the Health Visitor. As well as Child K's health needs, there had been concerns about inconsistent parenting by

Adult P, including failing to take Child K to medical appointments, poor behaviour management relating to Child K, allegations that Adult P smacked Child K and poor home conditions.

4.2.2. Following the Child Action Meeting in respect of Child K, Children's Social Work concluded that as Child K was being safely cared for within the family and Adult R was supportive of contact between Child K and Adult P; there was no continuing role for that agency. There is no reason at this point to suggest that this was anything other than a reasonable and proportionate conclusion. Nevertheless it is of interest that Adult R felt that she had been required by Children's Social Work to care for Child K and linked this to a sense of confusion about her legal rights and responsibilities.

4.2.3. The response to the concerns raised in the months prior to Child J's birth however requires a more critical analysis. The lack of information recorded by Children's Social Work regarding the CAMs in this period is of significant concern. There is no evidence that either an Initial Assessment, or a parenting assessment, took place at this point, neither is there information about what decisions were, or were not, taken in relation to Children's Social Work involvement. An action for the review Child Action meeting in, to which the Social Worker had given apologies, was that Adult R should contact Children's Social Work directly about her concerns. There is no explanation as to why the Health Visitor did not take responsibility for this action, or contact Social Worker 7 directly to ensure that Adult R had done so. Neither is there any information as to whether Social Worker 7 followed up this recorded action, either with the Health Visitor or with Adult R. Given the concerns being raised about the care for Child K and Adult P's failure to properly engage with agencies, this approach is difficult to understand and raises concerns about the effectiveness of the Child Action Meeting process in practice.

4.2.4. The next occasion when there is clear information about significant professional concerns was when Adult P was pregnant with Child J. Adult P was late in booking in for her ante-natal care and Midwife 4, who was concerned, appropriately completed a CAF assessment in two months prior to Child J's birth.

4.2.5. Late booking for ante-natal care is linked with a risk of increased health problems for both mother and child. In addition, whilst there is no definitive research linking late booking of pregnancy to, for example, future neglect, it is possible that 'concealment' of pregnancy may also be an early indicator of future concerns *"any level of concealment may indicate a wide range of problems, including: ambivalence towards the pregnancy; immature coping styles (it'll go away if I don't think about it) and a tendency to*

dissociate from the situation (which will tend to result also in dysfunctional and perhaps dangerous, parenting) [7] .

4.2.6. Three Child Action Meetings took place as a result of the CAF assessment. The first was attended by Adult P and Adult R, two midwives, two health visitors and two social workers from the district Referral and Assessment team. The meeting was called and chaired by Midwife 4. It is of note that there is no input to the meetings by the GP, who had not been made aware that a CAF had been produced or that the meetings were taking place. The concerns identified in the meeting were:

- Adult P booking late and not attending ante-natal appointments
- Adult R was still caring for Child K despite Adult P having said that Child K would be coming to live with her during a previous CAM
- Adult P 'disengaging' from input with professionals.

4.2.7. Adult P gave no explanation for booking late for her ante-natal care. However, she told the meeting that she would in future be taking more of a parenting role with Child K who would be staying with Adult P 2-3 nights per week. Adult R at this meeting stated that she believed it was Child K's health problems that led to Adult P "*struggling*"; however, this was not consistent with what had been said on previous occasions. There is no evidence that there was any professional challenge to this view. Adult P identified Adult AG as the father of unborn Child J, but stated that the relationship was over, as was a relationship with Adult AF, with whom she had been involved at the time of the last CAM. She would therefore be a single parent, with her mother and a friend as identified support.

4.2.8. An action plan was produced at the meeting in line with standard procedure and included:

- Adult P to access all ante-natal appointments
- Adult R to be contacted if professionals unable to contact Adult P
- Health Visitor 1 to assess parenting skills in relation to Child K
- Midwife 1 to assess parenting skills with the newborn baby
- Adult P to be introduced to Children's Centre activities
- Children's Social Work to be notified of any on-going concerns

A formal referral was made to the Children's Centre in order to access the identified support and Family Support Workers were allocated.

4.2.9. The two following review meetings took place. The notes provided for the first of the review meetings give quite a detailed narrative

[7] Earl, G et al 2000

about developments in the family, but the second set of review meeting notes are brief and handwritten.

4.2.10. Information of note is recorded at the second review meeting regarding Child K, who was attending a nursery 3 half days a week. Child K was described as having had problems with speech development and some behavioural problems, including apparently distressed reactions to males and a hysterical response to having the nappy changed. Child K is described as having 'outbursts' and the suggestion is made to Adult P that she engage with family workers at the Children's Centre to help improve this behaviour. The focus is on helping the family manage Child K's behaviour. There is no explicit view recorded as to whether Child K's behaviour suggests any other cause for concern, for example, the possibility of abuse. Given the nature of the described behaviour, the recording of a clear professional view, or the need for further enquiries at this point, should have been considered.

4.2.11. Other issues discussed were the Housing provider's concerns about anti-social behaviour, including reference to *"unsavoury characters gravitating towards Adult P's flat*". The police had been involved on a number of occasions and earlier in the year the situation had potentially put Adult P's tenancy under threat. This was now said to have improved.

4.2.12. Information about Child K's care arrangements remains confusing. One month it was recorded that Child K stayed overnight with Adult P 4 nights a week, yet the following month it was stated that this was not so frequent and the child's bedroom was not ready. The issue with Child K's bedroom not being ready had also been the explanation for the living arrangements in previous service contacts. It is also recorded that Child K's nursery placement had been suspended as Adult P was in arrears with the payments and there is reference to Child K's behaviour being '*worse*', although there is no explanation of what this meant. It is apparent that Adult P continues to miss appointments both for herself, for example with the Family workers who were intending to help her with Child K's behaviour, and for her children. It is also significant that Adult P did not attend the second Child Action meeting review.

4.2.13. There is specific evidence of recognition by the professionals involved in the CAMs of many of the pressures and vulnerabilities facing this family and of actions taken to address a number of these issues. However, with hindsight it is not clear whether there was an effective review of the degree to which the problems within the family had changed, or identification of how the outcomes for Child J and Child K were improved. The outcome of the two parenting assessments identified in the first CAM meeting are not clearly recorded, neither is there any information as to what form these assessments took.

4.2.14. It is therefore not entirely apparent as to what was the basis of the Social Worker's conclusion at the August meeting that "*things seem*

to be improving for Adult P and the children". There is a lack of explicit evidence as to how the family situation had fundamentally changed or improved. It would be unreasonable to assert that at this point there was evidence that the children's needs had crossed the threshold into Child Protection. Nevertheless given the available information there should have been explicit consideration of whether Child J might have been a Child in Need under Section 17 of the Children's Act and Children's Social Work should have taken a greater role in meeting those needs.

4.2.15. The Framework for Action also specifies that prior to a third CAM the lead professional should have a discussion with their line manager about the appropriateness of the level of need or concern and consider whether there might be any child protection issues. There is no information to suggest that such a discussion took place, or if it did, what the conclusion was. Instead, the second review meeting appears to have been the final meeting, with no explanation of why this was the case. This pattern of meetings and the repeating concerns raised within them suggests a level of unresolved concern over time and should have triggered a conscious discussion of whether the level of concern had increased and whether the interventions were proving effective.

4.2.16. Also during the two month after the birth of Child J the North West Ambulance Service instigated 2 safeguarding referrals. There is no reference to the first within the records of Children's Social Work. On the first occasion Adult P had called 999 as Child K had a rash. The attending ambulance crew were concerned that Child K in fact had serious sunburn which had gone untreated. They described Child K as very distressed and were concerned about parental failure to seek treatment. Whilst it is unclear whether the referral was received by Children's Social Work, the Health Visitor and Midwife undertook a joint visit a few days later and "*discussed safety issues*".

4.2.17. Given that NWAS is a regional service, the process for making referrals at the time involved any referral from an ambulance crew being faxed to a central Emergency Control Centre, who would then fax it on to the relevant Children's Services department. NWAS provided a chronology and factual information for this review rather than a full IMR; however the service demonstrated a concern to learn from Child J's experience and recognised that there was a potential weakness in their systems for managing referrals. The Safeguarding Practice Manager for NWAS was invited to a panel meeting and this was used as an opportunity for helpful information exchange with partner agencies in relation to changes within NWAS's procedures which have subsequently been made.

4.2.18. The second referral from NWAS, which was notified to Children's Social Work by the police, resulted from the fire in Adult P's home. The resulting strategy discussion involved Children's Social Work and the police. Normal practice would be to include the health visitor within the strategy meeting, but it is not clear from the records if she

was invited or if there was a discussion with her in order to inform the meeting. Nevertheless the health visitor and Social worker subsequently undertook a joint meeting to Adult P evidencing that there was communication between the two agencies.

4.2.19. This incident was clearly viewed by the relevant professionals as unacceptable from a Child Protection perspective, explicit warnings were given to Adult P about the implications of any similar reoccurrences and some reassurances received, although there appears to have been an element of doubt as to how far Adult P accepted what was said. The Initial Assessment subsequently completed by the Social Worker recognised that there remained some concerns about Child J and for this reason a decision was made that Children's Social Work attend the review CAM later that month.

4.2.20. What this incident highlights however is the difficulty for professionals in assessing the significance and seriousness of what appear to be "one off" incidents which could have led to serious physical harm, but in fact did not.[8] The records of the incident do not define this as neglect, however, the term merits consideration as an appropriate definition given that there was an obvious lack of proper care and supervision of Child J and in the context of known historical information about Adult P's parenting of Child K. With hindsight, supervisory neglect, or lack of proper attention to the capacity of those caring for her children may well have been a feature of Adult P's parenting.

4.2.21. Children's Social Work formally closed the case in two months after the referral relating to the house fire, a decision which is recognised within the Childrens Social Work IMR as being premature and over-optimistic. Adult P had not attended the final review CAM, she was not engaging with the family support workers and indeed the Children's Centre had closed the case themselves due to the lack of engagement.

4.2.22. There were two further points at which Children's Social Work became involved for brief periods, but which did not meet the threshold for child protection procedures. Neither were they considered to meet the threshold for Section 17 help by any of the agencies involved.

4.2.23. This relates to Adult R had reporting to Health Visitor 1 that she was worried about the potential risk posed by Adult V, who had just been released from prison having received a custodial sentence for offences of domestic abuse against another woman, and who she understood to be Child J's father. The Health Visitor responded quickly, contacting Adult P, making checks with the Probation Service and informing Children's Social Work. A joint visit to Adult P by Health Visitor 1 and the Social Worker was an example of good

[8] See Howarth, J (2007) re accidents and supervisory neglect

agency co-operation. An Initial Assessment was appropriately undertaken. On the basis that Adult P assured professionals that she did not personally feel under threat and would contact agencies including the police if she did; no further action from Children's Social Work was considered necessary. Bolton at Home allocated a Domestic Abuse Officer to Adult P, although Adult P did not in reality engage with this service.

4.2.24. Given the information available to Children's Social Work not least that there was no independent evidence of any threat being made to Adult P or Child J, the situation was assessed as low risk. Other agencies such as Probation and Health visiting were involved and were asked to monitor for any further concerns. A decision by Children's Social Work not to take further action was in its own terms therefore a defensible one.

4.2.25. The next significant concern arose when a Neighbourhood Safety Manager at Bolton at Home made a referral to Children's Social Work in consultation with the Health Visitor. A child (Child P) who was a friend of Adult P's younger sibling was found to be staying at Adult P's flat. This Child was himself known to agencies and had a history of abusive behaviour to members of his own family. There were also other concerns including Child J not having a cot and sleeping with Adult P and continuing anti-social behaviour around the flat, exposing Child J to inappropriate behaviour and putting the tenancy at risk.

4.2.26. The Initial Assessment was undertaken by a student social worker, Social Worker 5. Social Worker 5 appears to have worked actively to engage Adult P. Social Worker 5 liaised with other professionals and helped Adult P to resolve some of the immediate financial and practical problems, including accessing finances for furniture under Section 17. Action for Children also tried hard to engage Adult P encouraging her to get involved in programmes for parenting and domestic abuse as well as helping with accessing further education, managing money and providing furniture and food parcels.

4.2.27. Children's Social Work closed the case three months later concluding that outcomes were improved and referring to a "*very clear plan of action as to how progress should be monitored"*. However, it is not apparent to the Review which action plan is referred to. Action for Children had put together a plan, but by this time Adult P was already disengaging from the Family Intervention Project. The case was closed by Action for Children later the same month for that reason. There is no evidence what the progress which was to be monitored was, who was monitoring it and what would be considered a successful outcome or otherwise.

4.2.28. This episode could have provided an opportunity to review Child J and Child K's circumstances more systematically. Undoubtedly the provision of a cot and other practical support improved physical home circumstances and was a positive outcome for Child J. However, other identified improvements, such as a reduction in anti-social behaviour and inappropriate visitors, could not be assumed to be long

term given Adult P's previous history. Children's Services have recognised that this case, like others suffered from a lack of a chronology. Had there been a systematic review of history relating to both children, the development of a pattern of predominantly low level concerns should have been visible and a more cautious assessment adopted towards Adult P's ability to maintain improvements.

4.2.29. This was also an opportunity for a more structured parenting assessment which could have shifted the focus more clearly towards the children's experience. Much of the activity was effectively focussed on Adult P's needs, and while this can be a legitimate way to impact on outcomes for the children, there is a risk that it remains predominantly adult focussed. There is no recorded assessment as to the children's experience of being parented and what, from their perspective, might be considered good outcomes.

4.2.30. Whilst Children's Services IMR refers to the student social worker being closely supervised there is no information to confirm a clear practice direction that would have more clearly ensured focus on the children's experience and parenting capacity. Children's Services have provided this Review with evidence that practice tools have since this time been developed to support a greater focus on establishing children's experiences directly.

4.2.31. Given the reality both of the resources available to Children's Social Work and the thresholds for their continuing intervention, it is not the presumption of this author that continuing involvement either on the basis of Child in Need or Child Protection would have been the right course of action. However, what is not clear is why Child J was not seen as a child still in need of targeted intervention within the Framework for Action and consideration given to 'stepping down' into a plan of multi-agency work rather than simply case closure. By this point, there was a range of information to suggest that, at best, there was no significant change in the family circumstances.

4.2.32. When Adult P tested positive for pregnancy it might have been expected that consideration would have been given to updating the previous CAF. Adult P had shown ambivalence about her pregnancies, including a possible pattern of concealment; she was a single parent and was already identified as experiencing some difficulties in parenting her two existing children. This was a time at which she could be anticipated to experience increased stress and a multi-agency review would have been justified.

4.2.33. What can be seen with hindsight in analysing these events is a pattern of predominantly low level, but unresolved concerns, some involvement with services followed by fairly early disengagement from those services by Adult P. These concerns included:

- Possibility of disorganised attachment between Adult P and her children, both during pregnancy and the post-natal period.
- Existence of behavioural problems in relation to Child K and little professional understanding of the cause of the problems

- Adult P having difficulties in managing Child K's behaviour, and allegations that she responded by smacking
- Behavioural problems in relation to Child M, (Adult P's brother)
- Adult P's continuing financial difficulties and lack of material goods in the home, even taking into account her limited income
- Adult P apparently retaining Child K's benefits although being cared for by Adult R
- One known incident where 6 week old Child J was left with inappropriate babysitters and exposed to risk of serious injury
- Regular episodes of anti-social behaviour centred on Adult P's flat
- Speech delay in both children
- Adult P's apparent inability to regulate unsuitable, at times abusive, visitors to her home
- Professionals view of Adult P as "vulnerable"
- Some evidence of lack of adequate food and warmth in the home and inattention to safety in the home
- A significant proportion of missed appointments with all professionals that contributed to children not receiving treatment or assessment promptly; this was a significant reason for Adult R looking after Child K
- Unresolved professional concern regarding parenting capacity
- "Shadowy" unknown males in the background, one of whom was known to have committed serious offences of domestic abuse against another woman
- Absence of positive support and apparent isolation of Adult P as a young parent with a preschool child

4.2.34. There was also information that Adult P had been at some risk of harm outside the home when she was a teenager, and it was known that her younger brother was aggressive towards her and featured in the anti-social behaviour, parties and drinking in her flat. Adult R was regularly referred to as a supportive factor for her daughter, although given the experience of both Adult P and her brother and concerns about Child K's behaviour, a more critical appraisal of Adult R's contribution and parenting capacity was warranted.

4.2.35. The role of maternal grandmothers in families where there may be neglect or other parenting problems needs to be considered with some care. Whilst some may play a supportive role in their grandchildren's lives, the possibility that their own parenting may have been problematic should be considered. Adult P and Adult R had what appeared to be a close relationship, living near each other and having significant contact. Yet there were also clearly lines of tension, with disagreements about money and Child K's care, and on

one occasion the police being called to Adult R's home due to an argument when Adult P allegedly assaulted her mother.

4.2.36. Research has highlighted that the relationship between neglectful mothers and their own mothers is often problematic. There may be high levels of interaction and instrumental involvement with the grandchildren, for example frequent babysitting, but a lack of positive feelings between the two adults. Neglectful carers are more likely than other carers to have experienced abuse and to have insecure attachment patterns themselves.[9] This Review is not in a position to make an assessment of the relationship between Adult P and Adult R. However, the absence of any significant critique of this relationship by the professionals involved meant that an opportunity to understand the family and what interventions might be most effective was inevitably missed.

4.2.37. Child J and Adult P appear to have received appropriate primary care from their GPs, with any areas for improvement arising out of this review being properly identified by the IMR and Health Overview Report. None of the issues identified could be considered to have been pivotal in effecting the ultimate outcome for Child J. However, the areas for improvement are familiar in terms of the role of GP practices within safeguarding. As has been noted in the Health Overview Report: "*A recurrent theme in other management and serious case reviews both locally and nationally highlight that often GP practices are not fully engaged with the wider multi agency working in relation to children in need and children in need of protection".* In the context of changing commissioning arrangements for primary care, this Overview Report would therefore wish to specifically highlight and endorse the recommendations made to the Bolton PCT Clinical Commissioning Group within the Health Overview Report.

4.3 KEY EPISODE: Response to Domestic Abuse

There is no clear evidence that domestic abuse featured in the family's life prior to the assault on Adult P and her subsequent reporting. However, there is reference to Adult P being involved in relationships with two previous partners where domestic abuse may have been a feature. In the Child Action Meeting, Adult R stated that Adult P had a new boyfriend, Adult AF and "*there has apparently been some violence and police involvement"*. At this time Adult P was understood to be having very little contact with Child K, so there was unlikely to be an immediate Child Protection issue. However, given the changing nature of the arrangements and the fact that it was Adult P, not Adult R who had parental responsibility for Child K, it

[9] Horwath, J (2007)

would have been wise to make further enquiries about what risk, if any, might be posed to Adult P and Child J by Adult AF.

4.3.1. The second episode where domestic abuse was identified as a possible issue was when Adult V was released from prison having served a sentence for assault and abduction of an ex- girlfriend. Adult P had been in a short relationship with Adult V previously and stated that he was the father of Child J, although this later turned out not to be the case. In the event there was never any concrete information that Adult V was a current threat to Adult P.

4.3.2. An Initial Assessment was undertaken at the time and, not unreasonably, given the information available, concluded that no further action was required from Children's Social Work. Adult P made commitments to contact the police if she felt she, or Child J were at any risk and a referral was made by Bolton at Home to their Domestic Abuse Officer to provide her with support. The issue of her failure to engage with this service is something which will be considered again later in this analysis.

4.3.3. **Assault on Adult P by Adult Q**: Prior to the reported Domestic Abuse incident, none of the agencies involved with the family knew of the existence of Adult Q or could have been expected to do so. Adult Q lived in Area 2 and whilst he had been known to both the Youth Offending Team and the Probation Service in that area, neither organisation were involved with him at the time, nor did they hold information about him that would have necessitated sharing with other agencies.

4.3.4. Adult P disclosed to Midwife 4 that she had been assaulted by Adult Q on two occasions within a week, and was encouraged by the midwife to report this to the police. Adult P at this point was describing Adult Q as her former partner. The police subsequently interviewed Adult Q for assault and bailed him with clear conditions not to have contact with Adult P pending further investigations. Later that month however Adult P retracted her statement and a decision was made not to refer Adult Q's case to the CPS for a decision regarding a criminal charge. The available information suggests that Adult P had initiated contact with Adult Q and was herself actively seeking reconciliation.

4.3.5. The process of the police investigation has been analysed in detail within the GMP IMR, which concluded that it was not an effective investigation. GMP also referred the case to the Independent Police Complaints Commission and an investigation by the IPCC was ongoing at the time of writing. This analysis will therefore be focussing on the implications for learning from a multi-agency perspective, rather than the investigative role of the police.

4.3.6. The police followed established practice of referring the case to Children's Social Work and the health visitor, having completed the initial CAADA-DASH risk assessment and identified the risk as medium. A referral was made to MARAC, the multi-agency risk

assessment panel, a Police Domestic Abuse Officer made arrangements to meet Adult P as did an Independent Domestic Violence Advocate. The MARAC meeting took place and actions were identified for the Police Public Protection Investigation Unit.

4.3.7. A Detective Constable from the Public Protection Investigation Unit, (PPIU Domestic Abuse Investigator 3) prior to the MARAC meeting undertook a further risk assessment following Adult P's decision to retract her statement. This assessment is robust and shows a good understanding of the risk factors associated with domestic abuse cases, such as the fact that Adult P was 4 months pregnant and that Child J was present during the assault. The officer notes Adult P's statement that she did not intend to reconcile with Adult Q but is clear that he doubts this represents the reality. It concludes with a strong recommendation to proceed to charging, via the CPS, irrespective of Adult P's retraction and the officer also identifies that there are safeguarding implications. This SCR is not in a position to assess the appropriateness of the decision that was subsequently taken not to charge.

4.3.8. Irrespective of the decision not to charge Adult Q, other well established procedures to help support the victim and assess risks to them, appear to have largely been put in place. However two areas for learning have been identified. Firstly, after the decision was made not to take further action against Adult Q, a mistake, described by the police officer involved as human error on her part, meant that the information that no further action was to be taken was not passed on to the police Domestic Abuse Unit. Therefore they were not in a position to reassess any risk to Adult P or inform other agencies of the decision when Adult Q was released from his bail.

4.3.9. Recognising this mistake led the police to identify a gap in practice, in that there was no routine process for informing partner agencies of a decision not to take further action following a domestic abuse investigation. This has led to one of a number of recommendations by the police in response to gaps in policy and practice that have been identified during the course of this Review.

4.3.10. What is now also apparent is that several of the professionals were overly optimistic about Adult P's ability or willingness to separate from Adult Q, or to engage with services and the implications of this from a safeguarding perspective. Despite making several attempts to meet with Adult P the IDVA was unable to contact her after their initial phone conversation, which at the time she had felt showed Adult P to be positive about engagement. However, Adult P had already been texting and phoning Adult Q attempting by doing so to persuade the police to remove the bail conditions which prevented her from seeing him. An Initial Assessment was undertaken by Children's Social Work and advice given to Adult P about the child protection concerns with regard to Child J. The fact that Adult P planned to drop the charges does not appear to have been accorded adequate weight in terms of assessing her capacity to safeguard her child. Ultimately the

assessment concluded that there was no further action required and the case closed - a decision that the IMR considered premature.

4.3.11. Had the agencies, but particularly Children's Social Work, in conducting the Initial Assessment, fully understood the family history, especially Adult P's pattern of disengaging from services, it would have raised greater concerns about her potential to work with them. Adult P's actions suggest that she was primarily focussed on meeting her own needs at this point rather than focussing on any impact renewing her relationship with Adult Q might have on her children.

4.3.12. Despite this, the working presumption of agencies appeared to be that if given suitable advice and offered support, Adult P would be able to protect her children from harm arising out of any further violence. What we know from research however is that there are many barriers that can prevent mothers acknowledging the risks of domestic abuse or disclosing domestic abuse to agencies.

4.3.13. It is appropriate to acknowledge the increasingly high level of referrals regarding domestic abuse received by Children's Social Work and the difficult judgements that need to be made on a daily basis. The case was referred to Children's Social Work by the police within the agreed tiered approach as non-urgent and responded to within good time on that basis. In this context, criticising this as a stand-alone decision would run the risk of 'hindsight fallacy"[10] in assuming with the benefit of all the knowledge that is available to us now that this situation could have been seen to stand out as particularly risky and for example, justifying a Strategy Meeting or more direct intervention. Nevertheless a practice approach relying on one visit to the family and minimal historical information must risk being ineffective given the complex family dynamics that usually exist in situations of domestic abuse and the decision to close the case at this point has been acknowledged by Children's Services as premature.

4.3.14. Whilst the threshold for a Strategy Meeting had not been reached on this occasion, what should have been given serious consideration was the convening of a further Child Action Meeting. Such a meeting if working effectively should have identified the historical concerns and could then have indicated the need for a more active degree of involvement by Children's Social Work, given their statutory role in supporting children in need under Section 17 of the Children Act. Other professionals could have then been involved in monitoring and supporting the situation, for example the GP saw Adult P on three occasions following the assault but was unaware of the events and therefore not in a position to advise or contribute. It is not however the contention of this review that had this course of action been taken the tragedy of Child J's death could have been avoided.

[10] Beckett, C in Calder, M (2008)

4.3.15. Child J's experience suggests that there is room for further development of the understanding, skill base and practice when working with families where domestic abuse is a feature. The challenge to the Board will be to consider whether there is potential for improvement and development in the effectiveness of multi-agency responses to safeguarding of children in situations of domestic abuse. (**Multi-Agency Challenge 1).**

4.4 Was neglect a feature?

4.4.1. This Review has referred to the possibility that neglect was a feature in Child J's life. This was not an assessment that was consciously reached by agencies at the time, and so there was no specific assessment in line with local requirements, such as use of the Graded Care Profile. It should be acknowledged that the degree of neglect that may have existed has been the subject of considerable debate within the Serious Case Review Panel, particularly in relation to the point at which the standard of care provided to a child could reasonably be expected to trigger agency intervention.

4.4.2. It is however, the view of the author of this report that it is now possible to see that there was in fact an underlying pattern of neglectful behaviour by Adult P examples of which have been listed in paragraph 4.2.33. There was significantly no information that Child J was experiencing chronic physical neglect, and it is perhaps this fact that made neglect particularly difficult to recognise. There were episodes when there were questions about basic care, such as adequate provision of food, warmth and safety in the home, but it did not appear to be of the most serious kind and the level of these problems over time were, and still are, unknown.

4.4.3. What we do know clearly is that Adult P was inconsistent, at times to the point of dangerousness, in the supervision and oversight of both her children: the fire; the instance of serious sunburn to Child K; the presence of disruptive visitors to the home being examples. We know that although Child J's basic medical appointments were met, there were multiple missed appointments and health professionals constantly needed to chase Adult P for contact. Further, one of the main reasons that Child K moved to live with Adult R was that Adult P was not ensuring that health needs were properly met.

4.4.4. In the absence of evident and serious physical neglect, it can be more difficult for professionals to recognise the sort of neglectful care that can affect the health and development of a child over time[11]. Child J's age and limited speech development in the context of the unstructured approach to assessment apparently taken by practitioners, mean that it is difficult to know the degree to which

[11] Davies and Ward (2012)

emotional and psychological development was, or was not, being compromised by care. However, what is clear is that Child K was experiencing not only speech delay, but also exhibiting behavioural problems, demonstrating a level of distress through behaviour that may not have been able to articulate verbally. Without a proper assessment of needs, it is not possible to know what lay at the root of these problems; understanding needs required a holistic child focussed assessment that would encompass the role of all carers.

4.4.5. Neglect is widely acknowledged as difficult to assess and "*unless there is clarity about what constitutes neglect and the impact that it has on children practitioners will not be able to identify possible cases of child neglect effectively or undertake child-centred assessments.*"[12] The challenge to the multi-agency partnership is how to maximise the identification and effective response to the sort of neglect, which as in Child J's case may be seen as at the lower end of the spectrum. This forms the second challenge to the multi-agency partnership. **(Multi-Agency Challenge 2)**

4.4.6. This challenge will of course need to be seen in the context of local levels of neglect, deprivation and need and the real resources of the organisations to meet those needs. It is the view of this report that the starting point for these discussions should be prevention and the role of all agencies, including Children's Social Work in preventative work.

4.5 The significance of men in Child J's life

4.5.1. The issue of the role of men in children's lives is a familiar feature of Serious Case Reviews[13] and has been a feature in the consideration of Child J's experience. It is evident that professionals involved with the family asked Adult P on a number of occasions if she had a partner, and it was always denied. Visits to the house showed no sign of another adult living with her. In the face of Adult P's unwillingness to disclose information about significant men in the family's life, professionals were not in a position to assess any impact men might have on Child J, whether positive or negative.

4.5.2. However, it is also apparent that there were a significant number of men who had been involved with Adult P, several of whom were suggested as possible fathers of both children. This in itself deserves reflection. The police IMR identifies that some of the men with whom Adult P had relationships were known to the police, but also acknowledges that there is no evidence that any of these men were deliberately remaining 'hidden' as has been a theme in previous SCRs. Rather they appear to represent men who had limited

[12] Horwath (2007)
[13] Brandon et al., 2008, 2009

relationships with Adult P. The arrival of Adult Q within the family was unexpected, indeed unknown to agencies until the assault on Adult P took place. She immediately responded by saying that the relationship was over.

4.5.3. What this has raised is a complex issue about the role of safeguarding agencies in making judgements about the significance, or otherwise, of decisions made by parents about their personal and sexual relationships. It is however legitimate to consider this issue for two reasons:

i. the potential risks involved when men in relationships which offer little commitment are involved in the children's lives

ii. the particular impact for the children's emotional development on their understanding about who are the significant parental figures in their lives

4.5.4. There is minimal information about what involvement any of Adult P's partners had in relation to her children, and this is crucial in considering what approach could have been taken by the agencies concerned, including who might be part of any assessment. The Health Overview Report Author refers to '*cuckoo males'*, suggesting men who move into families for a period without any meaningful commitment to that family. It may however be that the men in Child J and Child K's lives were much less significant and were involved in effect only with their mother.

4.5.5. There is other information which suggests that there could be risks attached to Adult P's decisions regarding personal relationships. As a teenager there were concerns about the potential for her being exploited by adult males. Our understanding about child sexual exploitation has been developing significantly in more recent years and Bolton now has in place a specialist multi-agency team working with children at risk of sexual exploitation. Given Adult P's history; the view of agencies that she was 'vulnerable'; her experience of unwanted pregnancies; and visitors to the house who may have been at some level abusive or exploitative of Adult P, consideration might have been given to whether Adult P's intimate relationships were damaging either for her or for her children.

4.5.6. Professionals need to make careful judgements when seeking sensitive information regarding the personal relationships of adults with whom they are in contact. However, Child J's experience highlights that it is legitimate to make such enquiries in the context of the impact that such relationships or behaviour may have on the adult's parenting capacity or the child's safety. Adult P was asked on a number of occasions about whether she had a boyfriend or partner, but she chose not to share this information. Pursuing this line of enquiry without clear reason to do so, would have been highly intrusive. However, had there been a comprehensive assessment of the family dynamics, the significance of Adult P's relationships and

their relevance to her parenting might reasonably have been recognised as a legitimate area for assessment.

4.6 CONCLUDING REMARKS:

4.6.1. Two key issues particularly merit reflection within the conclusion of this critical analysis.

- Could Child J's death have been predicted or prevented
- What does child J's case tell us about the effectiveness of Bolton's Framework for Action

4.6.2. **Could Child J's death have been predicted or prevented?**

A clear conclusion has been reached by the SCR Panel and the independent author of this Review that Child J's Death could not have been predicted and as such could not have been prevented by the agencies involved.

4.6.3. Nevertheless, with the benefit of hindsight it is possible to conclude that Child J's emotional and developmental needs were being compromised to some extent within the family. A similar view could also be reached in relation to Child K. There is at least some evidence that the main carer, Adult P, gave inadequate attention to ensuring that the environment was safe and secure. There were some missed opportunities to better understand the family functioning; in particular Adult P's parenting skills and Child J's perspective on daily life.

4.6.4. However, even if the agencies had been able to gain better insights into the family's daily life, and as a result consider different, possibly more effective interventions, this could not result in the conclusion that Child J's death could have been anticipated. At best, Child J might have been viewed more specifically as a Child in Need under Section 17. Resulting services may have then provided a better targeted service, that might in turn have impacted on Child J's broader developmental needs as well as improving professional engagement with Adult P.

4.6.5. The first indication that Adult Q was a presence in the family's life and that he represented some level of risk was following the reported domestic abuse incident. Adult Q was subject to bail conditions which appeared to be effective in preventing contact with Adult P until he was released from bail without charge. Two days later Child J suffered the catastrophic injuries that resulted in death. Within this timescale, and on the basis of the comparative seriousness of the domestic abuse, agencies would not have been in a position to assess and protect Child J.

4.6.6. There is a considerable body of knowledge regarding the links between domestic abuse and child maltreatment.[14] However, it is also widely recognised that prediction of the risk of harm in relation to specific individuals is a complex and imprecise activity with the most accurate results arising out of the use of sophisticated assessment tools combining statistical calculations and detailed clinical assessment.[15] . Risk assessment in relation to domestic abuse has been much developed in recent years with the wide dissemination of the CAADA-DASH tools, as used in the case of Adult P. However neither this nor other tools should be understood as providing "complete predictive accuracy".[16] One of the difficulties faced in relation to prediction, is that many of the factors that can be identified as common to those who are violent to their partners is also common within wider population.

4.6.7. During the last two days of Child J's life Adult P allowed the child to be cared for by Adult Q, despite the fact that information available to this review suggests that during these two days she should have understood that Child J had already been injured. If this is the case it represents the final example of Adult P's inability to prioritise her child's needs above her own. There was no evidence available to professionals either at the time, or with hindsight that Child J could have experienced physical abuse. The pathologist has confirmed to this Review that there were no injuries which could have been identified by professionals in the days before Child J's death.

4.6.8. This Review has identified a number of opportunities missed, which could have led to further intervention or knowledge of the family situation by the agencies and possibly more positive outcomes during Child J's life. However, whilst these identify areas for improvement it would be significantly overstating the case to presume that had any or all of these opportunities been taken up the ultimate outcome for Child J would have been substantially different.

4.6.9. What does child J's case tell us about the effectiveness of Bolton's Framework for Action?

4.6.10. Ultimately, whilst there were positive aspects to the intervention of the various agencies within the Framework for Action, Child J's experience raises a number of questions about the effectiveness of the service provided to both Child K and Child J with regard to actual improved outcomes. It further presents a challenge to partner agencies as to whether these children's experience is particular to them or in fact provides us with a "window on the system" regarding the effectiveness of early help provision within Bolton.

4.6.11. Recent research by Davies and Ward has confirmed the value of investing in preventative and targeted approaches towards providing

[14] Brandon et al (2009), Cleaver and Unell 2011, Munro (2008)
[15] **Kemshall, H. (2001)**
[16] Robinson, A in Kemshall (2011)

early help for families. "...*programmes that prevent the occurrence of maltreatment are likely to be more effective than those that address its consequences. They also require practitioners to be more proactive, rather than reactive, moving the focus from considering thresholds for intervention to exploring how parenting can be improved in the population as a whole*".[17]

4.6.12. The implementation of Bolton's Framework for Action clearly identifies that prevention and early help is a key feature of the Board's approach to work with families. The Framework was launched in Bolton in 2007, and the partner agencies, particularly within the health family, have identified that there were some difficulties in the early implementation of these new processes. The view of the Serious Case Review Panel was that the management of Child J's case within the Framework was more likely to be representative of those early difficulties rather than indicative of fundamental weaknesses in current practice.

4.6.13. Agencies were able to point to both internal and external audits and reviews to support this view including:

- Internally, a number of case audits have been undertaken and identified a generally positive picture regarding the way that agencies have worked together
- A CAF quality assurance meeting is well established and evidences that CAFs are undertaken in appropriate circumstances
- The most recent OFSTED safeguarding inspection (February 2012) considered that there was :"*good evidence of strong, embedded partnership working across both the statutory and voluntary sectors*"

4.6.14. The challenge for the Board in the light of Child J's experience, is to consider whether the Framework for Action should be developed further to improve the process of Child Action Meeting reviews; maximise the achievement of positive outcomes for families; ensure effective and shared responsibility of the agencies in 'stepping up and stepping' down between levels of need. **(Multi-agency Challenge 3)**

4.6.15. This Review takes reassurance regarding Bolton's focus on ensuring the quality of the Framework, given that the Safeguarding Board has recently commissioned an independent Review of its Early Help through Lancaster University. The Lancaster University Review has been asked to consider three questions directly pertinent to Child J's experience:

- How well are use of levels 1 & 2 of Bolton's Framework for Action working?

[17] Davies and Ward (2012)

- What difference does it make for children, young people and families?
- What actions could improve use of the Framework and evidence progress?

This work was in progress during the time of this SCR with a verbal report due to be tabled at the Board Meeting.

Concerns raised by Adult R:

Child J's maternal grandmother Adult R raised 4 specific issues that concerned her regarding the services provided to Child J and the Review considered these required a direct response:

4.6.16 Firstly Adult R raised questions as to why agencies, such as Children's Social Work, had not intervened more forcefully with Adult P's care of Child J following the fire in the house. This has been considered more fully within this Critical Analysis, but to summarise, agencies accepted the assurances given at the time that Child J would not be cared for by inappropriate carers in the future. More generally, the services that were provided were done so on a voluntary basis as it was not judged that the children's needs had reached a threshold that would justify more intrusive involvement without their mother's consent. Whilst it is difficult with hindsight to take an absolute position on these decisions, the Review does not consider that different decisions at this time could have prevented Child J's death, the approach taken has been subject to some criticism within the body of this report

4.6.17 Adult R's three other concerns relate to the information available to family and community regarding the care of children that they have a proper interest in. The Review recognised that these are important concerns and has identified these as a Challenge for the Board to respond to. (**Challenge 4**)

5 INDIVIDUAL AGENCY REPORTS AND RECOMMENDATIONS

5.1 Action for Children

5.1.1. Action for Children, which was commissioned by Bolton Council to provide the Family Intervention Project, has provided a chronology and Individual Management Review for this Serious Case Review.

5.1.2. The report has been prepared by an Improvement and Consultancy Manager within the Practice Improvement Division of Action for Children. The author has had no operational responsibility in the case or any direct involvement with Child J and the family and as such met the criteria for independence.

5.1.3. The Report was countersigned by the Director of Practice Improvement. The countersigner had no direct knowledge or involvement with the services provided to Child J or the family.

5.1.4. The **recommendations** for Action for Children and Safeguarding are as follows:

1. Review content of Recording, Assessment and Analysis Training in Action for Children.
2. Development of Safeguarding Template for Transition Planning when line management changes

5.2 Children's Services, Staying Safe Division, Bolton Council

5.2.1. Bolton Children's Services, Staying Safe Division, has provided a chronology and Individual Management Review for this Serious Case Review.

5.2.2. The IMR has been prepared by a District Manager. The author has had no operational responsibility in the case or any direct involvement with Child J or the family and as such met the criteria for independence. The IMR was countersigned by the Assistant Director who had no direct knowledge or involvement with the services provided to Child J or the family.

5.2.3. The **recommendations** for action for Bolton Children's Services, Staying Safe Division are as follows:

1. District Managers in Staying Safe will create a Task and Finish Group of relevant staff to develop a Domestic Abuse Tool for Referral & Assessment Social Workers. The purpose of this tool is to help assess risk in situations of domestic abuse that will contribute to decision making about the safety of children. The tool will be specifically designed to aid Social Workers who do short term social work, assessments and interventions.

2. The Senior Management Team in Staying Safe will continue to work towards the improvements in the use of chronologies, family histories and case summaries in assessments and case files. This is already an action on the Division's Service Improvement Action Plan (SIAP) and on the District Action Plans.

5.3 Bolton at Home

5.3.1. Bolton at Home is s a social housing provider which provided accommodation to Adult P and Child J from the beginning of the timeline of this review until January 2012 Bolton at Home provided a

chronology and Individual Management Review for this Serious Case Review.

5.3.2. The report has been prepared by the Customer Support Manager. The author has had no operational responsibility in the case or any direct involvement with Child J and the family and as such met the criteria for independence.

5.3.3. The Report was countersigned by the Director of Housing Services. The countersigner had no knowledge or involvement of the services provided to Child J or the family.

5.3.4. The **recommendations** for action for Bolton at Home are as follows:

1. Introduction of a formal assessment and action planning process within the Neighbourhood Safety Team to reflect the good practice of STeP and Domestic Abuse services
2. Review internal processes for requesting and providing tenancy references and information to new housing providers and liaise with BCH partners to develop a consistent approach.

5.4 Greater Manchester Police

5.4.1. Greater Manchester Police has provided a chronology and Individual Management Review for this Serious Case Review.

5.4.2. The report has been prepared by a Review Investigator within the dedicated Investigative Review Unit. The author has had no operational responsibility in the case or any direct involvement with Child J and the family and as such met the criteria for independence.

5.4.3. The Report was countersigned by the Head of the Investigative Review Unit, who had no direct knowledge or involvement of the services provided to Child J or the family.

5.4.4. The **recommendations** for action for Greater Manchester Police are as follows:

1. The Detective Chief Superintendent GMP Public Protection Division to monitor the progress of the current criminal prosecution in respect of Adult Q, the coronial inquest into the death of Child J and the related IPCC investigation and at the conclusion of each process captures and disseminates any identified learning in respect of safeguarding.

2. The Detective Chief Superintendent GMP Public Protection Division considers an amendment to current PPD guidance to include a requirement for PPIU/DAU Departments to notify partner agencies and share relevant information in respect of previous domestic abuse referrals which are subsequently

subject of “no further action” decisions in relation to prosecution (Police or CPS decisions)

3. The Detective Chief Superintendent GMP Public Protection Division consults with Senior Leadership Teams (SLTs) in GMP to establish that robust processes exist on divisions (similar to the email notification system at Bolton) to ensure that where “no further action” decisions are taken on prosecution either by the police or by CPS in respect of domestic abuse cases this decision is notified to the divisional PPIU/DAU to reassess risk and notify partner agencies and to a representative of the SLT to ensure that decisions have been assessed and robustly challenged/appealed where appropriate.

4. The Detective Chief Superintendent Public Protection Division in conjunction with the Greater Manchester Police MARAC coordinator conducts a review of the functions and operating protocols of the MARAC coordination unit with a view to ensuring the unit is effective and able to service current demand and to report on the initiative to acquire and introduce audio recording equipment to record MARAC meetings and produce minutes/action plans.

5. The Detective Chief Superintendent GMP Public Protection Division considers as part of the post implementation review of PPD procedures to undertake a dip sample audit of the quality of information provided by initial DASH risk assessment submissions.

6. The Head of the Public Protection Division in consultation with representatives of Divisional Senior Leadership Teams considers publishing a reminder on Chief Constable’s Orders for police decision makers involved in making or reviewing “no further action” decisions in domestic abuse prosecution cases to robustly assess and verify the information relied upon during the decision making process.

5.4.5. Greater Manchester Police has initiated work in relation to all the recommendations identified.

5.5 Greater Manchester Probation Trust

5.5.1. Greater Manchester Probation Trust has provided a chronology and Individual Management Review for this Serious Case Review.

5.5.2. The report has been prepared by a Probation Operations Manager from another area within the Trust. The author has had no operational responsibility in the case or any direct involvement with Child J and the family and as such met the criteria for independence.

5.5.3. The Report was countersigned by the Probation Operations Manager from Bolton, who had no direct knowledge or involvement of the services provided to Child J or the family.

5.5.4. There are no recommendations for action for Greater Manchester Probation Trust, which is acknowledged as reasonable in the circumstances.

5.6 Bolton NHS Foundation Trust

5.6.1. Bolton NHS Foundation Trust has provided a chronology and Individual Management Review for this Serious Case Review. The report has been prepared by the Named Nurse, Safeguarding Children. The author has had no operational responsibility in the case or any direct involvement with Child J and the family and as such met the criteria for independence.

5.6.2. The Report was countersigned by the Associate Director of Patient Safety/Deputy Chief Nurse who had no direct knowledge or involvement of the services provided to Child J or the family.

5.6.3. The IMR provided information regarding the services provided to Child J and the family as follows: Midwifery, Health Visiting, School Nursing, Paediatrics, A&E, Walk-In Centre, Out-of-Hours GP Service.

5.6.4. The **recommendations** for action for Bolton NHS Foundation Trust are as follows:

1. Health records audit for children living in households where there is known domestic abuse
2. Domestic abuse issues to be included in single agency training and updates
3. MARAC rep to review all health referrals to ensure issues of risk to children are fully assessed

5.6.5. Bolton NHS Foundation Trust has identified a number of actions which it has already put in place as a result of this Review:

- Safeguarding Children and Domestic Abuse workshops planned
- Planned audit of records where Domestic Violence present
- Identification of staff who have used the Graded Care Profile as sources of contact for staff working with children where neglect is a concern to ensure more comprehensive use of GCP even at “lower” level

5.7 Bolton Primary Care Trust – GP Service

5.7.1. Bolton Primary Care Trust has provided a chronology and Individual Management Review for this Serious Case Review in respect of General Practitioner Services.

5.7.2. The IMR has been prepared by an Associate Medical Director of the Greater Manchester Primary Care Trust. The author is herself a GP but has had no operational responsibility in the case or any direct involvement with Child J and the family and as such met the criteria for independence.

5.7.3. The IMR was countersigned by the Interim Accountable Officer for Bolton Clinical Commissioning Group who had no direct knowledge or involvement of the services provided to Child J or the family.

5.7.4. The **recommendations** for action for Bolton PCT GP services are as follows:

1. Further training to be delivered to all GP practice staff in relation to Domestic Violence, the relationship to child abuse and how to act on concerns in line with local guidance including documentation.

2. Development of multi-agency policy, procedure and working practices to ensure the formal sharing of information in relation to domestic violence between GP Practice Safeguarding Lead and attached primary care staff (health visitors/midwives) in line with relevant information governance requirements .

3. Update training to all GP Practice staff in relation to Bolton policy for preventing and managing missed health appointments and contacts for children, young people and their carers. Training to include further guidance in relation to coding failures to attend within the GP practice electronic medical records and appropriate action following missed appointments.

4. Review current policy and procedure for copying referral letters relating to children between agencies in line with required information sharing guidance.

5. Review current communication mechanisms between general practice and health visiting teams.

5.8 NHS Commissioning Health Overview

5.8.1. NHS Bolton has produced a comprehensive chronology and Health Overview Report for this Review. The report has been jointly authored by the Associate Director Safeguarding (Designated Nurse) and the Consultant Paediatrician (Designated Doctor) for the PCT. The author had no direct knowledge of the services provided to the family or operational responsibility for those services. The report has been countersigned by the Interim Accountable Officer Bolton PCT/Clinical Commissioning Group, who had no direct knowledge of Child J or the family.

5.8.2. The Health Overview has identified 3 **additional Recommendations** for action for the health family as follows:

1. An evaluation of the arrangements and effectiveness of information sharing between health visitors and GPs since health visiting service redesign is undertaken by Bolton Foundation Trust and the finding reported back to BSCB. Improved communication between health visiting service and general practice in relation to children in need and their families.
2. In cases managed through to Child Action Meetings and additional health input due to compromised parenting a Child Action Meeting should always be considered if another pregnancy occurs even when there have been positive changes. Pregnancy is an additional stressor and the impact on parenting ability should be revisited
3. When health referrals are made by the health visitor or school nurse a copy is sent to the GP and child health referrals made by the GP are copied into the health visitor and/or school nurse to avoid duplication of referrals.

5.8.3. The Health Overview Report has also made three **recommendations** for the Bolton PCT Clinical Commissioning Group:

1. Bolton Clinical Commissioning Group demonstrate robustness of safeguarding arrangements through the development of a safeguarding structure and service model for safeguarding that will ensure statutory duties are met by commissioners and providers of health care for the Bolton population.

2. Bolton Clinical Commissioning Group to ensure Bolton NHS Foundation Trust as an integrated organisation have sufficient individuals available with the appropriate level of safeguarding knowledge, expertise and support (including administrative support) and access to relevant electronic systems, case files and archived records to respond to the requirements of a serious case review within the statutory timescales.

3. Training for primary care practitioners to improve awareness and response to domestic abuse and the impact of domestic abuse on children

5.8.4. NHS Bolton has identified a number of actions which it has already put in place as a result of this Review:

- Proposals made regarding a structure and service model for safeguarding which meets the requirements of authorisation to be a Clinical Commissioning Group as a statutory body by the NHSCB (NHS Commissioning Board.
- Planning of a safeguarding event for GPs re domestic abuse

- Promotion of the use of Royal College of General Practitioners e-learning package with GP practices

6 MULTI AGENCY CHALLENGES

In line with developing thinking regarding the most effective means of embedding learning arising out of Serious Case Reviews, this review made a conscious decision not to produce traditional 'SMART' recommendations to the Board, but instead to identify challenges for the Board to consider:

Challenge 1: The Board to consider whether there is potential for further improvement and developments in the effectiveness of multi-agency responses to safeguarding of children in situations of domestic abuse.

Challenge 2: The Board to consider whether the multi-agency approach to neglect is consistent with Bolton's Framework for Action and approach to early help and prevention, in providing an acceptable and effective level of service to those families and children at lower levels of need who therefore are not identified or managed as being at risk of significant harm.

Challenge 3: The Board to consider whether the Framework for Action can be developed further to improve the process of multi-agency Child Action Meeting reviews, achievement of positive outcomes for families, ensure effective and shared responsibility of the agencies in 'stepping up' and 'stepping down' between levels of need.

Challenge 4: The Board to consider whether the information provided to families and communities regarding:

a) the legal position of carers without Parental Responsibility

b) how and where to access advice and support out of routine office hours is adequately comprehensive and accessible.

Name of SCRP chair assuring quality of overview report	Peter Maddocks
Date	Redacted

1 Endorsement by LSCB

Name of LSCB Chair	Mike Tarver
Date of LSCB endorsement of overview report	Redacted

Signed on behalf of LSCB:

Position: Independent Chair of BSCB

Author: Sian Griffiths

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APPENDIX A: Terms of Reference

The following Terms of Reference have been developed following an Initial Serious Case Review Panel meeting on 16 May 2012.

1. Decision to hold SCR

Notification was sent to Ofsted in relation to Child J's death and that a Serious Case Review (SCR) was possible but not yet confirmed. An Initial SCR Panel meeting was held and members recommended that the criteria for an SCR were met. Bolton Safeguarding Children Board's Independent Chair endorsed this recommendation.

The Panel established that Child J had sustained a traumatic non-accidental injury which caused death. Child J had been in the immediate care of Adult P's partner and no adequate explanation for the fatal injury has been provided. Given the circumstances of the injury this indicated that abuse or neglect should at least be suspected as being a factor in the child's death. Hence the criteria described in Chapter 8, Section 8.9 had been satisfied,

*"When a child dies (including death by suspected suicide) **and** abuse or neglect is known or suspected to be a factor in the death, the LSCB should **always** conduct a SCR into the involvement of organisations and professionals in the lives of the child and family. This is irrespective of whether local authority children's social care is, or has been, involved with the child or family. These SCRs should include situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse. In addition, a SCR should always be carried out when a child dies in custody, either in police custody, on remand or following sentencing, in a Young Offender Institution (YOI), a Secure Training Centre (STC) or secure children's home, or where the child was detained under the Mental Health Act 2005."*

2. Key Lines of Enquiry

2.1 Recognition

a. To what extent were any vulnerabilities or needs of mother, Adult P recognised and taken into account in terms of any potential risks they posed for her child; to comment in particular on any action taken to ascertain whether there were any issues of learning or other disability relevant to agency involvement.

b. Was sufficient recognition given to the incidents of domestic abuse and how was this used in considering the implications for the safety and well-being of the child.

c. Was enough information sought about the relationship between Adult P and Adult Q or previous partners during the time frame for the review and the implications for the children?

d. What information was sought or known about in regard to the mental health and use of alcohol or drugs by any of the adults who were in or a visitor to the household.

e. Was there sufficient recognition and consideration of how well Adult P was able to provide a safe environment; including judgements about suitable carers, boundaries and routines, etc?

2.2 Assessment & Decision Making

a. How and to what extent was the relationship between Adult Q and the children assessed?

b. The quality and timeliness of any assessments and the extent to which they took account of relevant family or personal history, the cultural, ethnic and religious identity of the family, the needs of Child J and the capacity of Adult P to meet the needs of her children; this should include comment about any extended family or others and their role and impact in promoting the safety and wellbeing of Child J and siblings.

c. Comment on the quality of judgments and decision making and the extent to which it reflected a focus on the needs of Child J and siblings (including the unborn sibling) and represented appropriate professional standards and a competent understanding of any relevant guidance, research, theoretical and/or legal frameworks; particular attention should be given to how evidence of domestic violence was collated and analysed.

d. How and to what extent was consideration given to Child K not being cared for by Adult P and the circumstances around this decision? How did this impact on the assessment of Adult P's ability to provide care for Child J?

2.3 Using and Sharing Information

a. Identify whether information in respect of the family was shared among agencies to the best effect so as to inform appropriate interventions; in particular to identify when practitioners in contact with Child J or sibling saw either child and sought their views, wishes and feelings especially in regard to visitors to their home, the incidents of verbal and physical violence and the different partners.

b. To comment on the quality of reports and information provided for interagency enquiries and analysis including information provided in Child Action Meetings.

2.4 Planning and Interventions

a. Identify whether agencies and members of the Child Action Meetings and MARAC in contact with Child J's immediate family worked together effectively to provide services that safeguarded and promoted the welfare of the children.

2.5 Practice Support and Supervision

a. Consider whether all relevant single agency and multi-agency procedures were followed and the extent to which they facilitated or hindered sharing and analysis of information and informing action by the different services.

b. Consider whether the policy, procedural, management and resource infrastructure that surrounded each agency's involvement with Child J and the family promoted appropriate decision making; this should include evaluating the training, knowledge and experience of people working with Child J and the family, their workloads and the organisational stability; comment should also be made about whether any shortfall in resources were an impediment at any time during the period of the review.

c. Consider whether professionals working had sufficient and appropriate supervision commensurate with their role and responsibilities, and the extent to which the case was subject to appropriate and effective managerial oversight and promoted critical reflection.

2.6 Learning from SCRs and other review processes

a. Consider previous or concurrent serious case reviews conducted by the Bolton or other local safeguarding children boards. Take into account any common themes and actions arising from those SCRs that are relevant to the circumstances of this case and comment on what impact they had in this case.

b. Consider previous reviews of single agency practice. Take into account any common themes and actions arising from those reviews that are relevant to the circumstances of this case and comment on what impact they had in this case.

2.7 The terms of reference for the Health Overview Report

The health overview report should provide an overview of the information and analysis provided by all health services for the serious case review. In particular it should address the following:

a. Comment on the quality of information and analysis and identify significant themes and areas for learning

b. Provide comment on the extent to which evidence about domestic abuse and violence, substance misuse and was identified and acted upon by various health services

c. Comment on the extent to which the reports provided by health services have identified appropriate learning and have provided sufficiently informed analysis

d. Give particular regard to any implications for the likely reform of health arrangements in Bolton identified through the review

e. The quality of recommendations proposed by health services

f. Identify any further themes to be explored within the overview report

g. Make any recommendations necessary to ensure appropriate implementation of learning across the health service in Bolton

2.8 The terms of reference for the Overview Report

In conducting a serious case review BSCB will ensure that a multi-agency overview report is produced in accordance with the national guidance in *Working Together to Safeguard Children (2010).* In addition to the requirements of *Working Together to Safeguard Children (2010)* and taking into account the specific issues identified above, the overview report author should:

a. Comment on whether the individual management reviews have addressed the terms of reference and all relevant issues

b. Comment on the conduct of the serious case review by BSCB and whether there are lessons for BSCB for the future conduct of SCRs taking account of impending revised government guidance.

c. Examine the inter agency working and communication between all involved agencies

d. Determine whether services which were provided, actions taken and decisions made were in accordance with current policies, procedures and government guidance

e. Consider, using the benefit of hindsight, whether different decisions or actions may have led to a different course of events and outcomes for Child J.

f. Provide comment and analysis within the context of relevant research and national evaluations of services and serious case reviews and its application in this case

g. Identify whether there are any areas of learning that have implications for national policy or guidance

h. Provide an executive summary for publication on behalf of BSCB.

3. Independent Author

The Overview Report will be authored by Sian Griffiths. Ms. Griffiths is a self-employed Consultant who has been the author of a number of SCR overview reports. She has been commissioned by Bolton Safeguarding Children Board. She has not previously worked with any agency in Bolton.

Ms. Griffiths will be expected to author the Overview Report and Executive Summary within the timescale agreed by the SCR Panel. She will also contribute to the development of a SMART action plan based on the learning points and recommendations from the overview report. The Panel will not be chaired by Ms. Griffiths although she will be invited to attend Panel meetings.

The overview report will be written and presented in accordance with BSCB's template.

4. Time period over which events should be reviewed

The timescale has been agreed by the SCR panel as it covers the period when Child J was conceived and runs to the point where the child was confirmed to have sustained suspected fatal non-accidental injuries and death. This time period was agreed as sufficiently extensive to enable the identification of any lessons to be learned.

The SCR Panel have requested that services in Area 2 provide relevant contextual information, so far as possible, in respect of their contact with Adult P's partner and any knowledge of the family history. This will be done via the Chair and Business Manager of Area 2 Safeguarding Children Board.

5. Organisations to be involved in this SCR

The SCR Panel has identified the following agencies/services to provide Individual Management Reviews:-

- Children's Services Staying Safe; to include the involvement of social work teams and childrens centres
- Bolton NHS Foundation Trust; to include all relevant community and hospital based services
- GP; to include services provided to Child J, Adult P and Adult Q
- Health Overview Report; to include General Practitioner, Midwifery and Medical Services at Royal Bolton Hospital, Health Visiting Service and any other identified health support
- Bolton at Home
- Family Intervention Project
- Greater Manchester Police; to include the MARAC process and associated services
- Greater Manchester Probation

The agencies completing IMR's will be expected to use the Greater Manchester IMR template which is available from Bolton Safeguarding Children Board, and to complete the reports within the agreed timescale. IMR authors will be expected to attend the SCR Panel and authors' day to present their report and lessons to be learned.

Should any agency identify that they are unable to complete the IMR within the agreed timescale they should contact Bolton Safeguarding Children Board and the SCR Panel Chair. They should provide the reason for the delay and the date when they anticipate the report to be completed. Where there are on-going issues in relation to the completion of an IMR report this will be brought to the attention of the relevant Bolton Safeguarding Children Board member, or Chief Officer by the SCR Panel Chair. The expectation will be that the report will completed as a priority and no later than ten working days of the matter being raised.

In addition to the agencies/services above, the SCR Panel have also requested service statements from:-

- Affinity Sutton Trust
- North West Ambulance Service
- Greater Manchester West Mental Health Service
- Children's Legal Services Bolton
- Greater Manchester Fire Service, Bolton Borough
- All organisations represented on Area 2 Safeguarding Children Board who worked with the family

All liaison and queries in respect of the IMR or the SCR process will be managed by either the SCR Panel Chair or Bolton Safeguarding

Children Board Officer - 01204 337479 or email boltonsafeguardingchildren@bolton.gov.uk

6. Involvement of family Members

The on-going criminal investigation and child care proceedings will impact on when and how family members are involved. The SCR panel has agreed that the parents will be notified that the SCR process has been initiated and that they may have an opportunity to contribute. Any contribution will be carried out in consultation with the CPS, the Senior Investigating Officer and Childrens Legal Services Bolton. The most appropriate format for seeking family views will also be considered. This will ensure that due consideration has been given to ensuring that any investigative and other processes are not compromised.

Where it is deemed appropriate the following family members will be invited to contribute:-

- Adult P Mother
- Adult R Maternal Grandmother
- Adult S Maternal Grandfather

Where additional relevant family members are identified during the SCR process consideration will be given to including their views.

Contact and liaison with family members will be managed by either the SCR Panel Chair or Bolton Safeguarding Children Board Officer - 01204 337479 or email boltonsafeguardingchildren@bolton.gov.uk .

Any queries to individual agencies from family members about the SCR should be managed in the same way.

7. Other parallel reviews (eg PPO/homicide or suicide reviews)

As identified there are parallel processes on-going which will have to be considered as part of the SCR process. In order to address this Police and Children's Legal Services are Panel members to ensure consistent and coherent information sharing.

Liaison will also be undertaken with the Senior Investigating Officer and CPS as required and be undertaken by the SCR Panel Chair or Bolton Safeguarding Children Board Officer - 01204 337479 or email boltonsafeguardingchildren@bolton.gov.uk

8. Involvement of organisations in other LSCB areas

As detailed above in Section 5 an initial summary of involvement will be requested from Area 2 Safeguarding Children Board summarising the involvement of services and agencies in that area. This will inform the

SCR Panel as to whether IMR's should be completed by any agencies or services in Area 2.

The Panel Chair and Bolton Safeguarding Board Officer will take responsibility for ensuring the information requests are made and that an invitation is extended to Area 2 to be co-opted to the panel should this be required.

9. Coroner's Inquiries/Criminal Investigations

As detailed previously, the police investigation is on-going and Adult Q has been charged; consideration is still being given as to whether any charges will be brought in respect of Adult P. It is unclear how long the police investigation will take to conclude however it is not anticipated that this will impact on the completion of the SCR and the implementation of any lessons to be learned.

It should be noted that dependent on the outcome of the criminal investigation there may be an impact on the publication of the SCR findings to the wider public.

The coroner has been advised of the SCR and liaison will be undertaken by Panel Chair and Bolton Safeguarding Board Officer. Any advice issued by the coroner will be shared and actioned by the SCR Panel.

10. Media coverage/Enquiries

There has been some initial local and national media coverage of Child J's death. It is anticipated that further interest may be generated at the time of key court appearances.

The Local Authority's press office will manage any media enquiries and any panel member or other agency contacted by the media should discuss this with Bolton Safeguarding Board Officer who will liaise with the SCR Panel Chair and MARCOMs.

Given the nature of the case and that a significant amount of family information has been placed in the public domain it will be challenging to ensure complete anonymity. However the SCR Panel will ensure that in the reports family names, dates of birth, places of residence (other than town names) etc. will not be used. A key will be used to refer to the individuals involved, including family members and workers.

Media statements have been prepared should any enquiries be made in respect of the case and there will be liaison between the media teams in partner agencies.

11. Legal advice

A representative of Children's Legal Services is a member of the SCR Panel and they will provide advice and guidance to the Panel as required, including the need for any additional independent advice.

12. SCR Review Timescales

Confirmation to Ofsted and Department for Education has been made. The SCR will be completed within the six month time limit. Dates for submission and endorsement of reports have been set and it is not anticipated that the SCR will go beyond these dates.

13. Liaison with Ofsted and Department for Education

Bolton Safeguarding Children Board Officer will liaise with Ofsted and Department for Education in respect of progress and where any extensions to timescales prove necessary.

APPENDIX B: FULL GLOSSARY OF CODES

PRACTITIONERS AND AGENCIES:

Action for Children	
Senior Project Worker	**Senior Project Worker 1**
Temporary Service Manager	**Service Manager 1**
Service Manager	**Service Manager 2**
Not known	**Project Worker 2**
Affinity Sutton Housing	
Voids and Lettings Officer	**Voids and Lettings Officer 1**
Voids and Lettings Officer	**Voids and Lettings Officer 2**
Neighbourhood Housing Officer	**Neighbourhood Housing Officer 1**
Housing Administrator	**Housing Administrator 1**
Contact Centre Phone Advisor	**Contact Centre Phone Advisor 1**
Head of Housing	**Head of Housing 1**
Arrears Recovery Officer	**Arrears Recovery Officer 1**
Account Manager	**Account Manager 1**
Director of Customer Services	**Director of Customer Services 1**
Customer Services Officer	**Customer Services Officer 1**
Bolton at Home	
Tenancy Sustainment Officer	**Tenancy Sustainment Officer 1**
Tenancy Sustainment Officer	**Tenancy Sustainment Officer 2**
Young Person's Housing Officer	**Young Person's Housing Officer 1**
Housing Officer	**Housing Officer 1**
Housing Officer	**Housing Officer 2**
Domestic Abuse Officer	**Domestic Abuse Officer 1**
PATH Trainee	**PATH Trainee 1**
Housing Services Officer	**Housing Services Officer 1**
Housing Services Officer	**Housing Services Officer 2**
Neighbourhood Safety Officer	**Neighbourhood Safety Officer 1**
Neighbourhood Safety Officer	**Neighbourhood Safety Officer 2**
Senior Manager Neighbourhood Safety	**Senior Neighbourhood Safety Manager 1**
Community Housing Manager	**Community Housing Manager 1**
Bolton Council	
Assistant Director, Customer Services, Chief Execs Finance Dept – Revenues & Benefits	**Assistant Director 1**
Housing Benefit Officer, Housing Benefit Department	**Housing Benefit Officer 1**

Bolton NHS Foundation Trust	
Midwife	**Midwife 1**
Midwife	**Midwife 2**
Midwife	**Midwife 3**
Midwife	**Midwife 4**
Midwife	**Midwife 5**
Health Visitor	**Health Visitor 1**
Health Visitor	**Health Visitor 2**
Health Visitor	**Health Visitor 3**
Health Visitor	**Health Visitor 4**
School Nurse	**School Nurse 1**
School Nurse	**School Nurse 2**
Children's Services	
Assistant Director, Staying Safe	**Assistant Director 2**
District Manager	**District Manager 1**
Referral & Assessment Social Worker	**Social Worker 1**
Referral & Assessment Social Worker	**Social Worker 2**
Referral & Assessment Social Worker	**Social Worker 3**
Referral & Assessment Social Worker	**Social Worker 4**
Referral & Assessment Social Worker	**Social Worker 5**
Referral & Assessment Social Worker	**Social Worker 6**
Referral & Assessment Social Worker	**Social Worker 7**
Referral & Assessment Team Manager	**Team Manager 1**
Referral & Assessment Deputy Team Manager	**Deputy Team Manager 1**
Children's Centre Family Worker	**Family Worker 1**
Children's Centre Family Worker	**Family Worker 2**
Children's Centre Family Worker Team Leader	**Family Worker Team Leader 1**
Children's Centre Manager	**Children's Centre Manager 1**
EDT Duty Social Worker	**EDT Social Worker 1**
EDT Duty Social Worker	**EDT Social Worker 2**
Family Support Manager	**Family Support Manager 1**
General Practitioners	
GP for subject & Adult P, GP Practice 1	**GP1**
GP for subject & Adult P, GP Practice 1	**GP2**
GP for subject & Adult P, GP Practice 1	**GP3**
GP for subject & Adult P, GP Practice 1	**Locum GP1**
GP for subject & Adult P, GP Practice 1	**Locum GP2**
GP for Adult Q – GP Practice 2	**GP4**
GP for Adult Q – GP Practice 3	**GP5**
GP for Adult Q – GP Practice 3	**GP6**

GP Adult P	**GP7**
Practice Manager, GP Practice 1	**Practice Manager 1**
Practice Manager, GP Practice 1	**Practice Manager 2**
Receptionist, GP Practice 1	**Receptionist 1**
Greater Manchester Police	**GMP**
Criminal Investigation Manager	**Criminal Investigation Manager**
Response PC	**Response PC1**
Response PC	**Response PC2**
Response PC	**Response PC3**
Response PC	**Response PC4**
Response PC	**Response PC5**
Response PC	**Response PC6**
Response PC	**Response PC7**
Response PC	**Response PC8**
Response PC	**Response PC9**
Response PC	**Response PC10**
Response PC	**Response PC11**
Response PC	**Response PC12**
Response PC	**Response PC13**
Response PC	**Response PC14**
Response Supervisor	**Response Supervisor 1**
Detention Officer	**Detention Officer 1**
Prisoner Processing Unit Officer	**Prisoner Processing Unit Officer 1**
Prisoner Processing Unit Supervisor	**Prisoner Processing Unit Supervisor 1**
PPIU Officer	**PPIU Officer 1**
PPIU Domestic Abuse Investigator	**PPIU Domestic Abuse Investigator 1**
PPIU Domestic Abuse Investigator	**PPIU Domestic Abuse Investigator 2**
PPIU Domestic Abuse Investigator	**PPIU Domestic Abuse Investigator 3**
Domestic Abuse Unit Supervisor at Bolton	**PPIU Domestic Abuse Supervisor 1**
PPIU Clerk	**PPIU Clerk 1**
Independent Domestic Abuse Advocate	**Independent Domestic Abuse Advocate 1**
Home Office Pathologist	**Home Office Pathologist**
HQ Public Protection Division Supervisor	**HQ Public Protection Division Supervisor 1**
Officer in charge of Bolton PPIU	**PPIU Inspector 1**
Homicide Detective	**Homicide Detective 1**
Police Community Support Officer	**Police Community Support Officer 1**
Police Community Support Officer	**Police Community Support**

	Officer 2
Police Community Support Officer	**Police Community Support Officer 3**
Community Beat Manager	**Community Beat Manager 1**
Community Beat Manager	**Community Beat Manager 2**
Detective Constable, Bolton Divisional HQ	**Detective Constable 1**
Detective Constable, Bolton Divisional HQ	**Detective Constable 2**
Family Liaison Officer	**Family Liaison Officer 1**
Family Liaison Officer	**Family Liaison Officer 2**
Detective Sergeant, Major Incident Team	**Major Incident Team Officer 1**
Detective Sergeant, Child Protection Team	**Child Protection Team Officer 1**
Greater Manchester Probation Trust	
Offender Manager	**Offender Manager 1**
Offender Manager	**Offender Manager 2**
Community Payback Officer	**Community Payback Officer 1**
Community Payback Officer	**Community Payback Officer 2**
Community Payback Manager	**Community Payback Manager 1**
BSR Programme Facilitator	**BSR Programme Facilitator 1**
Probation Service Officer, Area 2 Spotlight Team	**Probation Service Officer 1**
Probation Service Officer, Area 2	**Probation Service Officer 2**
Assistant Chief Executive, Area 2 LDU	**Assistant Chief Executive 1**
North West Ambulance Service	
Paramedic	**Paramedic 1**
Paramedic	**Paramedic 2**
Emergency Medical Technician	**Emergency Medical Technician 1**
Advanced Paramedic	**Advanced Paramedic 1**
Other professionals	
Salvation Army Hostel worker	**Salvation Army Worker 1**
Headteacher at School 1	**Headteacher 1**
Teacher at School 3	**Teacher 1**

SIGNIFICANT OTHERS

Relationship	Code
Sister of Adult Q	**Adult T**
Grandmother of Adult Q	**Adult U**
Former Partner of Adult P	**Adult V**
Former Partner of Adult P	**Adult W**
Former Partner of Adult P	**Adult X**
Former Partner of Adult X	**Adult Y**
Cousin of Adult Q	**Adult Z**
Man living at Address 9	**Adult AA**
Adult P stayed 2006/07	**Adult AB**
Friend of Adult Q	**Adult AC**
Friend of Adult P	**Adult AD**
Woman living At Address 2	**Adult AE**
Former Partner of Adult P	**Adult AF**
Former Partner of Adult P	**Adult AG**
Friend of Adult P	**Adult AH**
Friend of Adult P	**Adult AI**
Friend of Adult P	**Adult AJ**
Cousin of Adult P	**Adult AK**
Partner of Adult T	**Adult AL**
Adult previously living with Adult Q	**Adult AM**
Half Sibling of Adult Q	**Child N**
Child of Adult T	**Child O**
Friend of Child M	**Child P**
Friend of Adult P	**Child Q**
Possible child of Adult Q	**Child R**

RELEVANT ADDRESSES

Code	Description
Area 1	Bolton
Area 2	Adult Q's home town
Address 1	Home Address of Adult P & Child J
Address 2	Previous Address of Adult P & Child J
Address 3	Maternal Grandparents & Child K's address
Address 4	Previous Address of Maternal Grandparents
Address 5	Adult Q's address
Address 6	Adult X's last known address
Address 7	Adult V's address recorded by Prison Service
Address 8	Address searched by Police
Address 9	Address of Adult AA
Address 10	Child K taken to address
Address 11	Address from which anonymous allegation made that Adult P selling drugs

Address 12	Adult P seen at this address
Address 13	Home address of Adult AK
Address 14	Previous Address of Adult Q