EXECUTIVE SUMMARY
OF THE SERIOUS CASE REVIEW

In Respect Of

Child J

Overview report prepared by:-

Sian Griffiths, Independent Author

Signature:-_____

Overview Report Endorsed by:-

Mike Tarver, Independent Chair, BSCB

Signature:-_____

GLOSSARY OF RELEVANT FAMILY MEMBERS

CHILD J	Subject of the Review
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
Child M	Maternal uncle
Adult R	Maternal Grandmother
Adult S	Maternal Step Grandfather

1. Introduction

1.1 This report summarises the findings of a Serious Case Review that was undertaken following the death of Child J, who died as a result of a cardiac arrest having received multiple injuries whilst in the care of Adult P's partner. Child J and the family had contact with a range of services and on occasion, provided with additional services as a child in need of extra support within Bolton's Framework for Action[1]. These additional services required the consent of carers as they were at a level below thresholds for statutory involvement. Four referrals were made by different agencies to Children's Social Work[2] during Child J's life, none of which necessitated child protection or other legal procedures.

1.2 Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires Local Safeguarding Children Boards (LSCBs) to undertake Serious Case Reviews in accordance with procedures set out in Chapter 8 of Working Together to Safeguard Children (2010).

1.3 When a child has been seriously harmed and there is cause for concern as to the way in which the authority, partners within the Safeguarding Children Board or other relevant agencies have worked together to safeguard the child, the LSCB is required to conduct a Serious Case Review (SCR) into the involvement that organisations and professionals had with that child and their family.

1.4 The purpose of a Serious Case Review is to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result and

[1] Framework for Action is the established multi-agency approach for agencies working with children to assess the level of need and required support for individual children

[2] 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.

- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children' Working Together to Safeguard Children (2010), Ch 8

1.5 The Serious Case Review in relation to Child J established the facts and analysed the actions and practice of the agencies which provided services to Child J and the family. The review produced a range of agency specific recommendations as well as a smaller number of key challenges for the Safeguarding Board to consider.

2. Terms of Reference

2.1 The Serious Case Review (SCR) was given comprehensive Terms of Reference which formed the basis of its work.

2.2 The Terms of Reference identified that the time period for consideration by the SCR should begin with the ante-natal period for Child J and conclude on the date of Child J's death.

2.3 The agencies required to provide an Individual Management Review were identified as follows:

- 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

2.4 The following agencies provided shorter written reports proportionate to the level of involvement they had had with Child J, Adult P and Adult Q:

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

3. Membership and Methodology of the Review Panel

3.1 This Serious Case Review was conducted in line with the requirements of Working Together 2010. However, the panel was aware of the ongoing redrafting of Working Together and a developing focus on the use of Systems Models for undertaking such reviews developed by the Social Care Institute for Excellence (SCIE). As far as

practicable this review sought to reflect aspects of this model as outlined in the recently published Munro report.[3]

3.2 The Panel further agreed that in line with the new approach to Serious Case Reviews developed by SCIE, the Overview Report would provide 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.

3.3 The Serious Case Review Panel met on 7 occasions and membership consisted of:

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

3.4 Also in attendance at the Serious Case Review Panel Meetings were:

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

3.5 The Panel considered Individual Management Reports (IMRs), including a full chronology of involvement with the family from each of the contributing agencies as identified in Para 2.3. Further information was requested and received from Area 2 Safeguarding Children Board, who identified agencies which had provided some service

[3] Munro, E: (May 2011): The Munro Review of Child Protection: Final Report. Department of Education.

to Adult Q. During the course of the Review, the Overview Author and Health Overview Author were also supplied on request with copies of original documentation.

3.6 Both adults were charged with criminal offences relating to Child J's death. Following a trial both were found guilty of the relevant criminal offences.

3.7 The Review was aware that other parallel processes were taking place, specifically: an inquest which had been opened and adjourned; proceedings in the family court in relation to future care of Child K and Child L; an investigation by the Independent Police Complaints Commission following a self-referral by Greater Manchester Police.

3.8 The Panel gave careful consideration to the involvement of the family in the Review. Given that criminal proceedings were ongoing legal advice was that Child J's mother could not be interviewed until the conclusion of the proceedings, but it was possible to meet with Child J's maternal grandmother. The panel made concerted efforts to establish whether the father of Child J could be identified, but without success.

3.9 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.

3.10 The Review was keen to know as much as possible about Child J's personality, relationships and experiences of the world. Information from various professionals described Child J as a child, who presented as healthy and was a little 'chunky'; chatty but not overfamiliar with workers, a quiet and contented child, who was quite shy when first meeting people but who enjoyed playing with toys and would engage in play after a while. Child J was described as having a warm relationship with Adult P.

4. Summary of Events

The following section summarises the key events and information known to agencies regarding Child J and the family.

4.1 Child J was a child of white British origin who lived with Adult P throughout. Child J had an older half-sibling, Child K who lived with their maternal grandmother, Adult R, nearby. Adult P was a single parent and neither Child J nor Child K's father has been identified to this Review. The family was reliant on benefits and known to be under financial pressure in a community where financial and social disadvantage were widespread. There is no information that Child J or Adult P had other specific needs.

4.2 Prior to the Review's timescale Children's Social Work had brief involvement with Adult P as a teenager, following concerns about her vulnerability. Child K also had increased contact with health services as there were additional health needs and a referral to Children's Social Work with regard to Adult P's care of Child K was made during this period. This was resolved following the agreement that Child K would live with the maternal grandmother.

4.3 Adult Q lived in a neighbouring area and was not known to any agency in Bolton prior to his arrest for assaulting Adult P. Whilst he was known to the Probation Service and GP

service in his home town, none of the professionals in that area had reason to be aware of his relationship with Adult P or contact with Child J.

4.4 During the timescale covered by this Review there were a number of concerns identified regarding the needs of both children and in relation to Adult P's parenting, although these were ultimately assessed as being below the threshold for any statutory intervention. Five Child Action Meetings took place within the remit of Level 2 of the Framework for Action and, as a result, a number of extra services, such as Family Support were offered. On two occasions Children's Social Work undertook an Initial Assessment relating to these concerns, both of which concluded there was no continuing role for that service. Adult P's engagement with the services offered was inconsistent and as a result these additional services were closed after a period of time given that they had been offered on a voluntary basis.

4.5 Throughout the period covered, there was a series of complaints of anti-social behaviour in and around Adult P's home, particularly in relation to visitors to the property. Adult P was referred to the housing provider's Tenancy Sustainment Service in an attempt to help her reduce the problems and ensure her tenancy was not jeopardised. The Housing Provider was involved in some of the Child Action Meetings and also made a referral to the Family Intervention Project run by Action for Children.

4.6 On separate occasions in 2009 North West Ambulance Service attended both children at home following calls made by or on behalf of Adult P. One of these led to a referral to Children's Social Work due to concerns about the speed at which Adult P had responded to the child's condition. Whilst the health visitor followed up the concerns and gave advice, there is no information to confirm that the referral was in fact received by Children's Social Work.

4.7 Referrals were also made to Children's Social Work in relation to two specific events. The first followed a fire at the home when 6 week old Child J was being cared for by unacceptably young babysitters. An investigation by Children's Social Work and the police resulted in no further action as assurances were given by Adult P and Adult R that this would not be repeated. The second followed concerns about a potential risk of domestic abuse from a previous partner of Adult P. Relevant support services were provided and an Initial Assessment undertaken given the possibility of contact with Child J. Adult P and Adult R agreed there would be no unsupervised contact and that Adult P would contact the Police if she felt at risk, therefore no further action was considered necessary.

4.8 Whilst agencies were not aware of it at the time, it is now believed that Adult P and Adult Q began a relationship some months before Child J's death. Adult P, who was now pregnant, disclosed that she had been seriously assaulted by Adult Q who was subsequently arrested and bailed with conditions not to have any contact with her. Adult P was provided with relevant advice and support and the risk of potential future harm assessed using the CAADA-DASH tool resulting in her case being considered at a MARAC meeting which put in place supportive actions.

4.9 An Initial Assessment was also undertaken by Children's Social Work. Adult P stated she was no longer in a relationship with Adult Q but was not willing to pursue charges as the stress of the process was affecting her health and pregnancy. Given Adult P's statement that she would not be resuming the relationship the continuing involvement of the Health Visitor with the family, it was concluded there was no further role for Children's Social Work.

4.10 A decision was subsequently made by the police not to pursue criminal charges and Adult Q was released from his bail.

4.11 Two days later a 999 call was made by Adult P stating that Child J had fallen down the stairs and been injured. Adult Q had been caring for Child J. Paramedics arrived on the scene within 6 minutes and attempted resuscitation. Child J was transferred to hospital where death was pronounced.

5. Key Themes Arising and Lessons Learned

5.1. Each agency involved with Child J's care produced an Individual Management Review and the specific recommendations arising out of those agency reviews are detailed in the subsequent section.

5.2. **Services provided within The Framework for Action:** Both Child J and Child K received universal services, in particular from health. Both children also on occasions received extra 'early help' services provided within the Framework for Action, these are services which require the consent of the Child's carers in that the needs have not reached a threshold which would lead to statutory procedures. Children's Social Work took part in a number of Child Action Meetings and undertook Initial Assessments at different times, only one of which, following the fire, was due to a direct Child Protection concern. Agencies were aware that Child K was cared for by the grandmother due to concerns about Adult P's lack of consistent parenting and there are some indicators of possible attachment problems with Child K.

5.3. There were undoubtedly positive aspects to the intervention of the various agencies within the Framework for Action. Health and other professionals appropriately identified vulnerabilities with the family, including:

- Concerns over missed health appointments for Child K
- Adult P's late booking for ante-natal care with Child J
- The effect of anti-social behaviour on the family's housing security and possible impact of inappropriate behaviour on the children
- The risk of potential violence with regard to a previous partner

Professionals triggered the Child Action Meetings as a way to help the family with these issues and identified support such as the Family Intervention Project and Children's Centre Family Support workers. Proactive support was also offered by Bolton at Home both in relation to sustaining Adult P's tenancy and regarding potential risk from domestic abuse. Professionals persistently attempted to engage Adult P in this work.

5.4. However, with hindsight it is not apparent that there was any effective review of the degree to which the problems within the family or the level of concern had changed, or identification of how the outcomes for the two children had improved. Child J's experience therefore raises questions about the effectiveness of the service provided at that time to both the children and has identified lessons for the Board to consider in its ongoing review of the working of their early help provision. In particular the Review identified:

- A lack of clarity about when Child Action Meetings should be brought to a close, with a lack of evidence of improved outcomes for the children at the point of closure

- An absence of conscious review of the level of need or managerial oversight after the first Review Child Action Meeting as required within the procedure, or following a number of episodes of early help
- The lack of consideration of undertaking a holistic family or parenting assessment given the repeated low level concerns
- An over reliance on plans to put in place support mechanisms given that Adult P had a pattern of not engaging with services after her immediate needs had been met
- An acceptance that Adult R was a positive and protective factor in relation to the children, without full assessment of her parenting capacity, given the complex family history
- The degree to which information about Child K's vulnerabilities and Adult P's parenting of Child K was recognised as relevant to the parenting of Child J

5.5. A related issue has been the degree to which Children's Social Work could, or should, have become more actively involved with the family at different points. The Children's Services IMR has acknowledged that the absence of a proper chronology in this case undermined their ability to obtain a proper understanding of what the children's day to day experience might be and this has resulted in a recommendation for the service. The IMR also recognised that on at least one occasion the case was closed prematurely and there was over-optimism about Adult P's ability to maintain improvements.

5.6. Even with the benefit of hindsight it would be unreasonable to assert that there was evidence that the children's needs had crossed the threshold into Child Protection. However, given the available information there should have been explicit consideration of whether Child J might have been a Child in Need under S17 of the Children's Act and whether, as a result, Children's Social Work should have taken a greater role in meeting those needs.

5.7. Much of the activity from agencies was effectively focussed on Adult P's needs, and while this can be a legitimate way to impact on outcomes for children, there is a risk that activity remains predominantly adult focussed. A structured parenting assessment could have identified the children's experience of being parented and what, from their perspective might be considered good outcomes.

5.8. What can be seen more easily with hindsight is a pattern of predominantly low level, but unresolved concerns, attempted intervention by 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 post-natally
- Existence of behavioural problems in relation to Child K and Adult P having difficulties in managing Child K's behaviour
- Adult P's continuing financial difficulties and lack of material goods in the home, even taking into account her limited income
- 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 and Adult P's ability to regulate unsuitable visitors
- Speech delay in both children
- 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.
- Unresolved professional concern regarding parenting capacity
- "Shadowy" unknown males in the background, one of whom had committed serious offences of domestic abuse against another woman

5.9. 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 report that their long term involvement either on the basis of Child in Need or Child Protection would definitely have been the right course of action. However, what is not clear is why Child J's situation was not comprehensively assessed and for example, 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 supported by Children's Social Work, rather than simply closing the case.

5.10. 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 identified areas for improvement are familiar in terms of the role of GP practices within safeguarding. This Review therefore particularly endorses the comments in the Health Overview Report that: "*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 the recommendations made to the Bolton PCT Clinical Commissioning Group within the Health Overview Report.

5.11. The Framework for Action 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 the 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. This perspective was supported by evidence of case audits, quality assurance processes and the most recent OFSTED inspection (February 2012) which referred to "*good evidence of strong embedded partnership working across both the statutory and voluntary sectors*." A recently commissioned independent review of the Early Help Provision through Lancaster University is also currently underway, providing further reassurance about commitment to ongoing improvement.

5.12. 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)**

5.13. **Agencies Response to Domestic Abuse.** There is no specific evidence that domestic abuse featured in the family's life prior to the assault on Adult P by Adult Q. There is reference to Adult P being involved in relationships with two previous partners where domestic abuse may have been a feature. However there was no concrete evidence that these presented current risks and Adult P did not respond to attempts to support her or enable her to make a complaint. In case of concerns about her ex-partner, there was understood to be very little contact between him and the family and no specific

information that he posed a risk to them. It was not unreasonable therefore for Children's Social work to conclude within the Initial Assessment that there was no immediate Child Protection issue, and no further action required from that service unless further concerns were raised.

5.14. Prior to the assault on Adult P none of the agencies involved with the family knew of the existence of Adult Q or could have been expected to do so. Although he had been known in the past to criminal justice services in his home town and was currently seeing his GP for irritability and depression, none of these services had reason to know he had contact with Child J and Adult P. Even had they been aware of this, there was no information at this stage to indicate the potential for domestic abuse.

5.15. Services responded quickly and generally appropriately following Adult P disclosing that she had been assaulted. Risk assessments were undertaken by the Midwife and the PPIU and active attempts were made to engage and support Adult P, including through the allocation of an Independent Domestic Violence Advocate (IDVA). A MARAC meeting took place and actions were identified. Although there was an element of confusion about who was responsible for the actions, this did not ultimately affect the outcome. The police followed agreed practice of referring the case to Children's Services.

5.16. Adult Q was quickly arrested and bailed with appropriately restrictive conditions to prevent him making contact with Adult P during the investigation. The process of the police investigation itself has been analysed in detail within the GMP IMR, which concluded that it was not effective. GMP also referred the case to the Independent Police Complaints Commission whose investigation is ongoing and as such the detail of the investigation could not be considered further here.

5.17. The specialist PPIU (Police Public Protection Investigation Unit) Domestic Abuse investigator undertook a further risk assessment following Adult P's decision to retract her statement. This assessment was robust, showed a good understanding of the risk factors associated with domestic abuse and appropriately questioned the likelihood that Adult P would not resume her relationship with Adult Q. The investigator forwarded this assessment to the investigating case officer with a strong recommendation to proceed to the CPS for a charging decision in spite of Adult P's retraction.

5.18. However, there were areas for improvement in the actions of agencies. Information about the decision not to charge Adult Q was not passed on to the PPIU; the police officer concerned acknowledging that this was an error. As a result the PPIU were not in a position to reassess any risk or to inform other agencies of the decision when Adult Q was released on bail. It was however already known that Adult P was unwilling to pursue charges against Adult Q. This has led to recognition of a gap in practice and has been responded to by the police as a result of this case.

5.19. An Initial Assessment was undertaken by Children's Services and advice given to Adult P about child protection concerns with regard to Child J in relation to domestic abuse. 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. Had the agencies, but particularly Children's Services 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.

5.20. It is appropriate to acknowledge the high level of referrals regarding domestic abuse received by Children's Services and the difficult judgements that need to be made on a daily basis. The case was referred to Children's Services 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"[4] 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. 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.

5.21. 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. This forms one of the key challenges to the Board. (**Multi-Agency Challenge 1).**

5.22. **Was neglect a feature?** It is the conclusion of this report, that whilst it would have been more difficult to recognise at the time than it is with hindsight, there was an underlying pattern of neglectful behaviour by Adult P (see para 5.7). This was not a case of serious chronic physical neglect and it is perhaps this which made it difficult to recognise. But there was evidence for example that Adult P was inconsistent, at times to the point of dangerousness in the supervision of her children, and that Child K lived with Adult R because of Adult P's failure to prioritise Child K's needs.

5.23. 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. There was information at the time that could have suggested that both Child K and Child J's development was being affected.

5.24. 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 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 Services in preventative work. **(Multi-Agency Challenge 2)**

5.25. **The significance of men in Child J's life:** The issue of the role of men in children's lives is a familiar feature of Serious Case Reviews[5] 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, although it is now clear that Adult P had had a number of short term relationships. As a result professionals were not in a position to assess any impact men might have on Child J, whether positive or negative. The arrival of Adult Q within the family was unexpected, indeed unknown to agencies until the assault on Adult P took place.

[4] Beckett, C in Calder, M (2008)
[5] Brandon et al., 2008, 2009

5.26. 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:

- The potential risks involved when men in relationships which offer little commitment are involved in the children's lives
- The particular impact for the children's emotional development on their understanding about who are the significant parental figures in their lives

5.27. There was also other information which suggested 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 and she had acknowledged difficulties in regulating visitors to the house. Professionals need to make careful judgements when seeking sensitive information regarding the personal relationships of adults with whom they are in contact. 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.

5.28. **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 would have been very difficult to prevent.

5.29. It is the case though that, 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 Child J lived in a safe and secure environment.

5.30. 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 S17 and resulting services may have then provided a better targeted service, that might in turn have impacted on Child J's broader developmental needs.

5.31. Services had no knowledge of Adult Q or his relationship with Adult P until a matter of weeks before Child J's death. Within this timescale, and on the basis of the comparative seriousness of the domestic abuse, agencies would not realistically have been in a position to properly assess and protect Child J. There is a considerable body of knowledge regarding the statistical links between domestic abuse and child maltreatment.[6] However, it is also widely recognised that prediction of the risk of harm in relation to 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.[7] . Risk assessment in relation to domestic abuse has been much developed in recent years with the wide dissemination of the CAADA-DASH

[6] Brandon et al (2009), Cleaver and Unell 2011, Munro (2008)
[7] **Kemshall, H. (2001)**

tools, as used in the case of Adult P. However neither this nor other tools should be understood as providing "complete predictive accuracy".[8]

5.32. There was no evidence available to professionals either at the time, or with hindsight that Child J could have experienced physical abuse from any of his carers. The pathologist has confirmed to this Review that, there were no injuries in the days before Child J's death.

5.33. Contact with Child J's maternal grandmother has raised a specific issue about the accessibility of information and advice for family members, both in relation to their legal position and how and where advice can be accessed outside of normal working hours. This has resulted in a further Challenge to the Board. (**Multi-agency Challenge 4)**

5.34. 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 Child J's death would have been prevented.

6. Single Agency Recommendations

The following recommendations were made by the agencies and endorsed by the Serious Case Review panel.

6.1 Action for Children

6.1.1. 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.

6.1.2. 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.

6.1.3. 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.

6.1.4. 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

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

[8] Robinson, A in Kemshall (2011)

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

6.2.2. 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.

6.2.3. 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.

6.3 Bolton at Home

6.3.1. Bolton at Home is a social housing provider which provided accommodation to Adult P and Child J. Bolton at Home provided a chronology and Individual Management Review for this Serious Case Review.

6.3.2. 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.

6.3.3. 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.

6.3.4. 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.

6.4 Greater Manchester Police

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

6.4.2. 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.

6.4.3. 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.

6.4.4. 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 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 Senior Leadership Team 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.

6.5 Greater Manchester Probation Trust

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

6.5.2. 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.

6.5.3. 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.

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

6.6 Bolton NHS Foundation Trust

6.6.1. 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.

6.6.2. 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.

6.6.3. 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.

6.6.4. 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

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

6.7 Bolton Primary Care Trust – GP Service

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

6.7.2. 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.

6.7.3. 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.

6.7.4. 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.

6.8 NHS Commissioning Health Overview

6.8.1. 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.

6.8.2. The Health Overview has identified three **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 the 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.

6.8.3. 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 CCG 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

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

7. 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 and respond to:

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 and 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.