Lancashire Local Safeguarding Children Board

Learning & Improving

A Serious Case Review report

Child N

In order to protect the identity of individuals this report has been anonymised.

The subject of this review is herein referred to as Child N.

Independent Reviewer: Kevin Ball, NSPCC Senior Consultant

Date: April 2015

This report has been commissioned by:

Lancashire Local Safeguarding Children Board

Contents

1. Introduction	3
- The reason for this case being subject to review	3
- Audience for this review	3
2. Brief synopsis of the case	4
3. Predictability and preventability	5
4. The Serious Case Review process	6
- Methodology for this Serious Case Review	6
- Scope of this Serious Case Review	8
- Family involvement in this review	8
- Limitations of this review	9
5. Chronological analysis of multi-agency involvement, including findings	10
- 2009: The year Child N was born	10
Summary of 2009	15
- 2010	15
Summary of 2010	18
- 2011	18
Summary of 2011	20
- 2012	21
Summary of 2012	27
- 2013	28
Summary of 2013	32
- 2014	33
Summary of 2014	40
6. Key findings	40
7. Thematic analysis of multi-agency practice, and learning	41
- 7.1. Assessment and provision made in relation to the mother's mental health	41
- 7.2. The use of information by agencies: recording and sharing	45
- 7.3. Agency responses to issues of domestic abuse, honour based violence and gender	52
- 7.4. The extent to which legal proceedings protected Child N's welfare	55
- 7.5. The extent to which agencies adopted a child centred approach	57
- 7.6. Analysis of interacting risk factors (focusing on 2014)	59
8. Conclusions	62
9. Recommendations	63
Appendices	
1. SCR Reference Group membership	64
2. Professionals interviewed or who have contributed to documentary evidence	65
3. Evidence submitted (and/or referenced), for the purpose of conducting the review	66

1: Introduction

1.1 Statutory guidance[1] states that "*professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others*". Case reviews provide a valuable opportunity to reflect on the quality of services and practice. A Serious Case Review (SCR) should be undertaken[2] where abuse or neglect is known or suspected and either;

- a child dies; or
- a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

1.2. This report provides an overview of a process that has taken nine months to complete. It has involved examining the contribution of 19 agencies across two geographical Local Safeguarding Children Board (LSCB) areas, covering a five year period. Agencies, practitioners and family members have provided invaluable information and evidence that has helped shape the findings, learning points, action plans and recommendations.

1.3. Inevitably, given the circumstances, many will ask the questions of whether Child N's death was predictable or preventable. Statutory guidance does not require such judgements to be made for SCRs – but they are reasonable questions to ask. The report will therefore offer a reasoned view in an attempt to answer these two questions on the basis on what was known and knowable at the time.

1.4. The overall purpose of the Review is to reduce the likelihood of reoccurrence and prompt agencies and practitioners to learn from the findings. Through the review process and scrutiny of action plans submitted by agencies it has been acknowledged that improvements in practice are required by a number of agencies.

The reason for this case being subject to review

1.5. In May 2014 Child N and mother died in a house fire in Liverpool. Following enquiries by the Police and Fire and Rescue Service concerns were raised about the circumstances surrounding the deaths. Child N was well known to statutory agencies. Given these events, concerns were raised about abuse and neglect and how statutory agencies worked together to safeguard and protect Child N's welfare.

Audience for this Review report

1.6. The Review has been commissioned by Lancashire LSCB as Child N was a resident child of this authority however spent a considerable amount of time living in Liverpool. Services from Liverpool and Liverpool LSCB have therefore also made significant contributions to this Review. The primary audiences for this report are Lancashire and Liverpool LSCB's, respective local services and professionals and family. The report may be of interest to the public but also a broader professional audience where learning and improvements arising from cases with similar features may be considered at a regional or national level.

[1] Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, 2013, HM Government

[2] Regulation 5 of the Local Safeguarding Children Board Regulations 2006

2: Brief synopsis of the case

Subject	Referred to as:	Subject	Referred to as:
Subject child	Child N	Father's child	Half sibling 2
Mother	The mother	Father's child	Half sibling 3
Father	The father	Step mother to Child N	Adult 3
Mother 's first child	Half sibling 1	Step father to Child N (divorced from mother)	Adult 4
Maternal grandmother	Maternal grandmother	Maternal Uncle	Adult 5
Maternal grandfather	Maternal grandfather		

2.1. Both the maternal and paternal families are Hindu. The first language spoken in both families is Gujarati and Hindi.

2.2. Child N's parents separated, acrimoniously, before Child N was born in August 2009. Within the first few days following the birth concerns were expressed about the mother's mental health, including allegations and counter allegations being made between both parents. This resulted in Child N becoming subject to Police protection, culminating in a brief placement in foster care.

2.3. This acrimony continued, to varying degrees up until the time of Child N's death in 2014. There were notable periods of time where the animosity intensified, especially in 2012 and 2014. There were also periods where circumstances seemed more settled, however a constant undercurrent of disharmony between the parents prevailed. Throughout, there were continued concerns about the mother's mental health which often necessitated her having time off work. Child N became the medium for the parents' continued antagonism, manifesting itself with further allegations and counter allegations being made about the care provided to Child N by either parent; these included allegations of physical harm and sexual abuse. Child N was also known by two different names by each parent.

2.4. A persistent feature throughout the case is that of the mother being seen as the victim of domestic abuse and harassment and the father being seen as the perpetrator. Review of evidence submitted does not entirely corroborate this perspective.

2.5. Child N resided in Liverpool for the majority of the first two years of life at the maternal grandparents home along with Half Sibling 1, Adult 5 and the mother. When not having contact with the father in Lancashire, Child N remained in Liverpool. Child N's development, as assessed by health practitioners was overall, within expected milestones. Both parents went on to meet new partners however in the case of the mother this did not appear to be a source of support, but rather further difficulty.

2.6. Throughout this time, Court proceedings were initiated four times as follows;

- August 2009 – eight days after Child N was born where the father applied for a Residence Order but which resulted in the mother being granted a Residence Order and the father being granted a Contact Order.
- September 2012 – Liverpool Children's Services were granted Interim Care Orders on Child N and Half Sibling 1 due to concerns about their safety and welfare. Private and Public law applications were consolidated. The Court determined that the care of Child N should be transferred to the father. A

Residence Order was granted to him in January 2013 and the mother was granted a Contact Order. A Family Assistance Order was also granted to Liverpool Children's Services.

- October 2013 – Child N's mother made a further application to Court as contact arrangements had broken down.
- April 2014 – Child N's mother applied for a Child Arrangements Order.

2.7. During the course of this final set of Private proceedings allegations were made by the mother during a contact visit and resulted in Child N remaining with her until the time of their deaths.

3. Predictability and preventability

3.1. In considering the questions of whether Child N's death was either predictable or preventable the report will show that despite there being a substantial number of pre-disposing hazards which increase vulnerability there were relatively few situational hazards that indicated any likelihood of a radical shift in the mother's care giving behaviour. If all pieces of information had been effectively assembled they would not have revealed a prediction. The Review finds that based on evidence submitted, research examined and that which was known at the time, the mother's intentions were not predictable.

3.2. The Coroner's verdict, delivered in September 2014, was that Child N had been unlawfully killed and the mother had taken her own life. The Coroner's report[3] states *"… it is found that the fire was started deliberately … with the intention of causing death or being reckless … this incident was unpredictable and there is no evidence from the investigation that there was known to be a real and imminent risk of … death by any other person or authority".* Police evidence indicated that mother had purchased petrol in a container in April 2014 which had been used as an accelerant to start the fire.

3.2. On the question of preventability, this report will examine in some depth the actions, timing and effectiveness of agencies and professionals involved in Child N's life. It will highlight a number of missed opportunities and where practice could have been better. Had these opportunities not been missed but maximised, a more informed and holistic understanding of Child N's day to day experiences could have been captured. This could then have been used to garner professional input into creating a more coordinated and protective framework. It is unlikely that this would have changed the agreed contact arrangements between the mother and Child N. Child N's father appreciated the importance to Child N of ongoing contact and maintaining a relationship with the mother. No evidence has been submitted to indicate that in April/May 2014 statutory agencies had cause to exercise their duties or powers based on the presenting circumstances. It is the view of this Review that Child N's mother could have chosen to take the action she did on any one of her contacts with Child N, at any point. She made a choice at a particular point in time and, on the basis of known information, professionals involved could not have prevented Child N's death.

[3] Record of inquest, Liverpool Coroner's Court, September 2014

4: The Serious Case Review process

4.1. Methodology for this Serious Case Review

4.2. Throughout, this review has remained mindful of the requirements and principles of statutory guidance[4] and has endeavoured to examine the case in a manner which is proportionate and transparent. The Review has aimed to capture those areas where the greatest learning and improvement can take place for single agencies as well as the multi-agency network[5]. The methodology for this Review has therefore comprised of:

- The formation of a SCR Reference Group in order to contribute to the gathering and analysis of information as well as ensure the smooth and timely completion of the Review. Members of the Reference Group were independent of line management responsibility for any member of staff involved in this case[6]. This group met seven times between August 2014 and March 2015. Membership of the Reference Group is contained in Appendix 1.

- The Independent Chair of Lancashire LSCB initially appointed Fiona Becker, NSPCC Senior Consultant as the Independent Reviewer for this Serious Case Review. Due to unexpected ill health, Kevin Ball, NSPCC Senior Consultant replaced Fiona Becker to become the appointed Independent Reviewer. Neither of the Reviewers has had any involvement with the subject of this Review, members of the family or the professional network[7].

- The Independent Chair of Lancashire LSCB appointed Jane Carwardine, East Lancashire Health, Designated Nurse, as the independent Chair of the Reference Group. This was considered necessary, and of added value, due to the large number of agencies involved with the family and the complexity of the case. Although a member of Lancashire LSCB, she has had no involvement with the subject of the Review or members of the family or the professionals involved in this case.

- Obtaining single agency chronologies from agencies that had involvement with the child and family[8] (taken from individual agency records) and single agency tabular time-lines[9] (taken from individual agency records, interviews held internally and reflection on the practice that took place) which identify key practice episodes[10].

[4] HM Government (2013) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, Chapter 4 including the principles for learning and improvement
[5] Ibid re; principle of proportionality for conducting a review
[6] Ibid re; principle of independence for conducting a review
[7] Ibid re; principle of independence for conducting a review
[8] Chronology detailing all contacts with the child and family from 1/1/09 to 8/05/14, including background contextual information
[9] Tabular time-lines: Adapted from a Root Cause Analysis investigative approach devised by the National Patient Safety Agency (NHS), 2011.
[10] Key practice episodes: concept drawn from work undertaken by SCIE (Social Care Institute for Excellence) to describe events *"… that seem to be points at which actions were taken that had a decisive effect on the future course of the case, an effect sometimes positive and sometimes negative …"* in Fish, S. et al., (2008) Learning together to safeguard children: developing a multi-agency systems approach for case reviews (SCIE, 19, p 78).

- Examination of relevant working documents to inform the review process e.g. policy and procedures (from the range of agencies involved), case information notes (from the range of agencies involved), and other pertinent documentation including SCRs, research, LSCB documents/reports and extracts from the Court documents (following consent given by relevant family members and the judiciary).

- Individual interviews (via phone and face to face) with key professionals who were involved in the case[11] where it has been possible, and interviews with family members[12] . In order to ensure transparency and fairness[13] professionals interviewed were provided with information about the review purpose and process.

- Holding a multi-agency practitioners' learning event mid-way through the SCR process (attended by 46 practitioners, managers and agency report authors).

- Requesting single agency action plans at the outset of the Review as well as at the conclusion of the Review process as a way of encouraging continuous learning and improvement [14] &[15].

- A review methodology which sought to balance an investigative approach with a wider understanding about the system in which agencies and professionals were operating. The process often required agencies to undertake a further analysis of specific information, policy and behaviours, following a period of interrogation by the Independent Reviewer and the Reference Group. The aim being to encourage greater local analysis, improved local ownership and accountability of issues, and a deeper appreciation of why events occurred as they did.

- The production on an overview report which has analysed and synthesized a significant amount of information presented to the Reference Group.

- Being respectful of parallel proceedings taking place alongside this case Review, or which are allied to the Review process. In this case the Coroner's Inquest concluded in September 2014 and an investigation by Merseyside Police concerning the deaths of Child N and mother concluded in September 2014.

[11] Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, 2013, HM Government, principle of involving professionals for conducting a review

[12] Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, 2013, HM Government, principle of seeking the contribution of families & children for conducting a review

[13] Improving the quality of Children's Serious Case Review through support and training, NSPCC, Sequeli, Action for Children, Department for Education 2013, based on Sequeli & Sequeli Consortium training materials, Sequeli 2012 and Sequeli Consortium 2013, Ensuring fairness

[14] Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, 2013, HM Government, principle of seeking continuous learning and improvement for conducting a review

[15] Marian Brandon et al., *New learning from serious case reviews: a two year report for 2009-2011*, Centre for Research on the Child and Family in the School of Social Work and Psychology, University of East Anglia/Health Sciences Research Institute, Warwick Medical School, University of Warwick

4.3. Scope of the Serious Case Review

4.4. The scope of this Review was set as:

1. To review significant and relevant events between 1st January 2009 and the date of Child N's death on 8th May 2014, whilst also considering any relevant background contextual information prior to this defined period of time.

2. To seek the involvement of immediate family members in the Review as appropriate and proportionate.

3. To produce a final report which:

- Provides a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of reoccurrence,
- Is written in plain English and in a way that can be easily understood by professionals and the public alike; and,
- Is suitable for publication without needing to be amended or redacted[16].
- Is completed within appropriate timeframes. These were initially set within a six month period (August 2014 – January 2015) however due to the unexpected transfer of Independent Reviewers this inevitably caused a delay, shifting timeframes back to the Review being concluded in April 2015.

4.5. Family involvement in this Review

4.6. The contribution of family members to this Review was desired from the outset. Research[17] has shown there to be added value when this can happen particularly in respect of promoting a child centred review and seeking key information from those closest to the child. Contact with the family has included face to face meetings, letters and e-mail correspondence. Both Independent Reviewers met with the father (alone and also accompanied by his sister and/or cousin) as well as the maternal grandmother and Half Sibling 1. A translator was present during meetings with the maternal grandmother.

4.7. Child N's father has been very keen to assist the Review process. In common with other families who have been through the Serious Case Review process[18] he wants to see "*changes brought in to safeguard children better*". His expressed wish is "*I will at all costs get some sort of justice for, I owe him that much. I feel I let him down as it was my job to protect him*". Child N's father believes that he worked co-operatively with professionals and the Courts and he complied with all agency expectations and Court Orders despite sometimes thinking that some decisions were not in Child N's best interests. He feels that he always ensured that the mother and maternal grandmother had contact with Child N even after he had residence of Child N because he recognised that Child N had a very strong attachment to his maternal grandmother believing that

[16] HM Government (2013) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, 2013, principle of a final report being suitable for publication in order to achieve transparency for conducting a review

[17] Morris, K., Brandon, M., & Tudor, P., 2012, *A study of family involvement in case reviews: Messages for policy and practice*, BASPCAN.

[18] Morris, K. et al (2012), *A study of family involvement in case reviews: messages for policy and practice*, BASPCAN.

it was in Child N's best interests to preserve it. The father has brought to the attention of the Review his concerns which fall into four areas:

- The management of the allegations of domestic abuse;
- The risks presented by the mother's mental health and behaviour;
- The agency responses during the last six weeks of Child N's life;
- The lack of enforcement of Private law court orders;

4.8. Child N's maternal grandmother has found it more difficult to engage with the Review process due to her feelings from bereavement, her attitude towards the agencies that worked with the family and her hostility towards the paternal family. She firmly feels that agencies, particularly Lancashire Children's Social Care and Liverpool Children's Services failed the mother and Child N but has not been able to clearly articulate or clarify when or how she was failed. She has been unwilling to accept the findings of the Coroner's Court.

4.9. From interviews, it is clear that there is a continuing and significant depth of hostility between the two families.

4.10. Nonetheless, the family's contributions have been invaluable and the Reference Group wish to acknowledge these at a time of loss and bereavement. It is hoped this report provides some reassurance that steps have or are being taken to reduce the likelihood of such a tragedy reoccurring.

4.11. Limitations of this Review

4.12. A number of professionals involved in this case no longer work for their respective agencies and have therefore not contributed to the Review. Poor record keeping has been identified in some agencies on some occasions. Hence these two factors limit our understanding of some key practice episode about why some decisions were made or actions taken.

4.13. The judiciary and the role of legal proceedings is a continual thread throughout this case and throughout Child N's short life. The Courts and judiciary are independent of local and central government and are not accountable in the same way that individual agencies and professionals who work with children and families are, as defined in the Children Act 2004. The Family Courts are not statutory partners of Local Safeguarding Children Boards and yet make a significant contribution to the protection and welfare of children. The SCR process has no authority to review decisions made within the Family Court; a separate appeals process exists for the review of decisions made in the Court. As such, a specific submission from the judiciary was not requested.

4.14. The Independent Reviewer did make contact with the judiciary in an effort to understand how the decisions made at Court affected the work of statutory agencies in their work with Child N and family. The response to this request was positive but set within limitations and the following advice was received *"… for constitutional reasons it is not appropriate for the judiciary to participate in serious case reviews … the principal of judicial independence prevents Judges from participating in a review conducted by a government or local authority agency, which is often based on non-disclosable confidential information, and which deals with wider*

questions than those which may have faced the court at any particular stage …"[19]. Helpfully, papers and documents from Court proceedings were made available. Due to the considerable volume of Court documentation available only a very limited review of key documents was completed.

4.15. The Reference Group has received over 1500 pages of information from 19 agencies, across two geographical LSCB areas. This does not include extensive Court held documents. This information has been considerably summarised in order to produce this report. A proportionate approach to this Review has been adopted, balancing a sufficient level of inquiry, time, costs and learning.

5: Chronological analysis of multi-agency involvement, including findings

5.1. The Review believes that it is important to consider the practice of each individual agency that came into contact with Child N and family so as to gain a thorough appreciation of individual agency effectiveness, but also the efficacy of a safeguarding network. This section of the report therefore systematically examines the contact and involvement of each agency from 2009 to 2014. Evidence presented in this section of the report represents a significantly summarised account of key practice episodes which have been submitted.

5.2. Findings[20] are made throughout the chronological account. These findings have primarily been identified by each agency and form part of the learning arising from the process of conducting this Review.

Relevant background information prior to 2009

5.3. The Reference Group is aware of a number of significant and complex life crises in the mother's background which are likely to have affected her emotional wellbeing and behaviour. These events, whilst beyond the scope of this Review to examine, affected both her personal and professional life and involved a number of statutory agencies.

2009 – The year Child N was born

5.4. From February to July 2009 Child N's mother either came into contact with a number of agencies, or information was passed between agencies about her, during her pregnancy with Child N. These contacts are significant, but given the passage of time and the need to report proportionately, are significantly summarised;

- Lancashire Constabulary investigated a domestic dispute between Child N's mother and father which included alleged death threats and self-harming. The Police concluded that the father had not committed any offence for which he could be arrested.
- Information sharing by Liverpool Women's Hospital about alleged domestic violence during pregnancy.
- The mother requesting a termination at 21 weeks pregnant due to alleged violence by Child N's father. This request could not be complied with due to the late stage of pregnancy. The mother threatened suicide but this was not judged to be a real risk. A MeRIT[21] risk assessment was completed and referrals

[19] Letter from presiding Judge involved in the case, 24/02/15

[20] Finding: a judgement or conclusion about a particular aspect of professional practice (positive or negative) where there may be learning.

[21] A MeRIT (Merseyside Risk Identification Tool) is used by agencies in Liverpool to identify the level of risk in cases of domestic abuse. Dependent on whether the level of risk is high, medium or low determines what actions are required. A high risk would indicate a referral to a MARAC.

to the local MARAC[22] and IDVA[23] were made. Merseyside Police were also notified. The mother was given details of a Women's Refuge but declined it as she was staying with her parents. The Liverpool GP was made aware of the suicide threat via a health professional's letter.

- Merseyside Police received the notification from Liverpool Women's Hospital the allegations of domestic violence and stalking of the mother by friends of the father. A MARAC meeting was held in May with one of the tasks being for Merseyside Police to follow up the allegations. This was not done. The Merseyside Police submission[24] notes *"this was a missed opportunity to safeguard [the mother] and the unborn [Child N]. This was the first notification of domestic violence between the parties and if recorded properly may have had a significant impact on the overall safeguarding picture as future events unfolded".*
- A health practitioner from Liverpool Women's NHS Foundation Trust attended the MARAC meeting in May, some 11 days after the last contact with the Hospital. Concern was expressed by MARAC partner agencies as to why the concerns held by the hospital had not been shared sooner with children's services. The practitioner stated that she had made a professional judgement (based on reasoned assessment) that this information could wait to be shared at the MARAC. The practitioner made appropriate contact with the Liverpool GP.
- Liaison between the Liverpool Woman's NHS Foundation Trust Hospital and the Community Midwife regarding information received from the Police about an altercation between Child N's mother and her own father which was dealt with by Merseyside Police. There was notable good practice in that the IDVA was contacted to gain further relevant information and to check if she had been able to make contact with mother; the mother did not engage with the IDVA. Liverpool Children's Services commenced an Initial Assessment. This was completed in acceptable timeframes (as required under statutory guidance in place at the time[25]). No further action was taken in respect of this incident. Advice was given to the mother as well as being signposted to domestic violence services.
- The Review has noted that during 2009 the Liverpool GP received four health professional letters from Liverpool Women's Hospital detailing events alleged by the mother.

5.5. The following findings are made about this series of key practice episodes prior to Child N's birth;

- There are examples of effective information sharing between agencies, mainly initiated by health professionals.

- Information was submitted to the MARAC, and although actions were assigned, they were not completed.

- Merseyside Police contravened procedures on investigating allegations of domestic violence. No assessment of the risk to the mother and the unborn baby took place. Honour based violence risks may have been an issue.

[22] A MARAC is a Multi-Agency Risk Assessment Conference. It has a wide membership of statutory and voluntary agencies. It's part of a coordinated community response to domestic abuse. The primary purposes of a MARAC is to:

- Share information in order to increase the safety of victims and survivors;
- Determine if an alleged perpetrator poses a risk to any particular individual in the general community;
- Conduct jointly and implement a risk management plan that provides professional support to those at risk and to reduce the risk of harm;

[23] IDVA: Independent Domestic Violence Advisor

[24] Merseyside Police submission, tabular timeline of key practice episodes, October 2014

[25] Working together to safeguard children, 2006, HM Government

- Letters sent to the GP from Midwifery/the hospital, with the intention of alerting another professional to concerns were treated as 'information only'; they did not raise concerns or prompt a more holistic assessment of the mother's circumstances and vulnerability.

5.6. The Health Visiting Service of Liverpool Community Health NHS Trust first made contact with the mother in August just prior to the birth of Child N, having already received four health professional letters from Liverpool Women's Hospital detailing their concerns about allegations of domestic abuse against the mother. The following findings are made;

- As there were no children named on the MARAC referral (because the meeting occurred prior to the birth), a copy of the minutes and actions was not forwarded to the Health Visiting Service. This practice has now changed in Liverpool.

- The Health Visitor did not liaise regularly with the GP for the mother and there was no joining up of the concerns expressed by the hospital.

5.7. In August, shortly after the birth of Child N, the mother disappeared and left Child N with the father in Lancashire. Lancashire Constabulary and Lancashire Children's Social Care dealt with matters concerning the care of Child N at the father's home. Merseyside Police conducted a 'found' interview with the mother in Liverpool during which she told the officers about her domestic history with the father, her fear of him and that she had left Child N with friends in Liverpool. In fact she had left Child N with the father. Correct policy and procedures were followed by both Lancashire Constabulary and Merseyside Police which included Child N being the subject of Police protection powers until the situation was resolved. Lancashire Constabulary took the mother to the Royal Liverpool and Broadgreen University Hospital for a mental health assessment. Liverpool Women's Hospital assisted in the identification of the mother. She was offered the option of staying in a Refuge but refused, wanting to return to her new partner. Information was shared with Liverpool Children's Services. A record was also made in the maternity notes of the outcome of the mental health assessment and that the mother refused secondary mental health services. There was no record of the details of the mother's new partner. In 2009 this information was not routinely collected; practice has since changed.

5.8. The mental health assessment at the Royal Liverpool & Broadgreen Hospital (and Mersey Care NHS Trust) was described as a '*difficult and complex'* due to the nature of the presentation and because many sensitive disclosures were made by the mother about her past history, including alleged incidents of domestic violence by the father. Evidence submitted to the Review[26] states: *"Mother denied any symptoms of mental ill health, depression or any current thoughts, intent or plans to harm herself or others". "[She] gave a history of low mood. No evidence of other mental illness was evident. She discussed her young [child] and events which led up to the fact [the child] was in the care of the father. The records show that complex emotional issues relating to this fact existed. The assessment concluded that mother's presentation was reactive and due to events in her life".* The mental health practitioner thought the mother was at high risk of developing separation anxiety as a consequence of leaving her child and at high risk of developing post natal depression. The mother was resistant to any support on offer stating she was a '*very private person'*. An appropriate plan of care was compiled and the mental health practitioner liaised with the Merseyside Police Public Protection Unit, Lancashire Children's Social Care Emergency Duty Team, Liverpool Children's Services, the Safeguarding Team at Mersey Care NHS Trust and Midwifery at Liverpool Women's Hospital (at the time policy was for Midwifery to then share with community health practitioners). Follow up support was offered but declined. Following review a decision was made that the mother would not be offered further support from Mersey Care NHS

[26] Mersey Care NHS Trust submission, tabular timeline of key practice episodes, September 2014

Trust because of her unwillingness to engage; she would be discharged back to primary care (GP). This was/is standard practice and the GP would be expected to act as the 'care coordinator' for her[27].

5.9. The following findings are made about this acute episode;

- There is evidence of good communication and information sharing between health service providers, the mental health service, Police forces and children's social care departments across geographical borders during this episode.

- An independent expert review conducted by Merseycare NHS Trust for the purpose of this Review concluded that the mental health assessment was of a high quality.

- MerseyCare NHS Trust did not take action with regards to the disclosure of domestic abuse by the mother because, at that time, not all staff were fully aware of the MeRIT or MARAC processes. Although staff were compliant with policy and procedural expectations at that time, best practice would have been to utilise these two processes.

- There is no documentation of any specific liaison between the Health Visitor and the GP or Social Worker in this period. There is no record that the Health Visitor received the results of the mental health assessment or that the Health Visitor had any discussion with the mother about her mental health. This is of particular concern because the mother was identified as being at high risk of developing post natal depression by the mental health team and she had refused any follow on support from them. Practice has now changed and health professionals are informed if a parent has had a mental health assessment.

5.10. Action taken by Lancashire Children's Social Care during this significant episode in August included Child N being briefly voluntarily accommodated (under section 20 of the Children Act 1989), completing a further and more comprehensive assessment and an agreed plan for Liverpool Children's Services to take on the responsibility for the management of this case. Child N was placed in foster care in Liverpool by Lancashire Children's Services, but then returned to the mother's care in September under an Interim Residence Order granted in the first set of Private law proceedings. The case was then closed to Lancashire Children's Social Care in October 2009. With the benefit of hindsight, one practitioner from Lancashire Children's Social Care has recalled that there *was "… little contact with* [the mother] *…"* and that the mother *"…. did not present well … she did not give consistent messages about* [the father] *…"*. Evidence submitted[28] highlights *"… a strong analysis about why this decision [to place back with mother] was reached is missing from the records – the outcome of the core assessment by Lancashire focuses on father and paints a positive picture …".*

Finding: There was a prompt and proactive response to the referral from Lancashire Children's Social Care. Due policy and procedure were followed however there are deficits in some aspects of analysis and record keeping.

5.11. Following the birth the GP in Liverpool received a further four health professional communication letters from Liverpool Women's Hospital giving details around the birth, the mother's disappearance, the placement of Child N in foster care and other agency involvement. These letters were read by the GP and scanned onto the electronic medical record but treated as 'information only'. It did not prompt any action or curiosity.

5.12. The Health Visiting Service of Liverpool Community Health NHS Trust made contact with the Health Visiting and Midwifery service in Lancashire to confirm arrangements about visiting in August and September.

[27] GP's monitor low level mental illness (up to step 3) but refer on to secondary mental health services (step 4) when specialist support is required.

[28] Lancashire Children's Social Care, tabular timeline of key practice episodes, October 2014

5.13. Following this brief but intense episode the father applied to Court for a Residence Order as he was concerned about the mother's mental health. At this point the father did not have Parental Responsibility[29] as Child N's birth had not been registered. Cafcass promptly confirmed the allocation of a Children's Guardian (under Rule 16.4[30]) who undertook the role according to statutory guidance[31]. The first set of Private law proceedings spanned 23 months (August 2009 – October 2011, involving 13 separate Court Hearings) due to their complexity. Liverpool Children's Services were directed, via the Court, to complete a section 37 report[32] and reported that "… *this case does not meet the threshold for significant harm. There are no major concerns about the welfare and safety of the baby at the moment*…". Child N was regarded as a Child in Need[33].

5.14. There were six contacts between the Health Visiting Service of Liverpool Community Health NHS Trust and the mother and Child N during late September to mid-November 2009. The mother informed the Health Visitor of the Private law proceedings. The Health Visitor did not have concerns about Child N's development and the mother accepted her advice about baby care. The Health Visitor received safeguarding supervision in late November as per Liverpool Community Health NHS Trust Supervision for Vulnerable Children Policy. She met with the Safeguarding Children Specialist Nurse. No concerns were reported during this supervision.

Finding: The Health Visiting Service of Liverpool Community Health NHS Trust have highlighted a number of significant deficits in respect of recording, analysis of risk to the children from the father, and overall scrutiny and governance of supervision practice. This includes there being no evidence in records or that key issues were discussed in the supervision session namely: the mother's mental health (at the time the Health Visitor did not know the outcome of the mental health assessment); her new partner; the liaison with the relevant professionals involved to inform assessment; the issue of domestic violence and its impacts; the progress of the Court proceedings; the Health Visitor's own safety when conducting home visits given the allegations of violence; the level of risk the case presented nor the Health Visitor's emotional response to the case; follow through of actions and workload of safeguarding cases at this time. This had implications for case management in later years.

5.15. The Liverpool GP was notified in September of Child N's change of legal status due to now living back with the mother. The policy would have been to code his 'looked after child' status as a significant event and change the demographic details on the GP electronic record system; this was not done.

Finding: Child N's change of legal status was not highlighted in electronic records as a significant event by the Liverpool GP and its importance was potentially buried in the record.

5.16. In December 2009 the mother alleged to Merseyside Police that she had been assaulted by an unknown male when returning to her flat and that Child N's father was behind it. A Police patrol responded, a witness statement taken, and she was taken to the Royal Liverpool and Broadgreen University Hospital Trust (RLBUHT) for assessment. Liverpool Children's Services and the Health Visitor were notified as well as the Safeguarding Team at the hospital. THE RLBUHT domestic abuse notification form was completed and child details obtained from the mother (the form has subsequently changed and a MeRIT assessment format is now used; in 2009 this format was not widely used across all services). Child N was at the maternal grandmother's at the time of

[29] Parental responsibility, Children Act 1989, section 2

[30] Rule 16.4 cases typically involve children who have been subject to entrenched and emotionally harmful parental conflict.

[31] Practice Direction 16A representation of children states of the role of the Children's Guardian as. *"It is the duty of a children's Guardian fairly and competently to conduct proceedings on behalf of the child. The Children's Guardian must have no interest in the proceedings adverse to that of the child and all steps and decisions the children Guardian takes in the proceedings must be taken for the benefit of the child"*.

[32] Section 37, Children Act 1989; A Court directed investigation of the child's circumstances, by an appropriate authority

[33] Children Act 1989, section 17, the provision of services for children in need, their families and others

the incident. There was insufficient evidence to arrest the father or anyone else. A Vulnerable Person Referral Form (VPRF1)[34] should have been completed by the initial reporting officer and submitted to the Merseyside Police Family & Child Investigation Unit (FCIU) for the purpose of a risk assessment of the victim. This was not done and the officer cannot recall the reason for not doing this. There was also a failure of the Critical Incident Managers/Call Centre Team Leaders in Merseyside Police to dip sample incident logs to assess compliance with expected standards and the quality of service delivered.

Finding: The alleged crime was investigated according to Merseyside Police procedures but the need for a risk assessment was never flagged with the FCIU. The implication being that it would not be taken into account during any future risk assessment of the mother and therefore may provide a false assessment of the level of risk.

Summary analysis of 2009:

- Long standing maternal mental health difficulties (as opposed to a defined and diagnosed mental illness) which resulted in stress and anxiety,

- Despite the mother initially seeking support and assistance during acute episodes of difficulty, the acceptance of longer term support was declined,

- Intractable dysfunction and hostility between Child N's mother and father,

- Many positive examples of agencies working effectively together, both within one area but also cross geographical boundaries – sharing information, effective collaboration, and managing risk to Child N,

- Missed opportunities by a small number of agencies (notably Merseyside Police and the Health Visiting Service of Liverpool Community Health NHS Trust) to effectively respond to information they received about alleged domestic abuse,

- A limited analysis by Lancashire Children's Social Care following assessment about circumstances,

- Systemic and organisational challenges for key practitioners in accessing and analysing information in order to fully appreciate the extent of potential risks to Child N (notably the GP and Health Visiting Service of Liverpool Community Health NHS Trust).

2010

5.17. The Health Visitor from Liverpool Community Health NHS Trust visited the mother and Child N in January 2010 after being informed about the mother's admission to hospital due to the alleged assault in December. Child N was reported to have been well and smiling. The Health Visitor was made aware that the ABC Project[35] had visited and would complete a risk assessment on the mother.

[34] VPRF1 form is a Vulnerable Person Referral form used by Merseyside Police. These should be completed for every victim and submitted to a supervisor for checking and signing, and then scanned and e-mailed to the relevant Family Crime Investigation Unit.

[35] ABC project (Addressing Barriers for Change Domestic Abuse Service) is a local domestic abuse support service in the Merseyside area for victims/survivors of domestic abuse

5.18. In February Liverpool Children's Services closed the case, having completed a section 37 report, citing that "*positive progress was achieved*". The case remained open to Cafcass due to the ongoing Private law proceedings.

5.19. A new Health Visitor was allocated the case from Liverpool Community Health NHS Trust and completed a home visit in June. Child N was noted to look well, with development recorded within milestones. The mother alleged she had been attacked again by a male at her flat (identity not ascertained). The visit was short as two workers from the ABC project were present so another visit for two days hence was arranged. The mother did not then pursue support from the ABC project.

Finding: There is no evidence that this new Health Visitor made contact with any agency or exercised any curiosity, despite policy and best practice being to do so. Information about the alleged assault, whether the assault was referred to the MARAC, and the outcome of the involvement of the ABC project, was not gathered. Such liaison would have given the practitioner a more holistic picture of the family circumstances and any current concern.

5.20. In June Merseyside Police became involved in investigating two incidents. An officer looked into one incident, which resulted in the mother attending the Royal Liverpool and Broadgreen University Hospital Trust. She alleged that she had been jumped on and hit by an unknown male when she returned to her home after work and that her assailant had stated she would be killed if she went to Court the next day. She was assessed and admitted but had no injuries. There was no evidence to identify the perpetrator. The second incident concerned the mother feeling threatened at a supervised contact session with Child N's father. The officer dealing with the previous incident made contact with the mother.

Finding: Due to workload pressures, the Vulnerable Person Referral form (VPRF1) took 10 days to complete and should have been done on the night of the incident. When it was completed it contained information about the two separate incidents. This can create a false picture of the risk to the victim as there are two differing incidents that are supposed to result in two separate risk assessments. No explanation can be provided for this.

Finding: The hospital safeguarding policy and procedures were not followed as no child information was gained to enable staff to inform the relevant agencies of the assault. The Doctor did not explore the issue of possible domestic abuse or give consideration to possible honour based violence however they were aware the mother had made a statement to the Police about the incident. The nurse's signature on the records was illegible.

5.21. Due to the above incidents the mother took sick leave from work. She was certificated by the Liverpool GP as being unfit for work for a continuous 28 week period. The certificates state *'anxiety and forgetfulness'* for her inability to return to work. There was no evidence to indicate that the mother needed medication to treat her symptoms.

Finding: A continuous period of sick leave for 6 months or more is considered a critical time period to be absent from work. Evidence prepared for the Review[36] suggests that this could have prompted a more formal review by the GP. The Practice has since introduced a policy to challenge patients over periods of extended sick leave as well as a monitoring process.

Finding: This episode of alleged domestic violence was reported to the GP by the mother, stating that the Police were already involved. Taken with the knowledge of the other reported domestic abuse and mental health issues this would have provided the GP with an ideal opportunity to review this case with other appropriate professionals. The GP did not communicate with the Health Visitor about any of this information. Health

[36] Primary Health Care (Liverpool GP) submission, tabular timeline of key practice episodes, September 2009

Visitors and Midwives have their own electronic record keeping systems and these systems do not communicate with the GP's electronic records. Liverpool based health services are now in the process of developing electronic systems that are shared.

5.22. The allocated Health Visitor from Liverpool Community Health NHS Trust received 1:1 safeguarding supervision in June from the Safeguarding Children Specialist Nurse. Records indicate that the discussion centred on the assessment of the child's development needs, parenting capacity and family and environmental factors. Due to complex support needs (potentially indicating a 'child in need') it was agreed the Health Visitor would conduct a developmental assessment, liaise with relevant professionals and continue to monitor Child N's health and development. This resulted in a home visit during which the Health Visitor discussed the Freedom Domestic Violence Programme[37] and, with the mother's consent, made a referral to them. There is no documented evidence to indicate that the Health Visitor was aware of the outcome of the referral and there is no evidence to indicate that the mother engaged with this service.

Finding: *The supervision paperwork does not contain a section to record the discussion which took place during the supervision. The focus on conducting a developmental health assessment reflects a failure to appreciate the vulnerability of Child N and any risk e.g. parental hostility, maternal mental health issues and domestic abuse. The mother appeared to be engaging well with the health visiting service with no reported concerns about her parenting skills. As a result of this Review, the documentation is currently being reviewed to address evidence of discussion at supervision, risk and vulnerability of children.*

5.23. The father was granted Parental Responsibility by the Court in July 2010 as part of the Private Law Proceedings. He subsequently struggled to get information about Child N's health from the GP in Liverpool without written consent arranged through both parents' respective solicitors. This should not have been necessary since the GP had received notification from the Court that the father had been given Parental Responsibility. This fact was noted in Child N's records only and not the mother's.

5.24. A third Health Visitor was allocated the case in November 2010 due to the previous practitioner being on sick leave. This Health Visitor found no concerns about Child N's development. The mother reported her frustrations about the contact arrangements and her belief that the father *"was not really interested in his child but wishes to control her life".*

5.25. Child N initially attended Nursery 1 (Liverpool) on a full time basis from August 2010 to September 2010. In August the induction policy for new starters was followed by Nursery 1 which included taking details of the family members who could collect Child N from nursery. The mother informed the nursery about the alleged incidents of domestic violence. The Nursery had no contact with Child N's father during the first period of Nursery attendance. Following initial attendance, Child N was then absent reportedly due to illness and then ceased to attend in September.

Finding: Nursery 1 did not speak to any outside agencies about the mother's disclosure of domestic violence incidents and the implications for Child N. The Nursery had not thought it necessary to do so as they did not have any contact with the father. *The Nursery did not keep a log of all the calls made to the mother. Staff were unclear about what information needed to be recorded when there is contact with parents and where staff have concerns about a family.*

Summary analysis of 2010:

- Overall Child N's health and development was considered satisfactory,

[37] Freedom Domestic Violence programme; a domestic violence support programme offering information

- Child N's mother engaged well with the Health Visiting Service of Liverpool Community Health NHS Trust, despite three Health Visitors being allocated the case during this time period,

- There were two further incidents (in June) when the mother made allegations. Given the history of previous allegations and incidents, neither of these was sufficiently investigated by Merseyside Police,

- The Private law proceedings continued throughout this year and Cafcass were kept informed of events and activities throughout this period,

- The mother was given an extended period of time off work, due to mental health problems. This episode was not considered alongside other information held by the GP and no holistic assessment considered,

- The impact of the allegations and the mother's mental health on Child N were not sufficiently recognised by the Royal Liverpool & Broadgreen Hospital, Merseyside Police and Liverpool Community Health NHS,

- There were two separate referrals made with the mother's consent to domestic abuse services (ABC and Freedom Domestic Violence Programme); the mother did not pursue these sources of support.

2011

5.26. In February 2011 the mother reported another incident to Merseyside Police that happened during a supervised contact session. A written statement was taken but there was no CCTV footage. The mother was advised to seek legal advice with regards to breach of the Contact Order. Initially she did not wish to make a complaint of assault but did want the incident logged. She subsequently changed her mind twice.

Finding: The incident itself was dealt with in accordance with Police policy and procedure in place at that time. However, once the mother decided she did wish to make a complaint there were delays in arranging to see her which ran counter to Police procedures. A notification of this incident should have been provided to Lancashire Constabulary as the alleged perpetrator lived in their area; this was not done. Reasons provided for these omissions concern workload and resourcing pressures in the Merseyside Police FCIU.

5.27. In May 2011 the mother attended an ante natal booking at Liverpool Women's NHS Foundation Trust Hospital as she was pregnant again. She disclosed ongoing disputes with Child N's father regarding child contact issues but no abuse. She was appropriately advised to speak with the Cafcass Children's Guardian regarding contact issues and to contact the Police regarding alleged harassment by Child N's father. She was made aware of the domestic violence drop in service provided at the hospital. Liverpool Children's Services were notified of the mother's concerns. No formal risk assessment was completed by Liverpool Women's Hospital but it was noted that if circumstances changed this may need to be reconsidered.

5.28. In May a fourth Health Visitor from Liverpool Community Health NHS Trust was allocated. In July, this Health Visitor conducted a two year developmental review. No concerns were noted. The mother and Child N were living with the maternal grandparents. The mother had been told the previous day that a scan had revealed her baby had serious complications such that she required a termination of pregnancy. There is evidence of good communication between the Liverpool Women's Hospital and the Health Visitor via letters and calls. There was then no further contact with the mother by the Health Visitor until March 2012.

Finding: Child N and mother had four changes of Health Visitor since birth, three of which occurred in the last 18 months. Evidence submitted[38] highlights "… continuity of service may have been delivered but this could have proved problematic for the Health Visitor and [the mother] as time is required for a new relationship and two way communication to be effective ..".

Finding: This fourth Health Visitor did not make any contact with other agencies involved prior to her first home visit although she did review the records. She maintained the focus on health and development rather than consider risk and vulnerability. Other than records relating to 2009 no further incidents were recorded under 'significant incidents' until February 2012 highlighting a gap in information. An earlier finding has been made about recording deficits by Liverpool Community Health. This further highlights how it would have been very difficult for this fourth practitioner to have understood Child N's history and vulnerability.

5.29. The report has already outlined the initiation of the Private Law Proceedings. This first set of Private Law proceedings concluded in October 2011, having spanned 23 months due to their complexity and included;

- a Finding of Fact hearing in respect of the domestic violence allegations made by the mother,
- the need to assess and monitor the contact arrangements for the father which were initially supervised and then changed to staying contact,
- the completion of a Section 37 report by Liverpool Children's Services to assess if they needed to apply for a Care or Supervision Order – they concluded an application was not necessary,
- the completion of specialist reports from a psychologist and a paediatrician.

5.30. Evidence[39] submitted states "*The paediatric assessment concluded that the frequent medical contacts for minor or trivial complaints were more likely to be as a result of maternal anxiety as opposed to a serious underlying condition. The psychologist concluded that she was pessimistic regarding the outcome; in particular, in respect of the mother who she believed would find it difficult to put aside her feelings in order to facilitate and encourage Child N's relationship with … father. The Children's Guardian assessment was that both parents were capable of parenting Child N, but they were not able to appreciate [the child's] emotional needs. The Children's Guardian view was that the father was trying to work towards a more settled arrangement for Child N but that the mother's very negative attitude towards the father would remain a barrier in the longer term ... the mother as beset with unstable mental health at an early stage in the proceedings and always took account of this in the continuous assessment and conveyed this view to the court both in written reports and oral evidence*".

Finding: Each parent called Child N by a different name. Cafcass have identified this highlighting that there was insufficient consideration in the reports prepared by the Children's Guardian of the implications of Child N having two names; both in terms of identity and for interagency working, although it was an issue discussed orally in Court.

Finding: Overall, the work of the Children's Guardian was appropriate in such a complex case. The evidence indicates that the Children's Guardian worked hard with the parents at an early stage toward a safe arrangement whereby both parents could have a relationship with Child N.

5.31. By the time of the Final Hearing in October 2011 contact arrangements were going well facilitated by the paternal family; the parents were also communicating via a diary. The final Court Orders made were that the mother have a Residence Order in her favour and the father to have a Contact Order.

[38] Liverpool Community Health safeguarding children service submission, tabular timeline of key practice episodes, October 2014

[39] Cafcass submission, tabular timeline of key practice episodes, October 2014

5.32. In respect of the 15 allegations made by the mother against the father, only four were proven against the father and two were partially proven; all other allegations were not proven. Although the Court made Findings of domestic violence it had to follow statutory guidance[40] in determining what contact arrangements, if any to allow. The summarised findings by the Judge were;

- Both parents had lost sight of the fact that Child N's welfare was or should have been their paramount concern,
- Any agency trying to help the parents had to be aware of the extent either parent would distort the truth to their own perceived advantage,
- Each parent had a justifiable concern about the behaviour of the other,
- At the time of the hearing there was no prospect of the parents being able to agree with each other about any significant matter concerning Child N's welfare,
- The father's contact should remain supervised and that the parents should not be together,
- Child N should reside with the mother,
- There should be an express prohibition against each parent taking Child N out of the jurisdiction,
- Consideration should be given to a Family Assistance Order to Liverpool City Council,
- Consideration should be given to non-molestation Orders against both parents and undertakings without penal notice from each parent,
- Both parents were told that their allegations against each other adversely reflected on their ability to promote Child N's welfare,
- The Judge did not believe a further psychological assessment of the parents was necessary,
- The Judge was interested to hear submission from the Children's Guardian as to the future involvement of the local authority if it was the Children's Guardian's view that a Family Assistance Order was not sufficient to promote Child N's welfare,
- Parental responsibility was granted to the father.

Summary analysis of 2011:

- Child N's mother continued to allege harassment by the father,

- Child N's mother experienced a terminated pregnancy,

- There were multiple changes of Health Visitor in a short period of time, which did little to promote a sound working relationship between the practitioner and the mother. As a result of these frequent changes in practitioner, information was not shared as effectively as it could have been,

- The Private Law Proceedings concluded with Child N residing with the mother and having regular supervised contact with the father. The Judge provided a very clear view about how the parent's behaviour was affecting Child N's welfare and that agencies should be alert to the potential for parental distortion for their own gain,

- Child N was being cared for by at least four adults – the mother, father, maternal grandmother and paternal grandparents – and was known by two different names. The impact of these circumstances on Child N was not sufficiently recognised by agencies outside of the formal legal process.

[40] Revised Practice Direction 2009 Residence and Contact Orders, Domestic Violence and Harm states where the court has made findings of domestic violence, but having applied the welfare checklist, none the less consider that direct contact is in the child best interest of the child the court has to consider what of if any directions or conditions are required to enable the order to be carried into effect.

2012

5.33. In February the mother was involved in a road traffic accident and attended the emergency department at the Royal Liverpool and Broadgreen University Hospital. She was diagnosed with a soft tissue injury and advised to see her GP as she stated she was pregnant. In April Child N and Half Sibling 1, were admitted to the Royal Liverpool and Broadgreen University Hospital following smoke inhalation from a minor house fire at the home of the maternal grandparents. Following an Initial Assessment by Liverpool Children's Services, the Social Worker was tasked with completing a Core Assessment[41].

Finding: No record of the Core Assessment can be found by Liverpool Children's Services. It is also unknown to what extent this assessment was completed. This was a missed opportunity to 'comprehensively' assess the home circumstances and Child N's day to day experiences.

5.34. Later in February the mother alleged that she was in a violent relationship with her husband, Adult 4, that it was not safe for the children to reside in her home, and that he was very controlling. Liverpool Children's Services submission states that there are several other allegations made by Child N's mother of a similar nature but there is no record of any action being taken to liaise with Merseyside Police or to complete an Initial Assessment.

5.35. In March 2012 the Health Visitor from Liverpool Community Health NHS Trust conducted two joint visits to the home of the maternal grandparents with the family support worker and Social Worker from Liverpool Children's Services who were conducting a Core Assessment in respect of Half Sibling 1. Half Sibling 1 had made an allegation about being kicked by Adult 5. The Health Visitor was unaware that the mother had moved back to her own flat to be with her husband. The Family Support Worker had concerns, due to their age and frailty, about the care the maternal grandparents could provide to Child N and Half Sibling 1. The Family Support Worker and Health Visitor, using the services of an interpreter, provided advice to the maternal grandmother with regards to Child N's diet, stimulation, behaviour management, routines, and benefits.

Finding: No information was shared with the Safeguarding Children Specialist Nurse by the Health Visitor about these risks. The Health Visitor liaised with Liverpool Children's Services and the School Nurse but there was no contact with the GP which could have prompted a professionals meeting. Reasons given for no contact with the GP are due to heavy caseloads at the time.

5.36. Half Sibling 1 made an allegation to teaching staff about being assaulted by Adult 5. Liverpool Children's Services then undertook a Section 47 investigation and this allegation was later retracted. This was however a significant turning point in the case, which resulted in Liverpool Children's Services becoming more involved in monitoring the welfare of Child N and Half Sibling 1. Adult 5 was reportedly hostile and aggressive during the investigation process. A written agreement was signed by the maternal grandmother stating she would ensure her son was not left alone with the children. Records indicate that this and other written agreements were not adhered too. Child N's mother alleged noticing numerous superficial abrasions and bruises on Child N's neck, torso and bruising in various areas of the child's body in May 2012. Several strategy meetings/discussions took place and Child N was medically examined at Alder Hey Children's Hospital to determine if the bruises and marks to the body were accidental or not. Although the findings by the assessing

[41] An assessment, to be completed *" … within 35 days, which should include an analysis of the child's development needs, parents' capacity to respond to those needs within the context of their family and environment …",* Working together to safeguard children, 2010, HM Government

paediatrician were not formally reported to the Social Worker until July 2012 (due to waiting for medical test results) an initial handwritten and signed report was provided on the day.

Finding: The use of written agreements by Liverpool Children's Services at this time as a way of managing the circumstances proved to be of very limited value especially given the age and frailty of the maternal grandparents who were seen as a source of protection to the children.

5.37. Liverpool Alder Hey Children's Hospital was involved with this family via three different routes. Firstly, the mother was employed by the Hospital, secondly, Child N attended the accident and emergency department for treatment for normal childhood ailments/injuries and thirdly, the hospital completed two child protection medicals.

5.38. In May 2012 the mother took Child N to Alder Hey Accident and Emergency department alleging that Child N had sustained bruises and scratches whilst in the care of the father at a contact visit. A referral was made by the Hospital to Liverpool Children's Services, and following discussion with the Social Worker, a child protection medical was carried out at the Rainbow Centre[42]. The medical opinion was that, "… *the pattern of bruising and marks to the left upper arm were considered as being consistent with a grip mark by a human hand; the bruise to the right upper arm was thought to have been caused by a grip mark; the numerous scratches and other small bruises were noted were nonspecific in nature and it could not be excluded that Child N had scratched himself".*

Finding: Alder Hey Hospital completed the child protection medical in accordance with hospital safeguarding policy and procedures however cannot locate any documentation or formal minutes to indicate a strategy meeting was held or that Alder Hey were invited or attended.

5.39. In June 2012 the mother made another complaint to Merseyside Police about the father breaching the terms of the Contact Order. At this point in time a section 47 investigation was underway by Liverpool Children's Services regarding bruising to Child N. Merseyside Police completed a VPRF1 form and passed it to Merseyside Police Family Crime Investigation Unit (FCIU). In mid-July the FCIU was invited to attend a multi-agency strategy meeting. This was the first time Merseyside Police had been notified about the possible non accidental injury to Child N.

5.40. In June and July the Health Visitor from Liverpool Community Health NHS Trust attended two Children in Need meetings in respect of Child N and Half Sibling 1 to share information about recent events and plan for support of the children and family. Parallel section 47 enquiries continued in respect of the bruising on Child N.

Finding: Evidence indicates a confused response to this series of events which include an investigation alongside dealing with Child N and Half Sibling 1 as children in need. There is no evidence within the Health Visitor's records to suggest that the agencies involved in these meetings considered convening a child protection conference; the focus was on support for the family, particularly the maternal grandparents through the use of written agreements.

5.41. Records indicate that the Out of Hours Service of Liverpool Children's Services attended the home four times in July. This appears to have been as a strategy to monitor a written agreement between Liverpool Children's Services and the family due to risks posed by Adult 5. Written agreements were used as an attempt to offer protection but were not created within a systematic child protection framework. On one visit Adult 5

[42] The Rainbow Centre; a dedicated safeguarding service provided by Alder Hey Children's Hospital that provides examination facilities.

was described as '*heavily intoxicated*'. It appears that assurances were given to the Social Workers that he would leave the family home, but these were repeatedly ignored by the family. Further written agreements were attempted as a means of managing the risks posed by Adult 5, with limited success. Child N spent a considerable amount of time living within the maternal grandparents' home in the first two years of life. In their submission[43], the author has challenged, with the benefit of hindsight, the agency response to this series of episodes. The following statements reflect this; *"… I am of the view that Initial Assessments should have been completed after the reported domestic violence incidents … I do question why the children were never subject of Child Protection Plans prior to the local authority initiating care proceedings … this was a very active and complex case with numerous case note entries that would have tested the resolve and tenacity of the most skilled and experienced practitioner …".* Supervision records indicate relevant issues were discussed however it is apparent that there were missed opportunities to systematically assess the children's circumstances over the course of these incidents with limited success in understanding the impact of emotional harm (and the potential for physical harm) to the children as a consequence of complex domestic circumstances occurring in the home of the maternal grandparents.

Finding: *The failure by the family to manage the risks presented by Adult 5 were not sufficiently challenged or responded to by Liverpool Children's Services until seeking a Court Order. Liverpool Community Health NHS Trust also failed to respond to this information following their joint visit and did not challenge Liverpool Children's Services about it. When responding to the number of referrals and allegations*, *professionals faced language and translation challenges when communicating with the maternal grandparents whose spoken language was not English. Interpreters were frequently employed however the need to be reactive to some of the referrals did not always make this possible to achieve*. *Written material was not translated however, an interpreter would translate it.*

5.42. In July the father contacted Liverpool Children's Services regarding a bruise on Child N's forehead. They undertook a Section 47 investigation and held a strategy discussion with the Police. The father was informed that Liverpool Children's Services would generate a referral to Lancashire Children's Social Care with respect to his other children. This was completed and Lancashire Children's Services responded in an appropriate manner to this referral. Due to the 'unexplained injuries' Liverpool Children's Services requested legal advice.

5.43. Following legal advice, Liverpool Children's Services commenced legal proceedings in August in respect of Child N and Half Sibling 1. Their concerns comprised of a) allegation made by Half Sibling 1 about being kicked by Adult 5 b) the two children were involved in a fire at the home of the maternal grandparents, and c) bruising to Child N in May 2012 (records are not clear about whether this included the outcome of the investigation into bruising to Child N's head). The father's application for increased contact made in July 2012 was consolidated into these proceedings. The local authority was granted Interim Care Orders on the children having satisfied the threshold for actual or likely significant harm however the Court determined that the children should remain in the care of the mother and that Adult 5 should not have unsupervised contact.

Finding: Following legal advice and discussion it was determined that the threshold for seeking an Interim Care Order had been met and that an application would be made to the Court. This Review has reflected on the hierarchy of available options in such circumstances and noted that the multi-agency child protection conference route was not used. The threshold for this option is also significant harm, or the likelihood of significant harm.

[43] Liverpool Children's Services submission, tabular timeline of key practice episodes, November 2014

5.44. In mid-August 2012 Merseyside Police and the Health Visitor from Liverpool Community Health NHS Trust received a Placement with Parents[44] request from Liverpool Children's Services concerning the local authority's proposal to allow Child N to remain at home with the mother on an Interim Care Order. The Merseyside Police Detective Sergeant at the FCIU disagreed with the placement. The Detective Sergeant's response stated "… *until the circumstances of the injury have been explored, I do not feel the child can safely remain with any family member …*". The Health Visitor responded to the request by saying *"I would not object to Child N remaining at home with mother however, I feel the situation must be monitored closely due to the following issues: mother previously leaving Child N in the care of maternal grandparents; previous domestic abuse reported within the relationship; lack of action when recommendations made by children's services around sleeping arrangements/attendance of Child N at play group/ contact with unclear/contact with father".* The Health Visitor also spoke about being unaware of the final outcome of the enquiry into the non-accidental injury. Records indicate that the Health Visitor received supervision from the Safeguarding Children Specialist Nurse during which all the information was shared and actions documented. The Cafcass Children's Guardian did not support removal but did provide initial support for the placement at home with the mother but with safeguards.

5.45. In August the mother made another complaint to Merseyside Police alleging she was concerned about Child N's safety having spoken to Child N on the phone during a contact visit with the father. As a result Lancashire Constabulary was contacted and a request made to check the welfare of Child N. Due policy and procedure were followed and Child N was seen as safe and well by Lancashire Constabulary. This demonstrated effective cross border communication.

5.46. In September the mother alleged to Liverpool Children's Services, via Nursery 1 that Child N had sustained bruising and other minor injuries whilst having contact with the father. A strategy meeting took place, involving Merseyside Police and Alder Hey Children's Hospital. Child N was medically examined as part of a further Section 47 investigation. The cause of the injuries were considered accidental, unexplained, non-existent or explained.

5.47. At that strategy meeting in September one of the Doctors from Alder Hey Children's Hospital suggested that as the mother was an employee at the Hospital a referral should be made to the Local Authority Designated Officer (LADO)[45].

Finding: The Review notes that it was good practice for the Doctor to identify the need for a professional notification. The hospital was not provided with any notes from the s.47 strategy meeting they attended.

5.48. Two days after the strategy meeting the Named Nurse for Safeguarding Children, Alder Hey Children's Hospital, notified the LADO at Liverpool Local Authority and the HR Adviser at Alder Hey Hospital about the concerns relating to the mother. The HR manager confirmed that the mother *"had been put on restrictive duties (not to be present at the delivery hatches i.e. no contact with children) pending further clarification of the situation".* Two internal meetings with senior members of staff took place, which then resulted in the mother being formally suspended.

Finding: A section 47 investigation took place in respect of the injuries to Child N. This included all relevant partner agencies, including Merseyside Police. The investigation concluded that the injuries were not attributed to any individual and the father's care of Child N was therefore not a cause for concern.

[44] Placement with parents Regulations made under section 23 of, and Schedule 2 to, the Children Act 1989 and set out special requirements in connection with the placement of children in care with their parents.

[45] LADO: Responsible for giving advice and support to employers about managing allegations against staff/volunteers in the workforce

5.49. At Court, the issue of Child N's name was considered and the mother brought the birth certificate to Court to confirm the name. However the use of the two names for Child N continued outside of the Court arena in the two sides of Child N's family. At a Court hearing in September 2012 the Court declined the local authority interim care plans to remove the children into foster care. The Children's Guardian's view was that there was no evidence that Child N was at risk from his father and that the risk of emotional harm was much greater than physical harm, the medical evidence at that time was not definitive about the cause of the injuries and there was no other explanation put forward by either parent as to how Child N may have sustained the bruising. The Children's Guardian suggestions were endorsed by the Court providing for the following arrangements; Child N to be cared for by the father (a change from the initial position), Half Sibling 1 to remain in the care of the maternal grandmother and, the mother to have supervised contact with Child N.

5.50. Following the Court hearing specialist reports were requested and filed - a paediatric overview and a parenting and risk assessment by Action for Children. During the process of the assessment by Action for Children Child N moved from the care of the mother to the father in September 2012 following a Court decision.

5.51. Action for Children conducted an intense piece of work between September and November. All policy, practice standards in relation to the conduct of the assessment were met;*"… practitioners embraced a methodological approach to assessment, which followed statutory guidance and made use of tools, templates and quality assurance processes … the assessment included session by session analysis and reflection on emerging themes which were then communicated and clarified with parents in an open manner*". Child care concerns brought to Action for Children's attention were appropriately communicated in writing to Liverpool Children's Services, including details about an injury to Child N which the father identified. The work was conducted in a timely manner with sessions in different settings, adding a depth to the analysis of family functioning and protective factors for Child N.

5.52. The Action for Children practitioner admitted having concerns about *"the mother's lack of honesty*" and said "*the mother provided unreliable information which conflicted with the Judge's Finding of Fact and /or information provided by the Social Worker… the mother's difficulties with contact arrangements and the dynamics with the father highlighted little had changed since the psychologist reports in 2010 and 2011 and the Guardian's report 2011 … she concluded that there has been no evidence to suggest the father's caregiving presents a risk to any of the children".* In respect of Child N the practitioner concluded in the Court report *"I would not recommend Child N returns to the care of the mother. Child N's needs appear to being met in his current placement with the father and as such I would recommend [Child N] remains in that placement with the support of the local authority*".

Finding: Action for Children conducted a high quality parenting and risk assessment in a timely fashion. Liaison with Liverpool Children's Services and the Children's Guardian was effective.

5.53. The Court ruled against having a Finding of Fact hearing concerning the injuries Child N sustained in May and September 2012 and ruled that the threshold for significant harm had been met.

Finding: The Children's Guardian appraised the Local Authority plans and advised the Court accordingly. However, there were gaps in the case file recording of the Children's Guardian about what the Local authority's safeguarding plan looked like for both children.

5.54. In September 2012 the Health Visitor from Liverpool Community Health NHS Trust attended an initial Looked after Children Review as per policy. Child N was now subject to Placement with Parents Regulations as a looked after child, subject of an Interim Care Order and living with the father. The Liverpool Health Visitor completed a verbal handover to the new Health Visitor in Lancashire and transferred the health records via the appropriate route.

5.55. In October an allegations strategy meeting was arranged under Liverpool Safeguarding Children Board procedures and chaired by Liverpool Children's Services LADO in order to determine any further actions in respect of the mother. The agreed outcome was that Alder Hey Hospital should follow internal procedures regarding capability and risk of the mother performing the role. Following full consideration about the impact of these issues and an Occupational Health assessment being completed, the decision was taken that the mother could return to work without restrictions. This decision was confirmed by the Trust's Nursing Director in November. Occupational Health informed the mother's GP however the reasons for her originally not working were unclear in the letter to the GP and referred to difficult domestic circumstances and Court proceedings; not child protection concerns.

Finding: No formal minutes of the strategy meeting were distributed to Alder Hey Hospital although all the actions were implemented. The mother's GP was not provided with full information about the circumstances of the mother's suspension from work. The mother had refused for information to be shared about herself from the GP to Occupational Health.

5.56. During this period Child N settled back well at Nursery 1 (having started re-attending in July) but then stopped attending in September due to living with the father. Nursery 1 has examined their practice during the period July to September.

Finding: Whilst the Nursery was supportive of the mother and her concerns they did not sufficiently record the concerns expressed by her about diet, feeding, sleeping, requests to administer medication when ill, arrangements about handover for weekend contacts with the father, the mother's attitude to contact arrangements. They did also not look for patterns in behaviour and were *not consistent in sharing information about such matters with the Social Worker. There was no clear transition procedure in place to ensure that records were handed over to the next Nursery setting and staff at Nursery 1 were unclear about what information they could legitimately share in respect of the family and concerns*.

5.57. The Lancashire Care NHS Foundation Trust Health Visiting and School Nurse Service (LCFT) have identified that due process was followed concerning the allocation of a Health Visitor and then conducting a home visit. Evidence submitted to this Review shows that the first home visit was routine and no particular issues were noted. A potential procedural risk has however been identified. As Child N was a Looked After Child, ordinarily a Child Looked After[46] meeting would be convened and attended by the relevant health practitioner. On this occasion, due to the cross boundary nature of the placement (Child N was a LAC by Liverpool Children's Services but placed in Lancashire) the health practitioner did not attend. It is not custom and practice in LCFT universal services locality to attend these meetings for out of area children placed however there is an expectation of a written report being provided, or where there is minimal information verbal information sharing when appropriate.

Finding: Children Looked After (CLA) children placed out of the areas could be at a disadvantage in relation to their health information, due to the distance for professionals to travel.

5.58. Child N attended Nursery 2 (Lancashire) during October 2012 to July 2013 (until transferring to a primary school from September 2013). The father asked the Nursery staff to examine Child N's scrotum in October; they agreed to do so with the father present. They noted what they saw as old wound marks but no fresh

[46] Lancashire Care NHS Foundation Trust refer to children in care as Child Looked After (CLA) rather than Looked After Child (LAC)

scratch marks. The recording of the examination was thorough and detailed. There is no record as to why this request was made and whether this information was shared with anyone else. The Nursery staff considered that they had a good relationship with the father and were keen to be supportive of him. In October the Nursery wrote a witness statement but there is no record of what this was prepared for and who had requested it. Interrogation of email accounts shows it was sent to Action for Children and the allocated Social Worker in Liverpool Children's Services. The Nursery manager recalled attending a Child Protection Review conference but there is no record of this – either minutes or a note of the outcomes in the Nursery records. This meeting related to action taken by Lancashire Children's Social Care in respect of the father's two children. In November Child N had a bruise to the side of the head for which the father could offer no explanation. The Nursery manager asked the father to inform the Social Worker.

Finding: The examination of Child N's scrotum by Nursery staff was inappropriate, as was asking the father to report the unexplained bruise to the side of Child N's head. This information should have been passed to the Social Worker by the Nursery. A record was not made about who requested the witness statement and the date and to whom it was sent. No records were made about discussions and the outcome of attending the child protection review; no minutes were provided.

Summary analysis of 2012:

- Liverpool Children's Services responded to a number of referrals concerning domestic violence and complex family circumstances. Strategies to manage risks within the home proved ineffective and procedural omissions have been highlighted during this period,

- The nature of the allegations shifted; they became allegations of physical harm to Child N rather than allegations of harm directed to the mother, from the father,

- Lancashire Children's Social Care responded appropriately to concerns about Half Siblings 2 and 3 due to an investigation into the father's behaviour with Child N. There was no consideration of Child N becoming subject of a Child Protection Plan despite increasing concerns,

- Concerns about the safety and welfare of Child N (and Half Sibling 1) did increase and legal proceedings were initiated by Liverpool Children's Services in order to protect the children's welfare. The threshold of significant harm was determined by the Court,

- As a result of the Public law proceedings, independent parenting assessments were completed on the mother and father by Action for Children,

- Professionals faced challenges with language when communicating with the maternal grandparents whose spoken language was not English, when responding to the number of referrals and allegations. This is significant as the grandparents had a significant role in Child N's life and also acted as a source of authority in ensuring whether the Adult 5 stayed out of the family home,

- There were conflicting professional views about whether Child N should be cared for by either the mother or father due to the potential risks,

- The need for coordinated and effective inter-agency and cross border collaboration intensified due to the number of allegations made, but also the initiation of Public law proceedings; this proved challenging for professionals,

- As a result of the mother working in the same place where Child N had received a child protection medical, she was suspended from work due to an investigation into alleged harm,

- Child N moved from living with the mother to living with the father, as he was considered the more suitable carer given the presenting circumstances,

- Nursery 1 did not keep a record of their concerns and were unclear about whether to share information with other agencies.

2013

5.59. In January 2013 the following information emerges from documentary review;

- The mother's solicitor requested an opinion from the GP regarding the mother's ability to care for Child N with specific regard to her physical and mental health. The GP stated that he had interpreted this as requiring just a brief statement and no evidence was requested to support the opinion. The GP's response was based on a judgement of the mother at that time and deemed her current physical and mental state to be stable. The GP felt justified to limit the response to what was requested and considered there was nothing at the time of the request to suggest anything untoward.
- Liverpool Children's Services presented a Final Care Plan seeking a section 31 Care Order[47] for Child N to be placed at home with the father under the Placement with Parents Regulations. The Court decided the threshold was not met for Care Orders to be issued. Instead, the Court awarded the father a Residence Order in respect of Child N and made a 12 month Family Assistance Order[48] (lasting to January 2014) for specifically overseeing the progress of the contact arrangements with the mother and granted a Supervision Order[49] in respect to Half Sibling 1 who was to reside with the maternal grandmother. At the Final Hearing in January 2013 the Cafcass Children's Guardian agreed with this plan.

5.60. In February the Liverpool Children's Services LADO made appropriate contact with the Named Nurse for Safeguarding Children at Alder Hey Children's NHS Hospital seeking an update about the mother's circumstances and position. As the mother had been reinstated there was no further action required on this matter. Also in February the Health Practitioner from Lancashire Care NHS Foundation Trust (Health Visiting & School Nurses) was informed by the father than Child N was no longer a Looked After Child; instead he had been granted a Residence Order. This information was not verified. Liverpool Children's Services did not inform the Foundation Trust about this change in circumstance and the health practitioner did not check back with the Social Worker.

Finding: *There was a failure to communicate the legal change in Child N's circumstances by Liverpool Children's Services in a timely manner*.

5.61. Liverpool Children's Services records reveal the following; in February the father report that Child N had a bump on the head, in March Child N alleged that Half Sibling 1 had touched his penis (resulting in a section

[47] An Order giving the Local Authority parental responsibility for the child
[48] An Order requiring a Cafcass officer or an officer from a local authority to advise, assist (and where appropriate) befriend any person named in the order
[49] An Order placing the child under the supervision of the Local Authority

47 investigation by Liverpool Children's Services), in June the mother arrived at the father's home address and threatened to kill him and his family (also resulting in a section 47 investigation, with a strategy meeting held in July). The outcome of this final investigation was that there would be no further involvement from Lancashire Constabulary but that Liverpool Children's Services would continue to monitor and support the family.

Finding: The above series of incidents from February reflect a sustained level of acrimony between Child N's mother and father following the conclusion of Court proceedings. These incidents were responded to by respective agencies with Liverpool Children's Services being the lead agency due to the Family Assistance Order being in place. Evidence submitted by Liverpool Children's Services indicates children were seen, case specific issues were appropriately discussed in supervision and there was management oversight of practice however workload pressures affected their overall response to systematically re-assess circumstances.

5.62. The above finding is further highlighted following the notification of an injury to Child N in March 2013. The Social Worker from Liverpool Children's Services informed the health practitioner that Nursery 2 had reported a scratch to Child N's penis and were concerned about weight loss. The Social Worker requested that the health practitioner contact the father to discuss the situation. One practitioner from Lancashire Care Foundation Trust has reflected on this episode that *"… the situation arose because of the complexities of the case being managed by Liverpool but that Child N was actually living in Lancashire".* Evidence suggests that the Health Visitor was being asked to perform the role of Social Worker and look into the injury. This included a lack of *" … explanatory information regarding the injury or circumstances … lack of challenge by the health practitioner to the Social Worker regarding context of injury and the need to follow necessary safeguarding procedures if relevant … lack of understanding of Health Visitor role and unrealistic expectations by children's services …"*

5.63. In March Nursery 2 (Lancashire) noted that Child N had a bloodshot eye. They asked the father to get it checked by the GP (which he did and they confirmed it was an infection). The Social Worker was not informed. The following day Child N had a deep scratch underneath a bloodshot eye and there was no explanation for it. The Social Worker was not informed. Because the Nursery felt that they had a good relationship with the father they deduced there was no reason to be suspicious about these injuries. In April the Nursery recorded that Child N was seen to have a mark on his penis. The Nursery Manager informed the father of this and that they would be informing the Social Worker. Although they did this they did not make a record of having done so. Nursery 2 described that Child N *'thrived and blossomed'* whilst at this Nursery.

Finding: The unexplained injuries were not referred to the Social Worker by the Nursery. The father was asked for an explanation on each occasion as per Nursery safeguarding procedures but this was insufficient action to take given the circumstances.

Finding: Child N was a Child in Need during the period of the Family Assistance Order and therefore should have been subject to regular review meetings by Liverpool Children's Services. Records submitted by Liverpool Children's Services indicate a very mixed account of whether these meeting took place or were recorded. There is one reference of the Nursery having been invited to attend meetings. There is no evidence of the Nursery having received copies of the minutes from those meetings. Lancashire Care Foundation Trust were not informed of Child N's Child in Need status or invited to attend meetings. This runs counter to LSCB multi agency safeguarding procedures which state out that all agencies should receive copies of child protection meetings and plans, looked after children reviews and Child in Need meetings.

5.64. Also in March the mother had a medical termination for a foetal abnormality. The GP's records indicate that she coped well with this. The GP did check for depression at the time but there was no significant evidence

to suggest the mother's mental state had suffered. She expressed concern about future pregnancies and a referral was made to Liverpool Women's Hospital for counselling.

5.65. During April and May 2013 the Health Visitor from Lancashire Care NHS Foundation Trust (Health Visiting & School Nurses) completed two home visits seeing Child N and the father. During the first visit, the father described Child N being unwell. The Health Visitor made a decision to weigh Child N with no clothes despite protocol not requiring this of older children. Health concerns were noted (skin integrity, bed wetting and anxiety) as well as scratches and a small bite mark. These minor injuries would not have been seen if the Health Visitor had weighed Child N with clothes on. Plausible explanations were provided about these by the father.

Finding: The Health Visitor made a sound professional judgement to weigh Child N without clothes given the presenting circumstances.

5.66. A follow on visit was made three weeks later where improvements were noted. The Health Visitor reported that a discussion had taken place with the father regarding Child N biting his lips and scratching and the father had suggested this was possibly anxiety related and exacerbated by eczema. A further 6 – 8 week visit was planned; this did not take place. No explanation can be given for this visit not taking place however Child N did not actually require a follow up visit as per the Family Weighting Tool[50] but the Health Visitor had agreed this visit to be supportive to the family. At this point, the Family Weighting Tool was reviewed and Child N was weighted at Level 1 (that of a core programme). In turn, this prompted a reduction in the level of service offered. The Health Visitor was not aware that Child N was no longer a Looked After Child, was not aware of the Family Assistance Order, and accepted the account from the father about current circumstances.

5.67. Lancashire Constabulary became involved in June 2013 when Child N's mother alleged an assault by Child N's father. The father was arrested and questioned. An ABE[51] interview was conducted with Half Sibling 1 who witnessed the incident. A file was submitted to the Crown Prosecution Service who decided there was insufficient evidence to support a prosecution.

Finding: This matter was investigated by Lancashire Constabulary with due policy and procedure being adhered to.

5.68. In June 2013 the reception Teacher from School 2 (Lancashire) visited Nursery 2 to meet with Child N to gather background information to ease the transition into school; this was good practice. Although Child N was late and therefore not present, the reception teacher was given information about Child N's development and was informed there was a 'custody battle' underway between the parents. Nursery 2 did not pass on any hard copy of records to School 2 as they thought they would not be needed although they were aware there had been safeguarding concerns. The father provided the school with other information including evidence of the Residence Order but the school were not provided with any information from Liverpool Children's Services. At that time a Family Assistance Order was in place.

Finding: School 2 was provided with insufficient information about Child N's home circumstances by both Nursery 2 and Liverpool Children's Services.

[50] Family Weighting Tool, LCFT Standard Operating Procedures for the completion of the child and family weighting tool, September 2013

[51] ABE: Achieving best evidence – an agreed protocol for interviewing vulnerable and intimidated witnesses, both adults and children, in order to enable them to give their best evidence in criminal proceedings issued as practice guidance under the Criminal Justice Act 1991

5.69. In August 2013 Merseyside Police attended a Liverpool North MARAC meeting following the alleged assault in June. Merseyside FCIU attended the MARAC and was given actions to contact Lancashire Constabulary. These were all completed and reported into the next MARAC meeting with no further action required.

Finding: The Review has noted four recorded incidents where Lancashire Constabulary investigated allegations made by the mother or father. On all occasions there was either insufficient evidence or no further complaint made in order to progress the matter.

5.70. The Social Worker from Liverpool Children's Social Care allocated to oversee the Family Assistance Order developed a plan for managing the Order which included regular meetings with the parents. This Social Worker went off sick in July 2013. Another worker took over but there are no records of any further meetings taking place.

5.71. During September 2013 the Health Visitor from Lancashire Care NHS Foundation Trust (Health Visiting & School Nurses) made contact with the father. Records indicate that Child N had settled and contact with the mother was proceeding well enough. Records then transferred to the School Nursing Service in December 2013.

5.72. The Health Visitor has reflected on practice and *"…identified that father appeared very open and honest and had been consistent throughout her involvement with the family … he appeared to be a 'stable factor' and had Child N's best interest in mind … taking what he said at 'face value' to be correct, and agreed that there was a degree of professional optimism present in her practice …"*

Finding: The Health Visitor maintained case responsibility for Child N despite Child N being of school age and being the responsibility of the School Nursing Service. This is an organisational wide arrangement and not just a locality or specific team arrangement and assists with continuity of care and workload arrangements.

5.73. In October a third set of Private law proceedings were initiated by the mother when she applied for increased contact with Child N. The case was heard by the Court the day after the application was made. The Court made a decision for increased contact for the mother without the Schedule 2[52] letter being filed by Cafcass and without a Cafcass Officer being present in Court. At the time that this Court hearing took place Child N was the subject of a Family Assistance Order granted to Liverpool Children's Services. The revised contact arrangements were made by the Court without full recent information being presented to the Judge; usual procedure of filing a Schedule 2 letter for the first hearing was bypassed. The decision to do this was endorsed by a Cafcass team manager as a final order was made the day after the application and there was a Family Assistance Order in place. The Cafcass submission[53] states that when routine safeguarding checks were requested by Cafcass *"… Lancashire advised that Child N was not known to their service. The adults were known as associates of other individuals known to their service. This error, in my view resulted from the change to Child N's name …".* There was a delay by Cafcass of almost four months in submitting the outcome of the routine safeguarding checks - due to prioritising the volume of Schedule 2 letters and the delay in receiving information back from the local authorities.

Finding: The standard procedure of the Court receiving information from Cafcass on which to then inform assessment and decision making was bypassed as a Final Order was made the day after the application.

[52] Schedule 2 letter; a preliminary report which provides information about safeguarding checks, Police convictions and history with the Local Authority

[53] Cafcass submission, tabular timeline of key practice episodes, September 2014

5.74. In November 2013 the mother made a request, unbeknown to the father, to the Liverpool GP to re-register Child N. This was not questioned and the transfer of registration commenced in December 2013. Hence Child N effectively had joint registration at two separate GP practices. This could have led to problems (e.g. dual prescriptions being issued). Following this request to re-register with the Liverpool GP no GP services were sought, in either Liverpool or Lancashire for Child N. Had GP services been required in Lancashire, the father would have then been alerted to the change of registration. The same could not be said if Child N was requested to be seen in Liverpool.

Finding: It is apparent from the Liverpool GP records that it was assumed that the mother was always responsible for making decisions about Child N however, at this time, the father had a Residence Order. As a consequence, her request to register Child N in 2013 (and have dual registration) was not questioned.

Finding: The NHS GMS1 form used for registering at a GP Practice does not ask about parental responsibility. It is considered best practice to verify who has parental responsibility for purposes of consent to examination and/or treatment. In situations of parental separation this may be important given the need to make decisions on behalf of a child.

5.75. Between January 2013 and January 2014 the mother had 17 contacts with the Liverpool GP Practice over alleged early pregnancy related issues. At no time was there any evidence that she was pregnant despite her claims. No letters or reports were received by the GP Practice to back up her claims of pregnancy or contacts with hospitals for ante natal care. Alder Hey Children's Hospital has noted that between 2011 and 2013 the mother claimed she was pregnant but had subsequently lost the babies due to either alleged miscarriages or terminations. The mother advised she was under the care of the Liverpool Women's Hospital during these alleged pregnancies but this proved to be incorrect when checked. Information relating to the mother's family circumstances was not known to Alder Hey Children's Hospital, aside from that which the mother shared herself. This had implications for the mother's sickness and absence from work, especially as it was discovered that she may have been working elsewhere whilst on sick leave from the hospital. NHS Counter Fraud and Mersey Internal Audit Authority were notified in 2013. The Liverpool GP Practice was warned by the Counter Fraud investigators not to document or convey any of the details of their investigation to the mother.

Finding: The Liverpool GP Practice did not challenge the mother as a result of her contacts with them over pregnancy issues, rather each consultation was addressed in isolation with no holistic view taken. The reason for this is that they felt constrained by a directive from the Counter Fraud Investigation Team.

Summary analysis of 2013:

- A Care Plan presented to the Court by Liverpool Children's Services seeking a Care Order (for Child N to be placed at home with the father) was not accepted as the Court determined that the threshold had not been met,

- The Court awarded the father a Residence Order in respect of Child N and made a 12 month Family Assistance Order for Liverpool Children's Services specifically overseeing the progress of the contact arrangements with the mother,

-The mother had numerous contacts with the Liverpool GP over alleged early pregnancy related issues however there was no evidence to back these issues up. Child N's mother was covertly under investigation for fraud, this affected how the Liverpool GP responded to the mother when she presented,

- The Liverpool GP failed to consider the history of maternal mental health when asked for an opinion for the Court, instead offering a limited view about her current presentation,

- A number of minor physical injuries were reported, or noticed, on Child N. These were either investigated, or not referred to the appropriate agencies by the Nursery and, as such, there was no overall analysis of this series of separate episodes,

- There were procedural omissions by Liverpool Children's Services, for example, failing to inform professionals involved in Child N's life about the change in legal circumstances, and not inviting other professionals to meetings or sending minutes of meetings to them,

- The mother returned to Court to seek increased contact with Child N; this was awarded.

2014

5.76. In January 2014 the Head Teacher at School 2 (Lancashire) contacted Liverpool Children's Services to check the status of the Family Assistance Order and was informed that the case had been closed and the Order had come to its end date. The Head Teacher demonstrated curiosity and tenacity in seeking this information.

Finding: There are opposing (and unresolved) accounts from School 2 and Liverpool Children's Services about whether contact was made between the two parties. School 2 state that they were not contacted, consulted or informed about the intention to close the case at the point when the Family Assistance Order expired. A meeting to confirm the expiry of the Family Assistance Order in January 2014 is reported to have been held by Liverpool Children's Services, but there is no record of it. Supervision records indicates Child in Need meetings took place in March, April, June , July, September and November 2013 however there are no records available of the actual meetings showing attendees or actions.

5.77. The maternal grandfather died in February 2014. The mother was given a medical certificate from the Liverpool GP as being unfit for work due to bereavement. She was seen four times by the GP between February and April 2014. No formal assessment was made of her mental state during this period.

5.78. The report will shift to a tabular format in order to provide a detailed account of events from March to May 2014.

5.79.	Event	Activity
Tuesday 25th March 2014	Merseyside Police were informed by Lancashire Constabulary about an allegation made by Child N of being inappropriately touched by Half Sibling 1. This was alleged to have happened at the maternal grandmother's home over the weekend in Liverpool and had been reported to Lancashire Constabulary by the father.	Cross border communications agreed that primacy for this investigation was held by Merseyside Police. A joint investigation took place and two separate ABE interviews were conducted by suitably trained officers from Merseyside Police with Child N and Half Sibling 1. Child N repeated the allegation during interview whereas Half Sibling 1 strongly denied the incident, as did the mother and the grandmother. Merseyside Police have reported that the investigation was prompt and thorough and concluded that, as there was no forensic or corroborative evidence to support the allegation, they would not take further action.
Finding: School 2 (Lancashire) were not informed by the relevant agencies of the allegations made by Child N or the plans following the joint investigation.		
5.80.	**Event**	**Activity**
Sunday 20th to Tuesday 22nd April	20th: The mother reported to Merseyside Police that the father had threatened her over a contact issue. She did not want to see a Police officer but wanted it recorded. 21st (07.29 hrs.): A further complaint was made by the mother to Merseyside Police over a contact matter. 21st (07.51 hrs.): The mother then reported to Merseyside Police an allegation of sexual abuse committed by the father on Child N and one of a threat to kill her. She stated that on the 10th April during staying contact Child N stated that the father had touched him inappropriately and that he had been told to lie about it being Half Sibling 1. The mother also reported that on the 20th April Child N said "*daddy is going to kill you soon*" and was scared of returning to the father's house the next day.	20th: There was already a marker that flagged the mother's address that she had been to MARAC previously regarding domestic abuse. It instructed that if any offences were disclosed then positive action was to be taken and the VPRF1 form should be emailed to the FCIU prior to the end of that shift. 21st: It was not necessary to deploy and officer as advice was given; the mother agreed with this. 21st: An investigation commenced with Lancashire Constabulary taking primacy over the investigation because the alleged offence occurred in Lancashire. Cross border liaison took place with both Forces. Merseyside Police obtained a written statement from the mother and agreed to conduct an ABE interview with Child N on behalf of Lancashire Constabulary.
Finding: The Review finds no VPRF1 form was submitted to Merseyside Police FCIU on the 20th or for the first incident on the 21st April. The call handler has explained this was because the form is only completed by an attending officer and the mother had not wanted an officer to attend. This has highlighted a gap in the system for Merseyside Police as the form is a trigger for a risk assessment. A VPRF1 form was submitted for the second incident on the 21st April but not entered onto the PROtect log[54] until 5 days later. This meant that if someone had checked the PROtect log they would not have found out the information that was on the VPRF1 form.		
5.81.	**Event**	**Activity**
Tuesday 22nd April	Following the two week Easter break in April Child N did not arrive back in School 2 (Lancashire). The father	The Head Teacher from School 2;

[54] Merseyside Police Family Crime Investigation Unit (FCIU) have an electronic records system onto which all incidents of domestic abuse and child protection are recorded – it is known as PROtect.

	informed the school that Child N had been staying with the mother. The school were concerned about Child N being absent from school and acted promptly to explore the situation.	- immediately made contact with the Social Worker at Liverpool Children's Services and liaised regularly with her throughout the period of Child N's absence from school, - contacted the mother on several occasions to stress the importance of Child N's attendance, - liaised regularly with the father, - sought advice from the Local Authority Missing Education Team who suggested the mother consider dual registration; that she registered Child N at a school in Liverpool, - liaised regularly with School 1 in Liverpool about dual registration, although this turned out not to be possible because the mother did not have a Residence Order in her favour (see below: the mother tried to register Child N at a Liverpool school – School 1), - sought advice from the Local Authority Attendance Officer and was informed that as Child N was not of statutory school age the mother was under no legal obligation to send the child to school. However, as the father had brought Child N to school the precedent had been set which explains why dual registration was suggested, - School 2 (Lancashire) did not consult with the Lancashire Safeguarding Officer for Education because they thought it unnecessary as there was already a Social Worker allocated to the case.
Finding: *Positively, School 2 rigorously monitored and recorded their actions from the time they first had concerns about Child N. They proactively sought to understand the complexities around Child N's home circumstances by liaising with other agencies and the family in order to get Child N back into school. They appropriately shared their concerns about Child N and the mother's mental state with the Social Worker.*		
5.82.	**Event**	**Activity**
Wednesday 23rd April	The mother requested a place at School 1 (Liverpool), having not returned Child N to School 2 (Lancashire). The mother completed a school admittance form and visited School 1 with Child N. The school reported that Child N was "*well presented, chatty and appeared happy*".	The Deputy Head at School 1 contacted the Head Teacher at School 2 to check the information about Child N. It was discovered that Child N was known by a different name there. School 1 shared their information and concerns about how the mother interacted with Child N, *"too emotional, clingy and intense*". School 1 made contact with the Social Worker in Lancashire Children's Social Care to alert her to the mother's application for a school place and to check the legal position. On learning that the mother did not have a Residence Order in her favour, School 1 rang the mother to inform her they could not give Child N a place.
5.83.	**Event**	**Activity**
Friday 25th April	The father contacted Merseyside Police anxious because the mother had not returned Child N to School 2, although he was aware of the counter allegation made by the mother. The mother also contacted Merseyside Police to reinforce the seriousness of the allegations made and that Child N had not yet been interviewed.	The father was informed by Merseyside Police that because there was a complaint against him, Child N would not be returned to him until the investigation had been resolved. Merseyside Police obtained a copy of the Court Order to check its conditions and found it did not contain any legal powers of removal. Later that day an officer visited the mother at home and saw Child N safe and well. Given that Child N had not yet been interviewed it was decided to leave Child N with the mother to avoid interference with any potential evidence. The mother was considered to be behaving reasonably. Later that day Lancashire Constabulary visited Child N's father who was also

		considered to be reasonable. It was agreed by Lancashire Children's Social Care that seeking alternative carers for Child N was an option. Paternal family members were identified and attempts to return Child N to the paternal family would be made the following day. The father was in agreement with this. This did not happen.
Finding: Merseyside Police completed a VPRF1 form that recorded a request for a welfare check to be completed on Child N by Lancashire Constabulary. This was not entered onto the PROtect log until 13 days later (8th May).		
5.84.	**Event**	**Activity**
Sat/Sun 26th /27th April	Child N's father had numerous conversations with Lancashire Children's Social Care which focused on his frustrations in trying to enlist the support of Merseyside Police to return Child N.	Lancashire Emergency Duty Team liaised with Lancashire Constabulary Public Protection Unit to gain the support of Child N residing with paternal relatives (whilst the father was still subject to investigation). This had already been agreed on the 25th April however Child N remained in the care of the mother.
Finding: Lancashire Children's Social Care records clearly indicate that Child N's father and professionals (Cafcass, Lancashire Children's Social Care) had concerns about Child N remaining in the mother's care because of the concerns around long standing emotional harm. There was however no evidence to indicate any likelihood of physical harm or immediate danger. Lancashire local authority's safeguarding policies and procedures, as well as the LSCB safeguarding procedures, were adhered to. Whilst there is evidence of record keeping and management approval there are also deficits around record keeping for some elements of the agency's involvement. These relate to records of discussions between Liverpool Children's Services and Lancashire Children's Social Care about who would take responsibility for certain tasks and a delay in the duty Social Worker recording a joint visit with the Police and supervision.		
5.85.	**Event**	**Activity**
Sunday 27th April	Lancashire Children's Social Care Emergency Duty Team (EDT) had decided with Lancashire Constabulary's PPU that Child N should be returned to the paternal family's care due to the risk of emotional harm.	Arrangements were made to place Child N with paternal relatives who had been vetted by Lancashire Children's Social Care given the father was, presently, not deemed a safe carer despite the Residence Order. Lancashire Children's Social Care requested the attendance of a Police patrol from Merseyside Police to prevent a breach of the peace when the relatives went to collect Child N from the maternal grandmother's home. The Inspector who was allocated this task had a conversation with EDT of Lancashire Children's Social Care. He recorded, "*I have discussed this Court Order and the Police powers in relation to the request and we agree the following: there is no power within the current Order for the Police to physically enforce the transfer of the child from mum to other family members; if mother fails to cooperate the matter will be referred back to Lancashire EDT and Lancashire PPU; there is no suggestion the child is in any immediate danger should he remain with the mother*". The Inspector informed the father of this. The Inspector attempted to speak with the Lancashire Constabulary PPU but did not get an answer via the telephone switchboard, so left a message on the answer machine. Later that day, the Inspector went to visit the mother and Child N accompanied by the father's two relatives. Child N was present and cuddling his grandmother. The inspector judged Child N to be

		content with both the grandmother and mother. The mother refused to allow the Inspector to remove Child N as she said the investigation had not been completed and she did not want Child N to be influenced by the father's family. The Inspector recorded that he "*was not prepared to forcible remove child N as there was not the authority within the Court Order and the child did not appear to be at immediate risk*". The mother informed him that she would be making an application to Court the following day and would seek advice from a solicitor. The Inspector did consider using Police protection powers but considered Child N was not at risk of immediate harm.
Finding: Merseyside Police took all reasonable steps, using professional judgement, in making their decision and deciding not to exercise powers of protection on the visit to remove Child N from the care of the mother on the 27th April. This professional judgement was based on intuitive reasoning i.e. observations and experience, as well as analytic consideration having made enquiries and understood the limitations of his authority. *Finding: Best practice might suggest that, given Lancashire Children's Social Care requested an officer assist with relocating Child N, a Social Worker should accompany any Police officer in such circumstances. The officer attended with two unknown relatives of Child N and it would have been helpful for a Social Worker to accompany them so as to provide a thread of continuity to the process of relocation.*		
5.86.	**Event**	**Activity**
Monday 28th April	The mother applied for a Child Arrangements Order, Specific Issue and Prohibited Steps Orders in respect of Child N.	A Court hearing was listed for the next day with a schedule set for checks to be completed and a return to Court on the 7th May. This began the fourth set of legal proceedings for Child N. The role of Cafcass prior to the First Hearing is to identify any safeguarding or serious welfare concerns affecting a child or vulnerable adult. As part of this, Family Court Adviser 1 checked if there had been any previous Cafcass involvement. Cafcass electronic records held a hyper-link to the third set of Court proceedings held in October 2013 but not those held in 2009 and 2011.
Finding: Cafcass electronic recording systems failed to make the link between current proceedings and two previous proceedings in 2009 and 2011. It is likely that the confusion of the different names that Child N was known by may have been a contributory factor. Of particular note, the application from the mother gave the wrong date of birth for Child N and had described the father as being 'the step father'. Addresses for the mother and father, to enable an address history check were also omitted. This deficit in the Cafcass system is being addressed with the introduction of a new electronic case management system implemented in July 2014.		
5.87.	**Event**	**Activity**
Tuesday 29th April	Court hearing.	The following directions were made; - Lancashire Children's Social Care to file and serve a short report setting out the recent involvement of the local authority and the proposals as to where the child should stay whilst the current allegations of sexual abuse are investigated, together with any updating information received from the Police, for the hearing on 7th May, - Liverpool City Council to file and serve an updating report as to their involvement as the acting local authority dealing with the Family Assistance Order which terminated in January 2014, by the 6th May,

		- The Chief Constable of Lancashire to file and serve details of the outcome of the interview with the child on 30/04/14 and what action, if any, they intend to take, by the 6th May.
Finding: Statutory agencies that had the most recent contact and involvement with Child N were requested to provide information in order to further the Courts understanding about the immediate circumstances.		
5.88.	**Event**	**Activity**
Wednesday 30th April	The mother rang School 1 (Liverpool) to request dual registration and requested the school prepare a letter for Court confirming that this would be possible. Also on the 30th April Child N was interviewed by suitably trained officers from Merseyside Police and made a disclosure about being sexually abused by the father. The details of this interview were shared with Lancashire Constabulary on the 7th May, some seven days later, although attempts were made to contact the relevant officer on the 6th May. Liverpool Children's Services received a request from the Court that a short report be prepared. Cafcass also requested information from them.	School 1 clarified that they could only offer a place once Child N's long term future was settled. The requests from Court were complied with by all parties. The author of the short report from Liverpool Children's Services was a night duty Social Worker. He noted that there were 492 entries on the electronic chronology of contact with the family. His report submitted to that hearing concluded, *"… as there are no current safeguarding concerns regarding the children, it is considered that the case can close. All agencies and parents are in agreement. Case closure was agreed on the basis that no further role was identified for Liverpool Children's Services plus the family are stable and are able to manage contact issues appropriately".* He stressed within his report that there was a long and detailed complex history which he advised the Cafcass worker to view for himself. This report was quality assured by a team leader within Careline and an area social work team leader.
Finding: School 1 acted appropriately in the management of the mother's application for a school place, communicating effectively with School 2 and the Social Worker at Liverpool Children's Services. *Finding*: *It took seven days for Merseyside Police to share the outcome of the ABE interview of Child N with Lancashire Constabulary who held primacy for the investigation. This was due to the officer conducting the interview going on leave but wanting to discuss the content of the interview with colleagues in Lancashire personally. The professional judgement of that officer was that there were no immediate safeguarding concerns for Child N. This response time meant a decision could not be made by Lancashire Constabulary about the outcome of the investigation and Child N's return or otherwise to the father. The Reference Group for this Review have concluded that this was a reasonable response time given the circumstances.* *Finding: The outcome of the investigation by Lancashire Constabulary into the alleged sexual abuse of Child N by the father was that no further action would be taken.*		
5.89.	**Event**	**Activity**
Tuesday 6th May	The mother brought Child N to School 1 in the correct uniform having disregarded their advice some days earlier. The mother contacted Merseyside Police and made an allegation of being threatened by an associate of the father's the previous evening. The mother told the Police she had been due to return Child N to the father that day but had not because of being too scared.	School 1 refused to admit Child N and informed School 2 of the incident. The officer from Merseyside Police liaised with the Social Worker at Lancashire Children's Social Care and stated that an officer from Lancashire Constabulary would contact the mother the next day when back on duty.

Finding: The response to this allegation was inadequate. A Police patrol from Merseyside Police should have been despatched that day to speak with the mother to ensure her and Child N's safety. Evidence gathering should have been undertaken and a written statement obtained. As no officer attended, no VPRF1 form was completed and submitted to FCIU, nor a PROtect log created to manage the matter. No explanation can be given for the lack of positive action by Merseyside Police.		
5.90.	**Event**	**Activity**
Wednesday 7th May	Court hearing.	The Court heard that there was no suggestion of any immediate safeguarding concerns or harm to Child N. The Court directed that: - the mother should return Child N to the care of the father on the 8th May, - the First Hearing Dispute Resolution Appointment be adjourned until the 9th May, - the previous Children's Guardian be appointed under Rule 16.4, - that Lancashire Local Authority file a Section 37 Assessment[55]. In the absence of other available and realistic options for returning Child N to the father's care, the Court and Child N's father agreed that Child N would remain in the care of the mother overnight and be returned the following day.
5.91.	**Event**	**Activity**
Thursday 8th May	Child N and mother died.	

[55] To determine if they needed to apply for a Care or Supervision Order

Summary analysis of 2014:

- The Family Assistance Order expired in January 2014. Liverpool Children's Services can find no record of a meeting (either single or multi-agency) to consider this expiry and the current circumstances for Child N,

- Child N's mother (and Child N) experienced a significant family bereavement and, with the benefit of hindsight, the Review now understands that this episode could have heightened the mother's mental health difficulties and anxiety,

- The mother returned to Court to seek changes in arrangements. The mother also alleged a death threat, orchestrated by the father. No risk assessment was conducted by Merseyside Police,

- Further allegations and counter allegations were made. Whilst these were investigated the mother failed to adhere to agreed contact arrangements and did not return Child N to the father,

- Whilst there is evidence of effective multi-agency and cross border working there is also evidence of agencies being challenged by the complexity of the history and circumstances they were presented with,

- Due to Child N being known by two different names, and the mother submitting inaccurate or incomplete information on her Court application in April, Cafcass were only able to retrieve partial background information about this case,

- The mother attempted to register Child N at a different school. The issue of Child N having two different names was also noted at this time,

- There were no enforcement conditions on the existing Court Orders. At this point, Child N's return to the father relied on parental cooperation and compliance,

- The investigation by NHS Counter Fraud and Mersey Internal Audit Authority into false claims for sick pay concluded in April 2014, when they intended to interview the mother. As far as this Review is aware the mother did not know about this investigation or any intended actions at the time of her death.

- Records highlight that in May 2014 a file of evidence was submitted to the Crown Prosecution Service reflecting a weak case with very little prospect of a prosecution against the father concerning alleged sexual abuse.

6: Key findings

6.1. The chronological analysis of multi-agency involvement has been extensive and has made a series of findings[56] from evidence submitted. These have prompted agencies to review their practice across a number of areas. This section outlines key findings[57] which are then used to inform the thematic analysis.

- The mother's mental health is a reoccurring feature. Section 7 will consider this: ***Assessment and provision made in relation to the mother's mental health.***

[56] Finding: a judgement or conclusion about a particular aspect of professional practice (positive or negative) where there may be learning.

[57] Key finding: an over-view from findings made which highlights an emerging theme or pattern, of sufficient weight and interest, to warrant further examination.

- The persistence of allegations being made, either in relation to domestic abuse or continued relationship difficulties between adults. Section 7 will consider these issues: ***Agency responses to issues of domestic abuse, honour based violence and gender.***
- The effectiveness of how agencies maintained a child focused response to concerns and information. Section 7 will consider this: ***The use of information by agencies: recording and sharing*** *and* ***The extent to which agencies adopted a child centred approach.***
- The involvement of the Court – through both Private and Public law routes - as a means for either one parent attempting to regulate and control the other or, more explicitly, to address welfare concerns about Child N. Section 7 will consider these issues: ***The extent to which legal proceedings protected Child N's welfare.***
- The single and multi-agency cross border response to a complex case. Section 7 will consider this: ***Analysis of interacting risk factors (focusing on 2014).***

6.2. The findings have revealed a number of missed opportunities by a small number of agencies to intervene. Reasons for these opportunities being missed, or not maximised, have been, or will be considered where-ever possible however it is apparent from further interrogation of evidence submitted that, in some instances, no explanation can be offered. This may be due to members of staff having left the respective agency, or being off sick/maternity leave, lack of records or simply due to the lapse in time.

7: Thematic analysis of multi-agency practice, and learning

7.1. Assessment and provision made in relation to the mother's mental health

7.1.1. There were four assessments of the mother's mental health between 2004-2012, three of which were undertaken by Occupational Health in 2004, 2008 and 2012; none resulted in a diagnosis of a mental illness. The mother did receive counselling following the assessment in 2008 where she claimed she had been feeling 'low' and had attempted to self-harm. There is no documented evidence showing that the GP either received or sought information about the effectiveness of the counselling the mother received. The mother made a suicide threat when she could not have a termination in 2009 but this was addressed within her consultation at Liverpool Women's Hospital and not seen as a 'serious threat'. Aside from these two mentions of self-harm there were no other presentations to any agencies about the mother self-harming over the period under review. There is no consideration of the impact of these episodes on her parenting capacity and the impact on children.

7.1.2. The mother's own reluctance to seek or accept help with regards to her mental health has been noted as a significant contributory factor.

7.1.3. Following the mental health assessment in 2009 after Child N's birth, the mother was referred back to primary care; this is standard procedure. The immediate follow up to the mental health assessment was extremely limited by the GP and absent from the Health Visiting Service. This is concerning given the potential high risk of developing post natal depression. There was no liaison between the GP and Health Visitor about this either when a more planned and joint approach would have been beneficial to assess and support the mother and Child N.

7.1.4. No other professional (directly involved in assessing Child N's safety and welfare) appears to have contacted the GP in order to request information about parenting ability given the mothers behaviours, nor

explore or initiate a dialogue with the GP about the possibility of there being an underlying mental health issue which might affect her behaviour and parenting style.

7.1.5. A critical feature from the findings is the crucial role the GP has in being able to access and synthesize information about parental health; and in turn the impact on parenting ability. From a child focused perspective research[58] shows us that *"… the needs of the child must take primacy over the needs of the parent and the principal focus must remain how the child has experienced, and is likely to experience, their parent's behaviour* … [requiring] *parallel … and … coordinated assessments …"* The GP has a very clear role in such cases. Considerable information was held in the GP records relating to Occupational Health assessments, pregnancy related issues, access to counselling and absences from work – spanning a number of years. Although the findings of the paediatrician and the psychologist from the Private law proceedings were not known about by the GP the totality of the other information concerning mental health would have been extremely valuable to other professionals in their approach and assessment of the risk to Child N.

7.1.6. Given the role of the Health Visitor, but also the significant lead role that Liverpool Children's Services had over time, this is remarkable. It highlights a number of missed opportunities to fully examine and appreciate Child N's day to day experiences by both agencies. Reasons given for this failure to communicate include staff turnover, workload and the need to prioritise casework.

7.1.7. During 2010 the mother had a period of 28 weeks absence from work due to *'anxiety and forgetfulness'*. No medication was prescribed and there is no evidence the GP shared information with other health professionals who were also in contact with the mother in order to discuss the implications of her anxiety and any potential impact on her parenting of Child N.

7.1.8. During 2013 the mother had frequent appointments with the GP in connection with pregnancies, miscarriage and contraception. When looked at altogether the information the mother presented was contradictory and there was no corroborative communications sent to the GP by antenatal providers during this period. The high number of consultations on matters concerning pregnancy, miscarriage and contraception appear to have been addressed as single events in isolation whereas they could have acted as a trigger for the GP to assess the mother's mental health further and to liaise with other agencies to share information. There was no consideration of the impact of these episodes on Child N. One reason given for this is that the GP felt under pressure to not be too inquisitive because of the NHS Fraud Agency investigation.

7.1.9. In January 2013 the GP was asked to comment on the mother's ability to care for Child N with specific regard to her physical and mental health. The GP assessed for depression at that time and deemed her current physical and mental state to be stable and that the assessment concurred with one conducted three months earlier by Occupational Health. This reflects a very narrow assessment and one from an adult perspective, and not child centred. This assessment was not helped by a poorly worded letter of instruction from the solicitor.

7.1.10. The GP continued to have regular contact with the mother during 2014 as she had taken sick leave from work due to bereavement in January 2014. There was no evidence to suggest the GP had concerns about the mother's mental health. During April 2014 a Social Worker also interviewed the mother with Child N present and although she had concerns about long term emotional harm that the mother may present to Child N she did not identify that the mother was displaying any signs of mental illness or behaviours that would

[58] Reder, P., Duncan S., & Lucey, C., 2007, Studies in the Assessment of Parenting, p.202, How do mental health problems affect parenting?, Routledge

suggest Child N was in imminent danger. From evidence gathered from the Police investigation it is possible to reasonably conclude that the mother was already contemplating suicide/harm at this point in time but she was either unwilling or unable to seek help with regards to her mental state.

7.1.11. The issue of the mother's mental health was certainly considered in the first and second set of Court proceedings and again the picture is one of contradictory evidence and outcomes. For example:

- In 2012 a psychological report was prepared for the Court proceedings. This provided strong evidence that the mother had some serious psychological issues as a consequence of her earlier life experiences and the internal conflicts she was experiencing as a woman caught between the traditional cultural expectations of her family against the western values of the society in which she was living. Cafcass[59] have noted *" … the psychologist had concluded that she was pessimistic regarding the outcome; in particular …she believed [the mother] would find it difficult to put aside her feelings in order to facilitate and encourage Child N's relationship with the father …"*
- The Children's Guardian also identified the mother as *'beset with unstable mental health at an early stage in the proceedings and took account of this in his assessments and evidence presented to court'.* However, the Guardian did not consider it was at a level where a referral to Liverpool Children's Services was warranted, rather that the principle issue was one of parental conflict over the contact arrangements and not the mother being any kind of danger to Child N.
- A paediatric assessment concluded that the frequent presentations of Child N by the mother at the doctor were 'a symptom of maternal anxiety' rather than any underlying physical condition of Child N.
- The parenting assessment completed by Action for Children identified that although the mother presented as calm and measured during assessment sessions the Social Worker doubted the reliability of much of what the mother said.

7.1.12. Liverpool Children's Services also did not indicate that they had concerns about the mother's mental health. The focus of assessment and visiting appears to have been due to the risk of emotional harm to Child N due to parental hostility and domestic disputes. The case was closed by Liverpool Children's Services in January 2014 when the Family Assistance Order expired. Records submitted by Liverpool Children's Services indicate that there were no safeguarding concerns in respect of Child N highlighted by School 2 or the school that Half Sibling 1 attended and that both parents were relatively settled with an agreement reached between them about contact arrangements. School 2 contest whether they were consulted. In the absence of a formal meeting to discuss the case, it has not been possible to conclude whether there was a continuing role for statutory services.

7.1.13. It is clear that despite concerns about emotional harm both professionals and the Court did not have, or did not consider, there was evidence to suggest the mother's mental health would put Child N at risk of significant physical harm

7.1.14. The mother frequently shared her feelings with professionals about the custody disputes and worries about Court hearings. Her accounts of mild symptoms of anxiety, depression and loss of self-worth were consistent with the experience of many people going through contested Private law proceedings where the residence or contact arrangements for children are disputed. It is therefore possible that some professionals

[59] Cafcass submission, tabular timeline of key practice episodes, September 2014

attributed the mother's behaviour and emotional state as being a consequence of this rather than there being any serious underling mental health problem.

7.1.15. Practitioners involved have identified that a particularly challenging aspect of this case was working with the mother who did not have a diagnosed mental illness but whose behaviour was a cause for concern and who was regarded as 'unreliable' in her accounts of events and had a tendency to blame others. Research[60] shows that those professionals working with children and families often have concerns but *" … because the parent's functioning varies, they remain unsure whether there is substantive evidence of significant harm …the threshold for taking child protective measures may not be reached until late in the day … which increases the potential for differences of opinion or miscommunications … A feature of a significant number of cases is that the parent expresses genuine concern for the welfare of their child …"*. The findings from this Review are echoed in research.

7.1.16. In this case, whilst there was no formal diagnosis of a mental illness, there was concern about the mother's behaviour. It is clear that insufficient attention was paid to the cause of it or the mother's behaviour, or the implications for Child N. Research[61] shows that *"… a core theme that underpins assessments when a parent may have a mental health problem – which is also central to other instances of parenting breakdown – is that harm to children is a function of their parent's behaviour"*. In the absence of a definable mental illness there was evidence of the mother displaying behaviours that were potentially harmful to Child N. With the benefit of hindsight, the specific risks were not fully understood, and in turn, not fully assessed or addressed.

7.1.17. Sidebotham (2013)[62] discusses filicide and offers a useful model which may assist this Review to contextualise, learn and frame future assessment work particularly where there are uncertainties about parental mental health. He states "*One element that seems to be frequently observed in different forms of maltreatment (fatal and non-fatal, physical and emotional, and against children and intimate partners) is that of control. This, in turn, potentially provides a more measurable perspective on perpetrator behaviour that could help in understanding how the range of circumstances in a family's life can lead to one member taking the life of another. At one extreme, we may observe a parent or parent figure who displays excessive or disordered control: this may express itself through domestic violence, manipulation (even after separation) and ultimately exerting the most extreme control through taking another's life; or through distorted perceptions of attachment and the perceived need to prevent separation or suffering in a child. These scenarios result in what might be categorised as more intentional filicide. At the other extreme, we observe parents or parent figures who lack control and respond to stressful events with violent outbursts, without necessarily any intent to harm, or whose lack of coping ability results in neglect or disordered parenting".* O'Hagan[63] notes that as well as mental illness and domestic abuse being predominant features associated with filicide, *"… most filicide killings and preceded by, and are wholly dependent upon an exceptionally high degree of premeditation and deception on the part of the perpetrator …".* It is apparent that there were a number of mitigating factors that may have influenced professional judgements when considering Child N's welfare – a father who appeared universally supportive and child focused (despite being the subject of numerous allegations), a supportive maternal grandmother, normal health and development for Child N, and a mother who was seen, at times, as capable,

[60] Reder, P., Duncan S., & Lucey, C., 2007, Studies in the Assessment of Parenting, p.195, How do mental health problems affect parenting?, Routledge
[61] Ibid, p206
[62] Sidebotham. P, Rethinking Filicide, Child Abuse Review, Vol. 22: 305–310 (2013), Wiley
[63] O'Hagan, K., 2014, Filicide – Suicide; the killing of children in the context of separation, divorce and custody disputes, p, 100, Palgrave Macmillan

intelligent and resourceful. Further research[64] is also helpful for learning *"… mental illness (especially depression), combined with parental separation, was the most commonly associated factor for mothers and fathers in the killing of their children …".* Nevertheless, this Review has found that based on research[65], practitioners and family need to remain mindful that *"…as there are so few cases of filicide-suicide it is difficult to compile enough data to attempt to draw predictions from … this makes predicting such events extremely difficult …"*

7.1.18. Enabling practitioners to feel more skill and understand the impact on a child's day to day experiences when faced with a parent displaying mental health difficulties and who fails to access support has been identified as a training need arising out of this Review.

Practice note[66]: Where adult mental health services have conducted a mental health assessment on a parent of a young child, sharing the outcome of this assessment with all professionals who may be involved in that child's life, may be crucial to the future safety and welfare of that child. Practitioners should think about the impact on a child, if the assessment findings are not appropriately shared.

Practice note: When the behaviour of an adult is causing concern, but there is an absence of a recognised mental illness, practitioners (of all disciplines who may be involved) could ask: a) are there children involved with this adult? b) Does the adult's behaviour impact on the safety or welfare of the child? c) Where can I turn to for further information, support or discussion e.g. Health Visitor, GP, community midwife? d) Are there other agencies/services involved and should I contact them? e) What role does supervision have in helping me manage this case and understand the impact of the adult's behaviours on the child?

Practice note: Health Visitors have a vital role in assessing and monitoring, not only children's health and development, but critically, children's vulnerability. A chronological summary, and importantly, an analysis should always be considered when a case is re-allocated to a new Health Visitor to enable practitioners to a) make sense of the life events which have been important for a child and their family, as part of any kind of assessment and to assist with decision-making and intervention, b) to identify, and make sense of, patterns of events or behaviour in the life of a child and their family and c) to reflect and analysis information especially after a serious incident.

7.2. The use of information by agencies: recording and sharing

7.2.1. Statutory guidance[67] in place during the period under review provides guidance and sets expectations for professionals on the use of information. This Review has found a very mixed picture of practice in respect of how information was recorded internally by single agencies, shared across agencies, and used to inform decisions about Child N's welfare. In taking a proportionate approach to the significant amount of evidence submitted, this section will focus on those agencies where there is greatest learning to be gained from examining how information was used. Whilst being proportionate in this section, it is important to state that all agencies involved in this case have submitted action plans to remedy deficits and identified omissions; they are not confined to just those highlighted in the following text.

[64] Brown, T., Tyson, D., Fernandez Arias, P., Filicide and parental separation and divorce, 2014, Child Abuse Review, Vol 23, 79 – 88, Wiley

[65] Berry, M & Cliff, R, Parents who commit suicide after killing their children, Family Law, June 2013 Vol.43, Iss.6 2 699-704

[66] Practice notes have been identified by the Independent Reviewer and are based on the findings but also relevant research and are designed to assist practitioners in the future.

[67] Working together to safeguard children, 2010 & 2013, HM Government

Recording information to aid the task of safeguarding

7.2.2. Statutory guidance[68] states *"Keeping a good quality record about work with a child in need … is an important part of the accountability of all professionals … it helps focus work and is essential to working effectively across agency and professional boundaries … they help with continuity … and they provide an essential tool for managers to monitor work … is an essential source of evidence for investigations and enquiries … and court proceedings …".* The importance of keeping up to date records of work with children and families is an absolute cornerstone of effective safeguarding practice and has been identified as a failing in numerous other SCRs.

7.2.3. Evidence of poor record keeping was most apparent for Liverpool Children's Services such that it has hampered the ability of their agency report author to critically asses the level of practice undertaken by the agency. It is clear, from review of this one case, that practice standards did not meet those expected in statutory guidance.

7.2.4. The absence of recording assessments, decisions, action plans, planning meetings, looked after children records and having a social work chronology has serious implications for safeguarding practice as they prevent the ability to understand risk over time, make it difficult for new workers or out of hours staff to identify previous interventions and risks, affects accountability for decision-making future, actions and interventions. There was evidence in this case of records not being made of professional meetings, for example Children in Need meetings, strategy meetings and meetings by the local authority regarding the mother's employment. There were also instances where meetings were held with the assumption that minutes were taken and yet other agencies not receiving minutes. The submission[69] states *"… could only find two initial assessments (2009 & 2012) … could not find CIN or plan covering periods when Child N was an open section 17 case (2009 – 2010, 2013 – 2014) … could not find the completed Placement with Parents assessment signed off by a senior manager (2012) … was unclear whether [the practitioner] completed the core assessment … risk assessment … action plans … LAC statutory visits …".*

7.2.5. It is impossible to comment on whether decision making would have been different in this case had all the records and minutes been completed and distributed as required by Liverpool LSCB procedures. This deficit also raises a question about whether the agency, who is to be the recipient of the minutes of a meeting, is responsible for ensuring they are received when they do not arrive and needing a system to be able to ensure this is tracked. Clearly this is only possible if the agency/practitioner is aware that a meeting is, or has, taken place. This matter has been addressed in the Alder Hey Children's Hospital action plan but not in other action plans and requires further attention by agencies involved in this Review.

7.2.6. Liverpool Children's Services did not adhere to their own expectations or those required by Liverpool LSCB Safeguarding Procedures on this case in respect of record keeping or assessment practice. Reasons given include workload pressures but also a recording system that does not lend itself to easily understanding the key issues in a child's journey.

7.2.7. Supervision records from individual staff supervision meetings were not uploaded into the appropriate section of Child N's electronic records prior to 2012 so key decisions and identified actions were not available for others to see or to inform subsequent judgements and assessments of risk. The lack of appropriate case records and assessments being recorded and maintained indicates that there was limited management oversight in respect of this particular issue over the period under review. This process has now changed and supervision records are uploaded onto the electronic system.

[68] Ibid, 2010, p 184

[69] Liverpool Children's Services, tabular timeline of key practice episodes, November 2014

7.2.8. The Review recognises that a huge amount of activity was undertaken with the family by Liverpool Children's Services but analysis about the actual face to face practice, and therefore lessons learnt, in the absence of records is problematic; this is a serious concern. That said, the Review is aware that the Judge in the second set of legal proceedings praised Liverpool Children's Services for their seven witness statements and the quality of evidence they provided to the proceedings. This would suggest that there was evidence of effective safeguarding practice, assessments and record keeping.

7.2.9. These findings do however reflect broader systemic and organisational challenges which help this Review appreciate the local operating conditions for practitioners. These highlight contributory factors for many of the omissions by Liverpool Children's Services. These issues have been recognised by national research into other case reviews as contributory factors[70]. These are issues which have already been recognised by Liverpool Children's Services, in part through their most recent inspection by Ofsted[71] in 2014. Ofsted found considerable strengths in social work practice and safeguarding work, however important contextual features, of relevance to this Review, were found including high social work turnover rates (at the time 16.6% and above regional average), high sickness rates, high usage of agency workers, high caseloads (in some cases 50 – 60 cases held by individual workers) and task focused supervision rather than an opportunity for workers to reflect on case management issues. The overall judgement was one of requiring improvement. Of particular note, Ofsted found that improvements were needed in recording practices, management oversight and recording systems*, "… the quality of case recording must be improved … management oversight … must be consistent, robust and properly recorded …".* Additionally, *"… The quality of some child in need cases shows limited understanding of the impact on children of domestic abuse, parental mental ill-health and substance misuse. Records also lack consistent analysis of risk, protective factors and children's needs … some good examples of holistic assessments … were seen".* Again, of relevance to this Review are the findings from a previous Ofsted inspection report[72] in 2011. Although it is accepted that the format for inspections has changed, the findings in the 2011 report are judged as good or outstanding. This inspection did find that *"… case recording sometimes lacks precision or depth of analysis of information derived through assessment … [and management] … oversight of cases is not always being reflected in records …";* it highlights particularly heavy demands on the safeguarding services during 2010. Research[73] into SCRs highlights the potential for errors and lapses in safeguarding practices to occur during times of organisational pressure. Examination of these two inspection reports highlights that the demands on services in the intervening period (2011 – 2014) has intensified and placed the overall workforce under greater pressure. These pressures would have occurred during critical moments on this case being open to the department and supervision notes examined for this Review do reflect the pressures individual workers felt. An action plan has been submitted in respect of these deficits.

7.2.10. Whilst Liverpool Children's Services is now investing substantially in a new electronic recording system with the aim of improving their recording and retrieval system it will not address the problem of Social Workers not recording their actions or of failing to minute meetings or distribute those minutes. This challenge will need a robust management footprint in order to ensure minimum standards are adhered to. The LSCB may choose to consider a schedule of focused audits to monitor standards and compliance on this matter.

---

[70] Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C., & Black, J., Understanding Serious Case Reviews and their impact: A biennial analysis of serious case reviews 2005 – 07, DCSF

[71] Ofsted: Liverpool City Council, Inspection of services for children in need of help and protection, children looked after and care leavers & review of the effectiveness of the LSCB, July 2014

[72] Ofsted: Liverpool, inspection of safeguarding and looked after children services, April 2011

[73] Brandon, M., Belderson, P., Warren, C., Howe, D., Gardner, R., Dodsworth, J., Black, J., Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003 – 2005, p 86/87

7.2.11. Liverpool Children's Services have also introduced a number of other strategies which will enhance their ability to consider these, and other practice issues, including the appointment of a Quality Assurance Manager, Principal Social Worker, the development of audit tools, a revised safeguarding policy and training programme.

7.2.12. Merseyside Police have identified problems in officers not completing the Vulnerable Person Referral form after they have dealt with an incident or delays in completing it. This resulted in two problems – an inability to update and amend risk assessments making them a static (rather than dynamic) exercise as well as other officers not being fully informed and aware of recent incidents when called out. The implication in this case is that Merseyside Police did not have a full appreciation of the risks to Child N or the ability for any pattern of behaviour to be noticed.

7.2.13. No specific explanation can be given for these omissions, other than oversight due to workload pressure and human error. Contextual information about the operating conditions for Merseyside Police FCIU has been noted as a contributory factor. During 2010 and beyond Liverpool North area FCIU were continually operating with a significant number of open cases that required closure. The vast majority of those were historic incidents that required a supervisor to close (at one stage it amounted to over 10,000). In addition to this, there was a daily review of current incidents on the respective databases, meaning that a backlog was created in inputting risk assessments. These processes have now been addressed and risk assessments and inputting is done within 24 hours. Additionally significant resources have now been put into place to manage the volume of work. An action plan has been submitted in respect of these deficits.

7.2.14. The Health Visiting Service of Liverpool Community Health NHS Trust have also identified significant deficits in recording, analysis of risk and overall scrutiny and governance of supervision practice particularly in 2009. Given the pivotal role that Health Visitors play in meeting, assessing and working with children and families it is crucial that such matters are addressed. In this case, the Health Visitor would not have known that the mental health assessment concluded that the mother was at potential high risk of developing post natal depression and separation anxiety – two issues that the Health Visitor could have potentially offered support with at a critical time. Reasons cited for these omissions and deficits include staff shortages and workload pressures. The Health Visitor carried a large caseload at the time and there were considerable pressures on the service due to high levels of staff sickness and low morale. Changes in Health Visitors were due to retirement, sickness, and high caseloads which caused difficulties. The Review has been informed that during this period there were difficulties both locally and nationally to recruit or retain Health Visitors[74]. At this time Liverpool Community Health was merged with the Sefton Trust and both areas were to be known as Liverpool Community Health. Recruitment of Health Visitors has been positive with the Trust currently at full capacity and with good retention levels. Each GP Practice in Liverpool now has a named Health Visitor. It is hoped that these measures will counter some of the deficits highlighted in this case. An action plan has also been submitted in respect of these deficits.

7.2.15. In both Nursery 1 and 2 there were instances of poor record keeping with staff not recording contacts with the family or professionals, concerns they had, actions taken or meetings attended and outcomes. Such omissions prevented them being able to identify patterns over time in terms of Child N's care or any concerns about the parents. The reasons for this are due to inadequate policy and procedures for staff to follow and staff uncertainty about the extent of their responsibilities. Both Nurseries have requested help to implement new recording systems as a consequence of the Review. These improvements and processes have begun during the course of the Review.

[74] Call to Action Health Visiting implementation plan 2011 – 2015, HM Government

7.2.16. This Review finds that there were no minutes of the MARAC meeting in 2009 in the Child Health Record held by Liverpool Health Visiting Service. The Review has been informed that as there was no child named (because it was pre-birth) on the referral to the MARAC a copy of the minutes and actions would not have been forwarded to the Health Visiting Service. This position has now changed and all agency representatives who attend the MARAC receive all minutes from the cases irrespective of whether representatives are from children or adult services. This finding, in effect, reflects a significant failure of the MARAC system, as it was, undermining its central purpose of protecting the vulnerable.

7.2.17. There was noted to be particularly efficient recording of information by Action for Children, Cafcass, and School 2. This potentially reflects involvement that was more tightly defined (through either procedural requirement i.e. Cafcass, or specific remit i.e. Action for Children) or where a particular individual appeared especially conscientious and insistent in their attempts to understand what was happening.

Information sharing

7.2.18. Government guidance[75] states that "*Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision*". This case became more complex as time passed and with such a large number of agencies involved the issues about the quality and timeliness of information sharing become critical.

7.2.19. This was illustrated on two separate occasions when Child N transferred between Nurseries and then into school.

7.2.20. Firstly, School 2 had no information about the past concerns about Child N and the family circumstances due to a fracturing of information sharing channels. This was exacerbated, in part, because the Nursery settings were either unclear as to what information they could legally share or they perceived that it would not be needed. Evidence indicates there was a basic lack of understanding about the parameters of information sharing by the Nurseries. As stated above, both Nurseries are addressing these issues as a result of the learning from this Review, in terms of introducing templates for recording and a policy on records transfer at transition points.

7.2.21. Secondly, Nursery 2 and School 2 were not invited to Child in Need meetings held by Liverpool Children's Services during the period of the Family Assistance Order; and yet this Order had been made as a consequence of the threshold of significant harm being met and when serious concerns about long term emotional harm to Child N were identified. In effect, they were excluded from understanding Child N's circumstances and contributing to planning and decision making.

7.2.22. Of particular concern was the lack of communication and liaison between the GP in Liverpool and any other agency, including health colleagues. The safeguarding practice of the GP runs counter to guidance produced by the General Medical Council[76]. Evidence indicates that the GP worked in isolation from others despite receiving many health professional communication letters about safeguarding and the many presentations that the mother made to the surgery in respect of her own health and that of Child N. This information, which if taken alongside other information, would have identified increased concern and need to monitor the mother's behaviour and mental health.

7.2.23. The Review recognises that the high number of registered patients and the volume of health professional communication letters put particular pressures on GPs to be able to identify risk and respond appropriately. There were multiple issues (mental health assessment, domestic abuse, frequent pregnancies,

[75] HM Government (2013) *Working Together to safeguard Children: a guide to inter agency working to safeguard and promote the welfare of children*

[76] GMC (2012) *Protecting Children and Young People: the responsibilities of all doctors*

custody disputes, miscarriages, terminations and extensive periods of sick leave) presenting in the mother's case; these could have prompted greater professional curiosity by the GP at the time and be a trigger for liaison with other agencies in order to safeguard Child N. This is a significant and serious omission in terms of understanding the vulnerability of both the mother but also Child N.

7.2.24. The submission to the Review, on behalf of the Liverpool GP[77] has captured the operating context of these issues, *"… health professionals were working within their own defined limits. Communications between health professionals are in the main by letter. What appears to happen is a passing on of information … without any obvious consequence … leaving a complete lack of clarity as time went by … There is very little evidence of those professionals that provide universal health services, communicating in a way that makes it clear what the circumstances are and results in clear and actions and agreed outcomes ..."*

7.2.25. These findings are echoed in recent research[78], *"… the longitudinal and universal nature of general practice means that there are particular opportunities for gathering and recording information … the potential of the primary healthcare record will not be realised if important information is not inputted or is buried deep in electronic files making it inaccessible to the GP …".* These are not challenges that are confined to Liverpool or Lancashire, they reflect a national issue.

7.2.26. Liverpool Primary Health Care has submitted an ambitious action plan to address these challenges in the local area. These include a system to identify patient vulnerability as a consequence of incoming health professional communications, a means to identify in the electronic record system those patients deemed vulnerable so as to prompt the GP at any consultations to monitor the particular vulnerabilities, and a process for checking the legal status of a child when a parent seeks to register any child under 5 years. The action plan also addresses more widespread actions to improve safeguarding practice across all GP practices in Liverpool.

7.2.27. Liverpool Community Health also identified problems in information sharing and liaison with the GP. There was no evidence of any liaison between the various Health Visitors involved and the GP Practice during the entire period that Child N lived in Liverpool. This is exacerbated by the fact that the Health Visitors and GP do not share the same recording system so one cannot inform the other of concerns through a records check. The challenges facing the Health Visiting Service at this time have been outlined and do partially account for these omissions. Health Visitors held a cooperative caseload which stipulated that they would maintain weekly communication with the GP but this was not achieved due to heavy caseloads and number of GPs that needed contacting within the geographical area.

Cross border working arrangements

7.2.28. The Review has highlighted both positive examples as well as difficulties with the exchange of information across geographical borders and cross border working arrangements. Of particular note are the relationships between Merseyside Police and Lancashire Constabulary, the respective Health Visiting Services of both authorities, and the respective Children's Services departments of both authorities. The challenges and difficulties found in respect of information sharing within one geographical area are replicated across a wider area and reflect the need for a robust, systematic and coordinated approach to case management.

7.2.29. Electronic database systems exist for the Police to share information – the Police National Database – and the Review has found that time delays in information being shared were due to information not being inputted by Merseyside Police in a timely manner. This is indicative of workload pressures and staffing

[77] Liverpool GP, Primary Care Health submission, tabular timeline of key practice episodes, September 2014

[78] NSPCC, Royal College of General Practitioners, University College London Institute of health, University of Surrey, The GPs role in responding to child maltreatment: Time for a rethink? , p 22, July 2014

resources. Examples of effective and well-coordinated information sharing and agreed strategy planning are also apparent for both Police forces.

7.2.30. The Health Visiting Service for Liverpool Community Health NHS Trust (LCFT) conducted a verbal handover with the Health Visitor in Lancashire when Child N became the subject of a Residence Order to the father. This process seems to have been effective however a procedural deficit has been noted in that there is no expectation for Health Visitors from LCFT to attend Looked After Children meetings out of their area. Whilst a verbal handover may be sufficient in many cases, there is a need to retain a degree of flexibility on this matter dependent on the child's individual circumstances. In this case we saw four Health Visitors allocated to Child N in a relatively short period of time in Liverpool, so continuity and intimate knowledge of Child N's history and needs may have been minimal; particularly given the persistent focus on health and development rather than vulnerability.

7.2.31. The respective Children's Services departments from Lancashire and Liverpool have both highlighted challenges faced when working across borders. Lancashire Children's Social Care have identified inadequate recording practices in relation to cross border discussions, and Liverpool Children's Services have identified significant challenges with sharing information within their local area as well as across a wider network of professionals.

7.2.32. Research[79] and inquiry[80] has identified communication, cross border working and case transfer arrangements as being a persistent area of difficulty.

Non corroboration of information shared by the family

7.2.33. The Review has found that professionals frequently accepted information from family members at face value without checking its accuracy; there was a lack of sufficient challenge. For example, on many occasions the parents reported to various professionals what had been happening in Court, allegations made and judgements given. However, given that parental relationships were so acrimonious it would have been prudent for professionals to check the accuracy of the information. This practice was not helped by the fact that Liverpool Children's Services did not contact or involve all agencies; agencies will not have realised that other professionals were involved. Had they done so, other professionals might have been apprised of relevant information that was submitted to the Court, which otherwise remained hidden.

Practice note: When closing a case, Social Workers should always ask themselves *"… have I spoken to, and informed, all the professionals and agencies involved in this child's life?"*

Practice note: Being a proactive, curious and bold professional in seeking information and asking questions may make the difference to a child's safety.

Practice note: Health practitioners may consider the following triggers for reviewing a case and sharing information with other agencies; multiple hospital/practitioner/health professional letters, repeated presentations, complex or conflicting clinical information, unusual health seeking behaviours, safeguarding concerns including self-harm and domestic abuse, extended and continuous periods of sick leave. Information sharing should be conducted in accordance with guidance[81].

[79] Calder, M., 2008, Contemporary risk assessment in safeguarding children, chapter 6, Professional dangerousness: Causes and contemporary features, p71 – 73, Russell House Publishing

[80] Lancashire safeguarding children board, themes from serious case reviews, undated

[81] Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers, March 2015, HM Government

Practice note: When writing to other professionals, all practitioners from all disciplines need to think about what they hope to achieve by making contact. If it is to share information – what is the value and purpose of sharing? If it is to share and seek a response and action, this needs to be made clear. Just because information is shared does not mean it is understood or acted on.

Practice note: Your agency may hold a significant amount of information about a child or family. Has anyone been able to take a step back, analyse it and form a hypothesis about what may be happening?

Practice Note: GP practices need to be vigilant when registering children and consider recommendations made by Lord Laming[82] to verify and clearly record who has parental responsibility for a child. Records should evidence the nature of the relationship between those with parental responsibility in respect of any child. This should be reviewed opportunistically or as the need arises and records updated accordingly.

7.3. Agency responses to issues of domestic abuse, honour based violence and gender

7.3.1. Research[83] has helped us understand the impact of domestic abuse on children, *" … while parents may understandably want to believe that children do not see or hear domestic violence, subsequent experiences often highlights that children are frequently aware of the issue … such effects include … depression and anxiety, trauma and behavioural problems. Children … describe feelings of fear, anxiety and guilt … ".* From this Review, we are aware of Child N being described as anxious but also displaying other potential signs and symptoms of troubled circumstances.

7.3.2. Over the period of the Review there were numerous occasions where the mother made allegations about the father being violent or threatening to be violent or, that an associate of the father had threatened or assaulted her. The mother shared this information with a number of agencies that knew her including Police forces, Children's Services, health practitioners and the Cafcass Children's Guardian. The mother provided conflicting information to Action for Children about the quality of the relationship between herself and Adult 4, and difficulties in her relationship with Adult 4's parents. This information was not known about by the Cafcass Children's Guardian and it seems that the mother did not provide a full account of her relationship with Adult 4 to the Children's Guardian. These conflicting accounts highlight how the mother shared different information with different professionals to varying degrees. In turn this invariably made it much more difficult to accurately assess the impact on Child N. Positively, and in likely recognition of this the Children's Guardian did recommend that the parents undergo psychological assessments to gain a better understanding in 2009. There were also instances of professionals accepting the mother's version of events without question and seemingly without considering the implications of them on the mother's own vulnerability and parenting capacity. Practitioners have identified and acknowledged this deficit. Guidance[84] in place at the time emphasized the need to provide support for the victim and believe the victim stating *"... they might worry that nobody will believe them – particularly if there are no physical injuries … "* and *"… always remember that a woman is the only person who has all the information about her own particular circumstances …".* The mother did not accept the support of services offered.

[82] The Victoria Climbié Inquiry report, The Lord Laming, 2003
[83] The Child's World, 2nd Edition, Edited by Horwarth, J., 2010, p. 330, Jessica Kingsley
[84] Responding to domestic abuse: a handbook for health professionals, 2005, p. 24/25, Department of Health, HM Government

7.3.3. The multi-agency response to these allegations is therefore mixed, with evidence of effective multi-agency collaboration and information sharing but also a number of missed opportunities to further understand Child N's experiences.

7.3.4. There is evidence of effective interagency communication and practice by health agencies who identified, responded and referred the mother's allegations of domestic abuse on to other agencies charged with responsibility for investigating it. There are also examples of Merseyside Police and Lancashire Constabulary responding to and investigating the mother's allegations according to policy and procedures and Merseyside Police placing a 'treat as urgent' marker on her home address so that subsequent officers would know that positive action had to be taken if they received a further call from her.

7.3.5. However, there are also examples which were contrary to policy and procedures. Most notably, Merseyside Police did not consistently take the correct steps in responding to a number of the domestic abuse allegations (10 episodes noted in their submission). Examples of this include them not interviewing the mother after she had made an allegation, not completing a risk assessment and/or not seeking corroborative evidence. In their submission[85] Merseyside Police have reflected on their contribution stating *"… we should have taken a more robust approach to her allegations. The need to take positive action was identified and highlighted on several occasions … but was never taken. We failed to record each incident … which would have highlighted her as a repeat victim … Merseyside Police have many and varied policies and procedures in place for dealing with incidents of domestic abuse and child abuse. One of the failings is none compliance with those policies …".* No explanation can be provided for these failings. A comprehensive action plan has been submitted to this Review by Merseyside Police to address the failings identified.

7.3.6. Additionally, there are examples where Liverpool Children's Services were notified about allegations of domestic abuse concerning Adult 5's behaviour in the home of the maternal grandparents, and others which were not responded to, with no clear rationale for the latter. No explanation can be given for this.

7.3.7. Mersey Care Trust did not take appropriate action in response to the disclosure of domestic abuse by the mother in 2009. A referral could have been made via the MeRIT and MARAC processes. In 2009 however, there was a low level of awareness of these two processes and they were not part of the Trust's domestic violence policy either. Since 2010, the Trust has addressed this through mandatory training on domestic violence for all front line staff and the policy amended accordingly.

7.3.8. The mother engaged with some of the professionals (notably health practitioners in Liverpool, her GP Practice and Liverpool Domestic Violence Service) by focusing on her own problems and issues, particularly around domestic violence and residence/contact issues. This served to distract the professional focus away from Child N's welfare with there being limited professional curiosity with the mother about her allegations of domestic abuse and the impact on Child N.

7.3.9. It is possible that over time agencies doubted the reliability of the mother's allegations in that when investigated there was found to be insufficient evidence to take the matter further. However, as already stated the emphasis for professionals was/is to believe the woman's account; such doubt of the mother's reliability would have been counter to guidance in place. If this was the case agencies could have considered the implications of her possibly fabricating the allegations to undermine the father's contact with Child N. Formal opportunities did exist for a multi-disciplinary group of professionals to examine this through LAC and CIN meetings, but also as a result of there being a Family Assistance Order and Supervision Order in place.

[85] Merseyside Police submission, tabular timeline of key practice episodes, October 2014

Evidence submitted shows that this did not happen, or were certainly never recorded. Reasons for this have been discussed earlier in this report.

7.3.10. In July 2010 the Finding of Fact hearing about the fifteen allegations of domestic abuse made by the mother found most unproven. Of those that were proven they were not found to be as serious as the mother alleged. However, of significance, this information was not made known to the rest of the professional network and so professionals perceived the father to be a perpetrator, that all the allegations of domestic abuse were true and that this was the justification for the Court awarding the mother custody at the end of the first set of proceedings. Professionals had no cause to exercise any curiosity or challenge to this perception.

7.3.11. The three incidents whereby the mother alleged she had been assaulted or threatened by associates of the father were identified in Merseyside Police records as potentially being instances of 'honour based violence'[86]. Aside from this label being used in Police logs there seems to have been no thorough assessment of this possibility by either Police force. There has been no evidence submitted to indicate that honour based violence was a feature of this case however it has been raised as a possibility. This raises questions about whether agencies sufficiently took into account the implications of the mother's ethnicity, her own family dynamics, gender and culture in their responses to her allegations of domestic abuse. The fact that the mother was Indian, unmarried, with two children born outside of marriage by different fathers, where there were already relationship difficulties within the maternal family, could have triggered a fuller consideration of the possibility of 'honour based violence'. Research[87] shows that South Asian women are at much greater risk of committing suicide than in other identifiable groups in the UK.

7.3.12. The mother was frequently signposted or referred onto local domestic abuse services including the drop in service at Liverpool Women's Hospital, the Liverpool Domestic Abuse Services (LDAS) and the independent domestic violence advocate (IDVA). There is evidence of effective follow up by the IDVA and the LDAS and of their persistence in trying to engage the mother despite her cancelling appointments or declining help. She declined support from LDAS in 2009 but then made use of their services in 2013/2014. However the evidence indicates that once referred agencies did not seek or receive feedback about the mother's usage of this service although LDAS did inform other agencies of their involvement. In fact the mother chose not to act on the advice from LDAS and declined the option of refuge provision for reasons which are not clear.

7.3.13. This Review has touched on issues which relate to the effectiveness of the Liverpool MARAC system. It is apparent that there were deficits in the process for information to be shared across agencies. Whilst beyond the remit of this Review, it has noted operational challenges for the MARAC system which relate to overwhelming numbers of referrals which compromised the effectiveness of the whole process to offer a service. For example, 903 individual cases being discussed between July 2013 and June 2014 and that being a 25% reduction on the previous year[88]. The relevance to this Review concerns the ability for agencies to work in a coordinated and coherent manner. The Review acknowledges the very large number of domestic abuse

[86] Honour-based violence is a phenomenon where a person (most often a woman) is subjected to violence by her collective family or community in order to restore 'honour', presumed to have been lost by her behaviour, most often through expressions of sexual autonomy. Honour based crime is illegal however it is underreported because victims are often too scared, shocked or have family loyalties that prevent them from coming forward or speaking out. [http://hbv-awaresness.com accessed 25/11/14]

[87] O'Hagan, K., (2014) Filicide – Suicide; the killing of children in the context of separation, divorce and custody disputes, Palgrave Macmillan

[88] Additional information submitted by Merseyside Police, March 2015

allegations that are received by Children's Services and the Police. Consequently, it is essential that there are clear thresholds and screening for those cases where children may be at risk and a means for agencies to prioritise and respond to those referrals. These are all the requisite dimensions of an effective MARAC system but it would seem were not in place at the time of the concerns about the mother. This Serious Case Review has been made aware of a review of the Liverpool MARAC and it is hoped that this will result in improvements that will further improve safeguarding arrangements for vulnerable adults and their children.

Practice note: Questions to consider: How you can you best assess the impact of domestic abuse, harassment or parental hostility on a child? Are there other professionals e.g. Health Visitor, Social Worker, GP or Police, that may be able to assist with your assessment? Are the effects for the child living in these circumstances being played down or minimised? How can supervision help me explore case management and what do I need from my agency to help me work with this child and family?

7.4. The extent to which legal proceedings protected Child N's welfare

7.4.1. As stated earlier, this Review has no role in reviewing the evidence presented to the Court, decisions and actions of the Court. The Court has a clear set of principles[89] to consider when making decisions about the welfare of a child and is independent of any professional agency involved in a child's life. The judiciary has also articulated the need to maintain judicial independence from any involvement in Serious Case Reviews.

7.4.2. Child N was subject to legal proceedings for nearly three years of a five year life (Private proceedings: September 2009 – October 2011, Public proceedings: August 2012 – January 2013, Private proceedings: October 2013 – January 2014, and then further Private proceedings initiated in April 2014). The legal process, whether for Private or Public proceedings, can only be effective if those parties involved adhere to the judgements and decisions made by the Court; it provides a very clear framework on which parents, carers and professionals structure their activities and approach to keeping a child safe. Of note to this Review, and of concern to Child N's father, no enforcement conditions were, or could be attached to the Orders in place around the time of Child N not being returned to him in 2014. Section 11 (7) (b) of the Children Act 1989 provides the Court with the power to impose conditions which must be compelled with by any person (i) who is named in the order as a person with whom the child concerned is to live, spend time or otherwise have contact; (ii) who is a parent of the child (iii) who is not a parent of his but who has parental responsibility for him; (vi) with whom the child is living. There is no power to attach a condition to the contact order authorising a third party who is unconnected with the child, does not hold parental responsibility and or who is not party to the proceedings to take steps to ensure enforcement and or warn if they fail to comply with the order or breach the order [90].

7.4.3. The Court does provide, for many, an opportunity to reflect on the impact of behaviour on children as well as a process to regulate behaviours and relationships. Nevertheless, the operationalising of legal impositions from the Court rests with those outside of the Court arena running as a parallel process alongside professional statutory based input and/or parental cooperation and compliance. In this case, we see a picture of parallel processes running alongside one another for a significant duration of Child N's lifetime and yet limited joining and alignment, as a whole, in order to maximise opportunities to safeguard Child N's welfare. Hindsight allows us to now extrapolate reasons for this;

[89] The welfare checklist, section 1, Children Act 1989

[90] Legal advice requested by Lancashire LSCB for the purpose of this Review

- A father who broadly cooperated and complied with Court imposed decisions in the interests of Child N,

- A mother who broadly appeared to test, defy and was unable to find settlement with Court imposed decisions (for whatever reasons) and seemingly with a limited appreciation of the impact of her actions on Child N. Her actions appeared to have perpetuated the hostility between the parents and served to increase, rather than settle, the stakes.

- The formalised and procedural Court process working alongside the statutory child welfare agency process where there was limited coordination. One example of this can be seen through the strategy of moving from Child N being a Child in Need[91] straight into legal proceedings, bypassing the multi-agency child protection route and making Child N subject of a Child Protection Plan. This may account for some disjointedness within the multi-agency network with some agencies/professionals not knowing or not being involved in planning arrangement for Child N during, and post the Family Assistance Order. Whilst it is acknowledged that professional judgement determined this approach and the threshold of significant harm[92] was reached when Liverpool Children's Services applied to the Court in 2012, the same threshold conclusion may have been reached via the child protection conference route; with a subsequent Core Group of professionals taking a closer, more operational oversight of Child N's day to day safety as defined in local procedures[93]. Clearly it is impossible to say whether a Child Protection Plan would have offered any greater level of protection to Child N than an Order; however, of note, whilst an Interim Care Order was granted, the outcome when these proceedings concluded (only six months later) was a Residence Order and Family Assistance Order in respect of Child N – a step down in threshold criteria; and one that may support the argument that there would have been value in using a child protection plan as a stepped approach.

7.4.4. Bainham[94] considers this hybrid situation *"… the Private law case with Public law elements and the Public law case with Private law elements …"*. In this case we see the Court seeking a section 37 report on two separate occasions (Liverpool Children's Services in 2009 & Lancashire Children's Social Care in 2014) to examine Child N's welfare arrangements, *"… where the authority* [in this case Liverpool and Lancashire Children's Services] *participates in Private law proceedings but does not issue proceedings itself, this amounts to a judgement by the authority that its concerns have not reached the level required to cross the Public law threshold. The Court is currently powerless, even if it takes a contrary view, about the level of seriousness, to go beyond requiring the authority to investigate and report …".* This reflects the level of discretion that a local authority has when reporting; firstly in this case Liverpool Children's Services in 2009 stated "… *this case does not meet the threshold for significant harm. There are no major concerns about the welfare and safety of the baby at the moment*…" and secondly in 2014 Lancashire Children's Social Care did not consider the situation serious enough to warrant more robust intervention.

7.4.5. The Review is interested in examining the meaning of these protracted and complex series of legal proceedings for the statutory professional network working in the community. Based on the hybrid of Private and Public law, this case was essentially defined by professionals as a custody dispute and one of emotional

[91] Child in Need, as defined in section 17, Children Act 1989
[92] Significant harm, as defined in section 31, Children Act 1989
[93] Liverpool LSCB Inter-agency procedures
[94] Bainham, A., Private and public children law: an under-explore relationship, 2013, Child and Family Law Quarterly, Vol 25, No 2, p 139 & 150

harm; a professional mind set was formed and shaped case management according to that definition. In the light of changing circumstances and new information mind sets did not seem to fundamentally shift – the case remained a custody dispute, albeit one becoming more complex – and the threshold of significant harm, or likelihood of significant harm had not qualitatively changed.

7.4.6. When placed within a context of the total workload a practitioner/team had to manage and prioritise alongside working in a challenging organisation climate it is possible to rationalise how this case was not given greater priority.

Practice note: Practitioners need to remain mindful of assumptions and bias when working with children and families. Be prepared to challenge initial hypotheses, seek a fresh pair of eyes to review the case history; base your judgements on evidence rather than optimism.

Practice note: Where children are involved in Court proceedings – Private or Public law – do not assume you have a lesser role or that simply because the Court is involved it will offer a greater level of protection to the child. Seek confirmation about your role, expectations of you and how this links to the wider plans for a child.

7.5. The extent to which agencies adopted a child centred approach

7.5.1. Statutory guidance[95] explicitly refers to keeping the child in focus and ensuring a child centred approach, *"… failings in safeguarding systems are too often the result of losing sight of the needs and views of the children within them, or placing the interests of adults ahead of the needs of children"*. This is supported by research and inquiry[96].

7.5.2. Numerous opportunities existed for a range of professionals, from a number of agencies, over an extended period of time to have focused on, and assessed Child N's needs. The most striking and reoccurring feature about the totality of evidence submitted is the lack of a thorough, coordinated multi-disciplinary assessment of Child N by statutory services. Individual findings have already been made on many aspects of this. Evidence does however reveal some clear and concrete examples of when professionals made child centred decisions. These include;

- The Consultant Doctor at Alder Hey Hospital realising, that whilst Child N's mother was subject of allegations being made about child protection concerns in 2012, she was also employed at the hospital. This resulted in the Local Authority Designated Officer being contacted and appropriate procedures being followed. This reflects a wider appreciation about potential risks to children.
- The Police Inspector from Merseyside Police making a reasoned decision to not forcibly remove Child N from the mother/grandmother's care in April 2014. Child N was seen to be safe and well. To have forcibly removed the child purely (regardless of whether there had been authority to do so) on the grounds of satisfying the current Court Order could have been a distressing and unnecessary experience for Child N.
- Action for Children conducted a comprehensive parenting assessment with a clear focus on parenting capacity. They maintained a child focus throughout.

[95] Working together to safeguard children, 2010 & 2013, HM Government

[96] a) The Victoria Climbié Inquiry Report, p 208, HMSO, London b) Ofsted, Learning lessons from serious case reviews 2009–2010 & c) Ofsted, The voice of the child: learning lessons from serious case reviews, 2011 d) Lancashire Safeguarding Children Board, themes from serious case reviews, undated

- The Head Teacher from School 2 was conscientious and diligent in her pursuit of information about Child N, having been excluded from the professional network. This reflects a sustained interested in keeping Child N's best interests in mind.
- School 1 demonstrated sound professional judgements when dealing with the mother's requests to enrol Child N. They maintained their line in respect of needing to follow due process, which, had they not followed procedure, would have undermined Child N's circumstances further.

7.5.3. Evidence also reveals episodes where, despite best intentions, it is much harder to see how decisions and actions were child focused given the presenting circumstances. These include;

- The Liverpool Health Visiting Service's multiple changes of Health Visitors in a relatively short period of time and re-assessment of Child N's health and development needs, rather than a consideration of vulnerability.
- The failures by Merseyside Police to investigate allegations of domestic abuse/harassment and the potential impact on Child N of these numerous allegations.
- Nursery 1 not appreciating the need to share information of a child protection nature with other professionals and taking the father's own account as sufficient.
- Liverpool Children's Services management of the multiple allegations against Adult 5, who lived at the maternal grandmother's house, in 2012. This man allegedly posed a risk to both Child N and Half-Sibling 1 however the management of this risk was left to the grandparents for a significant period.

7.5.4. Further to this, there are episodes where there appears to have been a lack of regard for Child N. These include;

- Omissions by the GP to think more broadly about the family and any impact of maternal mental health on the child;

7.5.5. It is beyond the remit of this Review to consider whether the Courts maintained a child focused approach to decisions and Orders made. A separate appeals process exists for such a review.

7.5.6. It is worth reminding ourselves of the findings from the Judge on 2011, especially *"… both parents had lost sight of the fact that Child N's welfare was or should be their paramount concern, and any agency trying to help the parents had to be aware of the extent either parent would distort the truth to their own perceived advantage …".*

7.5.7. This Review will never know the true impact of the parental hostility on Child N. It will not be able to understand what it was like for a young child to be cared for, on a regular basis, by four different adults in three different households – needing to adapt and become familiar with different routines, expectations, and comforts. Child N has been described by the father as a child who would easily conform and not cause any problems. The maternal grandmother has described Child N as a child who would often comment on the differences in what he was allowed to wear and eat when living in the different homes. The father has detailed the differences in care he felt Child N experienced when living with either him or the grandmother – boundaries, routines etc. One might guess about Child N being a very adaptable child with a developing resilience. It is impossible to understand what it might have felt like for Child N, if one account is to be believed, about being coached to make an allegation of inappropriate touching and the impact on the child of having, what may have been considered trusted and reliable relationships, undermined. We do know that Child N

experienced anxiety. This is unsurprising given the circumstances experienced. The impact of these issues becomes lost when the professional focus addresses multiple allegations, complex family dynamics, and parental hostility.

7.5.8. Adopting a truly child centred approach is challenging, especially when under pressure with competing workload priorities, working with multi-cultural settings and norms, staff shortages, organisational restructures and multiple other demands on human time. This remains the challenge for all professionals and agencies working in children's services.

Practice note: When working with a child, try to imagine what life is like for the child? Do the case file recordings give you a real sense of the child's the day to day experiences? What does the child need me to think about when I enter the family home? Has the child been seen and spoken to alone?

7.6. Analysis of interacting risk factors (focusing on 2014)

7.6.1. Table 1 (page 62) offers a simple analysis of interacting factors[97], outlining those factors that were known and unknown at the time. Their interactivity contributed to the case management pathway and is formed of four features outlined below[98];

7.6.2. **Family issues –** a complex background of cultural norms and expectations mixed with individual struggles particularly for Child N's mother, relationship difficulties and mental health issues.

7.6.3. **Individual workers issues –** evidence submitted indicates that individual workers, most notably in Liverpool Children's Services (Social Workers and managers) and Merseyside Police were compromised in their work for a significant period of time due to organisational pressures, workload demands and the need to prioritise. This placed individuals under pressure and stress, affecting their performance and standards of work. Opportunities were missed or not maximised due to this.

7.6.4. **Single agency issues –** Liverpool Children's Services, Merseyside Police and Liverpool Community Health Visiting Service have reflected struggles and challenges for delivering an efficient and effective service during certain periods of the time under review. This included deficits in electronic recording systems, vacancy levels (including staff turnover and sickness rates), and high workloads. This accounts for deficits in performance and helps the Review understand why opportunities were missed or not maximised.

7.6.5. **Inter-agency issues –** As individual workers were under pressure, this compromised their capacity to work in an effective collaborative way. Professionals from a range of agencies worked within their limits and failed to utilise other sources of expertise or support. This resulted in narrow assessment being conducted,

[97] Brearley, P., 1982, Risk and Social Work, Routledge and Kegan Paul; The following definitions [97] apply to this analysis;
- A hazard in this context is something which might result in a danger being realised. Something that helps to bring about the circumstances you want to avoid. These can be separated into two categories;
- Background hazards: A predisposing hazard makes the danger more likely. It is something that creates vulnerability, though it may need to be activated by something else, perhaps a situational hazard.
- Situational hazards: A situational hazard is something that happens, and which has an immediate effect directly related to the danger but which can be influenced or changed.
- Strengths/protective factors: Those factors whose effects counteract the danger, and make it less likely to become a reality.
- Dangers: A danger is something to avoid

[98] Calder, M., Contemporary risk assessment in safeguarding children, 2008, Chapter 7, Dimensions of risk: Professionals tipping the balance? by Phil Heaseman, Russell House Publishing

poor or confused communication, and limited effective interventions. Pockets of information were held by various agencies with no systematic linking or coordination.

7.6.6. In this case it is not possible to see or capture a neat and defined moment where, had all factors been known about and understood, critical and life preserving action could have been taken. Agency failures, omissions and deficits added to an already messy and complex set of family and parental dynamics.

7.6.7. Many of the above issues are reflected in national research[99] on SCRs *" … protecting children is not simple and that it is perhaps unhelpful to describe these complex matters of relationship and professional judgement as 'simple' … The capacity to understand the ways in which children are at risk of harm requires clear thinking. Practitioners who are overwhelmed, not just with the volume of work but by the nature of the work, may not be able to do even the simple things well …".* Practitioners who attended the learning event for this Review and those who have contributed to this Review have offered the following reflections,

"… Other people's interpretations and experiences on the case really opened my eyes to the complexity of this area … Information around the court hearings; I now know how vital this information was. This wasn't shared in this case but needs to be in subsequent cases …. Recognising emotional harm as a significant issue within families managing Private law proceedings …"

Practice note: The nature of child protection work is risky and uncertain. Working with other professionals from different disciplines can make case management more effective. Multi-agency working is part of the machinery of the child protection system. It exists to support effective implementation of procedures, to help all those involved learn and work the case, and to provide greater protection to children. Think – have I got the right people on board with this case? Are the right people in the room when at a meeting about a child, and if not, why not?

Practice note (for agency leaders): Questions to consider – Does our training provision equip our staff to meet the often complex and uncertain landscape of protecting children? What opportunities can we give to our practitioners to reflect on their practice with individual children/families, within our own agency but also as a multi-agency safeguarding network? How are workload pressures affecting the quality of service delivery and what do we need to do to assure ourselves that expected standards are being met?

[99] Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C., & Black, J., Understanding Serious Case Reviews and their impact: A biennial analysis of serious case reviews 2005 – 07, DCSF

Table 1: Analysis of interacting risk factors (focusing on 2014)

<table>
<tr>
<td>Background hazards which were known at the time;
- History of maternal mental health problems (10 years plus) concerning difficulties managing anxiety and stress resulting in several episodes of extended leave from work. Root cause uncertain, but known contributory factors include; strained family dynamics, cultural expectations, previous adult relationship difficulties, giving birth outside of marriage and subsequent issues concerning the care of those children, potential honour based violence,
- A capable, resourceful mother who was articulate and able to communicate effectively with professionals thereby influencing the professional mind-set,
- History of allegations made by the mother about the father; majority judged false or disproved, or not as alleged,
- Sustained parental acrimony and hostility,
- A dysfunctional MARAC system and silo working by agencies,
- A professional network that faced communication challenges when visiting the maternal family,

Hidden and not appreciated at the time;
- Liverpool Children’s Services facing significant organisational pressures,
- Cross border communication challenges between Police forces and Children’s Services departments,
- Merseyside Police’s failure to adequately respond to allegations, risk assess the mother’s situation,
- A failure by the professional network, as a whole, to coordinate information and assessment activity in a child focused way</td>
<td>Situational hazards which were known at the time;
- A significant maternal family bereavement, inevitably causing feelings of loss,
- An allegation of inappropriate touching between Half Sibling 1 and Child N,
- Child N removed from school and not returned, with attempts to register at a second school,
- A failure by the mother to comply with agreed contact arrangements and exerting control over the circumstances,
- Child N being known by two different names,

Hidden and not appreciated at the time;
- Cross border communication challenges between Police forces and children’s services departments,
- A delay by Merseyside Police in completing risk assessment forms,
- The impact on the mother of becoming de-stabilised, increasing stress and anxiety.
- Counter Fraud investigation into the mother (also hidden from the mother)
- Failure to retrieve background Court proceedings (2009 & 2012) by Cafcass due to incorrect information provided by mother.</td>
</tr>
<tr>
<td>Strengths/protective factors which were known at the time;
- A father who, despite allegations being made against him, was judged as the suitable and responsible parent who could best care for Child N,
- The involvement and authority of the Court,
- Child N at school,
- A capable, resourceful mother who was articulate and able to communicate effectively with professionals
- A mother, who appeared to genuinely love and care for Child N,
- Child N was observed to have a warm and positive attachment to the MGM</td>
<td>Dangers which were known at the time;
-The Court and professionals knew that they wanted to avoid Child N being subject to, and experiencing, further emotional harm,
- Merseyside Police wished to avoid forcibly removing Child N; assessment of the situation showed that removal was not deemed necessary.</td>
</tr>
</table>

8: Conclusion

8.1. This Review has been conducted in accordance with the principles as set out in statutory guidance. It has gathered and analysed evidence submitted from each individual agency involved with Child N and provided both a chronological and thematic analysis; findings have been made. It has ensured practitioners have contributed to the Review process and has sought the views of Child N's immediate family. Whilst there have been limitations, the Review has sought to understand the response and interventions of agencies at the time. At times this has been challenging for agencies due to the complexity of the case.

8.2. The Review, whilst aware of the findings of the Police investigation and Coroner's verdict, has found that there are a number of policy, procedural and practice areas where improvements can be made. These cover a range of areas and include:

- equipping practitioners (from a range of agencies) to better understand and recognise the impact on children where a parent has mental health difficulties, but no defined mental illness,
- supporting staff to understand and respond to complex family dynamics which are often further complicated due to issues of diversity, language and culture,
- ensuring the timely and effective assessment of risk to children is communicated to all relevant agency partners. This includes risk created through domestic abuse/harassment, complexity due to cross border professional relationships and the involvement of multiple agencies and risk created through sustained parental hostility,
- ensuring high standards of recording and record keeping by professionals; seeing recording and record keeping as an essential tool to aid the task of keeping children safe,
- reducing pressures within individual organisations allowing front-line staff to respond in a timely and effective manner to safeguard children whilst also promoting fertile conditions in which child focused practice can occur.

9: Recommendations

9.1. Agencies named in Appendix 1 have each submitted an action plan in response to deficits and omissions they have identified during the process of conducting this Review. These action plans reflect over 50 specific lessons that have been learnt by individual agencies. For some agencies action plans are rightly comprehensive and extensive. Action plans have been submitted to the respective LSCB, either in Lancashire or Liverpool.

9.2. It will be the responsibility of the respective LSCB to monitor and scrutinise the effectiveness of implementing these individual agency plans. Additionally, Liverpool LSCB will submit regular reports to Lancashire LSCB to provide assurance of progress. Given the breadth and depth of some actions identified supporting implementation will require a long term commitment from those respective agencies, with an equal commitment to monitoring and scrutiny. However, it is important to note that many of the identified actions are reported to have already been implemented.

9.3. In addition to those actions identified by individual agencies, the Independent Reviewer, in agreement with both LSCBs has made the following specific recommendations.

Recommendations to Lancashire LSCB	
1	To oversee the implementation of single agency action plans arising from this Review and reflect on progress in the annual report. In overseeing the implementation the LSCB should establish timescales for action to be taken, agree success criteria and assess the impact of the actions.
2	To ensure the learning from this Review is actively disseminated to all relevant agencies and practitioners.
3	To consider the most effective means about how to provide guidance to Nursery settings about best practice around information sharing when concerned about the welfare of children.
Challenge to Lancashire LSCB	
	To explore options to assist front-line practitioners (across a range of disciplines) understand and assess the behaviour of a parent who causes concern but where there is an absence of a recognised mental illness.
Recommendations to Liverpool LSCB	
1	To oversee the implementation of single agency action plans arising from this Review and reflect on progress in the annual report. In overseeing the implementation the LSCB should establish timescales for action to be taken, agree success criteria and assess the impact of the actions.
2	To ensure the learning from this Review is actively disseminated to all relevant agencies and practitioners.
3	To schedule audits of single agency recording practices in order to judge the quality of recording against LSCB procedures and statutory guidance for safeguarding children.
Challenge to Liverpool LSCB	
	To explore options to assist front-line practitioners (across a range of disciplines) understand and assess the behaviour of a parent who causes concern but where there is an absence of a recognised mental illness.

Appendix 1: SCR Reference Group membership

Agency	Reference Group member designation
East Lancashire Clinical Commissioning Group	Independent Chair of SCR Reference Group
NSPCC	Independent Reviewer
Lancashire LSCB	Business Manager
Lancashire LSCB	Administrator and minutes
Liverpool LSCB	Business Manager
Action for Children	Improvement and Consultancy Manager
Alder Hey Children's NHS Foundation Trust	Nurse Consultant/Named Nurse for Safeguarding
Children and Family Court Advisory and Support Service (Cafcass)	Improvement Manager
School 2 (Lancashire)	Lancashire Schools Adviser
Lancashire Care NHS Foundation Trust	Named Nurse for Safeguarding Children
Lancashire Constabulary	Review Officer
Lancashire Children's Social Care	Principal Social Worker
Liverpool Children's Services	Interim Service Manager for Quality Assurance
Liverpool Primary Care (GP Practice)	Named GP
Liverpool Women's NHS Foundation Trust	Deputy Designated Nurse
Merseycare NHS Trust	Deputy Designated Nurse
Merseyside Police	Detective Superintendent
Royal Liverpool and Broadgreen University Hospital	Deputy Designated Nurse
Liverpool Community Health NHS Trust	Deputy Designated Nurse
Liverpool Clinical Commissioning Group	Designated Doctor for safeguarding children
Liverpool Clinical Commissioning Group	Designated Nurse for safeguarding children
Greater Preston Clinical Commissioning Group	Designated Nurse for safeguarding children

Appendix 2: Professionals interviewed or who have contributed to documentary evidence

Agency	Designation of person interviewed	Agency	Designation of person interviewed
Lancashire Care NHS Foundation Trust	Health Visitor, School Nurse, Team Leader	Lancashire GP	GP
Action for Children	Children's Services Manager x1, Centre Social Worker x1, Practice Manager x1	Lancashire Children's Social Care	Social Worker x 4, Team Manager
Alder Hey Children's Hospital	None, as all have left the Hospital	Liverpool Community Health NHS Trust	Health Visitor , Team Leader
Nursery 2 (Lancashire)	Nursery Manager, Nursery Deputy Manager	Liverpool (GP Practice)	GPs x 2, Practice Manager
Cafcass	Senior Service Manager x2, Family Court Adviser, Children's Guardian	Mersey Care NHS Trust	Service Manager
Liverpool Children's Services	Social Worker x3, Family Support Worker, Team Leader, Independent Reviewing Officer	Merseyside Police	Detective Constable x 3, Police Constable x 3 Detective Sergeant x 2, Police Sergeant x 2 Call Handler x 2, Inspector x 1 Detective Chief Inspector (MARAC Chair) x 1
School 1 (Liverpool)	Head teacher	Nursery 1 (Liverpool)	Nursery Manager Deputy Nursery Manager
School 2 (Lancashire)	Head teacher	Royal Liverpool and Broadgreen University Hospital Trust	No staff were interviewed as all have either left the Trust, are off sick or unavailable for interview at time of review.
Liverpool Women's NHS Foundation Trust	Domestic Abuse Midwife, Enhanced Community Midwife	Lancashire Constabulary:	Police Constable x 3, Detective Constable x 4

Practitioners and agency representatives who attended and contributed to the case Review practitioner event;

29 practitioners attended from the following agencies: Liverpool Women's Hospital, Midwife, Lancashire Children's Social Care, Lancashire Care Foundation Trust, Nursery 2 (Lancashire), Merseyside Police Family Crime Investigation Unit, Lancashire Constabulary PPU, School 1 (Liverpool), Alder Hey Children's Hospital, Action for Children, CAFCASS, Liverpool City Council, Liverpool Children's Services.

17 members of the SCR Reference Group/Agency representatives also attended: Lancashire Safeguarding Children Board, Lancashire Constabulary, Lancashire Care Foundation Trust, Alder Hey Hospital, Named GP Liverpool , Liverpool Community Heath, Lancashire Children's Social Care, CAFCASS, Central Lancashire NHS, Chorley & South Ribble Clinical Commissioning Group, Action for Children, Liverpool Children's Social Care, Liverpool Designated Doctor, Liverpool Health, Merseyside Police, Lancashire Children's Social Care, Liverpool Women's Hospital

Appendix 3: Evidence submitted (and/or referenced), for the purpose of conducting the Review

Agency	Information/Evidence	Agency	Information/Evidence
Liverpool Women's NHS Foundation Trust	Chronology, tabular timeline of key practice episodes (7), policy & procedure, maternity notes, electronic & paper records, staff interviews, action plan.	Cafcass	Chronology, tabular timeline of key practice episodes (5), policy & procedure, electronic case records (including Court papers), staff interviews.
Alder Hey Children's Hospital	Chronology, tabular timeline of key practice episodes (5), policy & procedure, electronic & paper records (safeguarding, medical and HR), staff interviews, action plan.	Lancashire Constabulary	Chronology, tabular timeline of key practice episodes (4), policy and procedure, electronic case records and message logs, action plan.
Merseyside NHS Trust	Chronology, tabular timeline of key practice episodes (2), policy & procedure, case records, internal independent expert opinion sought on standard of practice, action plan.	Merseyside Police	Chronology, tabular timeline of key practice episodes (18), policy & procedure, electronic case records, staff interviews, action plan.
Lancashire Care NHS Foundation Trust	Chronology, tabular timeline of key practice episodes (7), policy & procedure, staff interviews, electronic & paper records, action plan.	Lancashire Children's Social Care	Chronology, tabular timeline of key practice episodes (2), policy & procedure, electronic case records, staff interviews, action plan.
Royal Liverpool & Broadgreen Hospital Trust	Chronology, tabular timeline of key practice episodes (8), policy & procedure, case records, action plan.	Liverpool Children's Services	Chronology, tabular timeline of key practice episodes (4 themes), policy & procedure, electronic case records, staff supervision records, staff interviews, action plan.
Liverpool Community Health Safeguarding	Chronology, tabular timeline of key practice episodes (15), policy & procedure, case records (including child health records), staff interviews, staff supervision records, action plan.	Action for Children	Chronology, tabular timeline of key practice episodes (2), policy, procedure & practice standards, case records, staff interviews, action plan.
Liverpool GP (Primary Care)	Chronology, tabular timeline of key practice episodes (12), electronic case records, staff interviews, action plan.	Liverpool Domestic Abuse Service	Letter to LSCB, case notes.
Lancashire GP (Primary Care)	Chronology, tabular timeline of key practice episodes (12), electronic case records, staff interviews, action plan.	Nursery 1 (Liverpool)	Chronology, tabular timeline of key practice episodes (8), policy & procedure, case records and log, staff interviews, action plan.
School 1 (Liverpool)	Chronology.	School 2 (Lancashire)	Chronology, tabular timeline of key practice episodes (6), policy & procedure, school records, action plan.
Nursery 2 (Lancashire)	Chronology, action plan.		