Warwickshire Safeguarding Children Board

Serious Case Review Report
Regarding a child to be known as Child K

Contents

1. Introduction

1.1.1 The Warwickshire Safeguarding Children Board (WSCB) decided to undertake a Serious Case Review (SCR) in respect of a child to be known as Child K in April 2017. They recognised the potential that lessons could be learned from this case about the way that agencies work together to safeguard children in Warwickshire.

1.1.2 Child K was 12 weeks old when she sustained a skull fracture. The parents state that Mother dropped Child K during a domestic abuse incident. They did not seek medical attention for Child K until 3 days after the incident. It does not appear that there will be any long-term health or developmental impact on Child K from her injury. Both parents made 'guilty' pleas in respect of 'causing injury to a child' and were given community sentences.

1.1.3 It was agreed that the SCR would consider in detail the professional involvement with Child K and her family during the bank holiday weekend 31.12.16 – 2.1.17; the date of the domestic abuse incident until the strategy meeting regarding Child K's injuries[1]. The review is therefore evaluating the effectiveness of Warwickshire's arrangements to safeguarding children out of hours.

2. Methodology[2]

2.1.1 Independent lead reviewers[3] were appointed to undertake the review. They had access to the key single and multi-agency documents in the case and met with practitioners involved with the family in a number of reflective sessions where the case was discussed. The pre-disposing risks and vulnerabilities[4] that were known at the time were considered, in order to understand the case. This is followed by the consideration of the preventative and protective actions taken, in order to understand the interventions.

---

[1] The scope of the review is three days in order to identify learning for the agencies involved and for the WSCB from the professional involvement undertaken during those days. The background information known by agencies prior to these dates was also shared with and considered by the review. The decision to review these dates took into consideration the lack of significant agency involvement with the children prior to this time, and the recognition of the potential to learn lessons from the way agencies worked together during the timescale being considered. This was a proportional and focused response to the need to review the case.

[2] The Government guidance Working Together 2015 states that SCRs should be conducted in a way that;

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

This review has achieved these objectives. Consideration has been given to whether it is necessary to 'identify improvements in the way that agencies work together for the prevention of death, serious injury or harm to children and to consolidate good practice'. The review has also clearly identified 'what lessons are to be learned both within and between agencies and within what timescale they will be acted on and what is expected to change as a result'.[2]

[3] Nicki Pettitt is entirely independent of the WSCB and its partner agencies and is an experienced chair and author of serious case reviews and safeguarding adult reviews. Cornelia Heaney is the WSCB manager and is independent of the case.

[4] Triennial Analysis of Serious Case Reviews 2016, Sidebotham, Brandon et al, Department of Education

2.1.2 The agencies that had involvement were asked to reflect on the agency specific learning.

2.1.3 The lead reviewers visited Child K's mother to discuss the SCR and she reflected on the work undertaken with the family during the timeframe of this review. Her views are included in this report. Child K's father has been written to about the report and the lead reviewers have offered to have a telephone conversation with him about the professional interventions at the time. Both parents will be informed of the conclusions of the review and the WSCB's response prior to publication.

2.1.4 Drafts of this report were shared with those involved as well as with the Special Cases sub-committee of the WSCB to ensure collaboration and ownership. The recommendations were written by the lead reviewers and Special Cases.

2.1.5 This report has been written in the anticipation that it will be published in full,and contains only the information that is relevant to the learning established during this review.

2.1.6 The children are the subject of care proceedings and are living with extended family members prior to the final hearing.

3. The Case

3.1.1 For the purpose of this report, the following family members are relevant:

Family member:	To be called:
Child K (12 weeks)	Subject child
Mother of Child K	Mother
Father of Child K	Father
Mother's son (Age 8)	Sibling
Mother parents	Maternal Grandparents
Father of Sibling	Sibling's Father

3.1.2 The family were known to a number of agencies in Warwickshire. Father had convictions for unrelated matters and was known to mental health services for anxiety and depression. When Father had been living with other families in the past, children's social care (CSC) were involved due to domestic abuse where Father was the perpetrator, and concerns about physical abuse perpetrated by Father. In one case, this resulted in a child protection plan, and in others multi-agency domestic abuse management plans (MARAC[5] and MAPPA[6]) were in place due to the assessed high risk of serious harm.

3.1.3 Mother's relationship with previous partner/s had resulted in five domestic abuse calls to the police between 2008 and 2014. The report of the incident in 2008 stated that Mother had been drinking. There was police involvement between Mother and Sibling's Father on one occasion in 2016 due to issues regarding contact with Sibling. Letters of advice were sent to Mother from CSC and on one occasion there was telephone contact with a social worker.

3.1.4 There was no reported domestic abuse between Mother and Father prior to 31.12.16.

3.1.5 Sibling's school had shared no concerns about him. He has contact with his father.

3.1.6 Complications during her birth led to a 2 week stay in hospital for Child K. No concerns or needs were identified by the midwives or the health visitor following her discharge home. Other than a

[5] Multi-Agency Risk Assessment Conference

[6] Multi-agency public protection arrangements

missed appointment with the health visitor due to a house move, Mother engaged with all ante and post natal support and Child K was immunised.

3.1.7 The family moved house when Child K was around 2 months old. This was into a social housing property where the tenancy was solely in Father's name. Father had made a request for social housing for him and Child K, stating he was to be the baby's only carer. This may have been a fraudulent application[7].

3.1.8 In the early hours of the morning on Saturday 31.12.16, Father called the police to state that Mother was intoxicated (due to alcohol) and needed to be removed from the home. Sibling was spoken to by the attending uniformed police officers and he stated that Father had his hands around Mother's throat that night. The next morning, when other officers attended, Sibling said that the night before he had been dragged by Father and that he had a bruise on his leg. Mother was left with the children when Father was taken to the police station to be interviewed about the potential domestic abuse earlier that morning, and the uniformed officers passed Sibling's allegation to CID colleagues.

3.1.9 Sibling was interviewed but did not sustain the allegation. CSC EDT (Emergency Duty Team[8]) made a written agreement with Mother that Child K would stay with Maternal Grandparents overnight, and that Sibling would go to his father. It became apparent the next day that the written agreement had not been adhered to however and Father made it clear to the EDT social worker who telephoned that he would not stay away from the children. The issue was discussed with a senior manager and it was agreed by CSC that it did not meet the threshold to enforce the plan, but that a full assessment should be undertaken after the bank holiday period.

3.1.10 The following day Father sought medical attention for Child K who had a swollen head. He stated Mother had thrown the baby on the floor in the early hours of 31.12.16. Mother and Father have since stated that Mother tripped and fell with the baby in her arms.

3 Analysis

3.1.11 To analyse the professional involvements and interventions with the family, consideration has firstly been given to the predisposing vulnerabilities and risks in the case, that were known or knowable to professionals involved at the time. This is followed by the preventative and protective actions taken by the agencies involved at the time.

Predisposing vulnerabilities:
Child K was a young baby who was entirely dependent on the care provided by the adult/s responsible for them. It has been established in previous SCRs that the frailty of babies is often under estimated by professionals and parents/carers[9].
At birth Child K had some complications that led to a two week stay in the special care baby unit.
Child K was pre-verbal and could not tell professionals about her life-experiences or what had happened to her.
Father had stated that he didn't want another girl as he had daughters from a previous relationship. This may have made Child K more vulnerable.
It is not known how long Father had lived with Sibling or the quality of their relationship other than as reported by Mother.
Mother had been in relationships before where it was believed that there had been domestic abuse. Mother may therefore be vulnerable to abusive partners. Mother disputes this, stating that

[7] This is outside of the scope of this review, but is being considered as a supplementary review due to the potential to learn lessons from the response to Father's request for housing.

[8] EDT provides an adult and children social care emergency social work service at night, at weekends and on all public and local-authority holidays.

[9] The Ofsted report: 'Ages of concern: learning lessons from serious case reviews' provides a thematic analysis of 482 serious case reviews that Ofsted evaluated between 1 April 2007 and 31 March 2011.

she acted to protect herself and her child when a previous partner had been violent and terminated the relationship.
It is known that women are more vulnerable to domestic abuse when they are pregnant and when they have a new born baby.
Mother was on maternity leave from work and the family had recently moved home. Father told the police that the family had financial pressures.
Father had a history of involvement with mental health services due to anxiety and depression. He was receiving no support at the time of the incident.

3.1.12 It is recognised that the adults predisposing vulnerabilities may pose a predisposing risk to the child. The following additional risks have been identified:

The risks in the case:
At the time of the reported domestic abuse incident Mother was said to be extremely drunk by the attending police officers.
Mother denied that there was any violence in her relationship with Father, although Sibling had stated that he saw violence early in the morning of 31.12.16 and marks were noted on Mother's neck. Mother was insistent to professionals that Father was a good man and that he treated her and Sibling well. This was felt by professionals to be erroneous at the time, and following the injury to Child K Mother has stated that Father was in fact emotionally abusive to her, although this was not known at the time.
Mother was observed to be coaching Sibling to report that Father was 'good to him'.
Police and CSC have evidence of a domestic abuse incident between Mother and another partner where she was said to be drunk.
Father has a history of domestically abusive relationships and of alleged physical abuse to children (described as 'chastisement' in records). This includes children in his care being made the subject of child protection plans.
The family home was described by those who attended as cold and sparsely furnished, with no covers on the bedding. Child K was said to be in a dirty baby-grow and soiled nappy.
Mother was found to be co-sleeping with Child K the morning after the domestic incident and following her heavy drinking.
At the time, Mother refused to make a statement to the police in regards to domestic abuse or the alleged assault on Sibling.
Sibling stated to Police during the night that Father had 'dragged him around like a dog' that evening, and that he was called 'a fairy' and 'a wimp.' He had a red mark on his shin. During the ABE interview he backtracked, and those present interpreted what he disclosed as 'rough handling'.
Neither adult's account of what happened during the early morning of 31.12.16 was consistent.
Mother and Father provided inconsistent accounts of who the home belonged to and who lived there regularly. This demonstrated a lack of honesty, and also meant it was not clear whether the home could be a place of safety for the children when the working agreement was being devised.

3.1.13 There was evidence of protective actions from the family when considering the case:

Protective actions – family
Although very delayed, Father eventually took Child K to a clinic for medical treatment.

Sibling went to his father's home overnight 31.12.16 – 1.12.17.
Mother believed she was protecting her children by seeking to avoid a confrontation with Father about his wish to return home on the 31.12.16.
Maternal Grandparents acted to ensure their grandchildren were safe by providing a home for them from the evening of the 2.1.17.

3.1.14 During the involvement of professionals with the family, there were both preventative and protective actions taken by the agencies involved. There were also further opportunities to ensure protection that were not taken.

Protective and preventative actions – agencies
Prior to the incident (around the time of Child K's birth) routine domestic abuse questions[10] were asked of Mother by health visitor and midwives and she answered 'no'.
The uniformed police officers who first attended the 999 call spoke to both the parents separately. Father appeared sober, was calm, and was comforting a crying Child K. The parents denied any physical violence, however Sibling told the police officers that there had been a fight and that his step-father had put his hands around Mothers neck leaving a mark. On considering this, they still felt that Father was best placed to care for Child K and Sibling overnight as Mother was so drunk and in the early hours of the morning they had limited options for alternative care. Before making this decision they checked with Sibling that he was happy to stay with his step-father, he said he was. They took Mother to the police station with the intention of taking a statement when she had sobered up. An awareness of good practice in responding to domestic abuse was shown by the uniformed officers.
After a shift change at 7 am on 31.12.17, where a large number of cases had been handed over, Mother was spoken to. She continued to deny any domestic abuse and would not make a statement. She was returned home by the police to care for the children, with the intention that Father would be taken to the police station to provide a voluntary interview. The police handled the return of Mother and removal of Father sensitively, with a police officer waiting with the children in the minutes between Father leaving and Mother returning to the property. This ensured the parents did not see each other.
The officer waiting with the children spoke to Sibling who made his disclosure that he had been physically harmed by Father. The decision was therefore made to arrest Father rather than take a voluntary statement and the investigation was handed over to CID in a timely verbal handover prior to the written information being available.
Two suitably trained CID officers were asked by a detective sergeant on duty to visit the family and negotiate with Mother to undertake an ABE[11] interview with Sibling. They were clear this was now a potential criminal investigation and that as Father was in custody they had limited time to undertake the interview. It is also best practice to secure an account as soon as possible from a young child to prevent any further contamination of the child's account and to enable it to be as easy as possible for that child to provide a recollection of events. They were aware there had been a domestic incident the night before, but this was not the focus of their involvement. The impact of this protective action however was reduced by being planned and carried out in isolation from EDT.
The CID officers had intended to ask Mother to accompany Sibling for an interview, but it was clear that Mother was trying to influence what he was saying about what happened. She kept reminding

[10] Routine enquiry means that health visitors and midwives ask all pregnant women and new mothers whether they are experiencing domestic abuse during routine contacts, whether they show signs of it or not. This has been common practice since 2006.

[11] The principles of ABE (Achieving Best Evidence) are set out in the Youth Justice and Criminal Evidence Act 1999 (YJCE). The interviews are visually recorded and used for: evidence gathering for use in criminal proceedings, the examination in chief of the child witness, and to inform child protection enquiries under Section 47 of the Children Act 1989.

him it was 'only play fighting'. The officers recognised the impact that Mother's behaviour could have on the interview with Sibling, and that she should not be part of it. As Mother was happy for him to be interviewed without her there, he was taken alone by the police to be interviewed with Mother's permission in writing[12]. They had requested that another family member be contacted to accompany Sibling. Mother stated Maternal Grandmother would do it, but she was unwell and there was no one else. No consideration was given to contacting Sibling's Father.

Despite it being a busy day, a lot of police resource was allocated to this case. At the police station two further CID officers were tasked with interviewing Father regarding the allegations and they agreed to do this following the result of the ABE interview.

CSC EDT were contacted and asked to attend the ABE interview to support Sibling. It is good practice for a child to have a supportive adult present when giving a witness statement. The reasons for using a professional rather than Mother to support the child were clear to the CID officers, but because EDT had not been involved up to this point, and had not been able to observe Sibling and Mother together, the EDT manager did not have the full picture and believed it would be more supportive for Sibling to have his mother present in the building. It would be very unusual to take such a young child for an interview without someone they knew. The EDT Manager therefore arranged for a social worker to visit Mother and bring her to the interview suite. This delayed the arrival of the social worker to assist with the ABE interview.

The CID officers developed a rapport with Sibling. While they waited they made drinks and toast for Sibling and engaged with him about football and school. They described him as friendly and chatty and that he didn't appear at all anxious. Developing rapport would be expected to improve the likelihood of the child speaking freely in their ABE interview.

The EDT social worker conducted an assessment interview with Mother, but this was brief because she was aware that Sibling was waiting for them at the interview suite. Mother stated that there had been no physical violence to her the night before or at all in her relationship with Father. If anything, she said, she would have attacked him and he may have pushed her away. She had marks to her face but stated these were due to the baby scratching her while feeding. She also spoke about the excellent relationship between Sibling and his 'step-father'. She explained that there had been a disagreement the night before about Sibling needing to go to bed, and that he was picked up and put to bed by Father, but this was not inappropriate in the circumstances as far as Mother was concerned.

The uniformed officer who held the baby while waiting for Mother to return on the morning of 31.1.17 told the review that she had noticed that Child K was not very responsive and that her head seemed soft and an odd shape. She had been told by Father that the baby was premature when born and she thought this might account for what she saw. The officer discussed this with her supervisor on her return to the station. They did not think it was anything significant however, and this information was not shared with CID or recorded until a statement was taken following the hospital attendance on 2.1.17. The EDT social worker also saw Child K and stated she seemed well cared for and was calm and settled during the time the EDT social worker was with them, which was some hours. She had a hat on for most of the time, as it was December. The social worker stated with hindsight that she had thought Child K's head was an unusual shape, but nothing to make the EDT social worker concerned. Child K was described as feeding normally and Mother, although tired, responded to her appropriately.

On arrival at the interview suite, the EDT social worker and CID officer spoke and it was agreed that Mother would not sit with the child during the interview, but would be in the next room with another officer who was making notes.

Sibling was interviewed, giving him the opportunity to tell the police officer and social worker about

[12] The police officers stated that taking Mother and Child K with them too would have been difficult as they do not have car seats in their cars. However the EDT social worker pointed out that Mother had a car and that she used the car seat from there when she transported them.

things at home that he was unhappy about. However he did not maintain the allegation during the interview. He had a red mark on his shin however and the Police took a photograph of this injury following the interview. This was to capture an image of this potential evidence in case any further evidence became available later. The Police officers noted a change in Sibling's demeanour when Mother arrived, and believed her presence in the next room restricted his willingness to speak.

The professionals had a reflective discussion following the ABE interview and made a shared assessment of risk. The social worker had looked at the CSC database, CareFirst, and noted concerns about domestic abuse in Father's previous relationships and about Father's mental health. This is good practice. They assessed that without intervention there was a risk of further domestic abuse during the weekend.

When making decisions on 31.12.16 both the EDT social worker and the CID officers considered the following:

- History of domestic abuse with previous partners of both parents
- Mother was denying this was a violent relationship, and was trying to get Sibling to say the same
- Mother seemed to be cooperating with the plan for the weekend
- Sibling did not sustain his allegation and the injury was small and Sibling said it was not from the incident
- Father was said to not live with the family full time

They did not feel they could let the family go home without taking any action, but did not think there were grounds for police protection or emergency protection of the children. A plan was made for the children to be cared for elsewhere and the compromise of a written agreement was put in place.

The social worker drafted a working agreement with Mother which stated that the children would be cared for by their maternal grandmother for the rest of the bank holiday weekend. Mother agreed and signed the agreement. In principle this was a suitable protective plan. Contact details for Grandmother were requested, but the social worker did not seek to make contact with her at the time of setting up the agreement, which undermined the integrity of the plan.

The EDT social worker met with Father at the police station on his release to seek agreement to the working agreement, but he stated that he was not intending to cooperate with the written agreement and would not sign it. This further undermined the integrity of the plan.

Father was released without charge in relation to the physical assault on Sibling. Father was on Police Bail for the domestic abuse allegations. The police officers making this decision were aware of the written agreement and the understanding that he would not have any unsupervised contact with the children at that stage. The criteria for bail conditions were not met in regards to the on-going domestic abuse investigation, and a domestic violence protection notice[13] are not considered when bail is in place.

Later that evening the social worker attempted to contact Maternal Grandparents to clarify that the children were there and explain the written agreement, but found she had the wrong telephone number. (It was later established that Mother had also given her the wrong address.)

The 1.1.17 was a Sunday. There were a number of attempts by EDT staff to contact Mother, and when they spoke to her on the telephone it became clear that Child K was at home and also possibly Sibling. Father came to the telephone, stated they were not willing to cooperate with the agreement made, and hung up. The EDT social worker had a discussion with the EDT manager who then spoke to the duty group manager and it was agreed there were no grounds to undertake

[13] Crime and Security Act 2010. DVPOs enable the police to put in place protection for the victim in the immediate aftermath of a domestic violence incident. Under DVPOs, the perpetrator can be prevented from returning to a residence and from having contact with the victim for up to 28 days, allowing the victim a level of breathing space to consider their options, with the help of a support agency. They provide the victim with immediate protection.

emergency action. The police were not informed of the change in the situation or the decision made.
Child K's injury was established on the bank holiday Monday 2.1.17. The safeguarding implications of her injuries were quickly identified by the Acute unit staff. EDT were informed by the ambulance service. The parents were arrested and held in custody that evening, Child K was in hospital and Sibling was considered in a timely way.
A plan was made by EDT and police that Sibling would be cared for by Maternal Grandparents. There was some confusion however about the children's legal status, with the police believing the children were accommodated under s20[14] and EDT believing the children were in police protection[15]. In fact neither were in place.
Mother told the review she was held in a cell for almost 24 hours, and that she had not been given any update on her baby's condition, despite requesting this hourly. She was aware that Child K was in surgery and she was incredibly worried. The review has requested that Warwickshire Police consider the impact on Mother of what happened that night, and how they can ensure that parents in police custody are given updates on their children, particularly if they are seriously ill, as in this case.

3.1.15 The review has established that the following areas require further analysis and provide us with the learning in this matter:

The context:

Police reorganisation

3.1.16 The review has identified that there were contextual issues which had an impact on the case. There had been a reorganisation of Warwickshire Police around 6 months previously which had an impact on the experience of officers who undertake investigations into child abuse allegations, and which may have had an impact on this case. Rather than having a standalone service for child protection within CID, child abuse investigations and police responsibilities under the Children Act 1989 and Working Together 2015 are now held within mainstream CID services. (Although it is acknowledged that the previous child protection teams did not cover weekends and bank holidays, which would have caused issues in this case.) The detective sergeant who was on duty on the 31.12.16 stated she does not have enough staff who are trained and experienced in child protection and in undertaking ABE interviews at any time, particularly on bank holidays. On the weekend in question however she had two officers who had the required training and she asked them to take on the case. There was a degree of urgency as Father was in custody, and because Sibling was just 8 years old. The officers however did not question what had been agreed prior to their involvement and they were not aware that there had not been a strategy discussion and that the expectation was that they would request one of CSC EDT social worker when they arrived at the interview suite. This might be due to a misunderstanding, inexperience, or a lack of understanding of procedures. (See below.)

3.1.17 EDT explained to the review that the reorganisation has had an impact on their relationships with those police officers undertaking child protection work. They now come from a much bigger pool of detectives who are inevitably less experienced in this type of work. The issue of suitability for the particular type of work was also discussed. The changes have made it harder to ensure good relationships between social workers and police officers, quality joint child protection work, and the meaningful involvement of CSC professionals in what may be seen as a police task. The police accept that just 6 months into the redesign there were issues, but that the investment in mainstream CID will lead to a better service as more officers are trained in child protection and gain more experience.

[14] S20 Children Act 1989, where children are accommodated by the Local Authority with the agreement of a parent.
[15] Police Protection s46 Children Act 1989, where a police officer has reasonable cause to believe that a child would be at risk of significant harm unless action is taken immediately s/he may: remove the child from the situation and take them to a place of safety or take action to prevent the child's removal from a place of safety, for up to 72 hours.

Out of Hours provision

3.1.18 As the work was not undertaken during the hours of 9 – 5 Monday to Friday, and was therefore 'out-of-hours', there were added complications. The lack of a strategy discussion to consider Sibling's allegations prior to the visit to the home to see the child and to request an interview was said to be because the MASH had not been involved as they would be in office hours[16], and that decisions 'out of hours' are often made without a formal strategy discussion or meeting. (See below)

3.1.19 The shift changes that happened during the early morning, then through the daytime and evening of 31.12.16, also had an impact both for the police and for EDT. A number of different uniformed and CID officers were involved, along with a number of EDT social workers. This may have led to a confusion regarding who had oversight of the processes and procedures that needed following, such as the need for a strategy discussion. (See below.) One of the police detective sergeants spoken to stated she had not been aware of contact between another sergeant and EDT on 31.12.16 until later in the day. From speaking to those involved that day it is still not entirely clear who did speak to whom that morning. Those involved are not entirely sure from memory. So much was happening that records were done later in the day as a summary rather than a blow-by-blow record of telephone calls and discussions. This is the reality. The same could be said for the evening of 2.1.17 when Child K was in hospital and Sibling was placed with grandparents without any legal remit such as police protection or S20 being in place. While this did not result in any issues for these children, the potential for difficulties to have arisen must be noted.[17]

3.1.20 The police were undertaking two investigations on the 31.12.16, one in regards to the domestic abuse and one in regards to the physical abuse allegation by Sibling. This added further confusion. For example regarding whether Father had been bailed or not. He had been for the domestic abuse but not for the child abuse.

Learning:

- There has been an impact on relationships and experience out of hours due to changes in the way Warwickshire Police now responds to child protection.
- The nature of out of hours work, with linked capacity and continuity issues, means that professionals have to make decisions as a holding plan in an evolving situation.
- Practice guidance and procedures do not differentiate between day time and out of hours situations when a child protection allegation is made. However it is unrealistic to think that out of hours services can fully replicate the daytime services.

Strategy meetings:

3.1.21 Working Together 2015 states that *'whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm there should be a strategy discussion involving local authority children's social care, the police, health and other bodies such as the referring agency. This might take the form of a multi-agency meeting or phone calls and more than one discussion may be necessary'.* It goes on to state that *'children's social care should convene a strategy discussion to determine the child's welfare and plan rapid future action if there is reasonable cause to suspect the child is suffering, or is likely to suffer, significant harm. The discussion should be used to: share available information; agree the conduct and timing of any criminal investigation; and decide whether enquiries under s47 of the Children Act 1989 should be undertaken.'*

3.1.22 Working Together states that it is the responsibility of CSC to convene the strategy discussion and make sure it:

[16] Although it is not the case that all day time child protection referrals will be taken by the MASH. Child protection referrals on cases already open go directly to the responsible social work team.

[17] When children are placed away from their parents for child protection reasons, it is expected that this is formalised by a s.20 agreement, or court order, which gives the carers the status of foster carers; or police protection.
http://localgovernmentlawyer.co.uk/index.php?option=com_content&view=article&id=21474%3Aplacing-childr%20en-with-family-members&catid=54&Itemid=22

- *considers the child's welfare and safety, and identifies the level of risk faced by the child;*
- *decides what information should be shared with the child and family (on the basis that information is not shared if this may jeopardise a police investigation or place the child at risk of significant harm);*
- *agrees what further action is required, and who will do what by when, where an EPO is in place or the child is the subject of police powers of protection;*
- *records agreed decisions in accordance with local recording procedures; and*
- *follows up actions to make sure what was agreed gets done.*

CSC should also lead the section 47 enquires and assessment of the child's welfare where joint enquiries take place.

It is the responsibility of the Police to:

- *discuss the basis for any criminal investigation and any relevant processes that other agencies might need to know about, including the timing and methods of evidence gathering; and*
- *lead the criminal investigation where joint enquiries take place.*

CSC did not take responsibility for a strategy discussion to plan S.47 enquiries in relation to Sibling's disclosure and the police did not discuss with CSC the plan for gathering evidence for a potential criminal investigation before commencing it. The opportunity to review the plan in a formal way by having a review strategy meeting/discussion following Sibling's ABE interview, and when it was determined that Father had returned to the home while the children were there, was not taken.

3.1.23 The lack of a timely strategy discussion at the start meant that the conduct and timing of the investigation was not agreed in advance, and this led to a mixed message being given to Sibling about whether Mother would be there for his interview, and to a degree of frustration within both CSC EDT and the police regarding the disagreement that was **apparent** about Mother's presence and the subsequent delay in the interview. When Mother and the social worker arrived at the interview suite the social worker and the CID officer planned the interview. Neither the social worker nor the CID officer thought they were having a strategy discussion, but rather a conversation about how best to undertake the ABE interview and manage Mother's presence. It was shared at the review that Sibling had to be interviewed again after the injury to Child K was established, and this may have been avoided if the original interview had been better planned and joint consideration had been given to whether Mother should be there. The impact on Sibling of repeated interviews was not foreseen but was significant.

3.1.24 There remains confusion about who should have been involved in the strategy discussion and whether in fact there had been one. The DS who asked the 2 CID officers to attend and undertake the ABE interview assumed that the officers would be undertaking a strategy meeting if it was required, but this was not communicated to them. They were under the impression that an allegation had been made and that it was a potential criminal investigation of an assault, and a decision had been made that it could be single agency. There was a degree of urgency as Father was in custody, and as it was the weekend there was no MASH processes to consider. They were aware there had been a domestic incident the night before, but this was not the focus of their involvement and specific questions were not asked regarding this.

3.1.25 The EDT social worker attended the interview suite under the impression that the police had requested an appropriate adult to support Sibling, and they did not stress that a strategy discussion was required in the case of an allegation of child abuse within the family. They stated they may have assumed that the EDT worker who took the referral had recorded the discussion as a strategy discussion, and were unclear when interviewed what had happened prior to their involvement. There is a view within EDT that there is a misconception within the police about the process, which is that the police tend to see the process as a criminal investigation and to consider if a crime has been committed, and that there is little understanding of CSC being the lead agency.

3.1.26 It would be good practice when having a strategy discussion to consider all of the children in the household. As there had been no allegations regarding Child K, she was not considered. Those who had contact with her were able to provide their observations, but there was no thought as to whether she was at risk, other than a concern about co-sleeping, and presumably as a child who was present during a domestic abuse incident.

3.1.27 The 2016 triennial study into SCRs states that 'strategy discussions provide opportunities for information and opinions to be clarified. Appropriate attendance or representation of all relevant professionals is essential so that effective challenge and clarity can take place when ambiguity is identified'. While this is difficult out of hours, a formal telephone discussion could have been requested and taken place either when the case was transferred to CID or when EDT became aware of Siblings allegations. Or at the very latest when the EDT Social Worker arrived at the interview suite. A review strategy discussion could have been held following the ABE interview, when Father was released from custody, and when EDT established that the children were at home with both parents on 1.1.17, in order to share information and plan if any further actions were required.

Learning:

- Strategy discussions are a central part of the safeguarding process both during office hours and out of hours, and should be held whatever the circumstances to plan both S.47 and criminal enquiries.

- If a strategy discussion has not been held and an investigation is underway, professionals should formally escalate their concerns that procedures are not being followed. It is acknowledged however that is hard for professionals to say 'stop, I don't agree with what is happening' in the middle of an investigation, and organisations need to support their staff to do this.

- The longer term impact on a child of an investigation that was not well planned is evident in this case.

<u>Understanding of procedures and each other's roles:</u>

3.1.28 It appears that when undertaking an investigation out of hours that the CID officers who undertook the ABE interview are aware that social workers need all the information from an interview in order to make a safeguarding decision for a child, however they do not consider the need for any social work involvement in an ABE interview and criminal investigation other than as providing support to the child. It was stated however that during office hours things are different because the MASH is involved.

3.1.29 As stated above there are views within both the police and CSC EDT about the roles and responsibilities of the other agency that are not necessarily compatible with what is expected in Working Together or local procedures.

3.1.30 When an investigation is required that involves an allegation against an adult who lives with a child, it is important to ensure that the child is protected while the investigation and an assessment is undertaken. Out of hours services are not always able to undertake a full assessment and so they often try to plan to keep the child safe until day time CSC services are able to undertake a fuller assessment. In this case a written agreement was drawn up. (See below). This agreement was not adhered to and the police were not informed of this, although they had been under the impression it remained in place.

3.1.31 There was a joint decision regarding there being not enough evidence following the ABE interview for Sibling to have a medical, which was appropriate.

3.1.32 On the 2.1.17 CSC believed the children were under police protection. The record of the strategy meeting held that day shows agreement that this would be the case. It has been acknowledged that

the paper work was not received to confirm this, and the EDT workers stated that this is not unusual as this takes time which is not always available when you are dealing with an emergency out of hours. However to request an email confirming the status is a compromise that would work.

Learning:

- Relationships between CSC EDT staff and police officers need to be developed across Warwickshire to enable better joint working and an increased awareness of each other's roles within joint investigations. This will build on the obvious respect and willingness to engage that has been observed during this review.
- Clarity is required in emergency situations regarding whether police protection is in place or if S20 agreement is required from parent/s.

Written agreements:

3.1.33 The professionals involved in the day following the domestic incident remained concerned about Father's reaction to Sibling's disclosures and about the possibility of Father perpetrating further domestic abuse. They had a helpful reflective discussion following the ABE interview. The social worker had looked at the CSC database, CareFirst, and noted concerns about Father being abusive in previous relationships and about Father's mental health. The EDT social worker agreed with her manager, the police, and then with Mother that the children would go to family members that night. They were aware it was New Years Eve and the social worker felt there was a high chance the parents would be drinking again. Mother gave her parent's contact details to the EDT social worker. A written agreement was drawn up at the interview suite while the police officers were present. The EDT social worker described Mother as cooperative and that she was confident that Mother understood the working agreement. Mother confirmed her understanding when she met with the lead reviewers. The opportunity was also taken to reinforce that Child K should not co-sleep with her parents, and this was written in the agreement. Although Mother was clear she would stay with Father herself, she agreed the children would have no contact unless it was supervised by the grandparents or a friend. Mother was told that someone from EDT would be in touch the following day.

3.1.34 EDT told the review they often use written agreements in order to make the provisional plan clear to family members until the daytime staff come in and can undertake a full assessment. In this case the plan for the children to go and stay with grandparents was a good one, but it was not discussed with the grandparents beforehand to check that it was convenient to them and to check their level of cooperation with the plan.

3.1.35 When it became evident on 1.1.17 that the written agreement had been broken, appropriate CSC management advice was sought and it was agreed that there was no evidence that the threshold for emergency intervention was met and that when daytime services returned on 3.1.17 they should start an assessment. This view was probably correct; however the information on the change of plan was not shared with the police.

3.1.36 Written agreements can provide a false sense of security. Their effectiveness as a tool to ensure compliance with a plan to protect a child is questionable. There is no reference to written agreements in legislation, statutory guidance or procedures. They are however a tool that is used to enhance understanding of expectations, provide evidence of cooperation or lack of cooperation, and may be used to provide an informal plan for a case before an early help, child in need or child protection plan is in place. They may be a good way of ensuring that the expectations of the parent are written down, rather than just explained verbally, but they do not ensure a child's safety.

3.1.37 In this case Mother agreed readily to all that the social worker asked, she said she understood the expectations over the next few days, and she signed the agreement. She was very detailed in how she would protect her children. It could be seen as disguised compliance as she did not adhere to the agreement in any way. Father had been clear that he had no intention of cooperating, and it appears that he persuaded Mother to disregard the commitment she had made. Mother had also

given false details and did not contact her parents before Father was released, which made the review question her commitment to the plan.

3.1.38 The use of written agreements in cases where there is domestic abuse has been questioned in a 2017 report from Ofsted and the CQC.[18] They conclude that the use of written agreements is largely ineffectual as the focus on the written agreement is usually the 'victim' and not the perpetrator who is the source of the abuse. In this case the EDT social worker did attempt to gain Father's support of the agreement, which is good practice. His outright refusal to cooperate made the effectiveness of the agreement questionable.

3.1.39 The Derbyshire LSCB SCR into the death of Ayeesha-Jayne Smith stated that 'the role of written agreements appears to be common and, yet, it is known that women who are in situations where domestic abuse is a risk will find it very hard to comply with such an agreement.' There is widespread agreement in both Ofsted reports and in SCRs that the use of written agreements in domestic abuse cases in particular puts unrealistic demands on the victim and is very unlikely, therefore, to protect the children.

3.1.40 In any circumstances where a working agreement may be suitable, support and cooperation needs to be sought from all the participants to the working agreement before it can be considered to have been made. This particularly applies to the agreement of any adults who are providing safety for the children, such as in this case, the maternal grandmother.

3.1.41 Concerns have also been shared about the use of police bail to manage risk in domestic abuse cases. There is recent learning from domestic homicide reviews in Warwickshire that shows that police bail should not be relied on the reduce risk to victims and their children.

Learning:

- The use of written agreements in cases where there is a possibility of domestic abuse and where the agreement asks for one parent to ensure there is no contact between another parent and the children may not be realistic and may provide false assurance.

- Adults whose role in a working agreement is to provide safety to children need to understand their role and be informed about what they are protecting the children from in order for the plan to be effective.

5 Conclusions

5.1.1 The interventions during the period from 31.12.16 until 2.1.17 included good and conscientious practice. There was little doubt that all those involved worked hard and tried to ensure that the situation was dealt with as thoroughly and quickly as possible, with the hope of securing the best outcomes for the children. As stated in the 2016 Triennial Analysis of SCRs, for many of the children who are the subject of an SCR, 'the harms they suffered occurred not because of, but in spite of, all the work that professionals were doing to support and protect them.'

5.1.2 It was not known in advance of Father's disclosure that Child K had been injured during the domestic incident on 31.12.16. No one had mentioned that she had been dropped, and she seemed well when seen by professionals. With hindsight her head was said to have been an odd shape, but this is not unusual in a new born baby, and Father's assertion that she had been premature provided some context around this.

5.1.3 The risks posed to the children in the household appeared to be around the accumulative risks due to domestic abuse and parental behaviours linked to Father's mental health and possibly Mother's drinking, rather than a serious physical assault on a baby requiring emergency action by agencies.

5.1.4 Good practice was evident, and has been outlined above. Most notably, Sibling was listened to, Managers were kept updated appropriately throughout 31.12.16 – 2.1.17, and there was prompt action to protect both children on 2.1.17.

[18] The Multi-Agency Response to Children Living with Domestic Abuse. Prevent, Protect and Repair. Ofsted, CQC, September 2017.

5.1.5 Learning has been identified about the response to Sibling's disclosures and this opportunity to consider out-of-hours practice has been valuable.

6 Learning and recommendations

6.1.1 The main issues that have been identified as learning from this case have been highlighted within the analysis section above,. The WSCB SCR Group, along with the lead reviewers, has considered the learning and has identified questions and recommendations for the WSCB in the area thought to be of most importance.

6.1.2 The Triennial Review states that 'good quality SCRs should incorporate particular characteristics. These include lessons learned which are clearly linked to the findings of the review; findings and questions for the LSCB, to promote deeper reflection on the lessons of the review, and leading to a response and action plan developed by the Board to address that learning; specific recommendations where there is a clear case for change, again with a response and action plan developed by the Board; and a strategy for dissemination and learning of the lessons that will reach relevant practitioners and managers within the Board's constituent agencies'.

6.1.3 The questions and recommendations for the WSCB are directly linked to the four learning areas of; the context, understanding of roles, strategy meetings, and written agreements.

Context and understanding of roles:

Recommendation 1

WSCB to consider how effective the current police structure is in ensuring that Warwickshire Police can fulfil their roles as stated in Working Together 2015.

Recommendation 2

Warwickshire police to consider whether officers directly involved in child protection investigations have sufficient participation in interagency safeguarding training, as set out in the WSCB Training strategy, in addition to the single agency role specific training provided in house.

Recommendation 3

Warwickshire police have informed the review that they have improved systems in place for ensuring Police Protection paper work is completed and shared with CSC. The WSCB should request that an audit is undertaken to ensure this is the case.

Strategy meetings:

Recommendation 4

WSCB to request a review of strategy meetings to ensure that any child protection concerns coming into the system, but not via the MASH, are meeting statutory requirements.

Written agreements:

Recommendation 5

WSCB to publicise to professionals the limitations of written agreements, using this case as an example.