Coventry Local Safeguarding Children Board

Serious Case Review concerning Child S

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SCR Chair: Prity Patel

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Section One – Introduction

1.1 What this review is about

Child S was born in the winter of 2010 at University Hospital Coventry. His birth was normal and he was discharged, with his mother, the following day.

Mother S relied on the help of friends to provide accommodation for her and her new son. At this time it was unclear who the father of Child S was; this has remained in dispute. Mother S appears to have led a somewhat nomadic and chaotic lifestyle which resulted in rare and sporadic visits to medical and other support services, for both herself and her son. Child S missed some mandatory health checks, although on those occasions he was seen by health professionals they reported that he was fit and healthy. Child S was not at any stage under the care of the local authority. Following the birth of Child S, Mother S continued to live a chaotic lifestyle, but was provided with permanent accommodation, in Coventry, in the early summer of 2011.

In the summer of 2013 Mother S resumed a relationship with a male who will be referred to as Male B. Male B had been convicted of assault against his former partner and had just completed a custodial sentence for those offences. It is not entirely clear what the status of the relationship between Mother S and Male B was, but he does appear to have been residing with Mother S and Child S on a part time basis.

In autumn 2013 Child S was left alone at home with Male B whilst Mother S visited a friend. On her return Male B stated that Child S had fallen down stairs and was unresponsive. Child S was taken by ambulance to Coventry Hospital and later transferred to Birmingham Children's Hospital. It was established that Child S had sustained a serious brain injury. Medical staff believed the injury was not consistent with the history described by Mother S, and invoked a section 47 investigation and also requested a child protection strategy meeting with the Police and Social Care. Despite the best efforts of health care professionals Child S died the following day from the injuries he had sustained.

Police arrested Male B and Mother S and an investigation commenced.

On 26th November 2013 the Independent Chair of Coventry Local Safeguarding Children Board (LSCB) agreed with a recommendation of the Coventry Serious Case Review Panel that this case should be the subject of a serious case review; under the requirements of the Local Safeguarding Boards Regulations 2006, section 5(1) (e) and (2).

1.2 Why this review was conducted

The statutory basis for conducting a serious case review (SCR) and the role and function of a Local Safeguarding Children Board is set out in law by: *The Local Safeguarding Children Board Regulations 2006, Statutory Instrument 2006/90*.

Regulation 5 requires the LSCB to undertake a review where –

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

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

Guidance for Local Safeguarding Children Boards (LSCBs) conducting a serious case review (SCR) is contained in Chapter 4 of 'Working Together 2013'.

The purpose of this serious case review is to establish the role of services and their effectiveness in the care of Child S, whether information was fully shared by the professionals involved, and whether procedures were appropriately followed. This process ensures that any deficiencies in services can be identified, and lessons learned to minimise the risk for another child. This should also reassure the public and prevent the need or demand for further external inquiries.

1.3 How this review was conducted

1.3.1 The Review Panel

Prity Patel was appointed by the LSCB as an independent chair. Ms Patel has over twenty years experience as a senior child protection lawyer in both the Private and Public sector. Ms Patel has overseen a substantial number of serious case reviews as an independent safeguarding consultant. The Chair reported directly to the independent chair of Coventry LSCB.

The lead reviewer/author was Stephen Ashley who has extensive experience in the compilation of high level reports into child protection issues, having been a senior police officer for thirty years and worked more recently for Her Majesty's Inspectorate of Constabulary. The author reported directly to Prity Patel.

Both parties are independent of Coventry LSCB in accordance with Working Together 2013 chapter 4 (9).

In addition, a review panel was established. Meetings were held at regular intervals and the panel was consulted about the progress of the review and were able to provide further information where appropriate. The panel included a senior manager from each of the key agencies listed below:

- Coventry Social Care.
- West Midlands Police.
- West Midlands Fire Service.
- Coventry and Rugby Clinical Commissioning Group.
- Coventry and Warwickshire Partnership NHS Trust (CWPT)
- University Hospitals Coventry and Warwickshire NHS Trust (UHCWT)
- Coventry Head of Safeguarding.
- Staffordshire West Midlands Probation Trust.
- Independent chair.
- Lead reviewer.

1.3.2 The Terms of Reference

This SCR has been conducted using a Partnership Learning Review model [1]. This methodology has been adapted to suit the circumstances of this review and is described in more detail in the next section. The methodology established how well systems have worked, and where they can be improved. It is not a criminal or disciplinary review designed to attach blame to individuals.

The period that the review covers, in detail, is the period from early summer 2010 to the end of 2013. This is the period that Mother S was pregnant with Child S, through the child's entire life, to the post mortem stage of early evidence gathering. Whilst this period was the basis for the review, contextual and relevant information falling outside of this period was also included.

The main subjects of this review are;

- Child S
- Mother S (Mother of Child S)
- Male B – male friend/partner of Mother S

The review was conducted in a way which:

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

This follows guidance contained in Chapter 4 (para 10) of Working Together 2013.

The review worked to terms of reference agreed with the chair of the Coventry LSCB.

The author took full cognisance of the first annual report of the national panel of independent experts on serious case reviews that was published in July 2014.

1.4 Methodology

The methodology agreed by the Coventry LSCB review panel for this review is based on a model consistent with the requirements of Working Together 2013[2]. It ensures that:

- A proportionate approach is taken to the SCR.
- It is independently led.
- Professionals who were directly involved with the case are fully engaged with the review process.

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[1] *Partnership Learning Review – a model for conducting serious case reviews in accordance with Working Together guidance.*
[2] *Working Together 2013 – this is a guidance document produced by the Government and can be found at www.gov.uk/publications.*

- Families are invited to contribute.

1.4.1 Chronologies and Management Reports

Agencies were asked to compile a report detailing their contacts with the individuals involved in this case, resulting in a combined chronology of events. In addition, each agency was asked to highlight areas of concern and of good practice. Where appropriate, an action plan, detailing those areas for improvement and the work being undertaken to address those issues, was included. All of the agencies that were asked for a report provided the information requested. In cases where further clarification was required agencies responded in an open and honest way. A list of the agencies providing reports is shown at appendix A.

In some cases, where contact with the subjects was minimal, agencies were only asked to provide a chronology and a covering report. In addition, the lead reviewer conducted a number of one to one interviews with front line staff and managers.

1.4.2 Learning Events

The Learning Events with front line practitioners are an essential part of the process. In the first Learning Event front line staff and managers that had had contact with Mother S, Child S and Male B were brought together for discussions around themes that had been identified from the chronologies and reports. This engagement provided a view of Mother S and Child S that enriched the information provided by agencies and ensured that all of the relevant facts were recorded. It was the most effective way of triangulating the evidence and ensuring that an accurate picture of the life of Child S was obtained.

This review seeks to determine **why** events occurred and not just record the facts of **what** happened. The front line view is invaluable in achieving this.

Whilst the details of discussions that took place were recorded, the comments made by the staff involved were non attributable and their comments are not quoted directly in this report. For many front line practitioners this was the first opportunity for them to discuss with other professionals their engagement with the family; it was pivotal to the learning from these tragic events.

The second Learning Event brought front line professionals and their managers back together. They were presented with the key findings and recommendations and provided with an opportunity to discuss them and comment on their accuracy and validity.

1.4.3 Family Engagement

Mother S was contacted by letter at the start of the process and informed that a serious case review would take place. No response was received. Neither Mother S nor Male B were asked to contribute or to be interviewed, following liaison with West Midlands Police and consideration of the legal position regarding the criminal investigation.

1.4.4 Parallel investigations

Throughout the period when this review was conducted West Midlands Police have been conducting a criminal investigation as a result of which Male B has been charged with murder and Mother S has been charged with neglect and allowing the death of a child. The senior investigating officer in this case was regularly consulted and briefed by the Police panel member.

The death of Child S was referred to the Coroner as a matter of course who is aware that this process is in place.

This report reflects the information available to professionals and the review panel at the time that it was written. There is a possibility that further information may arise as part of the criminal proceedings. If that is the case, an addendum to this case or a supplementary report will be published if required.

1.5 How this report has been structured

Following the introduction, section two provides a history of the subjects involved in this review. It attempts to understand the individuals and the nature and strength of their relationships.

Section three explains **WHAT** happened in the life of Child S. This section provides the detail about the contact that the various agencies had with the subjects. It focuses on the key events and explains **WHY** things happened and **HOW** they have changed since.

Section Four is an analysis of the evidence. It includes an analysis of how well professionals listened to the voice of the child, the key findings, areas that require some further improvement and good practice.

Section Five provides the recommendations that the review team believe are necessary to improve safeguarding in Coventry.

The final conclusion is, in effect, a summary and an evidence based view of the case.

This report has been written so that it can be read by the public without redaction. As a result the names of the main subjects are not used and there are no specific dates that might readily identify Child S, his mother or Male B.

Section Two – The Story of Child S

2.1 Mother S's Early Years

Mother S was born in Birmingham at the end of 1989. Mother S lived with her family and left home following a family dispute. Mother S was of Pakistani heritage and brought up in the Muslim faith. Initially she moved to a women's refuge that assists women who have suffered a variety of issues; including domestic abuse. It is believed that Mother S stayed at the refuge for several months, however exact timescales are unknown. Mother S states that she left home because she was being forced in to a

marriage that she did not want. The Police received an allegation of theft against her, made by her father, which was not substantiated.

In early summer 2010 Mother S registered with University Hospital Coventry and Warwickshire (UHCW) and informed them she was pregnant. Mother S stated she had met Child S's father whilst out in Birmingham and they were in an intimate relationship for about four or five months. It was during this time that Mother S fell pregnant with Child S. Although the alleged father was aware of the pregnancy, he had nothing to do with Mother S during the course of her pregnancy; or the birth or life of his son.

Mother S stated she would be moving to Milton Keynes with a new partner. In summer 2010 Mother S arrived in Milton Keynes and resided at a women's refuge, having been referred to them by a refuge in Coventry. Mother S stated that she had moved from Coventry where she had suffered domestic violence from a partner. Mother S received antenatal care in Milton Keynes but returned to Coventry to give birth.

Mother S is a difficult character to understand. Much of the information held by agencies relies on her version of events and was rarely verified. In particular she stated on a number of occasions that she was the victim of domestic abuse, but no agency has a record of any reported incidents. This was understandable given many of the organisations dealing with vulnerable people need to build trust if they are to help and support the individual. However, the version of events provided is often contradictory, and when taken together leave an impression that Mother S was adept at presenting herself, and her history, in a way that best suited her needs. This does not mean that there were no serious issues in her life, but the veracity of her account was, at times, in doubt.

2.2 The story of Child S and Mother S

Child S was born at University Hospital Coventry and Warwickshire NHS Trust (UHCW) in the early winter of 2010. The birth was normal and mother and son were fit and healthy. Mother and son were discharged the following day (Mother S having insisted that she was ready to leave the hospital), and went to reside with a friend. Mother S received the standard post-natal midwife visits, and there were no concerns raised.

In 2011 Mother S and Child S moved into a women's refuge where Mother S stated she had been suffering domestic and religious abuse at the hands of her partner in Milton Keynes. In the early winter of 2011 staff at the refuge informed Mother S that, due to her anti-social behaviour and a failure to follow refuge rules, she was required to leave the refuge. Mother S and Child S were dropped at a friend's house. The hostel made a referral[3] to Coventry Social Care. Social Care liaised with health visitors and the referral was treated as a contact[4] and Social Care took no further action.

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[3] *Referral* - Professionals in all agencies have a responsibility to refer a child to Children's Social Care when it is believed or suspected that the child; has suffered significant harm; or is likely to suffer significant harm. All referrals to Children's Social Care must be made in writing using the Multi-Agency Referral Form or CAF assessment. Further details can be found at: http://coventryscb.proceduresonline.com/index.htm

[4] *Contact*- These are the record of contacts by agencies or individuals that are received by Children's Social Care but fall short of a referral.

Mother S had contact with health visitors and the Housing Department over the months following her eviction from the refuge; nowhere were any concerns raised about Mother S or the health and welfare of Child S.

In early summer 2011 Coventry Housing Department arranged for Mother S to move into a two bed roomed terraced house in Coventry where they remained.

2.3 The relationship between Child S and his mother

It is difficult to get a picture of the relationship between Child S and his mother because professionals had relatively little contact with her and there is some contradictory evidence.

The day after his birth Mother S told staff that she wanted to be discharged and left hospital to stay with a friend. In post natal visits midwives saw no reason to be concerned; no additional needs were identified. Mother S stated that she did not have contact with the biological father of Child S. Whilst Mother S told health staff she had previously fled domestic violence, they believed she had mitigated the risk and there was nothing to believe it affected the relationship between mother and son. Health Visitors had a number of contacts with Mother S and her son over the next two and a half years. In total, health professionals saw Mother S on at least fourteen occasions in that time, which accords to the expected level of contact under the universal service provisions. At no point were any concerns raised around the relationship, which appeared normal.

Towards the end of 2012 and the first half of 2013 Mother S attended adult education classes and whilst she was in class, Child S was placed in an adjoining crèche facility.

The crèche staff state that Mother S and Child S had a normal parent/child relationship and at no point did they have any concerns or issues. Mother S was very attentive to Child S's needs and would share his likes/dislikes with the staff. Mother S showed an interest in the activities he had been involved in through discussions with the crèche staff. Mother S would ensure Child S had healthy snacks and nappies at each session. Staff remembered that on one occasion Mother S called a taxi as it was raining and she didn't want Child S to get wet. On another occasion while leaving crèche Child S became upset that he didn't have his toy cars that he had arrived with, so Mother S went back to the crèche to find them for him.

Other evidence relating to the relationship between mother and son comes from staff at a women's refuge where they stayed in the first few months of Child S's life. They commented at the Learning Event that Mother S had low level issues with her mothering skills and would leave Child S in his push chair for lengthy periods. These concerns were not considered serious enough to take any formal action.

The Police also had some engagement when called to Mother S's address in Coventry as a result of an anonymous report of a mother swearing at her child. The person reporting stated that this was not the first time. Police attended and found that Child S had smeared his faeces on a wall and Mother S said she had shouted and sworn at the child. Police officers found that Child S had been put in the bath by his mother and was physically unharmed. The house was in "good order" and consequently took no further action.

Mother S was poor at keeping appointments and missed several health checks with Child S. Mother S also missed immunisations and had to be 'chased' by medical staff to meet universal services[5]. Mother S did not always accept offers of help; either for herself or Child S, when it was offered.

When Child S arrived at hospital with a serious head injury Mother S was clearly distraught and spent her time beside his bed; talking to him and holding his hand. Her reaction to his death was entirely in keeping with 'normal' behaviour.

It is difficult to be sure just how strong the relationship between mother and son was. On one hand she presented as a good and caring mother, but her lifestyle and lack of engagement with support services was clearly not good for her child. It seems Mother S was able to present to authorities in a way that convinced them she was a mother who had a good relationship with her child and provided for his needs. The missed health appointments, reports by refuge staff and the anonymous call to the police suggest a different perspective.

2.4 What was Child S like?

Child S was born after an "uneventful" delivery and discharged into the care of his mother. There were no concerns for his health or welfare. In postnatal checks in the weeks after his birth midwives and health visitors reported that everything was normal and there were no identifiable concerns. Whilst more detail is provided later in the report around his history with health agencies, there was nothing 'out of the ordinary' when it came to Child S's progress. Child S was placed on Care Pathway 1[6] by health professionals, which is the level of universal care provided when there are no identifiable health needs.

At a fourteen week check the health visitor documented that Child S appeared "happy and healthy." At seventeen weeks the health visitor made a further physical assessment. Child S was; "a happy, smiling, well baby; gaining weight with age appropriate development".

At the next required health check at two years seven months old he was seen by a community staff nurse and assessed. It was recorded that all development was age appropriate apart from speech, which was unclear at times. Child S was documented as fit and well and all relevant assessments were satisfactory, apart from speech, which was recorded as "needing to be observed".

In addition to these checks Child S also attended his General Practitioner with a viral infection and Mother S took Child S to Accident and Emergency with a fever and sore throat. These two events were both events expected in a young child and did not raise any concerns.

The people who had most day to day contact with Child S, in professional terms, were the staff members at his crèche when he was two years old. Staff there reported that they had had no concerns with the development of Child S. He was a confident child who settled well into the crèche and interacted well with staff and other children. There was a lack of speech at that stage, this was not a concern, as he was still able to communicate effectively. He played alongside his peers and especially enjoyed

[5] *Universal services* – These are the child health care services that are available to all children and further information is available at www.gov.uk/childhealth
[6] *Care Pathway 1* – see appendix A for a description of the care pathway system.

climbing and playing in the garden. When Child S first joined the crèche he would regularly have tantrums and would throw himself on the floor and scream. The tantrums tended to occur when staff asked him to stop climbing, or to give toys back to other children. These tantrums could be controlled quickly with distraction techniques and the number of tantrums reduced over the months that Child S attended the crèche.

There is little evidence that Child S was anything other than a normal and healthy child. With the exception of some speech difficulties, there was nothing to suggest that his physical or emotional health was outside normal parameters.

2.5 The relationship between Mother S and Male B

Male B had a history of domestic violence stretching over a five year period. This involved violent assaults on his partner at that time; the mother of his children. In the summer of 2012 Male B was convicted of assaulting his ex-partner and placed on a Supervision Order. Male B breached this order later in 2012 by committing a further assault on her; he was put before the courts in early 2013 and was sentenced to 28 weeks in prison. Male B was released in April 2013.

At some point Mother S first met Male B and in 2013 when, following a contact over social media by Male B, the two resumed their apparent relationship.

The nature and status of the relationship between the two is unclear. Male B denied to probation officers that he was in a relationship and has described it to police officers as being an “as and when” affair. It does seem however, from various sources, that Male B was living with Mother S and Child S on a part time basis.

It has not been possible to establish how Mother S perceived the relationship with Male B and it would be inappropriate to comment further on this.

In autumn 2013 Male B was alone with Child S while Mother S visited a friend. On her return Male B informed her that Child S had fallen down stairs and was ill. An ambulance was called and Child S was transferred to University Hospital Coventry (UHCW). Due to the nature of his injuries Child S was transferred to Birmingham Children’s Hospital. Child S died the following day as a result of the head injuries he had sustained.

Section Three – Significant Events in the Life of Child S

3.1 Introduction

This section of the report looks at the significant events in the life of Child S. It describes what happened at those times and the interaction that various agencies had with the subjects. It highlights the critical issues. This section points out **what** happened and describes in more detail **why** these critical issues arose and what is being done about it. This section points the way to the analysis of events and the recommendations contained in the next two sections.

These significant events break down Child S’s life into four distinct sections. That is a period of nearly three years from the end of 2010 to the late autumn of 2013.

3.2 The first year

This section covers Child S's life from birth through to the point where he and his mother move into the house in Coventry where they lived, with a degree of stability, until Child S's death.

3.2.1 Introduction

In the first year of his life Child S left hospital with his mother and stayed initially with a friend of Mother S. This was not seen as unusual as this is common practice while the mother seeks a more permanent housing solution. Mother S and her son left the friend's home to move to a women's refuge, before seeking more permanent accommodation through Coventry City Council Housing Department.

Child S was to have relatively little contact with professionals throughout his life. The most significant contact for Child S was, as you might expect, with health professionals. The most critical period for any child is that first year and that is when he received the majority of that attention.

3.2.2 Provision of health care

Child S and his mother received universal health service provision throughout her pregnancy and during his life. The provision of health care to young children up to school is outlined in the Healthy Child Programme and this provides the foundation for universal health care. The purpose is to enable early identification of risk and need, through skilled assessment of children and families, to provide a personalised programme to the family's needs and choices. The programme starts in early pregnancy and continues until the child is nineteen. It involves a number of professionals including; midwives, health visitors, school nurses and primary care. These professionals work together through the various stages of the child and family's journey. This multi professional working should identify need, based on a holistic assessment and not just health needs. The programme consists of different pathways dependent on the assessment of that risk and need.

Child S and his mother were identified as having no additional needs, for the majority of his life, so the universal pathway of care (Care Pathway 1) was offered. It is standard practice to establish who the family unit are living with, whether there is a relationship in place and whether domestic abuse is an issue. For families who have no identified additional needs or risks the universal service health pathway provides the only engagement with statutory agencies up to school age; unless the family chooses to engage with children's centres, playgroups or nursery placements. If health services do not see the child it is unlikely that any other agency will be able to establish his health and wellbeing or identify opportunities for any additional support that may be required; unless mother asks for it.

There were three occasions where there were opportunities for health professionals and Child S and his mother to engage which were not taken up. They were:

At six to eight weeks of age a health review is offered, which comprises; a comprehensive physical examination of the child, review of feeding, general progress. It provides an opportunity for key messages about parenting and baby's health; including eating, weaning and accident prevention. A maternal health postnatal

examination is also offered. Mother engaged with health visiting but did not take Child S for his GP appointment at which the physical examination would have taken place. This had no adverse effect, as in later contacts there were no physical issues or significant risks identified. It would have provided an opportunity for a relationship to develop between mother and GP practice and for a statutory agency to examine Child S and identify any needs or concerns. There was no internal system within the GP practice to recognise and act on this lack of contact with Child S and his mother. There was no explanation given as to why these systems had not been developed. As a result of this case, the management company that are responsible for the GP practice have reviewed their systems and policies and are implementing a significant and SMART action plan to rectify this position.

The health visitor identified that Child S had not received this check and established that mother was evasive. She knew that she had a history of domestic abuse and appeared to be isolated. As a result she moved Child S to Care Pathway 2. This was good, diligent work by the health visitor. Unfortunately Mother S moved again, with her child, before any targeted action could take place. The health visitor provided a verbal handover to the new health visitor.

The second opportunity was in relation to immunisations and vaccinations; these are usually commenced at eight weeks of age, with a second and third immunisation at three and four months. Child S received his second vaccination at ten months of age after a delay in initiating the vaccination programme, with his 3rd vaccination being done at one year of age. This occurred because Mother S regularly failed to keep appointments and the fourth immunisation (MMR) was actually due at one year.

The third missed opportunity was when Child S did not receive the health review required by his first birthday, but usually undertaken at eight to ten months by the health visiting service. The purpose of this review is to assess Child S's physical, emotional and social needs, in the context of the family. It would include; predictive risk factors, provide parenting support, monitor growth, and health promotion. This again was an opportunity for Child S to have access to health care that was denied to him due to the behaviour of his mother.

The health visitor saw Mother S and Child S at their newly provided bed and breakfast when he was fourteen weeks old. The health visitor documented that Child S appeared "happy and healthy." She noted that she observed positive interaction between mother and baby, and that Child S had not yet had his primary immunisations that should have been done at the GP's surgery. She proceeded to discuss registering with a local GP, and booking an appointment for Child S to commence his immunisations.

The health visitor saw Mother S and her son again at home when Child S was aged seventeen weeks. Mother S reported that she had changed GP and commenced Child S's immunisations. The health visitor carried out a physical assessment. The health visitor's report states that Child S was a happy, smiling, well baby; gaining weight with age appropriate development. Mother S presented appropriately and reported that she had no contact with Child S's father and he had not had contact since the beginning of the pregnancy. The health visitor recalled that she had no concerns at this stage as Mother S appeared to be caring for Child S appropriately and used support to be re-housed with no plans to resume an abusive relationship. Child S was returned to Care Pathway 1. It seems that Mother S was able to convince the health visitor that she would now follow the required processes for immunisations.

Ultimately returning Child S to Care Pathway 1 had no significant effect on his future, since he remained apparently fit and healthy through to his health checks in his third year. However, it again seems that the professional took what she saw at face value and accepted Mother S's word that she would continue immunisations and see the GP. This lack of liaison between the professionals must be improved. The health visitor at this point dealt with the child as presented and there was no evidence to suggest that the child was in danger, despite the missed appointments.

Despite these three missed opportunities and the return to Care Pathway 1, it is important to identify that in each engagement with health professionals – including; a GP at the time mother sought a DNA test, health visiting, a practice nurse in the GP's surgery and a community staff nurse working at a children's centre - all professionals have identified a good relationship between Child S and his mother; he was healthy, clean and well presented; his development was age appropriate; he was taken appropriately by his mother to the local A&E department with an upper respiratory tract infection. There were no concerns identified by any professional. Health visiting clearly identified and recorded protective factors including; warm parenting with an affectionate bond of attachment between Child S and his mother as the primary care giver.

A child centred approach from professionals would include the principles that the child has the right to the highest standards of health care, including immunisations, and that missed appointments would be actively followed up. Professionals need to ensure that parenting styles and behaviours (for example not bringing a child to appointments) that may disadvantage the child, are managed and acted on.

Poor attendance for immunisations and appointments, and a failure to engage with healthcare, are behaviours that should cause health care professionals to be suspicious of neglect.[7] In this case three appointments were missed and this failed to spark further professional curiosity or consideration as a danger signal. Given the high number of missed appointments that take place in paediatric care (15% of total paediatric appointments are 'did not attends') three appointments in itself would not be particularly unusual. Whilst physical checks never suggested any abuse was taking place a better system of understanding missed appointments should be put in place.

Health visiting services has changed its system to ensure there is continuity of the health visitor as the lead professional. The recording of children failing to attend appointments, will enable health visiting services to conduct follow up visits with families and get a full understanding and history of the family. This will enable better informed decision making. Community midwifery services have also mirrored this approach, which has improved communication between professionals. As a result, local intelligence is becoming much more informed and this is reducing risk amongst vulnerable families.

This is being strengthened by the model of universal service provision for children under five, which provides a comprehensive health and welfare package delivered by health professionals in partnership with children's centres. This is being rolled out across the city in 2014. It involves the use of co-located services including; GPs, health visiting, midwifery, children's centres, and children's services. This will enhance information sharing and more effective multi-agency working.

[7] (RCGP / NSPCC Safeguarding children and Young people: A toolkit for general practice 2011).

3.2.3 Mother S and Child S leave the women's refuge

Mother S and her son were asked to leave the refuge when Child S was less than two months old, because of repeated breaches of the refuge conditions of residence by Mother S including her failure to engage in housekeeping tasks and allegations of her intimidating other residents.

Staff had worked with Mother S to ensure she understood the license agreement and house rules on the day of arrival. Risk assessments and safety planning were also carried out. Staff at the refuge ensured Mother S had registered with a doctor and did what they could to help her meet appointments with health professionals. Mother S was provided with baby equipment and informed how she could get financial support.

It seems that Mother S did not want to be in the refuge and used it as a 'stepping stone', as she had done previously. Mother S did not co-operate or follow the rules; she was reported as being abusive and disrespectful. Despite this, staff state they continued to offer all of the help and support they could. The refuge has a responsibility to more than one family and it is entirely reasonable that the staff should reach the conclusion that Mother S and her son would have to move on. In doing so they tried to ensure that accommodation would be found, but again Mother S refused their help.

Staff did not identify any signs of abuse or neglect towards Child S but were concerned about the fact that she left the baby in his pushchair for protracted periods. Staff stated that they were sensitive towards the needs of the mother and child and regularly offered practical support to appointments and made 'safe and well' telephone calls to her, checking she and baby were in good health.

When staff at the refuge decided that Mother S's position at the refuge was untenable they followed internal procedures and discussed with her how they could assist her to find alternative accommodation. She decided instead to go to a friend's house. Staff from the refuge took her to an agreed location. A friend of Mother S met them and following threats and abuse towards the staff they left Mother S and her son with the friend and departed.

On the face of it Mother S and her son were fleeing domestic violence and after a short stay were asked to leave the refuge. They were effectively dropped at a street corner. No further protective measures were put in place. After a short period a referral to Social Care was made.

It is clear that staff had difficulty in managing Mother S. They had some concerns around her mothering skills. It is unclear whether staff discussed with Mother S what her long term plans were or whether the support of Social Care might be appropriate. Finally, when staff asked Mother S and her son to leave the refuge there was a four day gap before a referral was made to Social Care by a member of the refuge staff. This review has spoken with the commissioning service, received a written report and been in direct contact with managers, however it was not possible to establish why there was a delay and there is no documentation providing a rationale.

Staff should have referred to, or asked for advice from, Social Care at an earlier stage. They considered calling Mother S the day after her move, to ask if she and her child had found accommodation; they should have done so. In particular, the organisation

must ensure that staff are more specific about the information they record about the child and the behaviours he/she exhibits.

The women's refuge has accepted that there were failings in terms of recording practices, and in particular the way in which Mother S left the refuge to an unknown location. The delay in the referral or earlier liaison with Social Care was caused by a failure of the organisation's systems and a lack of staff training. Whilst the refuge engaged in some training, the training packages available through the Local Children Safeguarding Board (LSCB) should have been accessed. Staff felt intimidated, and were fearful of Mother S and her friends. As a result, staff failed to make Child S the priority and allowed him to leave with his mother, unclear about how his welfare needs would be met. It was clear, from comments made by staff during the course of the review, that Mother S leaving the refuge was seen as a relief by staff and residents. Staff did not consider the possible effect on Child S of this action.

Whilst this is a charitable organisation it works under a contractual agreement with Coventry City Council Strategic Commissioning Team. Domestic violence and abuse supported accommodation services have recently been re-tendered and the organisation has been successful in securing the new contract in partnership with another local organisation. The new contract contains detailed requirements around training and safeguarding arrangements. This should ensure that staff are trained to the right standard and ensure accurate record keeping and referral processes. If this contract had been in place in 2011 the refuge would have breached requirements.

The local authority must continue to satisfy itself that the procedures, policies and training of staff in that organisation are at the right standard to ensure children entering the refuge are properly cared for. When a family are moving out of the refuge transitional arrangements must be in place to ensure that the safety of the child remains the priority.

3.2.4 Contact with Children's Social Care

On leaving the refuge Mother S initially resided with Child S at a friend's house and almost immediately applied for accommodation through Coventry Housing Department. They accepted their legal responsibility to house them and placed them in bed and breakfast accommodation.

A health visitor conducted a visit to Child S at the bed and breakfast accommodation when he was ten weeks old. She found nothing unusual or concerning and Mother S interacted well with Child S. The health visitor encouraged Mother S to take Child S for his six week health check and immunisations at the General Practitioner's surgery. The health visitor showed particular determination in ensuring that she traced Mother S to carry out these checks.

The health visitor and social worker liaised as a result of the referral they had received from the women's refuge. They agreed that the matter would be classed as a 'contact' and not a 'referral'. As a result, Social Care made no further assessment.

The health visitor attempted to communicate with family support workers but there appears to have been a breakdown in communication; no contact took place.

The health visitor and social worker had a detailed conversation which was correctly recorded.

At this point the facts were that a health visitor had conducted health checks; Mother S and her son were healthy, being housed and financially stable. It is perhaps not surprising that the good health of mother and child, without concerns around parenting or physical abuse, provided sufficient evidence for this case to be closed to Social Care. Thresholds[8] to engage an initial assessment[9] would not have been reached at that time or even now. That is because there was no evidence that Child S was at risk of physical or emotional abuse.

However, there appears to have been no investigation by the allocated social workers or health visitors as to why Mother S was at the refuge or what her history of domestic abuse amounted to. Further investigation may have provided sufficient grounds to initiate a Common Assessment Framework (CAF)[10] and provide Early Help[11] but neither party believed that Child S was at risk.

3.2.5 The Common Assessment Framework

The health visitor or social worker should have given more consideration to the Common Assessment Framework (CAF) and how Early Help may have been provided to the family. The CAF can be invoked by any agency. There appears to have been confusion as to who would take responsibility for a CAF and since the health visitor had spoken to a CAF coordinator, there was further confusion about whether a CAF had actually been initiated. In any event, no agency or professional did initiate the process. Appendix C describes the criteria for the initiation of a CAF. There is no doubt that Mother S and her son reached the criteria under level two, to receive Early Help.

The reason why the CAF was not initiated centres around poor communication and information sharing. There was no conversation between health visitors, social workers and the children's centre to discuss the use of a CAF. This is partly caused by some confusion between individuals. The health visitor states they left messages for a family support worker at the children's centre but this was not responded to and there are no records of messages being left. The social worker was not the lead professional and having spoken to the health visitor left the initiation of a CAF to her. There was further confusion because the health visitor states she did speak to a CAF coordinator, who informed her that Mother S was receiving support to obtain a permanent housing solution. This led to confusion for all involved; they simply assumed this meant a CAF had been put in place by the coordinator.

It has been accepted that the CAF process could have been used to put more Early Help around the family. It did not occur because no professional took responsibility for initiating the CAF, assuming that others would do that. There was no system in place for professionals to ascertain what progress had been made. The system relied on professionals physically visiting other professionals or at the least relying on phone calls. The position has been rectified by the introduction of an electronic system that records all CAF initiations and actions.

All of the professionals involved should have understood what could have been put in place, but heavy workloads and a complex initiation system resulted in no one taking

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[8] *Thresholds* - refers to the point at which Children's Social Care accept the referral and begin work on an initial assessment. More information can be found in the 'Threshold and Practice Standards' at www.coventrylscb.org.uk.
[9] *Initial assessment* – Once a referral has been accepted and meets the required threshold a social worker visits the family to undertake an assessment of their needs.
[10] *Common Assessment Framework* – See Appendix C for a description of allocation and allocation criteria for a CAF.
[12] *Early Help* – this is the support that is offered within the CAF process and may consist of training or support to be housed. In many cases there will be a multi-agency 'team around the child' to determine the most appropriate support.

responsibility and getting a grip. In effect each professional dealt with their own responsibilities, ensured and triangulated their belief that Child S was safe, happy and healthy with other professionals, and moved on to their next task. No professional took the lead.

A second opportunity was missed to engage Mother S in a CAF when she later attended an event where children's centre staff were present. Whilst staff completed documentation regarding Mother S and her child no assessment had been made of Mother S and her son; as a result there was no pro-active approach to provide her with support. It should be stressed that this occasion did represent an opportunity but was not a pro-active approach by Mother S to seek support but could have led to further engagement with universal services.

One of the purposes of the children's centre is to identify where a family may need Early Help and engagement in the CAF process. It is of concern that record keeping appears to be sporadic and as a consequence it is difficult to establish why systems failed to identify that Mother S and her son may have been suitable candidates for a CAF. Whilst Mother S did not ask for support (except with housing and later nursery care), the facts were there to raise concern.

It is unclear from this case how children are risk assessed at children's centres and how that process of assessment is led. This system has since been strengthened in 2013 with the implementation of the Acting Early Demonstrator sites and these now extend across 6 children's centres. Weekly integrated multi agency meetings are held and include social care, health visitors, midwifery, children's centre staff and CAF coordinators, which provide an opportunity and support to consider any threshold discussion and early help options. They also provide a forum for in-depth review of cases where information sharing protocols and processes are in place. Accurate records of these meetings are maintained and include actions which are timely and outcome focussed and linked to named professionals and regularly reviewed. This review reinforces the use of the CAF as the assessment of need for Early Help in children's centres.

The reasons why this service failed to engage with Child S are varied and caused by a combination of factors. Staff relied heavily on new entrants being assessed by other agencies and their needs clearly identified. Initial contact with a new client resulted in a registration form being completed. This form provided little detail and is basic in nature. There does not appear to have been any cross referencing with other agencies. In effect, the parent only provides the information they wish. As a result staff worked with limited information, in a difficult environment, where resources are stretched. The recent review referred to at section 3.2.2 has ensured that staff are now working with other services to improve information sharing.

Overall Social Care, health visitors and the children's centre missed an opportunity to engage Mother S and Child S in some form of Early Help programme. This occurred because professionals, including children centre staff and health visitors, did not have the training to fully understand their role in providing Early Help, or the support of systems that enabled them to check information and establish what levels of support were in place. This lack of knowledge was made worse by poor communication and a lack of formal meeting structures that resulted in assumptions being made about levels of support that were neither verified or accurate.

Since the death of Child S there have been significant changes in health visiting services in Coventry. It had been recognised by the Department of Heath that there

had been a significant under resourcing of the health visiting workforce (this is a national issue). As part of the health visiting implementation plan, the workforce will treble by 2015. A citywide review has recently been undertaken and the health visiting service is to become co-terminous with the seventeen children's centres within the local authority. The health visiting service is now working geographically, rather than as a registrant population, to individual GPs.

The Local Safeguarding Children's Board has held a 'Development Day' and agreed a summary document describing Prevention and Early Help that is provided to front line practitioners. A meeting of key senior leaders from all the relevant agencies in June 2014 discussed how agencies could ensure the effectiveness of Prevention and Early Help. It was also agreed that a session would be arranged for all LSCB members to discuss Prevention and Early Help and for agencies to identify and agree how this work can be taken forward. It is essential that the LSCB continue to monitor progress in terms of restructuring and ensure that agencies coordinate their responses to safeguarding.

3.3 A Permanent Home

This period covers the period when Mother S and Child S moved into permanent accommodation in Coventry. They moved into this accommodation in early summer 2011 and remained there until the death of Child S in autumn 2013. This period provided the most settled period in their lives. They were in permanent accommodation for a period of two years and four months; this compares with at least five addresses that Mother S and her son had resided in over the first six months of Child S's life.

3.3.1 Finding a permanent home

Once the option of friends and a women's refuge were no longer available Mother S turned again to the Housing Department who accepted their responsibilities. Following a brief period in bed and breakfast and temporary accommodation, a registered social landlord (RSL) on behalf of the Council provided permanent, suitable accommodation in Coventry.

It is clear from the evidence provided, that Coventry City Council complied with all relevant legislation and local guidance. In particular, reasonable enquires were made in line with Part 7 of the Housing Act 1996 and local guidance. Mother S was provided swiftly (same day) with interim accommodation (bed and breakfast) following her homelessness application under section 188 of the Housing Act, and moved to more suitable two bedroom accommodation two weeks later.

Housing officers conducting enquiries into homelessness appear to be fully cognisant of their safeguarding responsibilities, but in this case stated that they were given no indication that a child was at risk, except by way of homelessness; which they dealt with.

Whilst there does not appear to have been any reason for housing officers to believe there were any safeguarding issues for Child S, the circumstances surrounding him and his mother may have prompted some concern. A young homeless mother, moving from address to address in a haphazard manner, often quoting domestic

violence as a reason for a move, may have given cause to submit a referral or make contact with Children's Social Care. The fact is that officers dealt with the issue efficiently, from the perspective of their own agency, and it is to their credit that they ensured Child S and his mother were given appropriate accommodation quickly; they did not apply a more inquisitive approach to determine whether they should involve other agencies.

The City Council Housing Department has acknowledged that at the time of this event referrals to Social Care were only made when the housing options officer considered a child to be at risk. These officers were not always confident that the client fitted the referral criteria.

Following a review the Housing Department have reconsidered their instructions to housing officers and consideration is now being given to ways in which Social Care can receive information about a family where there may be safeguarding issues. Particular consideration is being given to those cases where domestic violence is an issue; even where they are non-specific, or below the threshold for a full referral.

Housing officers behaved in a reasonable and professional way when dealing with Child S and his mother.

3.3.2 Police contact

In the winter of 2011 Mother S was arrested for shoplifting and cautioned. In the early summer of 2011 the Police assisted Mother S when she was locked in her bathroom, but also found cannabis on the premises and Mother S was cautioned. Neither of these events triggered concern for Child S and no referrals were made.

These two incidents are minor in nature but are worthy of note. The incident where Mother S was locked in the bathroom appears minor, the fact is that the officers identified that Mother S was using drugs in the presence of her child, and it is not clear whether they considered the effect on Child S, or indeed whether he was considered at any point in the decision making process.

The shoplifting incident again raises questions about where the welfare of Child S may have been considered. There is insufficient information to draw conclusions as the information was no longer available, but it appears that Child S may have been with his mother when she was engaged in crime and potentially she used him in the commission of that crime. There were no referrals to Children's Social Care.

It has not been possible to establish what the detail of these cases was or why referrals were not made as records are no longer available. It seems that West Midlands Police safeguarding training did not alert staff to 'think child' at every opportunity and are addressing this in current safeguarding training packages.

In the summer of 2013, the Police received an anonymous call from a neighbour of Mother S stating the she could hear a child being shouted and sworn at, and that this had happened before. The call taker graded the call as 'immediate disorder'. The attending officers checked the premises and Mother S explained that Child S had smeared faeces on a wall and she had shouted at him. Child S was at this point being cleaned in a bath and the officers spoke to him and also checked the house to ensure there was sufficient food and that the environment was suitable for a child. They described the house as being; "presentable, clean and tidy".

This was the only confirmed time that West Midlands Police had direct involvement with Child S prior to his death. They do not refer to any other person being present in the premises. This event occurred before Mother S and Male B's relationship had resumed. It should also be noted that this interaction occurred at about the same time as Child S received his two and a half year health check. At that check he was found to be healthy, and there were no concerns for his welfare.

The officers did not speak with the original caller to establish if there were any further concerns; this should have been done, but the caller had not given details, so this was particularly difficult. The officers who attended this incident have explained that whilst they did ensure that Child S was safe and well they did not believe that the incident met the threshold to report the matter to either Social Care or the Police's child protection officers. West Midlands Police have acknowledged that at the time of the contacts with Mother S and Child S they had recently undertaken considerable changes to structure around child protection teams and the processes that operational officers were expected to follow when dealing with safeguarding issues. In particular, the referral processes, either through internal process or direct reporting, were causing some confusion to front line officers. None the less the officers acted responsibly in listening to the needs of Child S and no action they took impacted on the final outcome.

3.3.3 Lock outs

During this period Mother S locked herself out of her premises on four occasions. On two of those occasions the Fire Service attended to gain entry to the premises and on the other two occasions the registered social landlord (RSL) arranged entry. The RSL did not regard the 'lock outs' as unusual because at this time the design of the door locking mechanisms meant that when the front door shut it automatically locked and entry could not be gained without a key.

The Fire Service or the RSL did not link these incidents. No safeguarding concerns were raised although Child S was locked in the premises on these occasions.

Whilst changes to safeguarding training may have resulted in greater awareness about the significance of repeat calls, the fact is that the calls to the Fire Service would have been unlikely to meet threshold levels required to trigger engagement from any other agency. As a consequence, the fact that the Fire Service or the RSL did not connect the calls and escalate the issue, had no effect on the final outcome for Child S.

3.4 Male B

This section deals with Male B, his history and contact with Child S and his mother.

3.4.1 The history of Male B

Male B had a long history of domestic abuse against his former partner. In summer 2012 Male B had been arrested for assault charges against her and he was charged and put before the court.

The Probation Service prepared a Pre-Sentence Report (PSR)[12] and Male B was sentenced to a Suspended Sentence Order with two years supervision, a requirement to attend the Integrated Domestic Abuse Programme (IDAP)[13] and a sixteen week custodial term that was suspended. The Probation Service began supervision later that month and began the preparation for the IDAP.

Upon commencement of the supervision by Probation of Male B a full OASys (National risk assessment tool) was completed, detailing plans for supervision and risk management. The assessment stated that Male B posed a risk to identifiable children due to his violence towards his former partner. Risk to children was however identified as being low because he had not committed offences with children present and there was no evidence of abuse by him against children.

A Risk Management Plan was prepared to outline all measures in place, and included reference to: the Coventry Police Domestic Violence Unit, Coventry Social Care, completion of IDAP, the provision of a Women's Safety Worker and regular reporting for supervision.

Most aspects of this case were well managed for example, timely completion of the referral to the Integrated Domestic Abuse Programme, and timely completion of assessments. There were mistakes made with regard to some internal issues but none that would have affected this case. These issues are being dealt with by an internal review.

Supervision took place over the second half of 2012 and Male B was seen weekly. The offender manager stated that he was satisfied that Male B was not living with his children and was aware he was living with his father; this was not physically checked.

In early 2013 Male B was remanded into custody following a further assault upon his ex-partner. In spring 2013 Male B was found guilty at trial, and the suspended sentence was activated, with a custodial sentence totalling 28 weeks. At this stage the IDAP requirement was removed. When the Court removed the requirement for the IDAP they effectively removed any form of rehabilitative work and this should be addressed.

In Spring 2013 Male B was released to his father's address on a three month licence, which expired in mid-summer 2013. Given that Male B had no convictions against children, and his offending had not taken place in front of children the Probation Service considered it would be disproportionate to attach conditions to this licence preventing Male B having contact with children. It is acknowledged that a condition regarding disclosure of intimate relationships may have been proportionate and could have been considered. This would have meant that when being interviewed by the offender manager he would have been required to disclose whether he was in any relationships. This is a common licence condition.

Whilst there is nothing that the Probation Service could have done to affect the outcome in this case the Service has, under its Effective Practice Strategy, adopted an approach that encourages peer review and case discussion. This approach incorporates consideration of domestic violence issues. The Coventry Probation

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[12] A pre-sentence report is completed by the Probation Service to assist magistrates and judges in the sentencing process. It gives details of home circumstances and areas that may be relevant.

[13] This programme is conducted over a two year period and involves regular attendance at classes and one to one counseling sessions with the offender whose progress is recorded and monitored.

office has held sessions on key practice themes, including those issues arising from this review. These sessions are ongoing and are being developed across a range of areas.

Coventry Probation undertook a child safeguarding audit in 2014. The findings of this report are not published at this time, but the issue of "professional curiosity" to prompt action appears to be a prominent learning point arising from the draft results.

The Probation Service have acknowledged that there were some errors and omissions from their own policies. These did not affect the outcome in this case and are not pertinent to it. They were identified as a result of this case and are being addressed.

It is clear that the relationship between Mother S and Male B began as a short term one at some point in 2011 and this was long before the Probation Service engagement with Male B.

The relationship did not resume until mid-summer 2013 at which point Male B's licence had expired[14][15]. So the whole period that Male B was under the supervision of Probation Service falls outside of the time when he was in the relationship with Mother S. As a result any home visit would have been to Male B's father's address and any Social Care involvement would have been to Male B's ex-partner and children.

3.5 Autumn 2013

This section deals with the circumstances surrounding the final days of Child S's life.

3.5.1 Child S's fatal injury

In the autumn of 2013 Mother S called an ambulance to her home. Child S was found to be suffering from a serious head injury.

Child S was taken by ambulance to the University Hospital Coventry and Warwickshire (UHCW) accompanied by his mother, who stated that he had fallen down stairs at home. Male B remained at home and did not attend the hospital. Child S was exhibiting signs of profound neurological damage upon his arrival at hospital. It was clear when Child S's arrived at UHCW that he was gravely unwell.

Child S was transferred to Birmingham Children's Hospital (BCH) later that day because of the nature and seriousness of his injuries. Whilst Child S was in transit to BCH, the results of his CT scan were revealed to display diffuse axonal injury. This ~~was not in keeping with the hi~~story offered by his mother. Child S's condition had

[14] The introduction of the Offender Rehabilitation Act (ORA) 2014, on 1st February 2015, sees all offenders who are sentenced to more than a day and up to two years imprisonment, subject to 12 months supervision. This is delivered through a combined licence period and Post Sentence Supervision (PSS), as defined by section 20 of the ORA. The licence period and PSS will always equate to a 12 month period. The licence is enforceable by executive recall and the PSS is enforceable through the Magistrates Court.

[15] Had this legislation been in place at the time of the Child S case, Male B would have been released on a 12 months supervision period, as opposed to 3 months. This would have allowed more in-depth offender management oversight, which would have included offence focused work around Domestic Violence, restrictions on residence and other standard licence conditions.

deteriorated in the ambulance; his pupils had become fixed and dilated. Following a review of the scan Child S was taken straight to the operating theatre for emergency surgery.

On receipt of the scan results, staff at both UHCW and BCH became concerned that the injury may not be in keeping with a fall down stairs. A nursing sister contacted Coventry Emergency Social Care Duty Team and gave a background history of Child S's admission to BCH. She spoke to Social Care duty worker who confirmed that Child S was not currently a child protection case open to them. The sister also contacted West Midlands Police and informed them of Child S's admission. An Inter agency referral form was completed and faxed to Social Care. The Trust child protection documentation was completed and the Trust child protection nurse was notified of Child S's admission.

Following surgery, Child S was taken to the paediatric intensive care unit. He remained sedated and intubated. Despite the efforts of medical staff Child S died the following day from the injuries he had sustained.

All professionals demonstrated a high degree of awareness and competent application of local safeguarding procedures. There is also evidence of necessary information sharing with all other relevant agencies about Child S's situation. Liaison between agencies was good.

Later the same day both Male B and Mother S were further arrested on suspicion of murder. In Autumn 2014, following a Police investigation, Male B was charged with murder and Mother S with neglect and allowing Child S's death.

Section Four – The analysis

This section considers the evidence that has been gathered and describes the main issues that have been exposed as a result of this review. It describes: the weight given by professionals to the voice of Child S; the key findings that require attention; areas for further improvement, building on work already underway; areas of good practice that have been identified.

4.1 The child's voice

There was considerable evidence that, on the majority of occasions, individuals and agencies listened to the voice of Child S. In cases where the voice of Child S was not heard or considered, remedial work is being undertaken.

It is important that agencies put the child at the centre of their work. Whilst described as the voice of the child this is a far reaching requirement. When coming into contact with a child, professionals should ask themselves how their actions will support and protect that child. It is more than physically listening to a child; it is about observation, professional curiosity and an understanding of the signs of emotional or physical abuse.

In this case all of the agencies had a picture of Child S. It was not one that raised concern. There is evidence that he was seen, checked and spoken to and at no point did any professional raise any concerns about his health and well being. This review

could find no evidence that any signs of distress were missed or ignored by professionals.

Good examples of individuals and agencies being particularly adept at considering the voice of Child S were:

- Midwives and health visitors ensured that they undertook health checks as prescribed under the Healthy Child programme. This ensured that Child S was healthy and, by his two and a half year health check, had received all his immunisations.
- Police officers attending the home of Child S in response to a call from neighbours ensured they checked Child S, spoke with him and undertook a check of his living environment.
- Crèche staff at the Adult Education Service ensured that they kept a record of Child S's behaviour and were able to identify key behaviours suggesting a healthy child. This demonstrated an understanding of the significance of their role in ensuring the safety of the child.

Those occasions where there was insufficient weight applied to the voice Child S were:

- When police officers attended the Coventry address because Mother S was locked in the bathroom, they found drugs on the premises but didn't consider the effect this might be having on a baby.
- When Mother S was asked to leave the women's refuge it was unclear whether consideration was given for the circumstances Child S would find himself in.
- The visit to the GP for paternity testing did not result in a consideration of Child S's position. This issue is being addressed through action plans put in place at the surgery.
- Housing officers provided accommodation based on need but failed to understand the effect such a transient life could have had on a child.

4.2 Key findings

4.2.1 Overall Finding

This report has not found evidence that any agency or professional in Coventry could have prevented the death of Child S. This review has highlighted a number of areas where agencies in Coventry can improve their systems and work more effectively together; but these improvements would not have affected the final, tragic outcome.

In any case where systems are analysed there would be an expectation that areas for improvement might be found; that is true in this case. The rest of this section provides findings that point towards the changes that need to be made. The critical question is whether the system failed in such a way that the death of Child S would have been prevented if it wasn't for those system failures or weaknesses. There is sufficient evidence to be clear that Child S did not die because the system let him down.

Mother of Child S stated on a number of occasions that she had suffered domestic abuse; although there is no agency in Coventry or Milton Keynes that has a record of any specific incidents. Early Help intervention aimed at educating her and providing support may have altered her behaviour; but there is little evidence from her previous history that she would have willingly engaged.

It should be noted that the mother began her relationship with Male B as a result of her association with Male B's previous partner, who he was twice convicted of assaulting. There would seem little doubt that she would have known of his previous violence, but for whatever reason chose to ignore it. Given Mother S's history of selecting support according to her own need, it seems unlikely that Mother S would have engaged in any support that affected her lifestyle.

The facts that support this finding are:

- None of the agencies were aware that Mother S and Male B were in a relationship.
- No agency had any grounds to be aware of that relationship.
- No agency had powers to influence the relationship even if they had known about it.
- Missed opportunities to engage Early Help occurred before the relationship between Male B and Mother S had started.
- Male B had served out his prison sentence and was in effect 'off of the radar'.
- Mother S was adept at avoiding agencies when she wanted to.
- Professionals were presented with a mother and son who were happy and healthy.
- There was no evidence presented which suggested to professionals he was being abused.
- Agencies fulfilled their statutory responsibilities.
- There is no evidence that any agency, or individual within it, could have foreseen the final tragic outcome.

4.2.2 Early Help

There were occasions when agencies missed opportunities to provide support to the family. Early Help provision was not provided, and the Common Assessment Framework was not fully utilised.

Over the course of Child S's life there were a number of times when agencies had contact with both him and his mother. On the majority of occasions that front line practitioners engaged with them, they did so professionally and in accordance with their own policies and procedures. However, the purpose of this review is to examine where the system can be improved. The missed opportunities detailed below highlight that agencies did have chances to put more support around Child S. It should be noted that these are not major failings by either the system or individuals, but taken together point towards areas that need to be improved. There is no evidence that if any of these missed opportunities had been taken, the final outcome would have been affected.

In particular the following occasions provided opportunities to engage and support:

- In 2008 Mother S left her family home and informed police that she was under pressure to engage in a forced marriage. The officers provided minimal support to her, despite having good processes and resources in place.
- The liaison between GPs and health visitors was not as effective as it might have been. The opportunity to have joint case meetings was not in place, and there were few opportunities for health professionals to share information and identify risk.
- Housing officers followed procedures and complied with statute and policy but did not consider whether, given Mother S's history, a referral should be made to Social Care.
- Children's centres did not identify that Mother S and her son were a case that merited Early Help and the initiation of a CAF.
- Consideration of all of the information known about Mother S should have led to a CAF being triggered for Child S and his mother.

The LSCB has a clear responsibility, set out in Working Together, to monitor and assess the effectiveness of Early Help. In addition, the Coventry Improvement Board is currently dealing with the development of Early Help across the city and monitoring it rigorously. The Safeguarding Board is developing its capacity to evaluate the impact of Early Help on outcomes: this is a significant piece of work and should continue to be developed.

4.2.3 Tracking the child

The systems in Coventry are less effective when individuals who need support do not pro-actively engage with agencies; either deliberately avoiding contact or living a chaotic and nomadic lifestyle. In this case Mother S sought the minimum of help from agencies, rarely engaged with them, and made it extremely difficult for front line professionals to understand the needs of the family and support them appropriately. Procedures need to be reviewed to understand this problem, and put in place appropriate systems to track families and provide appropriate support and safeguarding measures.

There are numerous pathways that enable those at risk, or who are vulnerable, to seek help and protection. Those systems work on the basis that those in need will be identified by professionals, who will be able to engage with them and provide the support they need.

In this case Mother S led a chaotic and at times nomadic lifestyle. Mother S's lack of engagement resulted in professionals not identifying that Child S was a child; "who MAY have poor life chances" (see CAF information in appendix C) and should have been made the subject of a CAF.

Front line professionals at the Learning Events discussed how time constraints and other responsibilities reduced the opportunities to engage with her. Professionals were also concerned that without a strong evidence base for taking positive action services could become overwhelmed. There was however an acceptance that full parental consent should not be necessary before professionals intervened.

It is clear that in this case Mother S engaged when she felt like it. On some occasions she would keep appointments and on others she failed to attend. If she needed or wanted something she would ask (for instance; housing, further education and nursery facilities), but if it did not suit her, she would state she had no need for support.

In this type of case, where an individual chooses not to engage with services, it is essential that agencies are pro-active and do not allow the lethargy of the adult to prevent agencies supporting the child, even where the responsible adult does not want or request that help.

Paediatrics sees the highest levels of 'did not attends' in the health service; missed appointments run as high as 15%. In addition other agencies (children's centres, Social Care, adult education and housing) suffer from a similar failure by clients to attend appointments. This is an area that needs to be addressed as part of a multi-agency approach, so that those who are failing to engage can be identified.

The current process for managing situations where children are not brought to appointments needs to be reviewed; there needs to be a multi-agency approach in order to engage families, and to ensure that services are delivered in a way that promotes engagement. A multi-agency early intervention approach to managing scenarios where children are not brought to appointments, which includes; direct discussion with parents, a clear documentation of discussions, and an action plan to ensure that the child's health assessments and vaccinations are prioritised, would be of value to support professionals to work more effectively with parents.

There were occasions when professionals failed to triangulate what they were being told to ensure they were not being misled. One good example of this was Mother S's reports of domestic abuse. Mother S stated on a number of occasions that she was escaping domestic abuse but this was not followed up by women's refuge staff, health visitors or social workers.

The most obvious occasions when a more pro-active approach should have been taken were:

- Child S was not subject to a six weekly check by the GP. This would have been an opportunity to engage with Mother S but there was no follow up and very limited GP engagement. It appears unusual that a child should have so little contact with the GP, but this did not appear to have triggered a pro-active reaction from the GP service.
- Mother S failed to attend for her health visitor assessment at eight to ten months; there was no pro-active reaction.
- Mother S's appointment regarding paternity testing was a missed opportunity to engage with her and Child S.
- Following a referral to Social Care by the women's refuge the social worker did not establish the victimology[16] of Mother S.
- The Housing Department held considerable information about Mother S's accommodation history that pointed towards her vulnerability, but this was not shared with the appropriate agencies.
- Mother S had limited engagement with children's centres.

[16] "victimology" is the scientific study of victimisation, including the relationships between victims and offenders, the interactions between victims and the criminal justice system- that is the police and courts, and corrections officials- and the connections between victims and other social groups and institutions, such as the media, businesses and social movements.

4.2.4 The effect of cultural, religious and ethnic diversity

There was evidence that cultural, religious and ethnic diversity impacted on the lifestyle of Mother S and that of her son; this was not always identified by professionals.

In this case Mother S grew up in a family with a strong Pakistani heritage and in the Muslim faith. She had received a Muslim based education. When the relationship with her family broke down, she was left with few support networks and began to live in a world starkly different from the one she had grown up in.

Whilst it has not been possible to establish precisely the effect this had on her, and the way she brought up her son, this level of isolation was only commented upon by one professional. When Child S was moved to Care pathway 2 it was largely because the health visitor identified that she was isolated and had moved away from her support networks. Despite this she was later returned to Care Pathway 1.

The Police missed an opportunity when she first left her family home to engage her with their own well developed systems for women fleeing a forced marriage.

It seems that most professionals in this case did not give consideration to the effect Mother S's upbringing and apparent separation from her family and community had on her and her son.

There was no evidence to suggest that professionals were ignorant about the how cultural and ethnic diversity might affect their work; equally there was no evidence to suggest that they considered this when dealing with Mother S. Professional curiosity should have caused them to consider this issue.

4.2.5 Dealing with domestic violence offenders

The agencies in Coventry are aware of the dangers that domestic violence offenders pose to children. Policies and procedures are in place to deal with offenders and support victims. There needs to be a more coordinated response by agencies.

Considerable work is underway to improve the response of agencies and this work needs to be closely monitored to ensure that it does not lose momentum.

When passing a custodial sentence the courts in this case did not give sufficient consideration to their role in rehabilitating offenders.

Those who engage in domestic abuse against their partners present a real and present danger to the people they live with. Domestic abuse is often present in child neglect and emotional abuse cases. There are systems in place to identify domestic abuse offenders and put interventions in place to protect those who they make vulnerable.

In this case Male B had a long history as a perpetrator of domestic violence. At the time he met Mother S she had just been released from prison for offences of violence

against his former partner. He had a restraining order placing restrictions on his contact with his own children.

Despite this, he had unfettered access to Child S and no meaningful engagement took place with Male B or Mother S, to reduce the risk that he clearly posed.

The police investigated Male B and took the opportunity to charge him where appropriate and he was duly sentenced. The Probation Service dealt with him before the relationship with Mother S had properly developed and had little influence or control over him after his statutory supervision had expired.

The criminal justice system dealt with Male B's offending behavior and initially put in place, through the court system, a course of action to address his violence issues. It is counter intuitive that when he re-offended, and before he could begin this course, he was sentenced to imprisonment and the requirement to undertake any form of rehabilitation ceased. A new pre-sentence report by the Probation Service would potentially have highlighted to the court that engagement with the IDAP programme over a two year period may be the most effective course of action. As it was, a short custodial period with no form of rehabilitative element was selected. The Probation Service should bring this case to the attention of the courts for further consideration of future sentencing policy.

None of the agencies engaged with Male B were aware that he was potentially residing with Mother S and her son. Similarly, none of the agencies dealing with Mother S were aware that she had developed a relationship with Male B. It was not possible to have put interventions in place to prevent contact because, to put it simply; none of the agencies were aware of the relationship between Male B and Mother S, or had any way they could have known about it.

No support or intervention was made with Mother S to warn her of the threat that Male B posed, but no powers were available at that time to the agencies; in any event it is highly likely that Mother S knew of Male B's proclivity to domestic violence and chose to ignore the risk.

There was no liaison between women's refuges in Coventry and Milton Keynes to establish the extent to which Mother S had been subjected to abuse.

The areas in this case where domestic abuse and its effects should have had greater consideration were:

- The Integrated Domestic Abuse Programme (IDAP) provided an opportunity to address Male B's behaviour and would have ensured he was monitored over a two year period. The decision to revoke the Supervision Order resulted in a short term solution (a fourteen week period in custody) and withdrawal from that programme.
- The Court did not request a second pre-sentence report and sentencing took little account of the potential for rehabilitation through the IDAP.
- Licence conditions were not extended as far as they could have been.
- The Probation Service could have considered applying for further conditions on Male B's licence.
- The Housing Department acknowledge that training, policies and procedures need to be strengthened to identify and deal with clients that have been the subject of domestic violence or are perpetrators.

- Organisations who deal with the victims of domestic violence and abuse do not pro-actively share the information they hold with other agencies.

There is little that could have been done about Male B and his relationship with Mother S. However Coventry City Council and the LSCB have recognised that more needs to be done to deal with the threat that domestic violence poses to vulnerable people. It is a business priority for the LSCB. Significant multi-agency work is in train to improve the agency response to domestic abuse. It is essential that this re-shaping of strategy and resources continue to be followed through.

In addition consideration should be given to ensuring that all victims of domestic abuse, and those referred to a refuge, have a DASH risk assessment completed (Domestic Abuse, Stalking and Honour Based Violence - DASH 2009). This is a risk identification, assessment and management model that seeks to ensure that those that are at risk of domestic abuse are monitored and a support plan is put in place. This would have provided an additional opportunity (alongside a CAF) to assess and record key information regarding risk.

4.3 Areas for further improvement

4.3.1 Professional Curiosity

There were a number of occasions when practitioners, whilst conducting themselves professionally, failed to take 'the extra step' and engage their professional curiosity when examining the information in front of them. As a result they failed to fully appreciate the needs of mother and child. This resulted in some missed opportunities.

Agencies have clear systems in place to deal with the safeguarding of children. Front line professionals receive extensive training and have clarity around their role; they should know what is expected of them. In addition, the system relies on practitioners applying professional judgment and curiosity. This case highlights the need for professionals to go beyond the prescribed guidelines and instructions; which are often the minimum requirements. They should use their experience, intuition and professional curiosity to intervene and reduce the risk to vulnerable children. Practitioners should not just react to what is in front of them. It is their responsibility to pro-actively seek out the facts, engage with other agencies and satisfy themselves that a child is in a safe environment.

Professionals were clear, when asked at the Learning Event, that professional curiosity was an essential part of the process that should be followed. However, those that had been directly involved with Mother S and her son pointed out how difficult that can be when they are not in possession of all the available information, and when Mother S was adept at only revealing the information she wanted the agencies to be aware of. For those practitioners whose primary role is not dealing with children (for example the Fire Service), it is essential that training is able to supplement their skills with regard to stimulating a more inquisitive approach. The Fire Service has developed safeguarding training packages to include a wider range of information, including guidance on what environmental factors can affect the welfare of a child.

The reason why professionals appear, on occasion, to be reluctant to apply more professional curiosity are mixed. The first reason is when professionals do not have a

history of child safeguarding. For example, a fire fighter called to an address will be clear about their role and, to put it bluntly, are good at getting on with it. There is a tendency in this type of role to understand the significance of other connected events and safeguarding becomes secondary or is overlooked. Numerous call outs to an address being examples. This is not wilful neglect but a lack of understanding, and should be addressed by improved training. The fire service now include 'professional curiosity' as part of their safeguarding training

The second reason that professional's curiosity fails them is that they just don't have the time. Recent reviews and inspections have highlighted that Social Care and the health visiting service in Coventry were under resourced. Professional curiosity will only flourish where professionals have the time to engage in it and reflect on the actions that could be taken, this was reinforced at the Learning Events.

Thirdly, is the lack of communication between professionals and the failure to retain information and share it.

Whilst there were some limited occasions when professional curiosity could have been applied it would not have significantly impacted on this case.

4.3.2 Communication

It was apparent when interviewing professionals, and at the Learning Events, that good working relationships have developed in Coventry. This working relationship needs to be improved with enhanced information sharing.

Serious case reviews have often commented on the failure of agencies to communicate with each other to ensure they are all aware of the issues surrounding a child. The gathering and sharing of information and intelligence is critical if those responsible for protecting a child are able to provide the right level of safeguarding.

In this case several organisations had contact with Mother S and her son but did not share that information. This resulted in a number of agencies and individuals opening a small window into Child S's life. If they had shared information they would have had the wider view and been able to proactively engage with Child S and his mother, to reduce risks.

There were no major incidents in this case, prior to the injury suffered by Child S. In many cases front line professionals were unaware of the totality of contact with Mother S and her son until the Learning Event took place. They agreed that possession of more information might have changed the decisions they made. It is only when a number of small incidents are brought together that a picture of Mother S and her son's life begins to emerge.

The use of thresholds to assist professionals is a tried and tested technique to ensure that resources are well targeted. The use of thresholds can be counter-productive when it results in a failure to transfer information to another organisation. There was some of the evidence that not reaching the required threshold resulted in valuable information being lost. That information may have helped inform later decision-making processes.

There was also evidence that some agencies failed to understand the importance of their information to other agencies. It is essential that more work takes place between agencies, to understand the importance of intelligence gathering/information sharing and the needs of other agencies.

4.4 Good practice

4.4.1 Health visiting service

The health visitors in this case undertook some excellent work in the first few weeks of Child S's life. Despite moving from address to address the health visitor tracked down mother and child and was able to brief social workers about their circumstances.

The health visiting service has undergone a significant review and whilst this is not yet complete there are positive signs that the 'Healthy Child' programme will deliver on key objectives that have been set out in a comprehensive strategy.

4.4.2 Safeguarding procedures at hospitals

Despite difficult circumstances the agreed arrangements at both Coventry and Birmingham hospitals ensured that correct safeguarding procedures were followed and in addition to providing high quality care, the voice of the child and the needs of other agencies were met.

4.4.3 Housing Department discharge of duty

The Housing Department discharged its responsibilities efficiently and effectively. Despite a lack of cooperation from Mother S they were able to ensure that Child S was given suitable accommodation at short notice and the home in which he spent most of his life was provided with a minimum of bureaucracy and in a reasonable time.

4.4.4 Adult Education crèche programme

The Adult Education Service provides an excellent service to mothers who are in need of basic education. The crèche service they provide makes this a practical option for mothers with young children and the crèche is run by skilled, well trained and highly motivated staff.

4.4.5 Fire Service training

The Fire Service attended Mother S's address on two occasions when she was locked out. They have learnt from this experience that training for front line staff needs to incorporate a degree of understanding around professional curiosity and have quickly incorporated this into their training packages.

4.4.6 Coventry City Council Strategic Commissioning Team

The commissioning team has recently re-drawn contracts with service providers for hostel and refuge services. The contract for the women's refuge referred to in this review provides a comprehensive package of requirements for that organisation, to

ensure its services are fit for purpose and the safeguarding needs of the child are provided.

Section Five – Recommendations

It is to the credit of agencies in Coventry that much work is already underway to improve the safeguarding of children. There are major change programmes underway that deal with many of the issues described in the Key Findings section of this report.

The following section makes three recommendations to further improve safeguarding in Coventry. These recommendations are those that require a multi-agency response. This review has also identified a number of areas that individual agencies need to consider and take action against. In those cases where issues have been identified for a single agency, that agency should produce action plans that should be monitored through the LSCB performance framework. They should continue to be subject to regular scrutiny by the Board until completion.

5.1 Recommendation One

The Coventry LSCB should monitor the plans for changes in structure, policy and service provision by agencies to assess how they will dovetail; ensuring that levels of child safeguarding are maintained.

In common with most local authority areas Coventry is going through huge change in its public services. Whilst this review did not find significant problems in partnership working it was the opinion of the lead reviewer that change in Coventry is taking place on a very large scale and is being driven forward at great speed. This is not a criticism; it seems genuinely motivated by a desire to improve services.

It is important that the impact of these changes is monitored. The LSCB is in the unique position of overseeing multi agency working and is best placed to consider how changes, taken together, will impact on children.

The LSCB should ensure that its risk register includes impact assessments for major structural change. The register should provide detail on mitigation that has been put in place.

The work in this area should commence with immediate effect.

5.2 Recommendation Two

The Coventry LSCB should progress its priority relating to domestic violence and abuse (DVA) by;

- **forging stronger links with the Police and Crime Board**

- **refining and consolidating the post Daniel Pelka joint screening processes**

- **championing the work being done in Coventry to counter domestic violence and abuse.**

There has been acknowledgement across services in Coventry that there needs to be an improvement in work related to domestic abuse. The LSCB has as a business priority for the period 2013 to 2015 to:

"Monitor the further development of multi-agency services to prevent domestic abuse and support children and their families".

5.3 Recommendation Three

Coventry LSCB should ensure that all agencies:

- **Have policies and procedures in place for identifying those families that are proving hard to engage.**
- **Scrutinise and, where necessary, tighten their procedures for working with families who are hard to engage.**
- **Have protocols in place to share information between agencies about families that are hard to engage.**
- **Monitor staff compliance with the agreed procedures.**

In order to provide necessary help to families particular attention should be paid to those families who fail to engage. In this case Mother S was sporadic in her attendance at appointments both for health care and housing. This is not an uncommon problem faced by professionals. It is a potential indicator of neglect, and as such should be treated seriously.

Section Six – Conclusion

In 2008 Mother S left her family home and began a new life without the support of her family and in a degree of isolation. Initially she moved into a hostel and from there to housing provided through the local authority. It appears she had a number of relationships and these were often abusive in nature; although no organisation has formal evidence of this. In these early years of adulthood Mother S only had to be concerned with herself, her own welfare and happiness. This changed radically when, in the autumn of 2010, she gave birth to Child S. All of Child S's life was spent in Coventry with his mother. The nomadic and often chaotic lifestyle of the family was always likely to impact on his life chances. The first months of Child S's life were spent with his mother residing at a number of 'friends' houses, a women's refuge and bed and breakfast accommodation, before moving into permanent accommodation.

When Mother S renewed her relationship with Male B in 2013 the risk to Mother S and her son increased hugely. Male B was a man with a history of domestic abuse; he had committed serious assaults on his ex-partner on a least two occasions. But Male B was a man who had served his sentence. As a consequence, there was no agency or organisation that knew where Male B was living, or that he had contact with Child S. If they had known, they would have been unable to take any direct action.

There will be an expectation by many, that public services and the work of the third sector, would ensure that Child S and his mother were supported and any gaps in the mothering skills of Mother S would be filled by 'the system'. In many regards that

support was provided. Mother S and her son were housed and medical support was always available. On a number of occasions she was pointed towards further help. She rarely asked for help and when she did, it was specific and she received it.

The purpose of this review was to look at the systems that were in place to help, support and protect the family; and to determine the effectiveness of those systems. All of the agencies and organisations that had contact with Mother S, Child S and Male B co-operated with this review.

So how did Mother S and Child S present to the various agencies and organisations? There is a mixed picture. There is no doubt that Mother S was adept at only revealing the information she wanted people to know. There is some evidence that she could be aggressive, particularly when under stress. This did not reach the point where, for instance, the police were involved. Mother S was involved in low level criminal activity, but again this was not particularly unusual, or sufficiently serious, to raise any targeted activity towards her. When attending the Adult Education Centre she was seeking to improve her position and was seen as a bright and intelligent young woman who interacted well with others and showed herself to be a good and caring mother. The contrary position was true when she was resident at a women's refuge. Mother S was said to be aggressive to staff and residents, refused to conform to simple rules, was anti-social and there were some minor concerns about her mothering skills.

When Mother S needed something she would co-operate with the authorities; for instance to get housed. On other occasions she was obstructive, vague and avoided contact. This review was unable to get a clear picture of what Mother S was really like; how her break from her family may have affected her, or how good a mother she really was. The fact is she was difficult for agencies to deal with; she didn't ask for help, she could be evasive. When interviewed she could present as a reasonable, well-balanced individual. In a city with some considerable pockets of deprivation, it is perhaps understandable that Mother S and her son would not be seen as a priority for help and support.

Even less is known about Child S. All professionals engaged in safeguarding recognised the need to listen to the voice of the child. In the early years, professionals use their experience and training to understand how the child is coping in their environment. Once he had left hospital professionals saw Child S, with his mother, within a few days of his birth, residing with a friend. This was not seen as unusual, because many lone parents seek support when they first leave hospital. There was nothing to cause alarm and no concerns raised. Whilst some medical appointments were missed and one health visitor raised the level of care, contact in Child S's first year was sufficient for health visitors to conclude that he was healthy and that there were no concerns about him. There was then a gap of one year when health visitors did not see Child S. It may cause concern that this long gap occurred, but it is entirely normal and within national guidelines. Child S was seen at two years six months when he attended for an assessment, which formed part of standard universal services. He was reported as being of normal weight and progression, apart from a slight speech difficulty that was not unusual. Within four months of that assessment, Child S received the injuries that killed him.

This review has established that a number of agencies had contact with Mother S and her son but none of those contacts revealed any concern for them. Reference has been made to the Common Assessment Framework (CAF). Coventry LSCB have provided clear guidance around when a CAF may be triggered and what events should do so. Given all of the information now available, a CAF process should have

been instigated; not just to deal with housing issues, but to look at the more holistic support mother and son required. Use of the DASH risk assessment tool could also have been considered.

If a CAF had been put in place a number of support mechanisms may have been triggered in terms of Early Help.

Whilst a CAF may have helped Mother S and her son in their day to day lives, there is nothing to suggest that Mother S would have co-operated willingly with the authorities. The CAF would not have triggered any Early Help activity that would have significantly changed Mother S's lifestyle. Ultimately, at the time of his death; Child S was living in a two bedroom house, he had been given a rigorous assessment by health visitors less than four months previously and been in good health; none of the agencies had been given any cause to believe that Mother S was a poor mother or that Child S was neglected, the evidence was that she had moved away from abusive relationships. There was nothing to make any agency consider that Child S was at any raised risk. **The inception of the CAF process may have helped Child S if he had lived, but would not have prevented his death.**

Child S sustained fatal head injuries whilst alone, at home, with Male B. It is inevitable and right that there will be questions about how a man with a violent past could have been left with Child S that day. The Probation Service have been open about mistakes made in the handling of Male B when he was on a Supervision Order, and latterly on licence from prison. Those issues will no doubt be addressed, but they did not affect the outcome in this case.

Male B had very limited contact with Mother S in 2011 when it seems they had a brief affair. Their relationship resumed at some point in mid-summer 2013. Male B had been in prison between March 2013 and April 2013. He was then on a licence until mid-summer 2013.

The point at which the licence expired is (perhaps not coincidentally) the point at which Male B approaches Mother S on Facebook, and persuades her to resume the relationship. From mid-summer 2013 Male B was no longer supervised by any of the authorities and particularly not by the Probation Service. Male B had served his time and this meant there was no requirement for him to inform anyone of his whereabouts, his relationships, or who he had contact with. As such, the only person who had any control over whether Male B had contact with Child S, was Mother S; she clearly felt he did not present a risk. It should be noted that Male B's previous partner, and the subject of his offending, was very clear that she did not believe Male B posed a threat to children. Given that Mother S knew and had contact with that ex-partner; it is not unreasonable to assume she was aware of that view.

This review has presented a number of findings and recommendations that should lead to an improvement in the systems to manage safeguarding in Coventry. Many of the agencies that engaged with this review have already put in place action plans to address the issues that have been raised. Perhaps of most importance in addressing these issues will be the formation of the Coventry Multi-Agency Safeguarding Hub (MASH), which will directly impact on the recommendations of this and other recent serious case reviews.

There was a tendency by some professionals to take Mother S at face value and they did not always triangulate the facts to reach a better decision. Agencies have put

training, policies and procedures in place; but they do not do enough to monitor their effectiveness, or engage in continuous improvement processes.

The professionals responsible for childcare in Coventry have been open, honest and responsive to this case review. They have already started to look to improve and review systems in light of this case and others. As one front line professional said; "You can't stand still when it comes to safeguarding, if you don't keep improving another child gets hurt, you have to be hard on yourself, accept it when you make mistakes and improve". This is the right approach to be taken by professionals.

This case was about the sudden death of Child S, who was aged two years and ten months when he received a catastrophic head injury that ended his life. Whilst there were missed opportunities by agencies to intervene and place support around Child S and his mother, those interventions would not have prevented Mother S resuming her relationship with Male B, or prevented him from being in that house, alone, with Child S. There was nothing anyone, except Mother S, could have done to prevent him being there. None of the authorities or organisations that had involvement in Child S's life could have foreseen the events that occurred; they could not have prevented his death.

Appendices

Appendix A

Agency Reports

The following agencies provided full reports:

- University Hospital Coventry and Warwickshire NHS Trust.
- Birmingham Children's Hospital.
- Coventry and Warwickshire NHS Partnership Trust.
- General Practitioner's services (Independent report by Named Doctor).
- Staffordshire West Midlands Probation Trust.
- Coventry City Council Housing Department
- West Midlands Police
- Women's refuge Coventry (identity withheld).
- Coventry Children's Social Care and Children's Centre.
- Coventry City Council Adult Education Service.
- West Midland's Fire Service.

Agencies who provided a reduced report:

- Midland Heart Housing.
- Women's Refuge – Milton Keynes (identity withheld).
- Birmingham Council Children's Social Care.
- NHS ante natal services in Milton Keynes.
- Thames Valley Police.
- Milton Keynes Children's Social Care.

Appendix B

Care Pathways

Health Visitors make an assessment of the most appropriate care pathway and the summary of the three levels is described below:

Care Pathway 1

Is delivered to families with little or no identified health needs usually referred to as routine surveillance.

Care Pathway 2

A need to offer services above the Universal Care Child Health Programme i.e. follow up contact, referral to nursery nurse or other health team member, targeted visiting is often required

Care Pathway 3

Is delivered to children or adults within families with complex health needs, referrals to other professionals outside of health to support identified needs a multi-agency approach is often required.

In this case the assessment the documented Care Pathway within the records was initially at level 1. This decision is based on the health needs of the family at the time of the first visit.

Health Visitors make an assessment of mother and child and decide which care pathway is most suitable.

Appendix C

Common Assessment Framework process

The CAF guidance produced by Coventry LSCB is an excellent document that clearly lays out the CAF process. It is clear and simple in the way it explains the expectations it has of professionals. It produces a simple to follow flow chart with clear criteria laid out and examples of best practice. It was updated in December 2013 and can be found on the LSCB website at www.coventrylscb.org.uk

In summary the process involves three levels of care and dependent on where the child sits on that continuum will depend on the Early Help and support provided.

It describes the levels of provision expected at three levels:

- ***Level One - Universal Service Provision***
- ***Level Two - Children who May have poor life chances***
- ***Level Three - Children who WILL have poor life chances***

The guidance provides a checklist of those factors that will assist professionals in deciding which level a child may be considered. There was evidence from Health, Social Care and the women's hostel that Child S should have been regarded as falling within level two. The key issues that affected Child S within the **level two guidance** were:

- Defaulting on immunisation checks.
- Minor concerns re diet/hygiene/clothing.
- Starting to default on health appointments.
- Parental engagement with services inconsistent/sporadic.
- Parent requires advice on parenting issues.
- Parental stresses are starting to affect ability to ensure child's safety.
- Key relationships with family members not always kept up.
- May have different carers.
- Some support from families and friends.
- Transient family.
- Parent has limited formal education.
- Low income.
- Adequate universal resources but family may have access issues.

The Post Trial Addendum – July 2015

In July 2015 Male B was convicted of the murder of Child S and sentenced to15 years imprisonment. Mother S was convicted of causing/allowing the death of a child and sentenced to 3 years imprisonment.