Northamptonshire Safeguarding Children Board

Serious Case Review Report

Child Ap

Overview Report

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1. Introduction: Process and Rational for the Serious Case Review

The Process of the Serious Case Review

1.1.1 The Northamptonshire Serious Case Review Sub Group took the decision on 17 May 2018 that, with reference to the requirements as set out in Chapter 4 of *Working Together to Safeguard Children* (2015), the threshold was met to commission a Serious Case Review in respect of Child Ap.

1.1.2 Child Ap died of a suspected non-accidental injury. Mother's Partner, hereafter referred to as Mr X, was charged and subsequently convicted of her murder. There had also been concerns about the care of the four other children in the family, manifest in the previous history of involvement with statutory agencies. Given these factors, a Serious Case Review was considered warranted.

1.1.3 This recommendation was endorsed by the Independent Local Safeguarding Children Board (LSCB) Chair on 11 June 2018 (hereafter referred to as the Northamptonshire Safeguarding Partnership).

1.1.4 The mandatory criteria for carrying out a Serious Case Review as set down in Working Together to Safeguard Children (2015), is as follows:

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

(b) either:

(i) the child has died; or
(ii) a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

1.1.5 The purpose of a Serious Case Review is to undertake an independent, proportionate, appraisal of practice, whilst also recognising the complex circumstances in which professionals are working. A review also seeks to understand the role of all agencies involved with a family, to identify improvements which are needed and to consolidate good practice. It is not about apportioning blame but should encourage a culture of continuous learning.

1.1.6 For the purposes of transparency all Serious Case Reviews are required by the Department of Education to be published. The report author is aware of the sensitivity of the information contained in this report and the distress that it may cause to family members. All personal information is therefore anonymised, and pseudonyms have been used to refer to key family members and those connected with Child Ap.

1.1.7 It is expected that Northamptonshire Safeguarding Partnership will translate the findings from this review into programmes of action, leading to sustainable improvements and the prevention of death, serious injury or harm to children. Some agencies have already taken steps to improve practice as result of the untimely death of Child Ap.

1.1.8 **Scope and Terms of Reference**

1.1.9 The Terms of Reference and Scope for the Review can be found at Appendix 1.

1.1.10 **The time period for this review is 1 January 2016 to 7 May 2018.** This starts from the approximate point that it is believed the alleged perpetrator may have started to live in the family home to approximately one week after Child Ap's death to include an understanding of how the four siblings were safeguarded after the incident. Information which is considered to be relevant to understanding of the events that led to Child Ap's death have also been included.

1.2 Methodology

1.2.1 Northamptonshire Safeguarding Partnership decided to use a blended approach of traditional and new methodology:

- requiring agencies involved with the family to complete Internal Management Reviews (IMRs);
- whilst in parallel, ensuring a process of greater collaboration through conducting conversations with the practitioners and clinicians involved;
- holding a multi-agency practitioner event mid-way through the process;
- a briefing meeting near the end of the process, in order to identify learning and encourage reflection on their involvement;
- to examine the actions and decisions taken; and to understand the context.

Agency IMR Reports

1.2.2 The following agencies were requested to contribute to this review:

- Children First Northamptonshire (Children's Social Care)
- GP Services, Nene & Corby Clinical Commissioning Group
- Kettering General Hospital
- Northamptonshire Healthcare Foundation Trust
- Northamptonshire Police
- Leaving Care, Children First Northamptonshire
- Siblings School

<u>Statements of Information were requested from:</u>

- Youth Offending Service
- National Probation Service
- BeNCH CRC (Community Rehabilitation Company)

Practitioner Event

1.2.3 A practitioner event was held on 15 November 2018, which was well attended by representatives from all agencies. Prior to arranging the event, the Police and Crown Prosecution Service were contacted to ensure that by holding such an event the criminal prosecution of Mr X would not be compromised. Confirmation was received that the event could proceed. The event was extremely helpful to the report author and the consensus from those attending was that it proved useful and beneficial to their understanding of the case and events leading to the death of Child Ap.

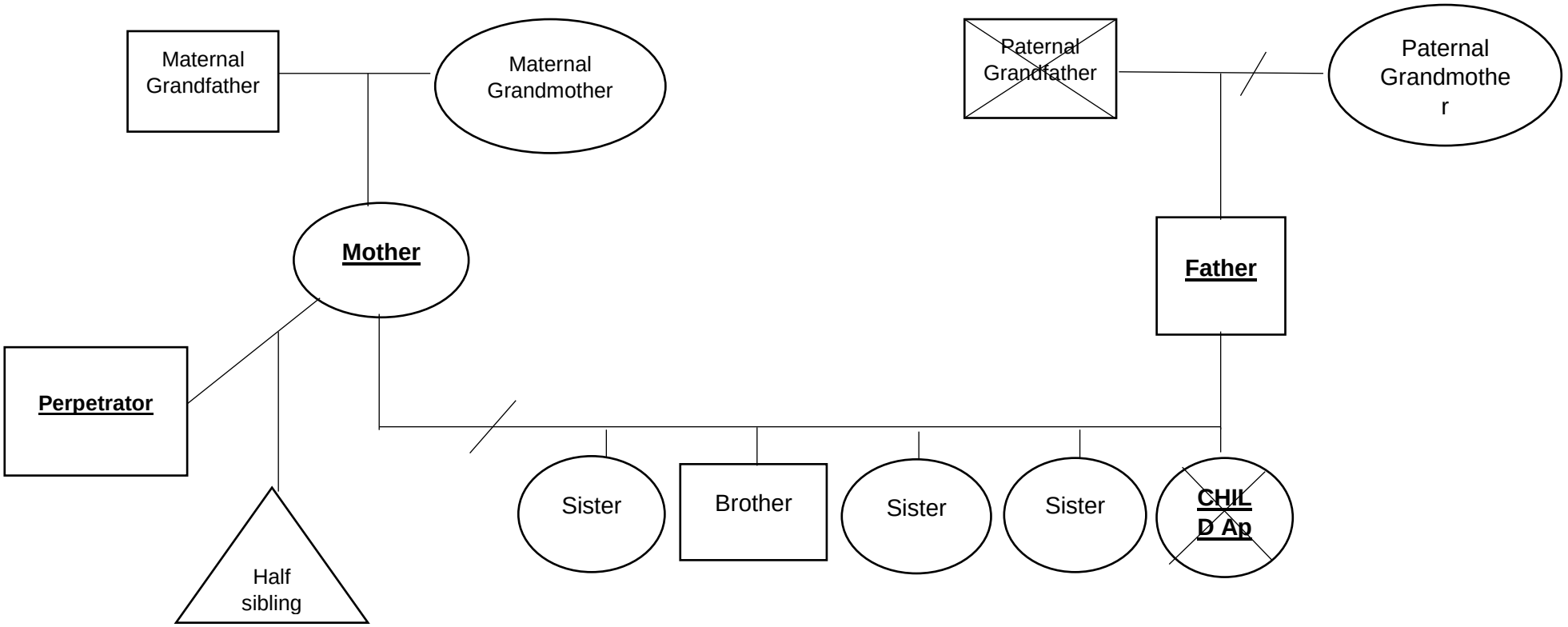
1.2.4 The report author would like to express her thanks to all those who attended the event and who contributed to this Serous Case Review. Most especially, the assistance provided by the Northamptonshire SCB Project Manager and her colleague, ensured that the event and the review process as a whole was smooth, efficient and professional. Thanks are also extended to the Designated Doctor for her support to the author throughout this review.

1.2.5 **Involvement of the Family**

1.2.6 The report author and the Consultant Paediatrician/Designated Doctor for Safeguarding met with Mother and Maternal Grandmother. The contribution to the review provided by Mother and Maternal Grandmother to the report author are attributed to them throughout the report. The report was shared with Mother and Maternal Grandmother prior to publication. The report author would like to thank Mother and Maternal Grandmother for their willingness to meet with her and the Consultant Paediatrician/Designated Doctor at such a sad and difficult time. Their contributions and reflections on Child Ap are appreciated and have been extremely helpful to the review.

1.2.7 Father and Mr X were informed of the review but gave no indication that they wished to participate in the process, until Father requested to read the Serious Case Review Report prior to publication. Arrangements were made to enable this to happen.

Genogram


Maternal Grandfather
Maternal Grandmother
Paternal Grandfather
Paternal Grandmothe r
Mother
Father
Perpetrator
Sister
Brother
Sister
Sister
CHIL D Ap
Half sibling

2. Who was Child Ap?

2.1.1 At the time of her death Child Ap had just celebrated her first birthday. She lived with her Mother, Mother's Partner Mr X, her three sisters and brother in a private rented house. Her father was in prison at the time of her birth and there was a restraining order in place, stipulating that he should not contact Mother. At the time of her death Child Ap was the youngest child of the family.

2.1.2 She was described to the report author by her mother and maternal grandmother, as a '*happy, contented, good baby, a cheeky monkey, who was adored by her brother and sisters*.' The impact of the sudden and violent death of Child Ap on the children, and the distress and upheaval caused to their lives as a result cannot be underestimated. Mother and Maternal Grandmother described to the report author how adored Child Ap was by all of her siblings. Not only did they lose their baby sister when Child Ap died, they also lost their home and their family.

2.1.3 Child Ap was born in hospital by normal delivery. Her mother's pregnancy was considered high risk and her care was managed by a consultant. Due to concerns about the growth of the baby, the pregnancy was induced at 36 weeks Following her birth, Child Ap was transferred to the Special Care Baby Unit (SCBU), because of concerns about sepsis, where she remained for two days. She spent a day on the postnatal ward with her mother, before being discharged home.

2.1.4 When she was 9 months old, Child Ap was admitted to hospital via ambulance in January 2018, following febrile convulsions. She was found to have bilateral pneumonia and a collapsed lung. Child Ap was reported as being unwell for six weeks prior to her admission and had been prescribed antibiotics by the GP.

2.1.5 Child Ap's next admission to hospital was on 26/04/2018, again by ambulance, when she was in cardiac arrest. She was accompanied by her mother, and her grandparents.

2.1.6 Child Ap was in the care of Mr X on 26/04/2018. When Mother left to go to work earlier that morning, Child Ap was reported as being fit and well. Later in the morning, Mother received a phone call from Mr X, saying that Child Ap was not responding, having fallen off the bed. Sibling 4 was also at home.

2.1.7 Mother called an ambulance on her way home. When Mother arrived, she found Child Ap to be pale, floppy and not breathing. She started resuscitation. The ambulance arrived within minutes of Mother's call. Paramedics found Child Ap was not breathing, they also documented that there were marks to her neck and face.

2.1.8 On reaching hospital, a CT scan was suggestive that Child Ap had suffered acute subdural haematoma with cerebral oedema (bleeding and swelling of the brain).

2.1.9 Child Ap was transferred to a regional medical centre for ongoing care on a Paediatric Critical Care Unit (PCCU). Her condition deteriorated whilst on the PCCU and a decision was made to take her off life support. Child Ap sadly died on 29/04/2018. It was subsequently discovered that Child Ap had suffered an earlier brain injury.

2.1.10 The explanations given by Mr X of the event concerning the circumstance leading to Child Ap's death were inconsistent and concerns were raised early in Child Ap's presentation at hospital as to the possibility of non-accidental injury.

2.1.11 Mr X was convicted of Child Ap's murder in February 2019 and sentenced to life imprisonment.

2.1.12 Child Ap's family was well known to health, social care and statutory agencies prior to her death. Her siblings had previously been the subject of child protection and child in need plans, due to a history of domestic abuse between their parents, resulting in concerns about the children's emotional well-being. At the time of Child Ap's death, the case was closed to Children's Social Care.

3. Key Events

3.1.1 Child Ap's Father was serving a prison sentence at the time of her birth. Mother had been involved with Father for over ten years and the relationship had at times been extremely volatile, with a history of domestic abuse and violence. The domestic abuse is said to have escalated in 2012 and it was at this time that Father is believed to have begun to use alcohol and drugs heavily. Father also had a criminal history of violence and drug dealing.

3.1.2 The older children had witnessed Father's violence against Mother and received support and nurturing whilst at school for the distress and trauma this had caused.

3.1.3 Whilst the children were subject to Child Protection Plans, Mother was required to complete the Freedom Programme.[1] Father was made subject to a restraining order, preventing him contacting Mother.

3.1.4 Throughout her pregnancy Mother maintained to midwifery staff and Children's Social Care that Father was not the father of her unborn child. Mother only acknowledged to the midwife that Father was Child Ap's father a week after her birth. Father had very limited contact with Child Ap but was present at the hospital when she died.

[1] The Freedom Programme examines the roles played by attitudes and beliefs on the actions of abusive men and the responses of victims and survivors. The aim is to help them to make sense of and understand what has happened to them. The Freedom Programme also describes in detail how children are affected by being exposed to this kind of abuse and very importantly how their lives are improved when the abuse is removed.

3.1.5 Mother had a history of depression, following the birth of Sibling 1 and maintained during her pregnancy with Child Ap that she had a compulsive behaviour disorder and had been diagnosed with Bi-Polar Affective Disorder.

3.1.6 Mother was reluctant to engage with health visitors, often not bringing (or delaying bringing) Child Ap for immunisation appointments and developmental checks, as had been the case for all her other children. Similarly, there were numerous GP and hospital appointments not kept by Mother for herself and for the children. Whilst there were frequent non-attendances for booked appointments, the family did however visit the GP Practice on numerous occasions, as well as the hospital A&E Department.

3.1.7 Mother met Mr X through a mutual friend via social media, a week after Child Ap was born, by which stage Father was back in prison. In May 2017, Mr X moved into the family home shortly after he and Mother met. He was 21 years old at the time. Mr X had a significant criminal history, including violence and had been a looked after child during his teenage years.

3.1.8 During the period that Mr X was living with Mother numerous reports were made to Police and Crime Stoppers that drug use, most especially cannabis, as well as dealing Class A drugs (cocaine and heroin) was occurring at the family home. Mother maintained that such reports were malicious and untrue.

3.1.9 Mother told the report author that she had no idea that Mr X had a history of violence and described him as a caring, loving person, who looked after the children very well. He collected them from school, did household chores and anything else that could assist Mother in caring for the children. Neither she nor Maternal Grandmother had any concerns about his suitability to look after the children.

3.1.10 **Concerns for the Health and Well-being of Child Ap's siblings**

Sibling 1 (aged 10 at the time of Child Ap's death):

- As a young child Sibling 1 was treated for frequent urinary tract infections.
- When she was 8 years old, (2016) Sibling 1 suffered a broken arm in two places, having been pushed off a 4-foot-high wall by Sibling 2. She was not brought to follow up fracture clinic appointments.
- In September the same year, Sibling 1 was seen by the GP and was diagnosed as having a possible scabies infection.
- In June 2017 Mother thought Sibling 1 was displaying signs of ADHD. A GP referral was made to CAMHS as Sibling 1 was 'obviously in distress due to her family situation.' Sibling 1 was not considered to have ADHD.
- The following year, in March 2018, Sibling 1, aged 9 attended Hospital A&E having sustained three head injuries in one day.

Sibling 2 (aged 7 at the time of Child Ap's death):

- Police attended an incident following a report that a two-year-old child was being carried on the handlebars of a motorcycle. Mother was spoken to by Police Officers.
- When aged 3, he was brought to Hospital A&E with a crushed finger and later that year with a head injury.
- In October 2015, aged 6, he fractured his wrist. As with Sibling 1, Mother failed to bring him to a follow up fracture clinic appointment, attending unexpectedly 5 days after the appointment date.
- In November 2015, Sibling 2 was brought by Mother to the GP Surgery reporting erratic and disruptive behaviour displayed at home and school. Mother told the GP that there was a family history of ADHD. She was advised to request a report from the school and compile a history of events at home before a referral could be made.
- Three months later Mother brought Sibling 2 to A&E with a head injury, which required staples after he fell out of a bunk bed.

Sibling 3 (aged 5 at the time of Child Ap's death):

- As was the case with her older two siblings, Sibling 3 was not brought for her routine immunisations. It was only when the GP Practice wrote to Mother asking her to bring Sibling 3 for appointments or formally dissent that she was eventually brought for her vaccinations**.**
- When aged two and a half, Sibling 3 attended the Surgery with Mother with head lice which had progressed to impetigo. This was Sibling 3's second attendance at the GP Surgery in six weeks with a head lice complaint and without appropriate treatment it was considered that the first infestation had developed into impetigo.
- Sibling 3 also had recurrent urinary tract infections and incontinence for which she was treated with antibiotics, as well as tooth decay.

Sibling 4 (aged 2 at the time of Child Ap's death):

- Attendances at the GP Surgery were in the main for coughs and colds.
- Sibling 4 was admitted to hospital in May 2016, when she was 18 months old with a secondary bacterial infection having had chicken pox.
- She was also taken to Hospital A&E on different occasions with respiratory symptoms, pyrexia and diarrhoea and vomiting, for which she was treated.

Sibling 5: born after Child Ap's death

Life at School:

3.1.1. School was a stable factor in the lives of Siblings 1,2 and 3. Mother and the children were well supported by the teaching staff, as was manifest in the sensitive care

offered to the children from teachers who took a real interest in the children's well-being, and by the provision of 1:1 nurturing and protective behaviour sessions. All three children were considered to be doing well academically and the school reported few concerns to Children's Social Care, although an internal school safeguarding record was maintained.

3.1.2. However, concerns noted on the internal school safeguarding record included:

- the behaviour of Sibling 2.
- the children's lateness for school and poor attendance record, about which the school wrote letters to Mother.
- School staff were concerned when the children began to arrive at school by taxi, unaccompanied at 7:55 in the morning to enable them to attend breakfast club.

For further details of incidents see paragraph 5.3.4

3.1.11 Apart from Mother and Maternal Grandmother's description of all the children liking and getting on well with him, little is known about how the children viewed Mr X. Sibling 1 displayed some indifference to Mr X, but at school Sibling 3 referred to him as 'Daddy' and the staff at School had no concerns about the interaction between Mr X and the children, when he came to collect them.

What picture emerges of what life was like for the children?

3.1.12 It is evident from the information provided to the review that the children experienced a series of accidents resulting in injuries requiring hospital treatment, possibly as a result of a lack of parental supervision. That they suffered neglect is reflected in the number of missed medical appointments, lice infestation, tooth decay, bacterial infections as a result of a lack of hygiene and urinary tract infections, which were not always followed up.

3.1.13 The domestic violence perpetrated against Mother by Father, and witnessed by the children, led to them being subject to Child Protection plans. However, the children clearly did have affection for their father. Extended family members ensured that the children did not lose contact with Father during his imprisonment.

3.1.14 The arrival of Mr X in the family home brought the children into close contact with a male, other than their father. Mother said she knew little about his background, and yet within weeks of meeting him, Mr X was living in her household caring for her children. Concerned neighbours and others had made a series of reports to Police about drug activity at the house, and Mr X had also been involved in a violent incident outside the home. Mr X, a man of 21 was left with responsibility for caring for five children whilst Mother was at work. This was a significant responsibility, not least for a young man with Mr X's past history of substance misuse, drug dealing and violence.

4. Analysis and Appraisal of Practice

4.1.1 This section considers the engagement of professionals from a range of agencies with the family. Examples of good practice and missed opportunities are noted.

The involvement of health professionals with Child Ap and the family

NENE & Corby Clinical Commissioning Groups (CCG)

4.1.2 Child Ap was registered at GP Practice 1 along with her Mother and four siblings. The Practice demonstrated a good awareness of the importance of safeguarding children and adults, as manifest in the resources invested in staff and training. In this case, once the children became subject to child protection procedures the Practice submitted reports to Child Protection Conferences in April and June 2016. This included information concerning new events in the children's medical records, Mother's depression and treatment and the risk presented to the children because of domestic abuse. However, there are discrepancies in records as to whether these reports were received by Children's Social Care to be shared with partner agencies at the Case Conferences and this is discussed further at 6.1.4. Information provided to the review indicates that there was a good standard of recording of the attendance and non-attendance by Mother and the children for appointments at the Practice.

4.1.3 During the time the children were subject to Child Protection and Child in Need Plans, they were regularly discussed in Practice safeguarding meetings (Multi-disciplinary Team Meetings). It is evident from the records that the Practice maintained good oversight of the family during their involvement with Children's Social Care.

4.1.4 It is evident that the medical records for all the children contained a significant amount of information, which would indicate that the children were subject to neglect, but this was not communicated to Children's Social Care. Whilst the children were subject to Child Protection Plans under the category of emotional abuse, there does not appear to have been any consideration given to the possibility that they were being neglected. This was in part due to Health Visiting Services and the School maintaining that they were well cared for and that there were no safeguarding concerns in this regard. This was a missed opportunity to consider the holistic picture of safeguarding concerns for the children.

4.1.5 Once the children were no longer open to Children's Social Care, they were removed from the Practice Safeguarding List and were no longer subject to regular discussion in safeguarding meetings. Had the children remained on the list for a period of time, post closure to Children's Social Care, some oversight could have been maintained around the family.

4.1.6 There was a lack of professional curiosity as to the identity of Mr X when he joined the family. It was assumed that he was the children's father, (he was not registered at the Practice) when he attended appointments with Mother and the children, as they were referred to as 'Mum and Dad'.

Midwifery and Hospital Services

5.1.1 All the children were born at the same hospital and at the time of Mother's pregnancy with Child Ap midwifery staff were aware of her previous history. It was documented that she was at high risk of being subject to domestic abuse and an alert was placed on the electronic system in November 2015 to this effect. This was good safeguarding practice, as was the decision that Mother should have consultant led care for her pregnancy with Child Ap because of her previous history of depression, growth restriction of the infant and previous social care involvement.

5.1.2 When Mother booked in for her pregnancy with Child Ap in September 2016, the allocated midwife contacted Mother's previous community safeguarding midwife who confirmed that the family was currently being supported by a Child in Need Plan. This demonstrated good professional curiosity on the part of the midwife.

5.1.3 A referral to MASH for the unborn baby was made in November 2016 and an appointment was made for Mother to meet with the Community Safeguarding Midwife. When in December 2016 the community midwife contacted Children's Social Care and learned that the case had been closed, she sent an email stating her concerns and recommending that an Early Help Assessment be offered to the family in the interim. This was good, proactive, professional practice on the part of the Community Safeguarding Midwife. However, the Child in Need Plan was closed.

5.1.4 In February Mother requested a referral to the acute mental health liaison team as she believed she had Bi-Polar Affective Disorder. A referral was made, and Mother maintained that she did have Bi-Polar Affective Disorder. However, midwifery services did not seek confirmation of this diagnosis from the mental health team or the GP Practice. From this time onwards, it appears that it was accepted that Mother was mentally ill with this condition, which was also noted in her records by the consultant obstetrician. The information that Mother was suffering from Bi-Polar Affective Disorder was also shared with MASH. Whilst this was good practice in theory, it would have been appropriate to confirm that Mother had been diagnosed with this condition. In the event there is no evidence to suggest that she had/has Bi-Polar Affective Disorder.

5.1.5 On 21 April 2017 Mother disclosed to her community midwife that Father was Child Ap's father and that his family was her only support. Mother also stated that Children's Social Care was aware of the paternity of the child. The community midwife made a re-referral to MASH to inform them of this new information.

5.1.6 The clinicians who were responsible for Mother's care demonstrated awareness to the risk presented to her and her unborn child by escalating their concerns to

Children's Social Care/MASH and making other agencies aware, as appropriate, including Health Visiting. These are examples of good practice and are commended.

5.1.7 It also needs to be recognised that there is evidence of less effective practice. A potential opportunity to refer Sibling 1 to Children's Social Care was missed when she presented to A&E with three head injuries over the course of one day. Similarly, there were several occasions when the children arrived in A&E with fractures after accidents but follow up appointments not kept; their being brought to A&E after numerous days of illness was not questioned as potential delayed presentation. Neither was there exploration as to who was caring for the other children when a child presented at A&E. Given the numerous occurrences of the children being seen at A&E, it is surprising that the possibility of neglect as being a concern was seemingly not considered.

Health Visiting Services (NHFT)

5.1.8 Mother was reluctant to engage with health and social care professionals, except when she decided it was appropriate to do so. This was evident in her contact with health visiting services and the GP Practice Nurses when the children required immunisations.

5.1.9 Although the family was known to Health Visiting services, at the time of Child Ap's death no concerns had been raised with statutory agencies in relation to Mother's care of the children. Prior to Child Ap's birth, it was the considered view of agencies involved in Child Protection Conferences that Mother had ended her relationship with Father, was acting proactively and that the children were no longer at risk of harm. Child Ap was therefore in receipt of Health Visiting Universal Services[2].

5.1.10 The Health Visiting Service had no knowledge that Mr X was in a relationship with Mother until early June 2017 when she told the Health Visitor that they had been in a relationship for two weeks. There is no information in the children's records that Mr X was living at the family home. However, it was good practice on the part of the Health Visitor to ascertain the name and date of birth of Mr X, when she became aware in June that he was Mother's 'new boyfriend'. This information was shared with partner agencies.

5.1.11 Although Child Ap was in receipt of universal service from the Health Visitor, the Health Visitor had knowledge of and had considered the history of maternal mental health issues, inconsistent engagement and domestic abuse. She therefore felt it was appropriate to offer additional support, although Mother made it clear that she did not require nor want any such support. This was good, proactive practice.

5.1.12 The Health Visitor was mindful that Mother could be difficult to engage with and when Mother decided she did not require health visiting support and declined the offer for

[2]Universal: health visiting teams lead delivery of the Healthy Child Programme. They ensure that every new mother and child have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation. DoH

Child Ap to have an 8-month developmental review, it was thought that there was little more that could be done. Whilst it was Mother's decision to refuse health visiting services, it should have triggered a further escalation of concern and challenge by the Health Visitor. There had been an element of disengagement by Mother with her previous children, however, it is significant that she refused to have contact with the Health Visitor at a time when Father was in prison and a new partner, Mr X was living with her and the children. This meant that essentially there was no agency monitoring Child Ap and her sibling whilst they were in the care of Mr X.

The role of Children's Social Care

5.2.3 The review commends the decision of the Chair of the Initial Child Protection Conference, with the support of the then Social Worker (Social Worker 1), to overrule the majority view of those attending and to make the children subject to Child Protection Plans.

5.2.4 However, there were significant concerns during the time that Children's Social Care was involved with the family.

5.2.5 The children had three social workers in 2016 during the period they were subject to Child Protection and Child in Need Plans, which resulted in delayed progress of the plans and lack of follow up with issues of concern.

5.2.6 The Child Protection Plans essentially appear to be concentrated on reintegrating Father to the family, as the prevailing view of professionals was that there were no concerns about Mother's care of the children, and she was seen to be '*parenting well*'. Given the degree and severity of domestic violence in the home, the disguised compliance on the part of Mother and the emotional abuse and neglect which the children had experienced, this view was over optimistic.

5.2.7 During the first period of the Child Protection Plans Social Worker 1 was off sick and there was an evident lack of recorded visits and follow-up on identified work. At the first Review Child Protection Conference the new Social Worker (Social Worker 2) had only been working with the family for two weeks and, at the time, Mother was refusing to engage with him, as he was male. When Mother did begin to engage, the focus appears to have become more optimistic, simply because Mother was engaging. Once she engaged, Social Worker 2 was focused on her engagement with him, rather than progression of the plans and there was a lack of analysis about what else was happening in the children's lives.

5.2.8 As time progressed the Child Protection Plan was stepped down to Child in Need, but there was no clear evidence that Mother had completed the Freedom Programme and there remained a lack of robust challenge to her poor engagement. Social Worker 2 recorded positive engagement on the part of Mother, despite a lack of visits to the home and the children not being seen. It is of further concern that when Social Worker did visit Mother at home, knowing that she was pregnant, he did not discuss this with her. It would seem that Mother stating that the unborn baby was not Father's was

accepted, even though Social Worker 2 was aware that she had expressed a wish to resume her relationship with Father two weeks prior to this visit. The lack of open and honest questioning of Mother meant that there was no analysis of risk, by Social Worker 2, to the children.

5.2.9 Once the case became one of Child in Need it began to drift, with little if any attention paid to the wellbeing and needs of the children. When Social Worker 2 suddenly left, Social Worker 3 very quickly decided to close the case, with the agreement of the Social Work Manager. This decision was made with the knowledge that Mother was pregnant with her fifth child and with a lack of clarity as to who was the father. The decision was also taken despite the Community Safeguarding Midwife expressing her concerns and professional opinion that closure of the case was inappropriate.

5.2.10 The voice of the children is not clear in Children's Social Care records. During visits to the home the children were rarely seen alone and were, more generally seen in a group with Mother present too. An over optimistic view of Mother, together with an over reliance on what Mother said, meant that there was little assessment of past and more recent concerns which were beginning to emerge in late 2016/early 2017.

5.2.11 Following the injures to Child Ap, the two Strategy Discussion Meetings which took place on 26 & 27 April 2018 did not consider the holistic needs of the children and risk factors in relation to the family or safeguarding actions required. There was no consideration at this point of potential wider concerns for the children and what they may have witnessed in the household prior to Child Ap being fatally injured. Additionally, there was no legal advice sought or discussion about where it might be safe for the children to live or how these decisions had been reached.

Leaving Care Service and involvement with Mr X

5.2.12 It is evident that Mr X was a vulnerable and troubled young person when he became a looked after child. That he was difficult to engage with is clear from the number of times he went missing from placements, his involvement in substance misuse and drug supplying activities and his refusal to accept support offered. Mr X's unwillingness to engage with professionals as a looked after child made it difficult to assess his behaviour and wellbeing. However, there is evidence from the Leaving Care Service IMR that insufficient attention was given by professionals as to the reasons why Mr X was persistently missing, and few follow up interviews took place on his return.

The importance of the School and its involvement with the family

5.3.1 School played a major role in the lives of Siblings 1, 2 and 3 and also in supporting Mother. It offered security and stability to the children and the care and concern for their wellbeing provided by the staff is to be commended.

5.3.2 A real understanding by the teachers of the anxiety the children were experiencing, particularly Siblings 1 & 2, resulted in extra care being offered to them in the form of nurturing sessions, protective behaviour work and the provision of time to talk on an individual basis with staff who knew them well and with whom they felt comfortable.

5.3.3 The awareness of and attention to the children's needs by the teachers is illustrated throughout the review and it is apparent that the children were happy and settled at school. There is much to commend School for the care and consideration offered to the older children.

5.3.4 It is also apparent that some of the actions of the school, however good the intention, were not necessarily in the children's best interests. The School recorded a series of safeguarding concerns about Siblings 1 & 2, but it seems that these concerns were not always referred to Children's Social Care nor were they shared with partner agencies and were sought to be addressed by only speaking with Mother. These included:

- Poor school attendance and lateness. The School dealt with these problems by speaking to and sending letters to Mother and funding the children's attendance at a breakfast club. Mother then arranged for all three children to be sent on occasions unaccompanied in a taxi in time for breakfast. It was usual for Mr X to collect the children. An 'internal child protection concern' was raised in school, but it seems that Mother had informed members of staff that this was her plan to ensure that they arrived on time and that it had been agreed by the school
- The disclosure by Sibling 1 that she and other children in the extended family had been watching programmes not age appropriate.
- Sibling 1 and a friend arrived at school wearing make-up and visibly tired, after not being able to sleep because of Mother having friends round during the night and playing loud music. An 'internal child protection concern' was raised.
- The School was aware that Mr X was living with the family from September 2017 but did not see this as a concern that Mother had a new partner who had moved into the home very quickly after meeting Mother.

5.3.5 There were only two safeguarding incidents which the School shared with Children's Social Care:

- When it was discovered that Mother was allowing a young person, and former student who was subject to Child Protection proceedings herself, to collect the children. The young person was living with Mother. This information was shared at the Review Child Protection Conference in June 2016.
- A mark on Sibling 1's face, which she said was caused by Sibling 3 hitting her in the face with a metal rod. Mother was asked about the injury and confirmed Sibling 1's account. The matter was passed to Children's Social Care for information purposes.

5.3.6 All of the above incidents are indicative of safeguarding concerns, which the School seemingly recognised by raising 'internal child protection concerns.' The School reported to the Child Protection Conference in April 2016 that there were no concerns about the children's behaviour, or their academic progress, that Mother had engaged

well with all the agencies. The focus of concerns was centred around Father's behaviour and his ability to change.

5.3.7 During the course of the Practitioners Event, representatives from School said that they were not aware of the health issues the children experienced. The School also recognised that Mother could be abrupt and difficult at times and questioned whether this was a reason for not challenging her care of the children.

The involvement of Police, National Probation Service, BeNCH CRC and National Youth Offending Service

Police

5.4.1 It is evident that Father, Mr X and Mother by association were well known to Police. The number of domestic violence incidents was high and the level of risk to Mother was therefore considered to be high. In the main, Police acted appropriately in their attempts to protect Mother and the children, and reported such incidents to partner agencies, not least through reports to Child Protection and Child in Need meetings.

5.4.2 The Police IMR makes the point that there was one important incident where a Police Protection Notice (PPN) should have been submitted to Children's Social Care concerning intelligence received in June 2017. This contained information that Mother was in a relationship with Mr X, that he was living in her house and there were concerns that there would be problems once Father was released from prison. No consideration was given to submitting a PPN knowing that Mr X was a prolific offender and drug dealer. Additionally, the potential for further violence at the home address where children were present was overlooked. This was a missed opportunity.

5.4.3 Mother and Maternal Grandmother expressed concern to the report author that safety advice had not been given concerning Mr X and Father. Whilst partner agencies could have provided information concerning Clare's Law[3], it should be noted that Mother had been referred to the Sunflower Centre[4] in the past.

5.4.4 Subsequent Police intelligence concerning Mr X and drug dealing was passed to Children's Social Care 'front door' but was not progressed to the Multi-Agency Safeguarding Hub (MASH). The referral was considered to be '*single strand intelligence and is not corroborated*,' and no further action was warranted. The decision was communicated back to Police (PVP unit) that this information would not be recorded in MASH, as it was unverified and was not seen to be critical. There is a discrepancy in the information recorded between the Police and Children's Social Care as to whether this decision was communicated to Police, which the review has not been able to resolve. It is important, however, to also question the response by Police

[3] See page 21

[4] The Sunflower Centre is a partnership-funded service that provides non-judgemental specialist support to victims of domestic abuse in Northampton.

(Protecting Vulnerable People unit) to the decision by Children's Social Care not to act on the intelligence as it was uncorroborated.

5.4.5 There were several missed opportunities at the time of the incident when Child Ap was injured and events in the days thereafter. These included:

- The bedroom was classed as being the crime scene and focus was placed on this room for Crime Scene Examination. The investigators did not keep an open mind as to other possibilities as to how the injuries to Child Ap had been caused and where else in the house events could have taken place. The scene was released before full medical evidence had been obtained and prior to interview with Mr X had been concluded.
- Child Ap's injuries were not photographed by a Crime Scene Investigator (CSI) on the first day of her admission to hospital. Such photographs can prove crucial when trying to establish causes of injuries, especially in the event of a child surviving.
- Sibling 4 was present in the home when the incident occurred and was placed with a family friend immediately afterwards. Although Police Officers carried out checks to ensure that this person was a suitable adult to look after her, there was very little recorded on the investigation log on the day in respect of the other three children, who were at school. There was nothing to indicate what conversations had taken place with partner agencies and the resulting decisions.
- Little consideration seems to have been given to the safeguarding needs of Sibling 4, who was according to Mr X when interviewed by officers, watching television alone downstairs.
- Mr X was initially released on bail after interview. However, he was not bailed to a specific address, and when arrested he was found to be at Mother's home. Even though his bail conditions stipulated that he should not go there, it is believed that he had returned to the family home and had been living there.
- In the immediate days following Child Ap's injuries, there was confusion as to the whereabouts of the older children.

5.4.6 Although opportunities were missed in the immediate aftermath of the incident, there were also further examples of good practice on the part of the Police:

- A Serious Crime Review was carried out within hours of the injury occurring on day one of the investigation. This was very good practice, as this should be done within 48 hours.
- On 28 April 2018, the Child Protection Team Detective Chief Inspector carried out a Review of the investigation and identified further lines of enquiry, this is regarded as good practice demonstrating the awareness and involvement through the chain of command within the department.

National Probation Service (NPS)

5.4.7 Information supplied by the NPS to this review concerning agency involvement with Father has been helpful. Father remained under their supervision until November 2018. The National Probation Service was represented at Child Protection Case Conferences due to their involvement with Father, and therefore the family circumstances and risks were known to the agency. The statement provided by NPS

to the review identified the risks posed because of his violence towards Mother and the measures which were in place after Child Ap's death to mitigate further possible risk.

BeNCH CRC (Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Relations Company)

5.4.8 The information provided to the Serious Case Review from BeNCH CRC was delayed due to the agency not receiving requests from the Safeguarding Project Officer, Northamptonshire Safeguarding Partnership, for a Statement of their involvement with Mr X. Once this difficulty was resolved, a detailed and helpful statement was provided by this agency.

5.4.9 Mr X was allocated to an experienced responsible officer. It was apparent that Mr X did not comply with the requirements of his Community Rehabilitation Order, and although an OASys[5] risk assessment was completed within the required timescale, it was not reviewed in light of Mr X's further offending.

5.4.10 There is evidence of some good practice by the responsible officer. Contact was made with MARAC to check whether Mr X and the family of Child Ap were known. There is also evidence in case records that the responsible officer carried out a check with MASH in November 2017, to establish whether the family were known and made MASH aware that Mr X was residing within the family home, and that he was subject to a Community Order. There is no information available to the review that this contact was followed up. It is possible that the initial contact was made with the 'front door' and because the case was closed, the information was not passed to MASH. A recent review undertaken of the functioning of the MASH has recognised the need for more robust information sharing between those receiving initial contact information (i.e. the front door) and their MASH colleagues.

5.4.11 However, more information could have been shared with partner agencies concerning Mr X's lack of engagement with BeNCH CRC, his cannabis use, reported anger management, long standing substance abuse, criminal record and convictions relating to violence. Similarly, given Mr X's lack of compliance with his Community Rehabilitation order, breach proceedings could have been initiated earlier.

5.4.12 The Police intelligence concerning Mr X's drug dealing and inappropriate sexual relationships with underage females would not have been routinely shared with BeNCH CRC. However, if a Strategy Meeting had been convened, this information would have contributed to a more informed appraisal of risk presented to the children.

5.4.13 When meeting with Mother and Maternal Grandmother, they told the report author that a Probation Officer knew that Mr X was living with Mother and the children as she had spoken to the Officer on the telephone on several occasions. Information from

[5] Offender Assessment System

BeNCH CRC indicates that Mother did contact the agency in respect of the issuing of warning letters to Mr X because of missed appointments. Mother also stated that Mr X was wearing an electronic tag, but she had no idea as to the reason why. Information provided to the review, clarifies that Mr X was subject to bail conditions imposed by Northamptonshire Magistrates Court in August 2017, which included electric monitoring at Child Ap's address. Mr X was subject to electronic monitoring until October 2017 when he was sentenced for new offences, which did not include a Curfew Requirement. Both Mother and Maternal Grandmother strongly expressed the view that Mother should have been informed about Mr X's past offending history and made reference to Clare's Law[6]. This is discussed further at Section 6.

National Youth Offending Service (NYOS)

5.4.14 This agency was involved with both Father in 2005 and Mr X in 2010, in relation to the assessment of young people involved in pre-court work. The NYOS IMR draws the conclusion that although there was some evidence of management oversight and co-working with colleagues in Children's Social Care concerning Mr X, it was not successful. The review was informed that the service has undergone significant change and in 2016, a more detailed and strengths-based approach to the holistic assessment of young offenders was introduced. This, together with the Risk and Safety/Wellbeing Panels, recently established in Northamptonshire, have introduced clearer communication processes and systems to support young people.

6 Key Learning Points and Emerging Issues

6.1.1 This Serious Case Review, like so many others, has identified several recurring themes for professional learning and improved practice.

The need for information sharing to support holistic assessment

6.1.2 Throughout the period when the children were subject to Child Protection and Child in Need Plans professionals concentrated on the risk presented by Father's domestic violence to Mother. From reviewing the Child Protection Conference minutes, it is evident that both the School and Health Visiting had a very positive view of the care offered to the children by Mother. Father was considered to be the person who presented a safeguarding risk to the children and when he was in prison the risk was considered to be less. Little importance appears to have been given to police intelligence (and Father's convictions) for drug use and drugs being supplied from the family home.

[6] The Domestic Violence Disclosure Scheme (DVDS) is often called 'Clare's Law' after the landmark case that led to it. Clare's Law gives any member of the public the right to ask the police if their partner may pose a risk to them. Under Clare's Law, a member of the public can also make enquiries into the partner of a close friend or family member.

6.1.3 There was a lack of assessment made as to whether the children were being neglected and information which supported this was not shared amongst partner agencies. Whether this was because the reports prepared by the GP Practice for the Case Conference were not sent or were received by Children's Social Care, but not logged on the system, is an issue which remains unresolved. The system currently in place does not allow for the acknowledgement of reports for Child Protection Conferences, nor does it appear that there is any follow up (i.e. in the form of a read receipt request) by the agency sending the report. This is a lesson learned and is a recommendation from this review.

6.1.4 Similarly**,** the information contained in the GP records concerning the number of A&E attendances by the children, their history of urine infections, bacterial skin infections, dental decay and not being brought for appointments does not appear to have informed professional decision making.

6.1.5 Whilst it is apparent that the children experienced emotional abuse, given the volatile nature of the parental relationship, it is also evident from this review that they were all also subject to neglect. However, reports from the School and Health Visiting Service maintained that Mother's care of the children was good, that there were no concerns about the children's progress at school and that they were reaching appropriate milestones. Essentially, neglect of the children did not feature as a concern for professionals, and this view had a major influence on decisions made by the Child Protection Conference.

6.1.6 The School became aware that Mr X was in a relationship with Mother and although Mother gave permission for him to collect the children, she did not share with staff that he was living in the family home. There was no questioning of Mother as to who this new person was in her life and more importantly that of the children. The School IMR raises an important question as to whether staff did not seek clarification from Mother because there was a culture that 'a change of partner was the norm' for families attending the school and that it was not the school's place to question such arrangements as it was 'mother's business'.

6.1.7 The agency which was aware of Mr X's background and that he was living with the family was BeNCH CRC. Information was shared with MARAC and MASH, however there was a missed opportunity by Children's Social Care 'front door'/MASH to make further inquiries about Mr X. If this had happened, a Strategy Meeting should have been convened to assess the risk posed to Mother and the children.

6.1.8 The intelligence report from Police of drug activity at the family home which was sent to Children's Social Care 'front door' should have been taken more seriously and passed to the MASH for investigation, and is a lesson learned from this review.

6.1.9 The passing on of information by midwifery services to MASH that Father was the father of Child Ap is an example of good information sharing. Unfortunately, there was a failure to analyse this information and the suggested outcome for referral to Early Help was inappropriate, given that Mother had refused any such engagement

several times. However, it appears that MASH Initial Contacts identifying that Early Help was required was not forwarded to Early Help Services and were not recorded on Early Help systems. There is no record of what happened to this recommendation and why follow up support was not put in place.

Disguised Compliance and Non-engagement

6.1.10 Disguised compliance on the part of Mother is a key theme of this review. There was an assumption by professionals that she had engaged with the Freedom Programme because she had completed the online course. In reality Mother only attended two out of the twelve face to face sessions.

6.1.11 Whilst not underestimating the power of a domestic abuser over a partner, even when he is no longer in the family home, the decision by Mother to continue to engage with Father, whilst action had been taken to protect her and the children, was dangerous. Agency focus was very much on Father's criminality, without any analysis of Mother's protective capacity or what this meant in relation to her being able to safeguard her children.

6.1.12 Social Worker 2 considered that Mother did positively engage with him but failed to realise that it was on her terms; given that a significant amount of contact was on the telephone, the children were not consistently seen and when they were seen it was as a group with Mother present. Similarly, Social Work assessment and intervention lacked professional curiosity and challenge.

6.1.13 Mother frequently did not attend appointments or was out when Heath Visitors wished to see her. The School was supportive of Mother and the children and considered that she in turn engaged well with them. Yet it was only when gathering information for this review that the school realised that Mother had not attended any parents' evenings, the children's attendance continued to be poor and Mother had not been as forthcoming about her continued involvement with Father and her subsequent relationship with Mr X.

Lack of Focus on the children

6.1.14 What is apparent from this review is that professional intervention, most particularly in respect of Children's Social Care, was very adult focussed and the children's voices were not fully or appropriately sought or captured. Apart from what happened in school there is minimal evidence of direct work with the children or appropriate child-focussed conversations to engage the children throughout agency involvement with the family.

Assessment of significant male adults in the lives of children

6.1.15 Whilst there was focus on Father's criminality, no assessment was made of his ability to care for his children. As is the case in many Serious Case Reviews, very little is known to this review about Father.

6.1.16 The same conclusion can be drawn in respect of Mr X and the parenting skills he offered to the children. What is known is that like Father, Mr X had a propensity for violent behaviour, drug use and drug dealing, as well as being homeless, prior to moving in with Mother and the children. The fact that Mr X had such troubled teenage years whilst a looked after child, ending up homeless on the streets of Northamptonshire, raises the question of whether he wasn't looking for a home himself, and Mother provided one for him, albeit with her five children.

6.1.17 The main information available about Mr X's care of the children has been provided by Mother and Maternal Grandmother, who considered him to be loving and caring towards all of the children, giving them no cause to think that anything untoward would happen. None of the agencies directly involved with Mr X whilst he was living with Mother made an assessment of or gave consideration to the risk he may have presented.

6.1.18 Mother vociferously put her view across to the report author that she felt 'let down' by agencies, most especially the Probation Service, because information was not shared about Mr X's background. However, it has emerged during the course of this review that information was shared with MARAC and MASH. Both Mother and Maternal Grandmother said that they should have been made aware about Mr X's past under Clare's Law. Under the Domestic Violence Disclosure Scheme, it is possible for anyone to seek information about a partner's history. Mother may have not been aware that she had the right to do so and it is a learning point from this review that awareness needs to be raised amongst parents about the risks of allowing a relatively unknown/new partner into the family home.

6.1.19 However, the review also recognises that Mother consistently declined to work with agencies until the point of Child Ap's death and was initially of the view that Mr X could not have been the person responsible for her daughter's death.

7 Conclusion and Recommendations

7.1.1 Child Ap died on 29 April 2018 after suffering a catastrophic brain injury whilst in the care of Mr X. Mr X has been convicted of her murder and sentenced to life imprisonment.

7.1.2 This Serious Case Review has provided a thorough and comprehensive examination of what happened to Child Ap during her tragically short life and has attempted to provide an explanation as to why events leading to her death occurred. It is clear that there could have been better information sharing by agencies to inform a holistic assessment of the safeguarding risks presented to Child Ap and her siblings. This has been extensively addressed in the review.

7.1.3 It is apparent that the focus of professionals was very much on the behaviour of the adults involved in this case, which sadly was to the detriment of the wellbeing of the children. However, whilst there was a focus on Father's violence against Mother and

the risk posed to the children, there was little if any, assessment of Mother's parenting skills. The need for professionals to be mindful to assess both parents when considering the protection of children is one of the key learning points arising from the review.

7.1.4 Disguised compliance on the part of Mother is a key theme of this review. Whilst professionals from Health, Children's Social Care and the School assumed that Mother was engaged with them, in effect she only engaged when she chose to, as illustrated throughout the period of agency involvement.

7.1.5 From what is known and from the discussions with professionals at the Learning Event it is apparent that no individual agency could have foreseen or prevented the death of Child Ap.

7.1.6 Agencies have already taken measures to change their policy and procedures as a result of the issues raised in this review. This is manifest in recent information shared with the Serious Case Review Panel that 40% of Police referrals to the MASH containing non-corroborated information were considered to require no further action. An audit is being undertaken of MASH decision making and outcomes. It is anticipated that the findings from this Serious Case Review will feature in the way in which such information is received in future.

7.1.7 The Serious Case Review has highlighted good practice. There are also a number of areas where practice can be improved, which are reflected in the recommendations to Northamptonshire Safeguarding Partnership.

Recommendations

Recommendation 1:

The Northamptonshire Safeguarding Partnership needs to be assured that all agencies involved in child protection processes work together so that there is focus on the needs and wellbeing of children, and that the interests of children are the first priority of professionals. This will be achieved by the Safeguarding Partnership undertaking a multi-agency audit, with external scrutiny.

Recommendation 2:

(a) The Safeguarding Partnership will remind all agencies involved in Child Protection and Child in Need Processes of the vital importance of sharing all information known to them in order that a holistic assessment can be undertaken of a family. This will include the requirement to be mindful of the need for professional curiosity, (including the arrival of a new partner in a family) which is embodied in thorough assessment processes, rather than consideration of episodic events, which can lead to disguised compliance on the part of parents being missed. This may necessitate the need for the provision of further professional training.

(b) **The Safeguarding Partnership will seek assurance from all agencies involved in Child Protection Conferences that when a representative cannot attend and a report is sent on behalf of the agency, a process is in place whereby receipt of the report is acknowledged.**
(c) **Where Police and/or Probation intelligence is shared with other agencies about the risks presented by the behaviour of adults to children this needs to be investigated to ensure that children are safe.**
(d) **Partner agencies will ensure that a Strategy Meeting needs to be convened when there is Police intelligence and/or where it is believed that drug dealing is taking place within a household where children are present.**

Recommendation 3:

(a) **The Safeguarding Partnership will consider providing a programme of training to all partner agencies on the importance of recognising disguised compliance on the part of parents.**
(b) **The Safeguarding Partnership will undertake multi-agency case audits to assure itself that agencies are fully utilising the Northamptonshire Graded Care Profile when assessments are made.**
(c) **Where cases are not progressing, the importance of reflective supervision and challenge needs to be emphasised and reinforced.**

Recommendation 4

The Safeguarding Partnership will assure itself that the seriousness and significant risk of cannabis misuse on the ability of a parent/carer to care and safeguard their child is fully understood by all professionals by:

(a) **Providing training which emphasises the risk of parental cannabis misuse to children and the potential impact on them.**
(b) **Reviewing the Threshold Assessment Framework so that cannabis use is included.**
(c) **Undertaking a local media campaign to raise awareness of the risk and impact of misusing drugs and alcohol around children.**
(d) **When undertaking any assessment, cannabis use by a parent/carer is taken into account.**

Appendix 1

SERIOUS CASE REVIEW
Child Ap
SCOPE & TERMS OF REFERENCE

The Serious Case Review Panel took the decision that, with reference to the requirements as set out in Chapter 4 of *Working Together to Safeguard Children* (2015) that the threshold was met to commission a Serious Case Review in respect of Child Ap.

The purpose of the review is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations will need to translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

The following **principles** should be applied by the LSCB and its partner organisations to all reviews:

- There should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring the child is at the centre of the process[7]
- Final reports of SCRs **must be published**, including the LSCB's response to the review findings, in order to achieve **transparency**. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must be described in LSCB annual reports and will inform inspections; and
- Improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

SCRs and other case reviews should be **conducted** in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;

[7] British Association for the Study and Prevention of Child Abuse and Neglect in Family involvement in case reviews, BASPCAN, further information on involving families in reviews.

- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

The methodology agreed for this review is a blend of traditional and new: with agencies involved with the family required to complete Internal Management Reviews that should be clearly focussed on addressing the issues for consideration outlined below. There will also, and in parallel, be a process of greater collaboration through conducting conversations with the practitioners and clinicians involved, and holding a multi-agency briefing at the start and near the end of the process, in order to identify learning and encourage reflection on their involvement; to examine the actions and decisions taken; and to understand the context.

Issues for consideration by IMR Authors and the Lead Reviewer (when conducting conversations and writing their reports):

Child Ap

- Voice of the child.
- What was a typical day like for the child?
- Does any agency have any understanding of the child having a previous head injury?
- Was a differential diagnosis of non-accidental injury (NAI) considered at point of presentation? Was the appropriate level of probability conveyed to the police and all relevant partners?
- Explore all medical appointments in terms of frequency, reason and outcome.

Siblings

- Voices of the siblings.
- What was a typical day like for the children?
- Explore all medical appointments in terms of frequency, reason and outcome.
- Protective behaviours offered to the sibling at school – understand what was offered and were there any barriers to this.

Mother

- Disguised compliance – mother does not consistently engage with services and appears to tell agencies different information.
- Knowing domestic abuse was a feature in mother's previous relationship, what work was undertaken with her regarding her relationships?
- What was mother's relationship like with the children's father?
- What was mother's relationship like with her partner, the alleged perpetrator?

Mother's Partner – Mr X

- What are professionals' understanding of his history and was it known he was caring for children?
- What was known about drug use – it appears drug use increased once the alleged perpetrator moved into the family home.
- What was known about his relationships and does he have any other children?

Household

- What was a typical day like for this family?
- Did anyone have a holistic understanding of what was happening in this household?
- How did agencies share health information and work together?

Father

- What was professional's understanding of his involvement with the children?
- What was professionals' understanding of his relationship with the mother?

General

- Decision making – when the initial contact came into MASH, the wider context does not appear to have been considered. The case was to be signposted to Early Help, but this was declined by the family.
- What support was offered by the school and what referrals and concerns were raised by them?

The time period for this Review is 1st January 2016 to 7th May 2018.

This starts from the approximate point that it is believed the alleged perpetrator may have started to live in the family home to approximately one week after Child Ap's death to include an understanding of how the four siblings were safeguarded after the incident.

Agencies should include a summary of any earlier contact with the family relevant to the learning aims of this Review.

Agencies should consider this case in the light of other recent SCRs, particularly Ref064.

Internal Management Reviews are not required to provide extensive background information against the general headings for enquiry as set out in *Working Together 2010*, but should concentrate on addressing the core issues identified above. This is in line with the greater discretion in methodology and concentration on learning and improvement as set out in *Working Together 2015*.

A template for the Chronology and reports will be provided.

Panel consists of:

Moira Murray Independent Chair and Author
Designated Nurse Safeguarding & LAC Countywide, Nene & Corby
Clinical Commissioning Groups
Detective Chief Inspector, Northamptonshire Police
Director of Nursing and Quality, Kettering General Hospital
Clinical Lead for Safeguarding Children and MASH,
Northamptonshire Healthcare Foundation Trust
Designated Doctor Child Protection, Nene and Corby Clinical Commissioning Groups
Safeguarding Project Officer, Northamptonshire SCB

IRO and CP Chair Manager, Children First Northamptonshire
Lead for Safeguarding in Education, Children First Northamptonshire
Service Manager, Children First Northamptonshire

IMRs will be provided by:
Children First Northamptonshire
GP Services, Nene & Corby Clinical Commissioning Groups
Kettering General Hospital
Northamptonshire Healthcare Foundation Trust
Northamptonshire Police
Team Manager, Leaving Care, Children First Northamptonshire
Siblings School

Statements of Information will be provided by:
Youth Offending Service
Probation Service
BeNCH Community Rehabilitation Company

The Serious Case Review Report Author

Moira Murray is a social worker by training and has been the chair and author of numerous Serious Case Reviews over the past nine years. She is a member of the Church of England National Safeguarding Team and has undertaken safeguarding audits for local authorities, the NHS, the Foreign & Commonwealth Office and the BBC. She was a non-executive board member of the Independent Safeguarding Authority for five years and in 2012 was appointed Safeguarding Manager for children and vulnerable adults for the London Olympic and Paralympic Games.