Serious Case Review

Overview Report

Relating to Child T

Date: 22nd April, 2015

Ethnic Origin: White British

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Part One

About the author

I have been a social worker for 19 years, having gained the relevant Diploma in social work from the University of North London in 1995, and have worked in social care for 22 years. Most of my work has been in child protection. Since 2008 I have worked as an independent child protection consultant and trainer and have undertaken a number of serious case reviews, usually as the overview author but also an IMR author. I am also an accredited lead reviewer in the Social Care Institute for Excellence (SCIE) "Learning Together" systems approach to case reviews and have, to date, been involved in four systems reviews. (I was involved in the Government's South West pilot of "Learning Together" reviews, alongside Bristol in 2011). As well as undertaking consultancy work I also develop and deliver child protection training and am a published author.

1. Introduction

1.1 Circumstances leading to this serious case review

Child T was admitted to the Bristol Children's Hospital on 11th January 2013 with an acute collapse. Child T tragically died at 02.19 hours on 14th January 2013.

CT scan revealed significant subdural and subarachnoid haemorrhages with hypoxic brain injury. Child T had some bruising on the ear and arms and extensive retinal haemorrhages. There have been no medical conditions discovered to account for these injuries so far and it is the opinion of all professionals involved that the most likely cause of Child T's death is non-accidental injury, probably due to a shaking injury.

The case was requested to be considered for a serious case review by the Community Paediatrician on call the weekend that Child T was admitted to hospital. The request was formally sent on 18th January 2013 and considered by the Serious Case Review Sub-Group on Monday 28th January 2013. It was considered that the circumstances of the child's death fully met the criteria for a serious case review, as set out in Chapter 8 of Working Together to Safeguard Children, 2010.

1.2 The Child Death Overview Process

From 1st April, 2008 Child Death Review processes became mandatory for Local Safeguarding Children's Boards in England. The processes to be followed are outlined within Working Together to Safeguard Children (2013). This process will work with this serious case review.

1.3 Criminal investigations, care proceedings and coroner's inquiries

1.3.1 All parallel proceedings have now concluded.

1.3.2 The Crown Prosecution Service (CPS) and coroner were informed of the SCR process. The independent chair of the SCR Panel liaised with the Senior Investigating Officer. It was the role of the Detective Inspector on the SCR Panel to ensure that any information relevant to the criminal proceedings, which arose from the serious case review process, be identified as such. No relevant information was identified.

1.3.3 The main body of the serious case review was concluded in December, 2013. Publication was delayed due to the requirement to wait until the conclusion of the criminal trial.

1.3.4 In December, 2013 Mr Z was found guilty of the manslaughter of his child, Child T. Ms A was acquitted of the charge of causing or allowing the death of a child.

1.4 Terms of Reference (TOR) of the review

1.4.1 In addition to the general requirements set out in chapter 8, Working Together to Safeguard Children, 2010 the serious case review and Individual Management Reviews (IMRs) were specifically asked to consider in respect of Child T:-

> TOR 2.1 In relation to this case was there a failure by agencies in working with this family in not recognising evidence of risk of significant harm? If such evidence exists, was this shared and/or acted upon in an appropriate and timely manner?
>
> TOR 2.2 In relation to the parents (and anyone who had care of Child T) are there any relevant medical, mental health, substance misuse (including alcohol) issues, previous convictions, intelligence and/or domestic violence or any children from previous relationships where these issues would apply?
>
> TOR 2.3 Did any agency working with this family fail to recognise previous evidence of risk of significant harm or need? Where such evidence exists was it shared and/or acted upon in an appropriate and timely manner?
>
> TOR 2.4 Do any issues emerge in relation to the safeguarding or management of risk in relation to domestic violence or abuse?

1.5 Methodology

1.5.1 The decision to undertake this serious case review was made at a time when the publication of the new statutory guidance, Working Together to Safeguard Children was imminent. The updated statutory guidance was to be informed by Professor Eileen Munro's report[1] to Government, published in May, 2011 Her recommendation regarding serious case

[1] The Munro Review of Child Protection: Final Report. A child-centred system. http://www.official-documents.gov.uk/document/cm80/8062/8062.pdf

reviews was that Local Safeguarding Children Boards (LSCBs) should use systems methodology when undertaking serious case reviews and, "Over the coming year, work with the sector to develop national resources to:

- provide accredited, skilled and independent reviewers to jointly work with LSCBs on each SCR;
- promote the development of a variety of systems-based methodologies to learn from practice;
- initiate the development of a typology of the problems that contribute to adverse outcomes to facilitate national learning".

1.5.2 Professor Munro specifically recommended using the systems model developed by the Social Care Institute for Excellence (SCIE). Subsequently the Government funded a pilot using this methodology, and Bristol was part of the South West pilot. This was in 2011.

1.5.3 In November 2012 the draft Working Together was published and this stated that LSCBs should use systems methodology when reviewing serious cases. However as this was only in draft form in January 2013 when the decision was made to undertake an SCR in respect of Child T the Independent Chair was clear that the methodology set out in chapter 8 of Working Together, 2010 must be used, as that was the current statutory guidance. This decision followed robust discussion amongst the SCR sub-group and it was agreed that within that framework an element of systems learning would be included. (BSCB had undertaken two previous SCRs in the past three years and wanted to ensure they maximised the learning potential from this review).

1.5.4 To that effect the IMRs were completed with guidance from myself, the overview author and the SCIE systems methodology was explained to the SCR Panel and the IMR authors. The IMR authors interviewed the key professionals from their agencies, who had been involved with the family and were still working with the organisation. Once the IMRs had been completed there followed two meetings with the IMR authors and the SCR Panel. The first meeting was to consider significant events in the chronology, events which may have led to events taking a different turn, if they had been responded to differently. From that I deduced some themes arising from this case. The second meeting was to go through those themes and agree the final themes for analysis.

1.5.5 It should be noted that although SCIE has been mentioned, because it was recommended by Professor Eileen Munro and the author is an accredited SCIE lead reviewer, this is not a SCIE review.

1.6 Contributors to the review

The Family

Child T – 3 ½ months at the time of death

Child U, sibling – Under two at the time of the death of Child T

Mother – 18 at the time of death of Child T

Father – 24 at the time of death of Child T

1.6.1 The parents of Child T were made aware of the SCR in writing and were invited to make their own contributions to the review. Neither parent responded to the letter sent to them initially. Following the conclusion of the criminal trial the parents were contacted again, as were the maternal grandparents and paternal grandmother. It is good practice to involve families in serious case reviews, wherever possible. Our learning should come from families, as well as professionals however this resulted in further delay. In February, 2014 I met with Child T's mother, Ms A and Child T's maternal grandmother. In April, 2014 I met with Child T's paternal grandmother. Their views are woven throughout the report. Mr Z has declined to contribute to the serious case review.

The Professionals

1.6.2 The SCR Panel is made up of the following members:-

Deborah Jeremiah Independent Chair SCR Panel

Service Manager, Safeguarding and Quality Assurance, Bristol Children and Young Peoples Service (CYPS)

Consultant Community Paediatrician from North Bristol Trust acting for the Clinical Commissioning Group

Designated Nurse for Safeguarding, NHS Bristol Clinical Commissioning Group

DCI, Avon & Somerset Constabulary, Bristol Public Protection Unit (PPU)

Service Manager, NSPCC

Crime reduction project officer Manager, Safer Bristol. Community Safety Partnership

Service Manager East/ Central, CYPS, Bristol City Council

Team Manager, Barnardo's Against Sexual Exploitation (BASE)/Safe Choices, Barnardo's

1.6.2 A Health Overview Report (HOR) was provided by Bristol Clinical Commissioning Group (CCG)

1.6.3 IMRs were provided by the following agencies:-

North Bristol NHS Trust

Avon and Somerset Constabulary

Avon and Wiltshire Mental Health Partnership Trust (AWP)

Avon and Somerset Probation Trust

CYPS, Children's Social Care

University Hospitals Bristol NHS Foundation Trust (UHB)

Bristol Youth Offending Team (YOT)

Learning Partnership West (LPW)

Bristol Drugs Project (BDP)

Next Link Domestic Abuse Services

CYPS, Early Years: Children's Centre

General Practice/Primary Care

The school attended by Ms A, the mother

The IMR authors were all invited to the two meetings, referred to in 1.5.4, and there was good representation of agencies at each of the two meetings.

1.7 The scope of this Serious Case Review

This serious case review is about Child T. Consideration will be given to relevant criminal history, intelligence, matters of medical history, education and social functioning of Child T's parents and where appropriate extended family members who were significant to Child T in order to provide some context of the life of Child T. The SCR Panel will not be prescriptive as to the range of records and time-frames to be considered by the IMR authors in their reports. Their professional judgement should be exercised in order to locate relevant information and outline the pertinent factors to include in their IMRs. However, the SCR Panel would expect the minimum to include all agency involvement prior to the birth of Child T and their sibling Child U and the commencement of their parents' relationship in 2007 until Child T's death on 14 January 2013. Consideration should be given to a thorough evaluation of records held regarding the histories of Mr Z and Ms A, Child T's Parents and Ms H the Maternal Grandmother.

1.8 Documents read by the overview author include:-

- Bristol City Council Ofsted Inspection of Safeguarding and Looked After Children, April, 2010

- Bristol City Council Ofsted Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board, December, 2014
- "The sexual exploitation of children: it couldn't happen here, could it?" Ofsted's thematic review of child sexual exploitation, which included eight local authorities, including Bristol
- Previous BSCB serious case reviews, including Child Z, 2009, Child M, 2011 and Child K, 2012
- MARAC Self-Assessment – Bristol (North and South). CAADA, 2012
- Bristol Safeguarding Children Board Serious Case Review Process
- BSCB Joint Safeguarding Children Protocol. Children and Families Living with Substance Misuse. Safer Bristol
- BSCB Joint Practice Guidance for Children's Services and Adult Substance Misuse Services. Children and Families living with substance Misuse. Safer Bristol
- Minutes of strategy discussions held on 16.1.12 and 3.7.12
- The partnership agreements drawn up on 16.1.12, 28.6.12, 26.7.12 and 30.11.12
- MARAC meeting minutes dated 20.1.11 and 17.11.11
- Barnardo's Against Sexual Exploitation (BASE) fact sheet
- Bristol BASE Annual Impact Results Report. March, 2013
- Engaging Fathers in Child Protection. An audit of Bristol policies and 20 child protection cases. Family Rights Group. May, 2012 and subsequent action plan, November, 2012.

2. The Facts

2.1 The Family

2.1.1 The immediate family consisted of the Mother, Ms A, the Father, Mr Z, the older child, Child U and the younger child, Child T. Ms A and Mr Z were known to have been together since Ms A was aged 13 and Mr Z aged 20, five years at the time of Child T's death. It will never be known how much of those five years Ms A and Mr Z were together, for reasons which will become apparent as you read this review. The professionals were under the impression that the couple were not together for much of the five years. The family describes a different scenario, that being that the couple were rarely apart.

2.1.2 The extended family members, who had involvement with the family and with whom the agencies had some involvement, consisted of the Maternal Grandmother (MGM), Ms H, the Maternal Grandfather (MGF), Mr G and the Paternal Grandmother, Ms E.

2.1.3 In addition to this Mr Z had two other known relationships, both prior to and possibly during his relationship with Ms A.

2.2 Genogram

A genogram of the family is Appendix Two.

2.3 Ethnic, cultural and other equalities issues

2.3.1 Ms A and Mr Z are both White British. There are cultural and equalities issues which will be considered in the analysis of this review. Those issues were assumptions made about the type of families and children who live in particular areas of Bristol and about Ms A and Mr Z generally. (See 3.1.11 and 2.6.15). There were also assumptions made about Ms H and Ms A being able to read sufficiently to receive written material, without any evidence that this had been confirmed. (See 2.6.6). Again, this will be examined in the analysis of this review.

2.3.2 There is no mention of any of the family members being affiliated to any particular religion and the family members interviewed made no mention of religion.

2.4 Information about the parents/carers, extended family and home circumstances of the children

The Mother – Ms A

2.4.1 The first concerns expressed by any agency were by the school in September, 2006, when Ms A was 12. The concerns were about her attendance, which was starting to drop. Prior to that her attendance had been excellent and she was described as "Well presented" in school. Ms A first became known to social care in April, 2007. The police had attended a domestic incident involving Ms A's parents. Ms A and her sister had witnessed the incident.

2.4.2 As Ms A's childhood progressed there were on-going concerns. She had a difficult relationship with her mother, with Ms A accusing her mother of physical abuse on more than one occasion. There was little reference to her father's involvement. She had periods of exclusion from school, was alleged to have physically assaulted another pupil, her disruptive behaviour increased, her attendance kept dropping and eventually it was decided she would be better suited to attend a vocational course at a college, at the age of 13 years and six months. It was around this time that Ms A's parents were separating and Ms A said it was this that led to her behaviour deteriorating. She described being very upset by their separation. There were also further recorded incidents of domestic abuse between Ms A's parents during this time and there was known to be excessive alcohol use.

2.4.3 Ms A was known to have started a sexual relationship with Mr Z when she was 13 and Mr Z was 20. Reference was also made to her drinking alcohol at this time. By the age of 14 Ms A had fallen out with her mother, was disappearing for days on end, according to her mother and was found living in a tent with Mr Z. Ms H described taking Ms A to social care

when she was 14 and handing her over, telling them to deal with her because she could not anymore

2.4.4 The rest of her childhood remained chaotic. She went to stay with a family friend but that then broke down and she returned home. In 2010 she was thought to be sleeping rough again and was offered bed and breakfast accommodation. She became pregnant with Child U when she was 16 and Mr Z moved in with her.

2.4.5 The relationship between Ms A and Mr Z was known to be abusive from November, 2011, when Ms A was in her second trimester of her pregnancy with Child U.

The Father – Mr Z

2.4.6 Very little was known about Mr Z's childhood, except that from the age of fifteen he became a prolific offender, until the criminal trial. What came from the trial was that Mr Z had one to one support from the age of two, in nursery, and he was not allowed to stay in nursery during lunchtimes because his behaviour was so disruptive. His mother, Ms E, confirmed this. She said that this continued when he went to school but his attendance at school was very poor. We would not have expected the workers working with the family to have had this level of detail about the family history. Murder inquiries allow for a level of investigation that is neither realistic, nor practicable in child protection work. Ms E did not engage with the school and he was only in secondary school for a short period before he dropped out completely. (It has not been possible to be more specific about Mr Z's school attendance because there was no mention of his schooling in the IMRs. The timeline under consideration did not go back as far as Mr Z's time at school. What is relevant and concerning is that the professionals working with Mr Z and his different partners and his children did not know about his history). This information has not been disputed.

2.4.7 In conversation Ms E did not express concern about Mr Z's behaviour, or lack of school attendance. When Mr Z was a child Ms E only spoke of one contact with professionals. She described asking the GP once if he thought her son had Attention Deficit Hyperactive Disorder (ADHD). Ms E said the doctor said he did not have ADHD and that was the end of it.

2.4.8 Between 2003 and 2007 Mr Z was the subject of 86 police reports, including dealing drugs and theft. None of these involved violent crime. There were some offences of assault and causing actual bodily harm, including assaulting a police officer in 2005, when he was 17.

2.4.9 Mr Z's offending behaviour decreased from 2007 and most of his contact with the police from that point was to do with child abduction and domestic abuse, although there continued to be some theft and criminal damage.

2.4.10 The first known domestic abuse incident between Mr Z and a female, an ex-partner, Ms X, was in 2006. From that time there were many recorded incidents of domestic abuse

between Mr Z and the three females he was/had been in relationships with. The first mention of Mr Z's mother was a domestic abuse incident between Mr Z and his mother, Ms E. Mr Z was the alleged perpetrator. He was 19 at that time.

2.4.11 The first reference to Mr Z and street drugs was in 2006, when he was arrested for dealing Class A drugs. At that time it was alleged he was also using Class A drugs. In 2009 Mr Z told his GP he was addicted to crack cocaine and heroin and had been using intravenously for two years. There continued to be issues of Mr Z and street drug use throughout the rest of the period under review, with his mother requesting the GP's help in November, 2012.

Home Circumstances

2.4.12 From the time of their births until Child T's death, in January, 2013, the children lived with their mother. As stated in 2.1.1 we will never know how much of that time Mr Z was also living in the home, however Ms A says he was there most of the time. She described being unable to keep him away. For much of that time he was not supposed to be having contact with Ms A and yet we now know he was.

2.4.13 During the periods Mr Z was accepted to be staying/living with Ms A he mostly presented to professionals as being supportive. It was recorded on occasions that he had a good bond with the children and he was keen to be a better father. Ms A's view of this was that he did not care for the children but that he knew what to say to professionals.

2.4.14 There were no particular concerns expressed by professionals about the cleanliness of the home, or the physical care of the children. There was no record of electricity running out, or food cupboards being bare. There was a concern that the parents were using Child U's bedroom for storage of items, which meant Child U was sleeping on the sofa in the front room. A family member had bought Child U a bed in October, 2012 but Ms A and Mr Z wanted to keep it until Christmas because Child U's bedroom was not ready. There was also a concern that when Child T was born Ms A did not have a double pram, which meant she was unable to leave the house with the children, unless there was another adult and another baby carrier, although she and Mr Z had recently spent money on non-essential items.

2.5 Summary of significant events

(Although all of the events listed below are considered significant, it must be accepted that some have only become significant with the benefit of hindsight and the knowledge of the tragedy that took place).

There is purposefully limited information in this review about Mr Z's previous known partners, Ms X and Ms W. The information included is relevant and necessary because it demonstrates a pattern of behaviour by Mr Z but is limited because the focus of this serious case review is Child T and Child T's life and family.

2.5.1 On 20.2.06 Mr Z was first accused of domestic abuse. He was prosecuted for punching his ex-partner, Ms X, in the face and for criminal damage.

2.5.2 On 1.6.06 Mr Z was prosecuted for the incident set out in 2.5.1 and found guilty. He was also found guilty of a further assault on Ms X. This time he punched her, pushed her over and smashed her mobile telephone. He was given a 12 month Community Order and 100 hours of unpaid work. Ms X was under 16 at the time.

2.5.3 On 15.11.06 police enforcement action was taken against Mr Z for dealing Class A drugs. He was also thought to be a user.

2.5.4 On 1.2.07 there was an alleged domestic abuse incident between Mr Z and Ms W. there was no further action by police as the incident was not officially recorded. Ms W was under 16 at the time of the alleged incident and was seven weeks pregnant with Mr Z's child.

2.5.5 In March, 2007 there were two incidents with Ms A in school. On 7.3.07 she refused to comply with school rules and sanctions and was excluded for one day. On 28.3.07 she physically assaulted another student and was excluded for another day. On 19.6.07 the school made a referral to social care because of concerns of neglect of Ms A and her sibling. Social care told the school they would make a referral to a family support service. (This family support service was one of the three services that had been commissioned by Bristol City Council to undertake the early intervention work in the three social care localities, at that time. The expectation was that they would undertake the assessment under the Common Assessment Framework (CAF)). This family support service has no record a referral was ever made. There were further assaults on other students on 11.10.07, 23.11.07, 3.12.07 and 16.1.08. These assaults included punching in the head on one occasion and in the eye on another. These resulted in further exclusions.

2.5.6 On 8.4.07 police attended the first domestic abuse incident between Ms H and Mr G. They were sent literature about domestic abuse. (See 2.3.1). In the next few months a number of further domestic incidents were reported. During this time Ms A alleged she was being physically abused by Ms H. In April, 2007 social care referred the family to a specialist domestic abuse service. In June, 2007 their records show there should be a referral to the specialist domestic abuse service and the family support service, again the referral to the family support service was never made. During this period Ms A's behaviour and attendance at school deteriorated and Ms H accused Ms A of stealing jewellery from her "To fund her cocaine habit". Although there was no evidence of a drug habit, Ms A was said to have an extensive knowledge of street drugs at 12 years old and said she frequented crack/heroin houses. (This information came from the initial assessment completed by the social worker at that time). As a result of this allegation there was a strategy discussion held between police and social care. Social care undertook an initial assessment. The outcome of which

was for the family support service to continue to support the family. (This was a misapprehension as the family support service had never worked with the family).

2.5.7 On 10.7.07 Ms W alleged Mr Z punched her in the stomach. She was seven months pregnant at the time. Mr Z was arrested for common assault and given a police caution.

2.5.8 On 21.8.07 there was an alleged domestic abuse incident between Mr Z and his mother, Ms E. There was a further alleged incident between them four months later. At the time Ms E said Mr Z grabbed her around her throat. Mr Z was charged with criminal damage to the property but the Crown Prosecution Service advised no further action regarding the domestic abuse because Ms E wanted to drop the charges and Mr Z said she had assaulted him first.

2.5.9 In the autumn of 2007 Ms W's child, Child V was born. Mr Z was present at the birth. Ms W was under 17 at the time of Child V's birth.

2.5.10 On 3.10.07 Mr Z agreed to counselling, as part of a partnership agreement between Ms W, Mr Z and social care. It was noted by social care that Mr Z could not read. Mr Z expressed remorse about his previous behaviour and told social care he wanted help on "Low self-esteem and anger management". Three weeks later Ms W told social care her relationship with Mr Z was over because she suspected he had been using crack cocaine and he allegedly pushed her in the street and tried to snatch the baby, Child V.

2.5.11 On 18.1.08 Mr Z was remanded in custody for stealing a car and related offences.

2.5.12 On 1.5.08 Ms H reported to the police that Ms A, aged 13, was in a sexual relationship with Mr Z, aged 20, she was also known to be drinking alcohol. As a result of this a strategy discussion was held between the police and social care. The police arrested Mr Z for abduction and served him with an abduction notice. Mr Z gave a "No comment" interview and the case was closed as an undetected crime due to insufficient evidence. Ms A had been unwilling to give a police interview. She said she had been going out with Mr Z for a few months and had not been pressured into having sex. Ms A told the police she would like to live with her father but all her friends are near where her mother lives.

2.5.13 On 21.6.08 There was an alleged assault of Ms W by Mr Z. He was said to have grabbed her, punched her in the mouth and pulled her around by her hair.

2.5.14 On 14.8.08 Ms A, Ms H and Mr Z were arrested for being in a series of assaults and damage against four other persons. Mr Z admitted one offence and was cautioned for common assault on 5.11.08. The victim declined to pursue a prosecution and as there was insufficient evidence the case against Ms A and Ms H was dropped. After this incident Ms A's father, Mr G contacted the police expressing his concerns about his daughter. Social care was advised. There was no further action.

2.5.15 On 29.8.08 Ms A and Mr Z were stopped by the police looking into gardens at 00.50. Ms A was 14 at the time. When the officers were asked about this, as part of this review the police IMR states "Young people out at that time of the night was not unusual, or out of the ordinary, in that area", hence they did not consider taking her home, or offering her a lift and did not consider it was necessary to report the event to any other specialist department, for example the police child protection unit". There was no further action.

2.5.16 On 2.1.09 Ms H told social care that Ms A continually went off with Mr Z, not returning home for days. Ms H also said that Ms A had tried to make her (Ms H) miscarry by kicking her in the stomach. Social care informed the police. Mr Z was in breach of his abduction order. Mr Z was arrested for abduction of a child and sexual activity with a child, Ms A. Mr Z was bailed and one of the conditions of his bail was not to contact Ms A. At this time Mr Z was also in breach of his court bail regarding an impending prosecution for driving whilst disqualified. Mr Z was sentenced to 40 weeks in a young offenders' institution for driving whilst disqualified. The charges for abduction of a child and sexual activity with a child were dropped because Ms A would not give evidence and the police did not think it would meet the CPS threshold. Social care did not take any action because they had previously referred to a specialist support service. They did give the family information about The Bristol Barnardo's Against Sexual Exploitation (BASE) project but did not refer to the project. Around this time during an argument between Ms H and Ms A, Ms A broke a mirror and cut her wrists. The police attended with paramedics. The injury was superficial. Social care was informed. There was no further action.

2.5.17 On 25.9.09 Ms H's partner at the time contacted 999 saying that Ms A had been drinking heavily. Ms A was taken to hospital. She said she had gone out drinking with a friend and someone had put an ecstasy tablet in her drink. She was 15 at the time. Social care was informed. They wrote to Ms A's parents advising them it was often at this age that children start take part in risk-taking activities and to contact their local social care office if they wanted support and advice. There was no further action.

2.5.18 On 7.10.09 Ms H informed the police that her daughter, Ms A was missing, following an argument. Ms A was found to be living in a tent with Mr Z, in the garden of the address Ms H had given the police. Social care was informed and contacted Connexions. Connexions was a service that offered information, support, guidance and activities to young people. Social care requested that Connexions undertake a CAF. Connexions sought advice from the local CAF co-ordinator and told social care they could do a joint CAF however on 16.10.09 social care informed Connexions that they were closing the case and would not be involved in a CAF. No CAF was undertaken. Ten days later the Connexions worker was advised that Ms A had been sleeping rough for the last week and had been sleeping in fields because her mother had asked her to leave the house. A strategy discussion was held between police and social care. The police took no further action because Ms A had previously refused to give evidence against Mr Z. (See 2.6.16). Social care allocated the case.

2.5.19 On 5.11.09 Mr Z was arrested for stealing a bicycle. He tested positive to a Class A drug. On 27.11.09 Mr Z informed his GP that he was a crack cocaine and heroin addict and had been using intravenously for two years. Mr Z was put on a Methadone prescription. During this period Mr Z was arrested five times for theft of items. He stopped collecting his Methadone script in April, 2010. In November, 2012 Mr Z's mother contacted the GP saying her son wanted help with his drug addiction. (In our meeting Ms E said that Mr Z had only ever used cannabis. He had never used Class A drugs). She was told her son should contact the GP, which he never did.

2.5.20 On 30.11.09 Ms A was arrested for assaulting a friend she was with and stealing her coat. There was insufficient evidence to proceed. Ms A denied the charges. Two days later the police receive intelligence that Ms A was in possession of heroin and was injecting regularly. The police did not share this information with social care. The Police Child Abuse Investigation Team (CAIT) was not aware of this information. The police system has now changed and the CAIT would have sight of all information that comes in to the police regarding a child. Ms A was 15 at that time.

2.5.21 On 16.1.10 Ms A was arrested for assault, following an argument in the street. There were others involved but the case was dropped due to lack of evidence.

2.5.22 In September, 2010 Ms A became pregnant with Child U. She was 16. Mr Z was the father. Shortly after this she was placed in Bed and Breakfast accommodation. Mr Z moved in with Ms A.

2.5.23 The first known domestic abuse incident between Mr Z and Ms A took place on 1.1.11. She was a known to be in the first trimester of her pregnancy. Mr Z allegedly pulled Ms A around by her hair, punched her in the eye and hit her with a bicycle chain. It was Ms A's father who informed the police. Mr Z was arrested as a result of the statement made by Ms A's father, and charged with common assault. Ms A was unwilling to support the prosecution, make a statement or have photographs taken. She also refused Victim Support. Ms A said that Mr Z had only hit her with a shower bottle. Mr Z was remanded to 3.1.11, then released on bail. One of the bail conditions was that he was not to contact Ms A. Two days later Ms A attended hospital with lower abdominal pain, back pain and vomiting. She was admitted to the ward and was seen to have a cigarette burn on the back of her hand and bruising on her outer thigh. The following day Ms H visited her daughter. When she arrived Mr Z was also visiting Ms A. The hospital was unaware of his recent arrest and bail conditions. He was escorted from the hospital.

2.5.24 As a result of the incident set out in 2.5.23 Ms A was made the subject of a Multi-Agency Risk Assessment Conference (MARAC), a way of working with victims of domestic abuse. In court Mr Z pleaded not guilty and Ms A continued to decline to give evidence. The case was discontinued at court.

2.5.25 On 28.1.11 Ms A moved to a new address. Mr Z also moved to the same address.

2.5.26 In the spring/summer of 2011 Child U was born. Social care was not informed prior to, or post the birth. Neither the midwives, nor the health visitors had any concerns about Child U.

2.5.27 On 28.9.11 police were informed of a domestic incident between Mr Z and Ms A. Ms A had allegedly telephoned a family member saying she was too scared to go home because Mr Z was threatening her. She said he had hit her that morning. Mr Z was arrested for common assault. Ms A told the police she had been violent too. There was no further police action. This information was shared with social care and the health.

2.5.28 On 2.10.11 a neighbour reported to the police that she could hear Ms A being "Beaten up" by her partner and there was a baby in the house. The police attended. Both Mr Z and Ms A said they had been having an argument but did not want to take it further and there was no further action. Social care was not informed.

2.5.29 On 6.10.11 a housing officer made a referral to Next Link, a domestic abuse service. Next Link contacted Ms A who told them that Mr Z had moved out. Ms A told the Next Link worker that previously Mr Z had hit her with a bicycle chain (Which until this point she had denied). She also said he had strangled her and had shaken Child U, an allegation she later retracted. Child U was four months old at this time. Ms A also said that the housing officer had made a referral to social care regarding the incident with Child U. This was not the case but Next Link did make a referral to social care. Ms A agreed to support from Next Link but declined the Freedom Programme, a programme for victims of domestic abuse. There was no further action regarding the alleged shaking of Child U and when questioned later Ms A said she meant Mr Z had looked as though he would shake Child U. Next Link referred to MARAC and Ms A was discussed at a meeting held on 17.11.11. Ms A had informed Next Link that Mr Z only had supervised contact with Child U, which was supervised by his mother, Ms E. At the MARAC meeting the social worker said that Ms A was keen to access the Freedom Programme (She had declined this with Next Link) and Mr Z was keen to access SPLITZ, the community programme for perpetrators of domestic abuse.

2.5.30 Six days later on 23.11.11 Mr Z was present when the health visitor undertook a home visit. Ms A said he was staying two nights a week. The health visitor was aware of the MARAC meeting but did not inform social care that Mr Z was back in the family home.

2.5.31 On 13.1.12 there was a further domestic abuse incident between Mr Z and Ms A. Ms A had been at a party and Mr Z had "Dragged her out of the house". The police attended and arrested Ms A for assault. Mr Z refused to give a statement and Ms A was released without charge. The MARAC co-ordinator was informed and a strategy discussion between police and social care took place. It was agreed social care would undertake a child protection investigation under s.47, Children Act, 1989 to see if Child U was suffering

significant harm as a result of the domestic abuse. Ms A was recognised as a child in this strategy discussion but it was decided that no specific services needed for Ms A "As she will be supported by services to Child U". Ms A denied still being in a relationship with Mr Z. The first partnership agreement was drawn up between social care and Ms A. and signed on 16.1.12. Ms A agreed that Mr Z would not visit the family home and would only have contact with Child U supervised by his family. Social care was clear they would take further steps to safeguard Child U if the agreement was breached.

2.5.32 On 28.2.12 Ms A moved home. She advised professionals she was no longer in a relationship with Mr Z. A week later, on 8.3.12 Ms A was confirmed as 12 weeks pregnant with Child T. Child U was under one at the time. Ms A talked of having a termination. She told the GP Mr Z was not the father. Maternity records in April, 2012 show Mr Z as the father.

2.5.33 On 27.6.12 a neighbour, supported by their local children's centre, made a referral to social care. They said Mr Z had been living with Ms A all along. They hear Ms A screaming and swearing at Child U, Mr Z is physically abusive towards Ms A and the home smells of cannabis. The following day social care visited the home, early in the morning and unannounced. Initially Ms A denied Mr Z was living in the home but then he appeared and admitted he was. A second partnership agreement was drawn up between social care, Ms A and Mr Z. Mr Z agreed not to live in the family home and Ms A agreed not to smoke cannabis, or shout at Child U. Mr Z agreed he would only have contact with Child U supervised by his mother (There was no known contact between social care and Ms E). Both parents agreed that any domestic abuse or risk of domestic abuse would be reported to the police. Ms A also agreed to engage with the children's centre, the health visitor, the teen pregnancy midwife, the community midwife services and social care. A strategy discussion was held between police and social care. It was agreed social care would undertake a child protection investigation and would proceed straight to an initial child protection conference if the agreement was breached.

2.5.34 On 4.7.12 Mr Z and Ms A told the social worker that they had been together for the last five months, except for a brief split after the domestic abuse incident in January. Both parents denied shouting at Child U. There followed a third partnership agreement with social care. Social care accepted that Mr Z was living with Ms A. This agreement was similar to the partnership agreement of the previous month but this one stated that neither parent would shout at Child U and that both parents would engage with all of the services. It continued to say that Ms A would not smoke cannabis. Once again the agreement said that social care would proceed to an initial child protection conference if the agreement was breached. Social care now viewed Child U as a Child in Need (CIN). A multi-agency CIN meeting was held.

2.5.35 On 16.8.12 Child U was seen by the health visitor to have a bruise on the right side of the forehead. Ms A was unable to explain how the injury had occurred. Child U was under

18 months old at the time. No further action was taken. (It was during this period that Ms A was supported by the family support service. The support was for a 12 week period and took the form of weekly visits by a family support worker.

2.5.36 On 21.9.12 Child T was born. The family did not have a double pram, so Ms A was not able to leave the home with both children. The family had limited money and had prioritised buying non-essential items.

2.5.37 On 4.10.12 social care undertook a home visit. The home was thought to smell of cannabis. Child U had a bruise on his forehead. Ms A said this happened because the child head-banged. Child U also had two facial scratches. Ms A said they were self-inflicted. An appointment was made for two weeks' time. No medical advice was sought regarding the regular administration of Calpol. The following day Mr Z was arrested for cannabis possession. Three weeks later he was arrested for burglary and tested positive to a Class A drug.

2.5.38. On 9.11.12 Child U was seen by the health visitor to have a graze on the forehead and scratches to the nose. Ms A said Child U had fallen over. No further action was taken. Four days later Ms H visited social care's local office because she was so worried about her grandchildren. She told the social worker that another family member had observed Mr Z a few days earlier throw a talc bottle at Ms A which had hit Child T, who was three weeks old at that time, leaving a mark. She alleged that Mr Z used heroin and Ms A gave him money. Mr Z admitted to smoking heroin but only at his mother's house. Ms H also said that recently Ms A and Mr Z had been out with the children, in two prams but Mr Z had stolen a bicycle and left Ms A with the two prams. Ms H said she had now bought a double pram for Ms A. When these concerns were discussed with Mr Z and Ms A, during a home visit by the social worker, Mr Z initially denied using heroin but when Ms A said later in the conversation that he only smoked heroin at his mother's, Mr Z did not deny that. Ms A said she smoked cannabis. Ms A's view at that time was that Ms H was vindictive; she had never approved of Mr Z and was just trying to cause trouble. All other allegations were denied. Social care decided to carry on working with the family under CIN status, although only one meeting had been held. It was decided a core assessment would be undertaken. A core assessment was started and was completed shortly before Child T's death. A CIN meeting had been arranged. This had been due to take place shortly after 14.1.13, the date of Child T's death.

2.5.39 Eight days later on 21.11.12 the graze on Child U's forehead was seen to be healing. A yellow bruise was seen next to it. (Despite popular belief, medics cannot accurately age a bruise from the colour of it[2]). Ms A was not asked about the bruise and no further action was taken.

[2] Can you age bruises accurately in children? A systematic review
S Maguire, M K Mann, J Sibert, A Kemp

2.5.40 On 23.11.12 Ms E contacted the GP asking for help with Mr Z's drug problem. Ms E told the GP that he was willing to engage with the GP. The next day there was a domestic abuse incident between Mr Z and Ms A. Mr Z forced entry to the property. Ms A alleged Mr Z hit her with a metal dog chain, kicked her and threw a cold drink over her and Child U. Ms A told the police that she had told Mr Z their relationship was over. She said that when she was pregnant he had kicked her and punched her in the stomach and the violence is now getting worse because of his drug problems. Ms A said that he "Is extremely controlling and will flip out if I am late and out longer than I say. He does not want me to see anyone. He controls my phone and where it is. He has kicked the dog and uses heroin and crack cocaine". Mr Z was arrested. He admitted the criminal damage but denied hitting Ms A with a chain. He said he had thrown her to the floor in self-defence because Ms A had punched him. He was charged with criminal damage but on the advice of the CPS there was insufficient evidence to charge him with assault. He was remanded in custody because his mother refused to have him at her home. He was given a Community Order and a Restraining Order, one of the conditions being that he must not contact Ms A or go near their family home. The Restraining Order was for six months, so would expire on 29.5.13. The police made a referral to MARAC, social care, Next Link and the health Safeguarding Children Team.

2.5.41 On 29.11.12 Mr Z told the Criminal Justice Intervention Team (CJIT) that he smoked three to four spliffs of cannabis every day and he snorted cocaine at the weekends. He said he lived between his girlfriends and his stepfather's. He also told CJIT that Ms A smoked cannabis, drinks alcohol and snorted cocaine at the weekends too. CJIT contacted social care. The next day Ms A told social care during a telephone call that she had bruises on her neck and arms from play-fighting with Mr Z. Later on 30.11.12 social care visited Ms A. She was not asked to show the bruises. A fourth partnership agreement was drawn up between Ms A and social care. This agreement stated that Mr Z would not reside at, or visit, the family home and that Ms A would contact the police immediately if he tried to contact her. Ms A also agreed that Mr Z would have no contact with the children. That Ms A would engage with the children's centre Freedom Programme and with Northern Arc, the Next Link domestic abuse service. The agreement also said that Ms A would be in and available for all appointments. There was also mention of finding a child-minder. The agreement stated that "Failure to comply with the terms of this agreement may be referred to the court if court proceedings are commenced in respect of the children. Parents may wish to seek legal advice".

2.5.42 On 13.12.12 Child U was seen by the health visitor with a graze to the forehead, a red mark and a pin-prick size bruise on the cheek. Ms A could not explain how the injuries had occurred. Child U was under two at this point.

2.5.43 On 7.12.12 there was a pre-MARAC panel. The action plan was for Next Link to try to engage with Ms A and to encourage links with the children centre. Next Link was to refer

back to MARAC, if necessary. Next Link closed the case on 27.12.12 after numerous attempts had been unable to contact Ms A. They had not left a message because they were unsure whether it was safe to do so. Next Link did not inform any other agencies that they were closing the case. Also on 19.12.12 social care agreed to undertake a Child in Need (CIN) review. A Child in Need meeting was arranged for 24.1.13.

2.5.44 On 20.12.12 Ms A told the GP she was two weeks pregnant and wanted a termination. Ms A told social care and the worker who took the call noted that they should ring Ms A over Christmas because of their worry about Ms A. The next contact by social care with Ms A was not until 7.1.13.

2.5.45 On 11.1.13 Child T was taken to the hospital. Child T died three days later.

Part Two

3. Themes and analysis

In the analysis the points raised in the terms of reference (See 1.4) will be addressed. There is no comment on individual IMRs but following the reading and critical analysis of the IMRs and the two subsequent meetings with the IMR authors and the SCR Panel, the following themes have been identified and agreed. These themes have been discussed in great detail at the meetings and practice will be analysed, in order to maximise our understanding of how agencies work individually and together in Bristol and to consider how we can best improve our practice.

3.1 Child sexual exploitation

National Context

The definition of child sexual exploitation is “Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability”. This definition of child sexual exploitation was created by the UK National Working Group for Sexually Exploited Children and Young People and is used in statutory guidance for England.

Since 2007 there has become an increasing awareness of child sexual exploitation, reporting of child sexual exploitation and convictions but our understanding of the scale of the problem and the way in which victims are groomed are evolving all the time
In the last three years there have been a number of high profiles child sexual exploitation cases, including Rochdale, Rotherham and Oxford. These cases have all involved gangs grooming victims. There has also been the case of child sexual exploitation in Torbay, which involved individuals grooming a number of victims, as well as the historic alleged child sexual exploitation perpetrated by Jimmy Savile and others. Serious case reviews have been published and in Rotherham there was an independent inquiry. All of these cases have attracted a considerable amount of press interest and have raised the profile of child sexual exploitation. LSCBs have responded by developing policies and procedures and screening tools, to ensure they are addressing this type of sexual abuse and protecting the children in their areas. Many have also put on training for staff, to increase their understanding of what the issues are and to look at how we deal with child sexual exploitation.

Ofsted has recently published a thematic inspection of child sexual exploitation across eight local authorities "The sexual exploitation of children: it couldn't happen here, could it?"[3] which included Bristol. The main findings of the inspection demonstrate that we still have a long way to go, in terms of effective multi-agency responses to victims of child sexual exploitation.

One of the main challenges for professionals across the country is that while we might identify a child who is particularly vulnerable to child sexual exploitation, or identify that a particular child is being groomed, if that child, or young person, does not see themselves as a victim, how do we work effectively with that child? Educating young people is important but we can only work with an adolescent if they will work with us. We cannot "Do to" young people as we can "Do to" children. We can make decisions about young people but if the young person does not agree, they may vote with their feet. That is the dilemma for all LSCBs, including Bristol.

There is also an increasing body of research that makes it clear that going into care is not necessarily the answer, particularly with older children. One of the vulnerability factors for child sexual exploitation is being in care. The Association of Directors of Children's Services published a position statement earlier this year *"What is care for: Alternative models of care for adolescents*[4]*.* This document considers alternative ways of working with vulnerable adolescents, including family therapy.

Local Context

[3] http://www.ofsted.gov.uk/sites/default/files/documents/surveys-and-good-practice/t/The%20sexual%20exploitation%20of%20children%20it%20couldn%E2%80%99t%20happen%20here%2C%20could%20it.pdf

[4]http://www.adcs.org.uk/download/position-statements/2013/ADCS_position_statement_What_Is_Care_For_April_2013.pdf

Since the death of Child T there have been two trials involving perpetrators of child sexual exploitation, following the police operation, Operation Brooke, which started in the Spring of 2013. In the first trial, in the Spring of this year, six men were convicted of child sexual exploitation offences. The second trial began in October, 2014. Following this, a further seven men were convicted of child sexual exploitation offences.

The Bristol BASE (Barnardo's Against Sexual Exploitation) service was established in 1997. The service aims to oversee direct support to 100 Bristol children each year and offers consultation and the use of resources to many more cases. In addition training is provided through the LCSB and 4YP, a public health team for young people in Bristol, to promote awareness and early identification of cases across the workforce.
Bristol BASE support males and females, up to the age of 18, who are abused through sexual exploitation.
Increasingly due to limited capacity at the service the referrals allocated at Bristol BASE need to demonstrate clear evidence of sexual exploitation or be at immediate risk of being so. Allocated cases usually have a child protection social worker coordinating the case or the child may be in the care of the Local Authority. Due to limited capacity Bristol BASE would rarely work with a case that is deemed to be at a SAF level but works closely with lower threshold services, in particular Brook Advisory Service, to ensure 'preventative' cases are not overlooked.

Factors which commonly feature in the children supported at BASE include;

- Relationships with older/risky adult(s)
- High risk taking sexual behaviour
- Repeat and acute missing episodes
- Family breakdown/being in care
- Past abuse
- Trafficking (internally and externally to the UK)
- Problematic substance misuse
- Significant emotional/mental health concerns, attachment difficulties and marked learning needs
- Risky internet use
- Gang involvement/drug running"[5]

BSCB is part of the South West Safeguarding and Child Protection Group (SWSCPG). This group provides policies and procedures for the South West of England. There is a "Children Facing Exploitation"[6] procedure and a draft "Safeguarding Children and Young People at Risk of Sexual Exploitation" procedure. BSCB also has its own "Safeguarding Children and Young People at Risk of Sexual Exploitation – Practice Guidance and Procedure"[7]

[5] Bristol BASE. Background information.
[6] http://www.online-procedures.co.uk/swcpp/contents/guidance-child-protection/sexual-abuse-and-sexual-exploitation/children-facing-sexual-exploitation

[7] http://www.bristol.gov.uk/sites/default/files/documents/children_and_young_people/child_health_and_welfare/CSE%20guidance.v1_08.pdf

BSCB has a Child Sexual Exploitation sub group to ensure that all agencies co-ordinate and work together effectively to support young people who are at risk of exploitation and to work to prevent sexual exploitation occurring. Membership of the group comprises the Police, Health, Youth Services, Barnardo's BASE, CYPS, Brook and Bristol Sexual Health Service.

Bristol has four different components of the MARAC. Two of these were particularly relevant to child sexual exploitation during the period under review. There is the Sexual Violence MARAC and the Perpetrators MARAC. These are not exclusively related to child sexual exploitation but deal with referrals for victims and perpetrators where identified. The Sexual Violence MARAC no longer considers cases of child sexual exploitation. A multi-agency meeting is held where a management plan is discussed and agreed to manage the issue in question. The actions are then reviewed as part of a formal process in the style of the Multi-Agency Public Protection Arrangements (MAPPA) meeting.

Avon and Somerset Constabulary reports they are utilising multi-agency relationships developed particularly during Operation Brooke to ensure that a joined up approach is adopted by partners to identify and safeguard children from child sexual exploitation and to identify and target perpetrators.

Bristol City Council has recently had an Ofsted inspection of services for children in need of help and protection, children looked after and care leavers, which included a review of the effectiveness of the Local Safeguarding Children Board. They have also been part of a thematic inspection of child sexual exploitation by Ofsted of eight local authorities.

Bristol's individual Ofsted inspection[8] has highlighted that "Although there is an increased level of awareness of child sexual exploitation, more needs to be done to consolidate this area of work. There is no overarching strategic plan to tackle child sexual exploitation. Although a wide range of help and support is available, services are not well co-ordinated and practice is inconsistent". The same issues were raised around children who go missing. The report does also say "A wide range of voluntary sector, local authority and partnership services is available to victims of child sexual exploitation, and these are having a positive impact in reducing risk to children and young people" and "The most recent audit on child sexual exploitation is much improved in quality. It draws up themes for improvement and a clear plan of multi-agency action. This includes developing a multi-agency child sexual exploitation strategy and reconvening high level multi-agency meetings about children at risk of child sexual exploitation.

Early help was also considered in the inspection. The report concluded that "Early help services for children and families are now well targeted and coordinated so that they receive the help and support they need at the right time".

8

http://www.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/bristol_city/051_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf

3.1.1 When we analyse the death of a child we have to look back. Is there any time in the adults' lives where, if they had taken a different course, this tragedy may have been prevented? What roles did the professionals in their lives play and how can we learn from this and improve our practice?

3.1.2 During the Summer Term at school A, when Ms A was 12, the police were attending domestic incidents at home and there were other concerns about what was happening in the home. This was the term that Ms A's attendance started dropping significantly and when she was in school her behaviour was often challenging – on more than one occasion she spent the day running round the school all day, avoiding teachers and lessons. The school's response to this was to exclude her on two occasions that term, each time for two days. (The previous term they had excluded her twice, for one day each time). They also made a referral to social care that term.

3.1.3 When a 12 year old is experiencing troubles at home and that manifests itself in her behaviour what will make that child even more vulnerable is excluding her. The challenge for the school is that they have 30 other children in the class that they have to educate and one of the options they have to consider is exclusion of the disruptive child. This particular school had over 1,000 pupils and a child who will not attend lessons and is running around the school all day is very disruptive to the other children, not just in their class. Ms A had also previously assaulted another child in the school, the previous term. Ms A was remembered by staff at the school as being violent and aggressive. She was also described as "A sad young lady, who had great potential".

3.1.4 The Department for Education (DfE) issues statutory guidance around pupil exclusion[9]. The guidance makes it clear that schools have a duty of care to a child and they must consider the child's safety when s/he leaves the school. The school must also notify the local authority that they have excluded the child. These notifications are collated and analysed on a six-weekly basis. The department that deals with this does not have access to social care's data base. There are examples of good working practices between the Behaviour and Inclusion Team and social care however this tends to be at the crisis end of the work we do, not the preventative. Bristol City Council also has local guidance on school exclusions[10]. In order for a school to know whether there are concerns in the home there needs to be communication with other agencies. Because the school thought social care had made a referral to another agency, the family support service, to undertake a CAF they thought work was being done. The school's IMR has acknowledged that schools need to be pro-active and follow up referrals.

[9] http://media.education.gov.uk/assets/files/pdf/s/the%20school%20discipline%20pupil%20exclusions%20and%20reviewsengland%20regulations%202012.pdf

[10] http://www.bristol.gov.uk/page/children-and-young-people/school-exclusions

3.1.5 If the CAF had been in place one would have hoped that all the agencies would have been asked to contribute and then the school would have known more about the home situation and how vulnerable Ms A was.

3.1.6 It is clear from the members of staff interviewed as part of this process that there were teachers who demonstrated great commitment, and a considerable amount of time, to Ms A. Her head of year had daily contact with her. She also had support from a learning mentor and the assistant head of year. However the school excluded Ms A eight times, for a total of thirteen days, during a ten month period.

3.1.7 Research and practice shows certain groups of children and young people are at higher risk of being sexually exploited through street grooming. Some of these risk factors include:- children with prior experience of emotional abuse or neglect, adolescents or pre-adolescents, girls (boys are also at risk but current research suggests a greater number of victims are girls), children not in education through exclusion, children who use drugs and alcohol, children going missing, children from families or communities with offending behaviours, children living in poverty or deprivation[11]. Ms A was witnessing domestic abuse, included within the definition of emotional abuse of a child, there were concerns of neglect and other troubles in the home. There was also one known incident of self-harm and Ms A was arrested for assault, for the first time, aged 15. One would hope that now Ms A would be considered in the context of child sexual exploitation.

3.1.8 Social care has acknowledged in their IMR that Ms A's case should have been seen as child protection, when she was in a relationship with Mr Z. Their IMR states "Children's social care has developed considerably since the events described in this review. Furthermore the Children's Change program is redesigning services to strengthen the 'Early Help' Offer and ensure more secure pathways through services and as set out in the "local context", this is proving to be effective.

3.1.9 The police have also made considerable changes since the time Ms A was a child, as have other agencies. There are now specialist investigation teams within the Public Protection Unit and specialist officers will have oversight of all incidents involving children.

3.1.10 Torbay Safeguarding Children Board's sexual exploitation serious case review[12] concerned individuals who were grooming girls. One of the findings from that review was that "Early intervention may have reduced the offender's progression to becoming abusers". In a recent BSCB Quality sub group audit it was recognised that there needs to be better co-ordination of child abduction notices. In this case the police IMR has addressed the need to respond more robustly to child abduction notices.

[11] http://www.nspcc.org.uk/Inform/resourcesforprofessionals/sexualabuse/identifying_sexually_exploited_children_wda85119.html

[12] http://www.torbay.gov.uk/c26executivesummary.pdf

3.1.11 It is also concerning that when Ms A and Mr Z were stop searched at 00.50 in August, 2008, when Ms A was 14, the officers did not consider taking her home, or informing the police child protection team because it was not unusual for young people to be out at that time, in that area.

3.1.12 Nothing was done to explore Mr Z's history, other than his involvement with the police. For a child to be receiving one to one support at the age of two, and having to go home at lunchtimes because they are so disruptive, is unusual and Mr Z's history, beyond his police record, should have been explored further at this point, in order to effectively assess the level of risk to Ms A. Later in the report there is reference to Mr Z's learning difficulties, particularly his communication and understanding difficulties. The police may have been able to deal with him more effectively if they had understood this. This was not explored or understood at the time and may have impacted on his ability to understand why he was being told to keep away from Ms A.

Lessons to be Learned and Recommendations to BSCB.

(The recommendations are made in the context of the two recent Ofsted reports referenced in this review).

Lesson One
Too often we have seen from child sexual exploitation serious case reviews that professional intervention comes too late and risk indicators of additional vulnerabilities are not responded to. In this case a child who was excluded from school and was beyond parental control was left to her own devices during the days she was excluded. The most effective way to keep any child safe is for all the agencies to talk to each other about what their concerns are, and how they are dealing with the child, within the framework of the law. This needs to happen when concerns first arise, not just when the work becomes crisis intervention. The most effective way we can work to prevent the sexual exploitation is to recognise and respond to risk indicators.

Recommendation One
When a school excludes a child, as well as following the current required procedure the school must check if that child is open to social care, or if there is a SAF (Single assessment framework) in place. If the child is open to social care, the school must inform them each time they exclude the child. If there is a SAF in place, the school must inform the lead professional.

Lesson Two
The most effective way of working with young people is to educate them, so that they make safe and right choices for themselves. There needs to be greater awareness of young people, and their parents, across Bristol about child sexual exploitation and particularly the

grooming process.

Recommendation Two
BSCB commissions the drama "Chelsea's Choice[13]" to be offered annually to all Year 8 children and their parents. Chelsea's Choice is a 30 minute drama in which a sexual exploitation case is played out. It is an extremely powerful production, which brings in all the issues and clearly shows children what is really happening. (Teachers will also see the production and this will bring added benefit because it will raise awareness amongst professionals).

Lesson Three
There needs to be a multi-agency approach to individuals who are known to be in sexual relationships with children and about whom there are concerns, as well as children at risk of sexual exploitation, so the two can be brought together and potential patterns can be identified early on. Assessments need to include the full history of both alleged perpetrators and victims, in order to consider levels of risk.

Recommendation Three
Relevant BSCB partners develop regular multi-agency meetings. The purpose of these meetings will be to consider possible victims and perpetrators of child sexual exploitation, including their histories from each of the relevant agencies, as well as the locations of alleged offences.

The rest of this review will focus on Mr Z and Ms A as the parents of Child U and Child T

3.2 Levels and means of intervention

National Context

Throughout the period under review the statutory guidance was *"Working Together to Safeguard Children, 2010".* The guidance sets out clearly "Where there are concerns that a child may be a possible child in need, and in particular where there are concerns about a child being harmed" advice should be sought". *"Working Together, 2010"* also highlights the particular vulnerability of children exposed to domestic abuse, both pre and post-birth.

"Working Together to Safeguard Children, 2013" sets out clearly who should be involved in strategy discussions: - "social care, the police, health and other bodies such as the referring agency".

The research carried out by Brandon et al, on behalf of the Department for Education, over the last eight years has highlighted the increased risk to children where there are issues around parental substance misuse and domestic abuse, as well as the increased

[13] http://www.justwhistle.org.uk/index.php/home/members

vulnerability of a child under one and the greater likelihood of a child being the subject of a serious case review if the mother is under 21[14].

As well as Brandon's research there is a considerable body of research which highlights these additional risks. Domestic abuse and substance misuse, along with mental ill-health are often referred to as the "Toxic trio" because of the increased risk to the child in the home when there is one, or more of these factors.

There was also the publication of the Advisory Council on the Misuse of Drugs 2011 report "Hidden Harm"[15] which focused on the children of problem drug users.

There has been a national drive, in view of this increasing body of research, to highlight the risks to children, whose parents are dealing with issues around domestic abuse, substance misuse and mental ill-health. (In 86% of all serious case reviews between 2009-2011 one, or more, of those issues was involved).

Local Context

BSCB has undertaken three serious case reviews in the last seven years which have involved young children. Child Z died in July, 2007 from ingesting Methadone and Morphine, Child M drowned in a pond in June, 2010 and Child K died in August, 2011 from ingesting Methadone.

BSCB published the updated "Joint Safeguarding Children Protocol. Children and Families Living with Substance Misuse" and the "Joint Practice Guidance for Children's Services and Adult Substance Misuse Services" in November, 2012.

In addition to this BSCB also has the "Domestic Abuse/Violence" Protocol, as well as "Keeping Your Child Safe if You Use Drugs and Alcohol".

In common with other local authorities, in Bristol there are two types of strategy discussion that are held. The telephone strategy discussion, when the matter requires urgent attention. This will involve the police, social care and the community paediatrician. If the matter is not so urgent there will be a "sit-down" meeting held, when all those involved will be invited. If it is the former there has been much discussion about how other professionals working with the family are given information about the strategy discussion. There has also been an issue with the community paediatricians taking minutes of the discussion. These minutes may differ to the minutes taken by social care. This all requires greater clarity. A strategy discussion is held when there is reasonable cause to suspect a child is suffering, or is likely to suffer significant harm. It is the responsibility of social care to convene the strategy discussion and they will formally minute it.

[14] http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eOrderingDownload/DFE%20-%20RR226%20Report.pdf

[15] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf

3.2.1 One of the perplexities of this case is that it was never seen as child protection, either by other agencies, or by social care. It is usual to see cases across children's services where the other agencies are "Banging on the door" of social care. Those agencies believe very strongly that a case is child protection and social care does not agree and thinks the child is not suffering significant harm and is therefore not in need of protection. What is extremely unusual is to see a case where no agency thinks the children are suffering significant harm, despite clear evidence that they are witnessing domestic abuse and there is substance misuse and possible evidence of physical abuse.

3.2.2 What is also extremely perplexing is that Child U was born two months prior to the death of Child K, the BSCB serious case review referred to above. Professor Munro, in her final report[16] describes the usual reaction following the high profile death of a child, such as the death of Peter Connelly, "Waves of anxiety travel through the system when there is a high profile death, leading to more referrals being made. Social workers, in turn, can be driven by anxiety into applying to remove children from their birth family at a lower level of risk". Prior to the death of Child T, in Bristol there had been three child deaths, which had led to serious case reviews, within a four year period. It would therefore be natural to assume that the anxieties of all professionals would be heightened and the threshold level for intervention would be lower.

3.2.3 Despite much discussion with IMR authors, SCR Panel members and analysis of the IMRs it has not been possible to conclude why this case was not seen as child protection, either by the other agencies, or by social care. Between January, 2010 and December, 2012 numbers of children on child protection plans increased by 25%, children with child in need plans by 6% and Looked After Children by 11%. This demonstrates an increasing awareness of risks to children and yet we are still no nearer to understanding why this case was not seen as child protection when the SCR Panel, the IMR authors and myself are all absolutely clear that this was a child protection case. Everything seemed to be minimised – the horrific domestic abuse, drug-taking and the injuries to the children, including the incident on 6.10.11 when Ms A said that Mr Z had shaken Child U. She later retracted that statement, as she often did but Child U should have been seen immediately by a paediatrician. There seems to have been inertia amongst staff from other agencies, who were not reporting high levels of concern to social care, despite the high level of risk. It may have been that there was a false sense of security amongst agencies, that if there is social work involvement they will know when to escalate. There may have been a feeling that social care would have had the whole picture. This feeling can abdicate professionals of their role to challenge and scrutinise the safeguarding process.

[16] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf

3.2.4 There were several findings from the previous three serious case reviews which should have resonated with workers in this case. From Child K SCR "In-depth parenting assessments of drug-using parents are essential". In the Child M SCR it was described as "Striking that neither CAF, child in need or child protection processes were put in place". In the Baby Z SCR "For those families who do not come within the threshold of child protection concerns, the co-ordinating processes between adult and child focused services do not seem to be in place, as they are when child protection processes have been invoked. Baby Z's name was never on the child protection register so he was not receiving a co-ordinated service. The issue of whether Baby Z was a child at risk or not would matter less if BSCB had a more co-ordinated response to children in need, particularly those whose parents are involved in illegal drug taking". That SCR also found that "Child in need cases are not as well co-ordinated as they could be". One of the recommendations was "BSCB need to develop systems to co-ordinate children in need cases". Baby Z died in 2007. Child M, recommendation 6 of the SCR says that BSCB should ensure the involvement of parents/carers in child in need meetings, as well as other agencies, in multi-agency meetings to achieve improved outcomes for children". In this case, even when the children were deemed to be children in need there was only evidence of one multi-agency children in need meeting and this meeting did not include all the agencies involved with the family, especially the father.

3.2.5 There is reference in many of the IMRs recommendations to address this lack of action, within their own agencies. There also needs to be a multi-agency response.

Lesson Four

It is essential that there is a clear process in place for minuting strategy discussions in Bristol and the dissemination of those minutes across partner agencies and that health are invited to take part in all strategy discussions, in line with the statutory guidance.

It is also essential that workers across all adults and children's services understand the increased risk to a child when there is domestic abuse in the home and substance misuse. An extremely effective tool for assessing risk is an integrated chronology. Currently in Bristol the only time an integrated chronology is completed is when a serious case review is being undertaken, which usually means a child has died, or suffered significant injuries. The integrated chronology is stark, is evidence of increasing risk, or an improving situation and is factual. It provides clarity in usually complex, and sometimes chaotic, families.

Recommendation Four

a) BSCB agrees the process for minuting strategy discussions in Bristol and the timely dissemination of those minutes across all partner agencies, including the GPS of both the mother and the father. In addition to this BSCB must satisfy itself that health colleagues are invited to contribute to all strategy discussions.

b) BSCB introduces the use of chronologies across all partner agencies. When a child is the subject of a SAF, a child in need plan, or a child protection plan there must always be an integrated chronology and it will be the responsibility of the lead professional to integrate the chronology and ensure it is kept up to date.

Lesson Five

The fact that the numbers of children on child protection plans and children in need plans and Looked After Children in Bristol have increased over recent years does demonstrate an increasing awareness of risks to children and yet this case could not be more concerning, in terms of a lack of recognition of risk indicators, inertia amongst workers in agencies other than social care and a seeming lack of understanding about their own accountability. It is equally concerning that social care did not recognise the significance of the risk indicators.

It also cannot be overlooked that some of the critical lesson to be learned from serious case reviews in Bristol do not seem to have been learned by those working on the frontline, or their supervisors. (Although the recent Ofsted report stated "Learning from serious case reviews and multi-agency training has led to improvements in front line practice").

The most significant factor of this serious case review remains that this case was not seen, by any agency, as child protection.

Recommendation Five

5a) BSCB brings together all of the recommendations from the three previous serious case reviews, and this one, into one training day, which will be delivered to the designated safeguarding leads across all partner agencies. It will then be their responsibility to disseminate the information across their agency. This will ensure that all the messages are heard.

5b) The training set out in 5a must emphasise to all agencies their accountability, responsibilities and ownership and significance of the information they hold. Although not relevant in this case, all agencies should be reminded of the escalation policy.

3.3 "Think family"

National Context

The issue of the role of men in children's lives is a familiar feature in serious case reviews[17] The focus is too often only on the primary carer, usually the mother and we ignore the sometimes shadowy figure of the father, or other men in the mother's/children's lives. Assessments of risk are done with insufficient knowledge about the men in the family.

[17] Brandon et al 2008, 2009

"There is a need for public services to engage with both mother and father except where there is a clear risk to the child …" Children's Plan, Department for Children, Schools and Families, 2007. From that time and leading up to 2009 there was an increasing awareness of the need to think about the family as a whole and not just the children. The Government at the time described itself as being committed to a national programme of reform and culture change and introduced the "Think Family Toolkit"[18]. The intention of the toolkit was to "improve the identification and support of adults experiencing problems who are parents or carers; and to co-ordinate the support that is provided by different agencies to each family, especially those experiencing significant problems".

Since 2009 the national agenda has very much been for all professionals, working across adult and children's services, to think about the family as a whole.

In 2011 Professor Munro's report highlighted how important it is that all professionals in contact with a family are mindful of children who are vulnerable to abuse or neglect.

Local Context

The agenda of Bristol Safeguarding Children Board and Bristol Safeguarding Adults Board's annual conference, in May, 2011 was "Think Family".

Bristol's children and young people's plan 2011-2014 sets out wide-ranging objectives for how the needs of children in Bristol should be addressed based on a thorough needs analysis. The document refers to parents throughout and not specifically to fathers or mothers.

Bristol has a Parenting and Family Support Strategy, this refers to families throughout and not specifically to fathers, or mothers.

The Fatherhood Institute, in partnership with Family Rights Group, was funded in 2012 by the Department for Education's Voluntary and Community Sector Grant to support local authority safeguarding services to engage more effectively with fathers and other men in families. This project built on previous work led by Family Rights Group called the Fathers Matters Projects. This work addresses a need referenced in the Munro Review Final Report, and builds on the growing understanding about how to engage better with fathers where there are child welfare and safety concerns. This project encompasses work with six local authorities, including Bristol, to develop and test a broad package of sustainable resources, consultancy and training, aimed at building stronger local safeguarding strategies, policies, procedures and practice for engaging with, assessing and supporting men both as risks and resources in the lives of their children.

As a result of this work and the subsequent report by the Family Rights Group, BSCB has developed an action plan, based on the recommendations of the report. The action plan

[18] http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eOrderingDownload/Think-Family.pdf

was finalised in November, 2011 and the work is on-going. These recommendations include:-

- All policies relevant to child protection should explicitly address the needs of Fathers and underpin the development of father-inclusive practice.
- There should be an expectation that all fathers, whether they are in contact with the child or not currently, should be interviewed by a social worker who is completing a core assessment.
- More consideration needs to be paid to inviting fathers to child protection conferences.
- The father's involvement with the child together with both his risks and strengths should be discussed at all child protection conferences.
- Contact details for fathers need to be rigorously inputted and updated.
- The importance of the role of fathers in a child's life to continue to be discussed and raised as an issue.

The recent Ofsted inspection noted that although "Recent practice is much improved and there are many examples of good assessments. The quality of social work assessments is not consistently good enough".

3.3.1 As has been said elsewhere in this report little was known about Mr Z, other than his criminal record. During the criminal trial into the death of Child T Mr Z was the subject of a number of psychological and psychiatric assessments. These assessments were inconclusive, some stated that he had learning disabilities, others learning difficulties. What was agreed upon was that he had a level of learning difficulty and this was particularly around communication and understanding and he had an extremely low IQ. He also had difficulties reading and writing. During Child T's life professionals were asking him to sign the partnership agreements and it must now be questionable whether he even understood what was being asked of him. Again, assumptions were made without further exploration.

3.3.2 When there is not a SAF, child in need plan, or child protection plan in place it is even more essential that each and every professional working with any individual thinks about any child, or adult, who might be affected by the issue the adult themselves is dealing with.

3.3.3 As set out in 3.2 much work has been done to raise awareness of the risk to a child if a parent is misusing substances. The emphasis in Bristol has been on parents on a Methadone programme because of the deaths of Child Z and Child K. In this case Mr Z was only on a Methadone programme for five months, in 2009-2010. The first information that he was a Class A drug user was in 2006 and there continued to be information / evidence he was using Class A drugs until November, 2011. There are two possible hypotheses for why this was not seen as a concern, both in terms of his relationships with young girls and then as a father. Either it was because professionals were not sharing information with each other about his drug use because often it could not be proved – unlike when someone is on a Methadone programme, or because for much of the time Mr Z was not supposed to be

having contact with Ms A and the children and therefore the risk his lifestyle posed was underestimated.

Lesson Six

It is essential that all professionals working across adults and children's services think of the family as a whole and what risks are posed to the children by the lifestyles and circumstances of the adults who are caring for them. In order to do this effectively they need to know the history of each individual and explore any significant issues.

Recommendation Six
As it was a concern in the Child Z SCR and Child K SCR, **Recommendation Five**, above will ensure that professionals are reminded of the necessity to "Think Family". In addition to this professionals will need to be reminded that they must be confident that they have sufficient information about all those around the child so that assessments are evidence-based.

3.4 The use of partnership agreements

National Context

The concept of partnership agreements, also known as written agreements, between parents and social care have evolved over time and are not framed by legislation or statutory guidance. They are usually used by social care as a way of providing clarity for what social care expect of the family and what the likely consequences will be if the family do not adhere to the partnership agreement.

If the agreement is broken the consequences, which should have been clearly spelt out, should then ensue. Because of the level of concerns that there are when partnership agreements are used the consequence will usually be that the local authority will seek legal advice.

N.B It is important to note that this is only my experience of partnership agreements, having worked across different local authorities, as there is no official reference to these agreements.

Local Context

Partnership agreements are used routinely by social care in Bristol.

3.4.1 In the Child K SCR concern was expressed about the use of partnership agreements, in that they were not adhered to and there were no consequences. The same is true of this

SCR. In total there were four partnership agreements drawn up, two between social care and Ms A and two between both parents and social care. No other agency was aware of the agreement. The first three times were within a six month period, each time the agreement was broken and there were no consequences. The fourth time was six weeks prior to the death of Child T. It was only confirmed that agreement had been broken following Child T's death.

3.4.2 Each of the family members interviewed made reference to the partnership agreements. Ms A's view was that "All social care were interested in were the partnership agreements and going to groups". She said she signed the agreements because what choice did she have? In her words, "Either I signed them and kept the kids, or I didn't and they would take my kids". She also said that as she signed each one she knew she would never be able to adhere to the agreement because there was no way she could keep Mr Z away from her property. We now know from the criminal trial that Mr Z has limited reading abilities, so there remains a question, did he know what he was signing? We have not been able to explore that with Mr Z because of his unwillingness to engage with this process. Ms A's view is he could not read them but signed them to "Get social workers off our back".

3.4.3 Social care have addressed the need to tighten up these agreements and the use of them in their IMR but there is also a multi-agency aspect.

Lesson Seven

When social care draw up a partnership agreement with parents it is essential the agreement is realistic and practicable and that all of the agencies who are working with the family are aware of that agreement and the contents of it. This provides a safeguard, particularly if the child is not on any plan because it will raise awareness with other professionals as to what the concerns are and will also make clear their responsibility if they receive information that is relevant to the agreement.

Recommendation Seven

BSCB will draw up a "Partnership with Parents" Protocol and disseminate it across all partner agencies, including GPs. The protocol must include the need to advise all agencies working with the child, including the father and the mother's GPs, if different, and will include the responsibility of all agencies to inform social care if they believe the agreement has been broken.
The protocol will also emphasise that agreements must be realistic and practicable and advice will be sought from relevant partner agencies to ensure this happens. (Particular attention must be paid when there is thought, or known, to be domestic abuse in the relationship when the victim may be under the control of her partner).

3.5 Disguised and Non-compliance

National Context

The term "Disguised compliance" was coined by Peter Reder, Sylvia Duncan and Moira Gray who outlined this type of behaviour in their book *"Beyond blame: child abuse tragedies revisited"*[19]

Defined by the NSPCC, "Disguised compliance involves a parent or carer giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention."[20]

In their bi-annual analysis of serious case reviews Brandon et al state ""Apparent or disguised cooperation from parents often prevented or delayed understanding of the severity of harm to the child and cases drifted. Where parents engineered the focus away from allegations of harm, children went unseen and unheard."[21]

In Lord Laming's report to the Government following the death of Peter Connelly he wrote "Professionals were over-optimistic, they need to exercise "respectful uncertainty"[22]

It should be noted that disguised compliance is not something that families that we work with do and we do not. Disguised compliance is a natural response, whether it be tidying our home before a professional comes round, or being economical with the truth with our doctor about how much we smoke, weigh, drink etc. We, as professionals, say to families "Be open and honest with us" but sometimes the family is and we become so concerned about what is happening that the local authority applies to the court to remove the child. It is a natural response to hide the truth, if the family thinks there will be negative consequences. What professionals have to get better at is looking at facts and evidence, not what is said.

Local Context

BSCB has guidance on the use of Multi Agency Professionals Meetings The purpose of the guidance is to support all practitioners in the use of meetings especially where there are issues of professional disagreement or concerns regarding disguised compliance or parents who are avoiding engagement with one or more agencies.

BSCB has put on training around working with disguised compliance and reluctant parents. This is currently under review but will be on-going. This training includes action learning sets.

A core component of the BSCB business plan 2013-2014 is to build a more confident workforce. The business plan was in the process of being developed and was not available

[19]Beyond blame: child abuse tragedies revisited. Peter Reder, Sylvia Duncan and Moira Gray. 1993
[20] NSPCC Safeguarding Information Service, 2010
[21] Analysing child deaths and serious injury through abuse and neglect. What can we learn. A biennial analysis of serious case reviews 2003 – 2005. Brandon, M. et al.(2008a)
[22]The Protection of Children in England: A Progress Report . Lord Laming 2009

at the time of writing this review.

The recent Ofsted inspection has noted that "Lessons learned from serious case reviews help to shape practice. For example in cases seen by inspectors where 'disguised compliance' was an issue, this was effectively identified and acted upon as part of the assessment and planning process".

3.5.1 Ms A did not want to lose her children and so she was not honest with professionals about her situation. From her perspective social care were "The enemy" and she could not be honest with them. Ms A said she did want to tell some professionals that she liked what was going on, including her health visitor and the student social worker working with her but she was too afraid. She felt that all social care ever said was "If you do not go to groups and keep to the partnership agreements we will go to court and ask the court to take your children away from you". She felt that that was all they cared about and to her mind no one ever offered her practical solutions about how she could keep herself and her children safe.

3.5.2 In October, 2007 Mr Z agreed to counselling, as part of a partnership agreement between himself, Ms W, the mother of his first child and social care. The counselling never happened. At that time he expressed remorse to social care about his previous behaviour and he told social care that he wanted help with "Low self-esteem and anger management".

3.5.3 In October, 2011 Mr Z told social care he wanted to access the community programme for perpetrators of domestic abuse. It never happened. (The programme requires a self-referral and a commitment and honesty by the perpetrator of his/her behaviour).

3.5.4 In June, 2012 as part of the partnership agreement Mr Z agreed to only have contact with Child U supervised by his mother and agreed to not live with Ms A. Not only did he remain in the family home but also there is no evidence that social care spoke to Ms E about the proposed arrangement. There was no assessment of Ms E as a suitable person to supervise the contact.

3.5.5 In July, 2012 Mr Z agreed to engage with all of the services named by social care. There was very little engagement with these services.

3.5.6 In the two partnership agreements between social care and Ms A she agreed to not allow Mr Z to visit the family home and there were different requirements around the children's contact with their father. None of these were kept to. (There is an issue around whether it is realistic to make partnership agreements with someone who is a victim of domestic abuse which has been addressed in 3.4.2 and will be considered further in 3.6). Ms A also agreed to attend the Freedom Programme, for victims of domestic abuse but failed to do so. It is not clear that anyone thought about who would look after the children if she

were to attend the programme. There was talk of a child minder by social care but that never materialised. (Peter Connelly's mother attended a parenting course, as a requirement of the child protection plan and it was never known where her children were while she attended the course). Ms A said in interview that she found groups intimidating and she did not want to talk about her circumstances in front of other people, she was also afraid of the consequences, if professionals knew what was happening in the home.

3.5.7 Following the alleged incident involving Mr Z throwing a bottle of talc, which was meant to hit Ms A but actually hit Child T, Ms H went to social care to inform them of that and her other concerns, as set out in 2.6.38. Ms H said she had not witnessed the incident but another family member had. Ms A and Mr Z's response to this was to assure professionals that Ms H was just causing trouble and that was accepted. Social care did not attempt to speak to the family member who had witnessed the alleged incident. It appears that Ms H was not seen as credible, because of the family's history and her troubled relationship with her daughter. Ms A and Mr Z successfully deflected professionals from doing a full investigation. (The social care IMR acknowledges that the incident should have been investigated)

3.5.8 There is little evidence that professionals considered the facts, as opposed to what was being said by the parents and it is here that an integrated chronology plays a useful part (See **Recommendation Four).**

3.5.9 Disguised and non-compliance is another reason why effective supervision is essential. It should be part of the checks and balances that should be happening along the way when any agency is working with a family. There is little evidence that supervision was effective in this case. This was also a finding of the Child K SCR and the Child Z SCR.

Lesson Eight

Although it is positive that Ofsted noted good practice in this area there is always work to be done across the workforce looking at the extremely complex area of disguised and non-compliance and how there needs to be effective oversight.
It is essential that workers look at evidence, not what is said by families and consider the deeper analysis as to what is the impact on the child of a family not engaging with a particular service. Is there a negative impact, or not? There may not be. It should not be seen as a positive if families engage and attend appointments and a negative if they do not. If a family engages it may only be superficial because they know professionals put great stock on that. It always has to go back to "What is the impact on the child?" and "What is the evidence?" As stated above, the integrated chronology will help with this.

Recommendation Eight

As this has been an issue in previous serious case reviews in Bristol, this will be covered by **Recommendation Five.**

3.6 Domestic abuse

National Context

There has been an ever-increasing understanding of the impact of domestic abuse on children over the last 10-15 years. Across all police forces now the police have to consider the risks to the children if they attend a domestic incident and there are children in the home.

In 2002 the definition of emotional abuse of a child was broadened to include "Witnessing, or hearing, the abuse of another".

The number of children on child protection plans because of the domestic abuse element of emotional abuse has increased over the years and there is increasing research about the impact of domestic abuse on the unborn baby and the potential impact on the development of the baby's brain[23].

There is also research that shows that domestic abuse is likely to start, or if it is there already, increase when a woman becomes pregnant[24].

Domestic abuse is still predominantly male to female. On average two women die every week in this country as a result of domestic abuse[25]. Although violence perpetrated by women is on the increase, generally[26], it remains rare for a woman to kill a man.

What is discussed much less is when there is violence on both sides of a relationship. Violence perpetrated by women is still seen as much less acceptable, culturally, than it is with men and our responses may be less clear if the female is violent too.

Local Context

Bristol has a domestic abuse forum, known as Bristol Against Violence and Abuse, a domestic violence and abuse, prevention tool kit, a domestic violence and abuse policy.

Bristol has a Violence and Abuse Against Women and Girls and Domestic and Sexual Violence Against Men Strategy (2012-2015). This work is governed by the Domestic and

[23] http://www.cyc-net.org/features/viewpoints/c-domesticviolence.html
[24] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2126542/pdf/9158458.pdf
[25] http://www.womensaid.org.uk/domestic-violence-articles.asp?section=00010001002200410001&itemid=1280
[26] http://www.independent.co.uk/news/uk/girls-get-violent-1345290.html

Sexual Abuse Strategy Group and supported by a specific Joint Commissioning Group and a Prevention Group.

The MARAC process in Bristol has four strands, two of which are mentioned above. In addition to those Bristol holds two MARAC meetings each month to discuss and action plan for victims of domestic violence and abuse who are at high risk of harm. These processes are governed by the MARAC Steering Group. Since October 2011, pre-MARAC meetings have also been held to deal with the high volume of referrals received.

A range of local guidance is available for professionals working with families experiencing domestic violence and abuse including the Early Years Domestic Violence toolkit, guidance for schools, learning difficulties and domestic violence toolkit, safeguarding children living with domestic violence and abuse, talking to children about domestic violence and abuse. There is also guidance for health professionals and midwives - Domestic violence in pregnancy.

The recent Ofsted inspection noted that "Although a domestic abuse protocol has now been developed, there is not yet a shared understanding of risk in such cases between the police and children's social care". It goes on to say "Domestic abuse is the most commonly recorded risk factor in children in need and child protection cases. From April to June 2014, 777 open social work cases had domestic abuse as a significant risk factor. Work with families where there is domestic abuse, is closely aligned to other interventions in, for example, drug and alcohol misuse and mental ill health. Of the cases involving domestic abuse, 485 also involved substance misuse and 437 alcohol misuse, while in 510 cases, parents were identified as having some level of mental health need. Multi-agency risk assessment conferences (MARAC) ensure that high-risk domestic abuse cases are managed well and services effectively engage families".

3.6.1 There are four elements to consider here. The first is was it realistic to expect Ms A to agree to have no contact with Mr Z when she was a victim of domestic abuse? Secondly, would the response have been different if Ms A had been seen purely as the victim and not as a perpetrator too? (There was a comment by one worker that the couple were "Both as bad as each other", as if one being abusive negated the other, when of course the opposite is true). Thirdly, was there a good enough understanding of Mr Z's history of domestic abuse, with some of the main workers involved with Child U and Child T and fourthly, did workers have a good enough understanding of risk factors around domestic abuse?

3.6.2 The fact that the relationship between Ms A and Mr Z kept resuming, even when there were partnership agreements in place and MS A had told social care she would not see Mr Z clearly demonstrated that she was either unwilling to separate from him, or she was more frightened of him than she was of social care, or he was in control of her and that was why their relationship kept resuming. There is no evidence that that was explored with Ms A. (In interview Ms A said it was the latter). In 3.5.5 the question is asked "Is it realistic to expect a woman who is a victim of domestic abuse to keep away from her partner?" As always, that

will depend on many factors but we should not assume, which happened in this case, that by professionals telling Ms A she must not have contact with Mr Z, that would happen – particularly as the evidence was their relationship kept resuming. (Interviewing a mother in another recent serious case review elsewhere, the mother said "I did not know who to be more frightened of – him or social services").

3.6.3 In interview the maternal grandmother, Ms H, described her anxiety about her grandchildren and also her child, Ms A. It is not unusual for grandparents in domestic abuse cases to describe the fragility of their situation. They may be worried about their child and their grandchildren but they are also worried their children will prevent them from seeing their grandchildren if they ask too many questions, or go to the authorities. In this case Mrs H said she always knew when Mr Z was around because she would not hear from her daughter.

3.6.4 In interview Ms H said she contacted social care on a number of occasions following the visit she made to them in November, 2012. She said no one ever returned her calls. There is no record of those calls. In interview Ms H acknowledged that social care will receive malicious and false allegations her expectation is not that all are accepted, rather that they are investigated. Ms H is correct. All allegations should be investigated and decisions should not be made on assumptions. If the allegation regarding the talc bottle had been followed up and had been found to be true, that would have increased Ms H's credibility with social care and she would have felt that they listened to her concerns and took them seriously, rather than feeling that they thought she was a trouble-maker.

3.6.5 Ms A had a history of violence. She had physically assaulted other pupils in school as a child and was first reprimanded by the police for physical assault when she was 13. She was arrested a further three times between August, 2008 and January, 2011. There is no evidence that the fact that Ms A was known to be violent did impact on how professionals responded but what was not demonstrated was an understanding of the increased level of risk to the children if both partners are violent, particularly when there are drugs and alcohol are involved. Although alcohol is not a trigger for violence it can act as a disinhibitor.

3.6.6 There is nothing in any of the IMRs about Mr Z's childhood, except the police IMR referring to his offending and one reference in the social care IMR to an Acceptable Behaviour Contract when he was 13. As set out earlier in the report it is only through the criminal trial that we have learnt about his educational history. None of the professionals working with Ms A as a child, or Mr Z and Ms A as parents had looked into his history, to the extent that would be considered reasonable, other than his criminal record. He was using Class A drugs by the age of 18, was a prolific offender by the age of 19, his ability to read or write is limited and he has been using violence against others since he was young. (There was also little known about Mr Z's mother, Ms E, although social care had concluded she could supervise Mr Z's contact with Child U, at one point and little about Mr G, or Mr H). It is

a frequent finding of serious case reviews that little is known about the family history but family history is vital.

3.6.7 It cannot be ignored that Mr Z was given a custodial sentence for stealing a car and related offences but was not sent to prison for offences that most people would consider much more serious – child abduction and domestic abuse. It has not been possible to involve the courts in this serious case review but should be considered in the future. The message to the perpetrator is very clear – stealing cars is more serious than child abduction, or domestic abuse. There was horrific domestic abuse in this case and it seemed to be minimised, not only by Ms A and Mr Z but also by professionals.

3.6.8 There was not a clear understanding across all agencies of what a Pre-MARAC meeting is. In this case there was a Pre-MARAC meeting on 7th December, 2012. It is essential that all agencies understand the processes in place to protect children and vulnerable adults.

3.6.9 The first recorded incident of domestic abuse occurred when Ms A became pregnant with Child U. As stated above violence in an abusive relationship is more likely to start when a woman becomes pregnant. Ms A told social care, on 20th December, 2012 that she was pregnant. Although the worker noted that social care were worried about Ms A and she should be contacted over the Christmas period, a time of difficulty for many vulnerable people, no contact was made with her until 7th January. This meant that Ms A, who had told social care she had very little contact with her mother at that time due to their relationship difficulties received no support over the difficult period of Christmas and New Year and yet she may have been at greater risk of physical violence from Mr Z, due to her pregnancy and this would have implications for the children too. There is no acknowledgement of the risk factors increasing, or assessment of risk over this time.

Lesson Nine

Domestic abuse needs to be seen within the context of child protection, particularly when a woman is pregnant, or there is a baby in the home. As stated above, it is not clear why this case was never seen as child protection, or whether thinking was clouded because Ms A could also be violent.
It is also essential that we have realistic expectations of victims of domestic abuse; otherwise we may be prolonging the danger to the child and the victim.
As part of any assessment of risk and looking at the balance of probabilities there is much research about the links between a boy witnessing domestic abuse and going on to be a perpetrator and girls witnessing domestic abuse and entering abusive relationships. This research should have been considered. Ms A witnessed domestic abuse as a child.

Recommendation Nine

Advanced domestic abuse training should be mandatory for all social workers and frontline

staff working in child protection. The advanced training needs to include the use of written agreements with mothers who are victims of domestic abuse, the complexities of both partners being perpetrators as well as information about the increased risk of violence when a woman is pregnant, or there is a baby under one in the home.
Currently BSCB delivers basic and advanced domestic abuse training. BSCB needs to satisfy itself that the course content, of both courses, is fit for purpose. (Ofsted's comment on BSCB training was "The Board plans to implement an evaluation of the impact of training on improving practice but does not yet rigorously evaluate the impact of training. Work is underway to achieve this").
In cases when social care is involved and it is known there is domestic abuse BSCB should consider the proposal that a domestic abuse advisor will be attached to the case. Their role would be to consider the plan that is put in place, whether it is realistic and to advise the other professionals on all the issues around domestic abuse.

Lesson Ten

It is essential that all agencies understand the processes put in place to protect children and vulnerable adults.

Recommendation Ten

BSCB to draw up and circulate a list and statement of purpose of all the meetings that are held about children who are supported through SAFs, child in need plans, child protection plans. In addition to this BSCB to draw up and circulate a list and statement of purpose of the four different components of the MARAC meetings, the pre MARAC, the MARAC, the sexual violence MARAC and the perpetrator MARAC.

Lesson Eleven

Professionals may make judgements about family members, including extended family, based on assumptions and misinformation. In this case an assumption appears to have been made that the maternal grandmother was an unreliable source of information, possibly due to previous involvement with social care. If the alleged incident with the talc bottle had been followed up and the extended family member who witnessed the alleged incident interviewed, maybe professionals would have drawn a different conclusion and may have taken further steps to protect Child U and Child T. (It was only two weeks later that there was evidence of the domestic violence escalating). At the very least it would have helped to build a picture of the violence in the home. Equally assumptions were made about Mr Z without sufficient knowledge of his history, his abilities or his learning difficulties.

It is essential that all decisions are evidence-based and all allegations are followed up.

Recommendation Eleven

This recommendation repeats **Recommendation Six.** Professionals need to be reminded of the need to ensure that assessments are evidence-based. In addition to this BSCB needs to send out a clear message to all professionals that allegations of child maltreatment must be

followed up.

General Lesson

One of the themes of the specific lessons and recommendations of this serious case review is the concern that some recommendations from previous serious case reviews have not been embedded in practice. This has been addressed by **Recommendation Five**. In order for the lessons of this serious case review to be learned and embedded in practice there must be buy-in from across all partner agencies of BSCB.

General Recommendation

The work that is generated from the recommendations of this serious case review must be shared amongst all BSCB members. This will ensure maximum shared learning across the Board.

3.7 Summary of good practice

3.7.1 Although it seems insensitive talking of good practice when a child has died, it is important that we learn from the poor practice and also acknowledge and learn from the good practice.

3.7.2 There is evidence of commitment and dedication by some of the school staff. The decision to move Ms A from School A to College A was made in the best interests of the child. The view was that her progress at school was hampered by the number of family members at the school and the disruptive influence they had on her. The school also did not want to permanently exclude Ms A but felt that would be inevitable if she remained there. They felt Ms A would be more likely to achieve if she was away from her family members and was doing a vocational course.

3.7.3 The GP tried several times to contact Ms A to have her contraceptive fitted after Child T was born.

3.7.4 The pregnancy advisory service nurses carried on supporting other health professionals after Ms A turned 18, which was beyond their remit but they were concerned about Ms A's vulnerability and the safeguarding concerns.

3.7.5 The Children Centre supported the neighbour to make a referral to social care when she was concerned about what she was hearing from the flat.

3.7.6 A Children's Centre worker offered to go in on her day off to look after the children, so Ms A could attend a clinic without them.

3.7.7 The health visitor tried three times to introduce Ms A to the Children's Centre

3.7.8 The Teenage Pregnancy Midwife took Ms A groceries on one visit because she was worried about her.

3.7.9 The social worker did an early morning visit to Ms A, having been given information that Mr Z was living there, at a time when he was not supposed to be there. During the visit Ms A repeatedly denied that Mr Z was living there but the social worker persevered and insisted on seeing every room in the home. At this point Mr Z appeared.

4. Conclusion

4.1 Many of the findings of this serious case review are similar to the findings of the previous three serious case reviews in Bristol. Whilst acknowledging that, it is also important to consider what we can learn from this case. Blaming individuals, or organisations, achieves nothing, accountability is vital. Although there have been concerns about some individuals' practice it has not been to the extent that it was considered disciplinary action needed to be taken. I agree with that decision. There are examples of good practice but as always there is much that we can do to improve our practice and I hope that the recommendations set out in this review will do exactly that.

Appendix One – Explanation of acronyms used in the report

Acronyms

ADHD – Attention Deficit Hyperactivity Disorder

AWP – Avon and Wiltshire Mental Health Partnership Trust

BASE – Barnardo's Against Sexual Exploitation

BDP – Bristol Drugs Project

BSCB – Bristol Safeguarding Children Board

CAF – Common Assessment Framework. The CAF was offered to children who have additional needs to those being met by universal services. The practitioner assesses needs using the CAF. The CAF has now been replaced in Bristol with the Single Assessment Framework (SAF)

CAIT – Police Child Abuse Investigation Team

CCG – Clinical Commissioning Group

CIN – Children in Need. Under Section 17 (10) of the Children Act 1989, a child is a Child in Need if:

- He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or
- He/she is a Disabled Child.

Child Protection – Section 47(1) of the Children Act 1989 states that: Where a local authority have reasonable cause to suspect that a child who lives, or is found, in the area and is suffering, or is likely to suffer, significant harm, the authority shall make such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

CJIT – Criminal Justice Intervention Team

CPS – Crown Prosecution Service

DfE – Department for Education

HOR – Health overview report

IMR – Individual management review. Under *Working Together to Safeguard Children, 2010* as part of the serious case review process each agency has to produce an individual management review, which feeds into the serious case review.

LPW – Learning Partnership West

LSCB – Local Safeguarding Children Board

MAPPA – Multi-Agency Public Protection Arrangements

MARAC – Multi-Agency Risk Assessment Conference

MGF – Maternal grandfather

MGM – Maternal grandmother

PGM – Paternal grandmother

PPU – Public Protection Unit

UHB – University Hospital Bristol

SAF – Single Assessment Framework. The Single Assessment Framework has replaced the Common assessment framework in Bristol and is now being used in all areas of the city, including Early Help, Bristol Youth Links and the council's Family Intervention Teams.

SCIE – Social Care Institute for Excellence

SCR – Serious case review

SWSCPG – South West Safeguarding Child Protection Group

TOR – Terms of reference. Under *Working Together to Safeguard Children, 2010* as part of the serious case review process there had to be terms of reference

YOT – Youth Offending Team

Appendix Two – Genogram