Oxfordshire Safeguarding Children Board

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Serious Case Review into the death of Child N

Overview Report

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Final 05/08/2014

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Serious Case Review

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1 ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

Introduction

1.1 This report was prepared for Oxfordshire Safeguarding Children Board (the LSCB) in order to fulfil the requirements of the statutory guidance *Working Together to Safeguard Children 2013*.[1] The guidance sets out the arrangements for the local interagency review of serious child protection cases. The LSCB is required to undertake the review in order to identify opportunities to improve the provision of services for vulnerable children. This report sets out the findings of the Serious Case Review (SCR).

1.2 In keeping with statutory requirements the LSCB has published the SCR Overview Report in full.

Reasons for conducting the SCR

1.3 The SCR concerns the services provided for a child aged one who is subsequently referred to as Child N. In May 2013 Child N was found dead in the flat where she had lived with her mother.

1.4 Child N had been the subject of contested proceedings for residence and contact in the family court between her mother and the father. She is believed to have been in her mother's care during the last days of her life and her mother is known to have left the UK in the hours following the child's death. The initial post mortem examination of Child N was unable to ascertain the cause of her death; however it noted that Child N did not have the commonly observed symptoms of unexplained sudden infant death. The death of Child N is therefore being treated as suspicious and is the subject of a continuing criminal investigation. As yet there has been no inquest.

1.5 *Working Together 2013* states that the LSCB in the area where the child lived should conduct a SCR when a child has died and '*abuse or neglect … is known or suspected'.*[2] The recommendation to hold the SCR was made by the LSCB SCR group meeting in June 2013. Andrea Hickman, who was at that point the Independent Chair of the LSCB, judged that the circumstances met this criterion and made the decision to undertake the SCR on 20th June 2013. Work began at that point to agree the scope and focus of the review.

The scope and focus of the Serious Case Review bearing in mind the circumstances of the death and the involvement of agencies with other family members

1.6 The purpose of the SCR is set out in *Working Together 2013.* It is to provide a '*rigorous, objective analysis'* of the services that were provided to the child and family '*in order to improve services and reduce the risk of future harm to children'*. The LSCB is then required to *'translate the findings from reviews*

[1] HM Government, *Working Together to Safeguard Children – 2013*. Chapter 4
[2] LSCB Regulations 2006 (Regulation 5)

into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.[3]

1.7 It is the responsibility of the LSCB to determine the scope and focus of the SCR. In its initial discussions the SCR panel agreed that agencies would be asked to consider the following aspects of their practice:

- How well potential risks to the child arising from parental vulnerabilities had been identified and understood, including possible concerns about domestic abuse, parental mental health, marital conflict and unstable accommodation
- Whether assessments and decisions had been reached in a timely, informed and professional way
- The actions taken to safeguard Child N in relation to any identified risks and how effectively agencies had worked - both individually and collectively
- Whether there had been effective communication and working between agencies in Oxfordshire and those in other local authority areas
- Whether any safeguarding risks had been identified and acted upon in the private law proceedings in relation to residence and contact arrangements
- Whether appropriate local single agency and inter-agency procedures and professional standards were in place and were implemented in an effective fashion
- Whether practitioners were sensitive to the specific characteristics and needs of the child and other family members arising from race, culture, language or religion.

1.8 Individual agencies that had provided services to the family made enquiries about all of these areas. This report summarises the findings of those enquiries and focuses on the matters judged to be the most significant. These findings are set out in detail in section 4 of this report.

[3] Working Together 2013 4.1 and 4.6

Findings and recommendations

1.9 The SCR has made recommendations to individual agencies or to the LSCB on areas where it found that services could be improved because the findings in this case highlighted a wider weakness in services. In some instances the SCR has produced findings which require further work of the LSCB and member agencies before deciding what action to take.

The time period covered by the SCR

1.10 The SCR has taken account of events during the period between January 2011 and May 2013, covering the mother's pregnancy with Child N and the child's life.

Agencies involved

1.11 The SCR considered the work of the following agencies and contracted health professionals who had the most significant involvement with the family:

- Children and Family Court Advisory and Support Service (Cafcass)
- Oxfordshire Clinical Commissioning Group in relation to GP services
- Oxford Health NHS Foundation Trust - in relation to health visiting and a service providing community based psychological therapies
- Oxfordshire University Hospitals NHS Trust – which provided antenatal services
- Oxfordshire County Council
  - Children's Social Care including hospital based social workers
  - Early Intervention Service
  - Legal Services
- Northamptonshire County Council - Children, Families and Education Directorate – which had dealings with the family when the mother and Child N lived briefly in Northants
- Thames Valley Police.

All of these agencies prepared individual management reviews describing and evaluating their involvement with the family in detail. Other agencies (all outside of Oxfordshire) which had only very brief contacts with the family assisted the SCR by providing chronologies of their involvement.

Engagement with the parents' solicitors

1.12 The father represented himself throughout the family court proceedings. The mother was represented by two solicitors. There was a break and a change in her legal representation due to the availability of funding from the Legal Services Commission ('legal aid'). The LSCB approached the solicitor who was representing the mother at the time of Child N's death in order to seek information about his actions. This would have enabled the SCR to have a better understanding of the advice given to the mother during the latter part of the proceedings. The solicitor told the LSCB that he was unable to

disclose information about the case because it was subject to professional privilege, an aspect of common law embodied in Chapter 4 of the Solicitor's Regulatory Authority (SRA) Principles and Code.[4] He had taken specific advice from the SRA on this which supported his understanding.

1.13 The SCR recognises that this leaves a gap in its understanding of events which cannot be filled. This is apparent from Section 4.7 of the report. However it is hoped that the learning from the SCR will be of value to this solicitor and to others working in the family courts.

Parallel processes that have impacted on the conduct of the SCR

1.14 Thames Valley Police has conducted a criminal investigation into Child N's death. The SCR panel has been kept informed of relevant information gathered during the course of the investigation. Careful consideration has been given to the contents of material published by the LSCB and its potential impact on the criminal investigation.

Agreed extensions to the normal timescale for completion of the SCR

1.15 The SCR has taken longer to complete than the six months set as a guideline in *Working Together 2013.* This was largely due to two factors: the impact of the work being taken by agencies in Oxfordshire on another SCR which was being conducted at the same time and delays caused by the need to take account of the progress of the criminal investigation. The Independent Chair of Oxfordshire LSCB has been briefed about the progress of the review. Where it was possible to take action in relation to shortcomings in practice identified during the course of the SCR, participating agencies have done so.

Involvement of family members

1.16 The whereabouts of Child N's mother remain unknown, making it impossible to inform her about the SCR or to involve her in it. The child's father was informed about the decision to undertake the SCR and invited to contribute. He has done so through an interview with the overview report author. The views of the father about the involvement of agencies are incorporated in the report at relevant points and a number of his concerns are addressed in Section 4 of the report.

Agreement of the SCR findings and arrangements for publication

1.17 A draft SCR overview report was discussed by the SCR panel and agreed after amendments. Staff who were had direct contact with the family have been involved in the review and have been offered feedback about their work as the review has progressed.

[4] http://www.sra.org.uk/solicitors/handbook/code/part1/content.page

1.18 The Overview Report was presented to the LSCB on 28th July 2014 and its findings were accepted by the Board. The Overview Report will be published in full as required by Working Together 2013.

1.19 Other documents prepared by member agencies and for or by the review panel, the notes of interviews with members of staff and family members and the records of service users will not be published or disclosed.

2 STEPS TAKEN TO UNDERTAKE THE SERIOUS CASE REVIEW

2.1 *Working Together to Safeguard Children 2013* sets out a series of principles that should inform the methodology for SCRs. These are reproduced in Appendix 3 of this report.

The review process and methodology

2.2 At the time of Child N's death, Oxfordshire LSCB and member agencies were involved in substantial work undertaking a SCR in relation to the sexual exploitation of a number of children in Oxford. Given this consideration the LSCB Independent Chair decided that the LSCB would conduct this SCR in line with the method of enquiry set out in the previous (2010) version of statutory guidance.[5] This would enable member agencies to carry out a thorough review, in a timely manner, using a familiar approach rather than have to commit substantial additional resources to training members of the review team in an untested review method.

2.3 In order to comply fully with the requirements of current statutory guidance particular care has been taken by member agencies to involve staff in the review as fully as possible in the SCR.

2.4 Paul Kerswell acted as the Independent Chair of the SCR panel. Keith Ibbetson wrote the SCR overview report. Both have substantial experience of conducting SCRs and are independent of the agencies involved in the review.

2.5 A full list of the roles and job titles of SCR panel members is contained in Appendix 1 of this report. Panel team members are experienced clinicians or managers in member agencies or designated health professionals with substantial experience of safeguarding children. None of the panel members had had any previous contact with Child N or other family members.

2.6 The SCR panel team met on 4 occasions in order to review the materials prepared by contributing agencies to evaluate the provision made by agencies and to discuss and agree a report to be presented to the LSCB.

2.7 The overview report findings were circulated to participating agencies for formal comment and agreement before being submitted to the LSCB for discussion and agreement.

[5] HM Government (2010) *Working Together to Safeguard Children,* Chapter 8

The framework for making judgements about the actions and decisions of professionals

2.8 Self-evidently there is value in reviewing the history of professional involvement with a child, with an overview of events and knowledge of the outcome. However along with the clarity that hindsight brings the SCR has taken account of the danger of what is termed 'hindsight bias'. This arises when the evaluation is unduly influenced by knowledge of the outcome because '*looking back the situation faced by the clinician is inevitably grossly simplified'*.[6] In the investigation of serious incidents in health services, air accident investigation and other high risk industries the dangers of this are recognised. It is easy to criticise the decisions and actions of professionals because they can now be seen to be part of a chain of events that had a tragic outcome.

2.9 If decisions and actions are judged out of the context in which they occurred it is likely to reduce the value of the investigation. It may also be unfair to the individuals who were involved. More valuable learning can be obtained by seeking to understand and explain why decisions were made and actions taken taking full account of the influences over professionals arising from the circumstances within which they were working. The SCR has therefore sought to take advantage of hindsight whilst avoiding hindsight bias.

2.10 In keeping with this approach judgements about actions and decisions take into account the information that was available to the professionals who took them. At certain points it is necessary to evaluate the overall service provision in relation to information that was known to the network of professionals as a whole or ought to have been available if relevant information had been shared.

2.11 The review has sought to judge the actions of professionals and agencies against established standards of good practice as they applied at the time when the events in question took place. Nevertheless where the actions of individuals, groups of professionals or agencies as a whole are found to fall short of established professional standards this will be stated, together (where it is possible) with an explanation of why that happened.

[6] Charles Vincent (2010) Patient Safety (second edition) Wiley-Blackwell BMJ Books, pages 50-52

An organisational or systems approach

2.12 As well as focusing on the actions and decisions of the individuals who were directly involved, the SCR has tried to understand and distinguish the influence of a range of organisational factors in the decisions and actions taken. The additional focus on the team, the service, the agency as a whole and the collective actions of agencies together does not diminish the responsibility of individuals to act professionally and to work effectively. It explains the factors that sometimes make it harder for them to do so.

Recognition of strengths in professional practice

2.13 Research points to the value of identifying strengths in practice and ordinary things that were done well. Agencies need to learn from these and promote them as well as learning from shortcomings. When these are judged to be significant, they have been highlighted, either in Section 3 or 4 of this report.

Recommendations and challenges to the LSCB and member agencies

2.14 The review has distinguished in its findings between the following:

- Practical actions that the agency concerned has already or may swiftly act on to ensure compliance with an established procedure or professional approach
- Firm recommendations that the agency or the LSCB has agreed to implement
- Areas where more information or research is required before the LSCB can decide what action to take.

3 NARRATIVE OF KEY EVENTS

3.1 This section contains a detailed narrative of the main professional contacts with family members and events reported to professionals. In Section 4 key episodes are evaluated in more detail where this assists in understanding important aspects of the provision made for Child N and her family or where it offers an insight into the wider working of safeguarding services.

Contacts with agencies prior to the period under review

3.2 In 2010 Child N's mother and father made a joint application to Oxfordshire County Council to act as carers for vulnerable adults under a project known as 'Shared Lives'. They were approved following the normal assessment process and two vulnerable adults spent short respite periods in their shared household. After this trial period they decided not to continue with this work. One of the stays ended ahead of schedule but there was no indication of any concern about the couple's conduct.

> This occurred some 12 months before the birth of Child N and is not considered to be relevant to main findings of the SCR. Information about this was not known to the local authority children's service during its involvement with Child N and her parents because records of it were stored on a separate adult services database dealing with carers.
>
> As there might be occasions when information such as this would be relevant to children's services the local authority has agreed to review its arrangements for checking the 'Shared Lives' database when undertaking an assessment of a child's circumstances. The local authority has adopted a recommendation in relation to this.

3.3 In May 2010 an allegation was made against the father who at that time was employed as an agency worker in a residential school. This was investigated by the police who decided that there were no grounds for further action. The police judged that the allegation did not meet the criteria for reporting to the Local Authority Designated Officer (LADO) – who should coordinate the response to allegations of abuse against those working with children in a professional capacity. Again agencies dealing with the Child N subsequently had no knowledge of this event.

> This incident occurred 18 months before the birth of Child N and was judged by Thames Valley Police not to require further action as a criminal matter or under inter-agency safeguarding arrangements. There is no indication that this was not a legitimate judgement. Nor is there any indication that it adversely affected the way in which Child N's circumstances were dealt with. There is no evidence or reason to suspect

that Child N was ever caused any harm by her father.

The parents' personal background and family history

3.4 The mother is approximately 40. She grew up in Africa but had lived for almost all her adult life in the UK and was a naturalised UK citizen. The father is in his mid-thirties. He grew up in a different part of Africa and he is not a UK citizen. None of the agency reports state the date of the parents' marriage. There is no significant background information in the GP health records about either parent. Neither parent had a criminal record in the UK.

3.5 In general agency records contain descriptions of contemporary events but very little background information about either the mother or the father. There is no work or social history and there is almost no information about either parent's life in their own family or country of origin, or their reasons for coming to live in the UK.

The lack of background information obtained by agencies and the reasons for this are discussed further in Section 4.3. This describes the nature of the various assessments that were undertaken by the agencies involved and considers why they obtained so little information about the parents.

Professional involvement with the mother during her pregnancy

3.6 In early January 2011 the mother was referred for antenatal care by her GP. She stated that she was very happy to have conceived. The referral contains no significant medical or social information.

3.7 In February 2011 the mother attended her antenatal booking appointment at John Radcliffe Hospital. At the first appointment the midwife undertook a medical, obstetric and social assessment. This highlighted some medical concerns making the pregnancy 'high risk' from a medical perspective and requiring monitoring by the Consultant Obstetrician.

3.8 The assessment dealing with social issues scored the mother as being 'low risk'. This assessment had included standard enquiries about any history or current concerns about domestic abuse, to which the mother answered 'no'. The mother gave details of the father's identity and reported that he was involved and supportive, even though the couple were now separated. There is no record that the father attended and it is assumed that he did not as the questions about domestic abuse would not have been asked in his presence.

3.9 The mother later gave 15 March 2011 as the specific date of her separation. This contradicts the information provided at the booking appointment. It is not clear if she was providing misleading information on either occasion or was simply mistaken.

3.10 The GP and community midwife subsequently shared routine aspects of the mother's medical care, entering information on the mother's hand-held antenatal care record with basic details also entered into the mother's GP records. This is normal practice. The mother attended the scheduled appointments and followed treatment suggestions and plans. The mother was also reviewed by the hospital consultant on three occasions prior to the birth because of the potential medical complications.

3.11 Midwives did not record details of whether the father attended each appointment because they were not expected to do so. They remember the father attending some appointments at the hospital, but not the majority. Midwives have no specific recollection of his attendance at the children's centre where the community appointments were held. The question of how professionals relate to fathers during pregnancy and early childhood is considered further in Section 4.8.

3.12 On 14 April 2011 the mother went to a police station and reported having had an argument with her husband in which he had shouted and screamed at her. This was categorised as a domestic incident and a risk assessment was carried out using the standard format employed by Thames Valley Police.[7] The assessment questions 'prompt' for information about aspects of the incident that could point to a higher level of risk. The mother reported being frightened and it was noted that she was pregnant and that the couple had separated during the past year (all of which are factors found in research to raise risks associated with domestic abuse).

3.13 The incident was classed as 'no crime' (because there was no allegation of any crime) and the risk assessment was passed to the police force Domestic Abuse Investigation Unit (DAIU) in order to screen the details of the incident and establish what information (if any) needed to be shared with other agencies. Noting that there had been no criminal offence alleged or committed but also noting that the mother was pregnant the DAIU assessed the risk as 'standard' and arranged for emails containing summaries of the incident to be sent to the local authority (children's social care) and the maternity service.

3.14 Oxfordshire County Council social care service reviewed and noted the incident and decided to take no further action.

3.15 The hospital antenatal service has no record of having received this notification and as a result it did not become part of the hospital's records. Records have been thoroughly reviewed and the trust cannot identify the reasons for this.

The management report provided by Thames Valley Police has identified a

[7] This is the DASH- CAADA Risk Identification Checklist template which is the standard approach used in most police forces and many other agencies nationally

> number of aspects of the response made to this domestic abuse report and subsequent ones which did not fully comply with its internal procedures. None of these are considered to be significant in relation to the overall findings of the SCR. They have led to a number of internal recommendations which are set out in detail in Appendix 5 of this report.
>
> On the basis of the information available to the local authority at this point the SCR takes the view that there was no need for the local authority to seek further information about the circumstances. However it is noted that the local authority would have assumed that the maternity service had received the notification (because that was the standard procedure) and would be able to take that information into account in its further contacts with the mother.
>
> Section 4.4 of this report evaluates the response of agencies to reports of domestic abuse in detail.

3.16 On 4 May 2011 the mother phoned the local authority's social work service based at the hospital and spoke to a trainee social worker. The mother stated that she was 23 weeks pregnant and wanted to discuss relinquishing her baby. An appointment was made for the following day, which the mother did not keep.

3.17 During a second phone call two days later the mother spoke to the same worker about domestic abuse saying that she had recently reported it to the police for the first time and that it was '*getting worse*'. During the call the mother alleged that her husband had '*only married her to remain in the country*'. However, the mother had no current concerns about domestic abuse telling the worker that the father was no longer speaking to her and that the locks on the former family home had been changed.

3.18 The mother was seen by the same worker for an initial assessment on 14 June 2011. By this time the worker had access to the police notification of the alleged incident on 14 April 2011. The mother stated that the main reasons for considering giving up her baby were her financial insecurity and her desire for the baby to have the kind of stable family life that she had experienced; however prior to her separation she had been relishing the prospect of becoming a mother. The worker formed the view that the mother was an intelligent and articulate woman who already had an emotional attachment to the unborn baby.

3.19 During the assessment discussion the worker provided advice about financial and practical supports that might be available to address the mother's concerns and enable her to bring up the child, including social contact with other new mothers and parents mothers. The mother was given some informal advice and advised to see a solicitor over the custody of the baby.

3.20 Initially it was agreed that the worker would make a follow up visit prior to and after the birth of the baby in order to see that arrangements were in place. In the event following further positive phone contacts the worker – having written up her assessment and twice consulted her supervisor – decided to close the case and offer further contact if the mother requested it.

3.21 During these contacts no checks were made of other agency records and no information was provided to the midwives in the antenatal team.

> This contact is evaluated in Section 4.3 of the report which deals with professional assessments.

3.22 On 23 August 2011 the father phoned the police and stated that during a phone call the previous night the mother had started screaming and shouting at him. He explained that she was heavily pregnant. He was concerned that she might call the police and make trouble for him. He believed that he had been offering practical support to the mother. He stated that he intended to contact his solicitor about the situation the following day. The father told the SCR that he had a particular concern that he was very vulnerable to a false allegation of domestic abuse because of his job in a caring profession and his immigration status and that this was why he had contacted the police before the mother could.

3.23 Police officers visited the father the following day and undertook a risk assessment along the standard lines set out in Section 3.12 above. This revealed an additional comment by the father that the mother had threatened suicide two years previously.

3.24 Records of the contact were reviewed by the Thames Valley Police DAIU which agreed with the grading of the contact as 'standard'. On this occasion no notification was made to the local authority.

> The Thames Valley Police management review has commented on this episode and identified some learning for the police service. In particular it highlights possible learning about the value of 1) investigating historic allegations of crimes – even if they are minor and tenuous and 2) seeing both parties in a dispute to obtain a full account and give advice.
>
> The fact that this was not done in this case has no bearing on the final outcome. Overall the SCR has found that the police reacted in a thorough way and operated a low threshold in response to episodes that most people would consider barely constituted domestic abuse.
>
> Section 4.4 of this report addresses the wider problem of how agencies should view current approaches to domestic abuse, especially in relation to 1) those incidents that are less serious but fall within current definitions 2) whether agencies attempt to see both parties or seek additional information

in order to corroborate accounts.

3.25 With the exception of the mother's routine involvement with the antenatal service there was no further professional contact with the mother or father prior to the birth of Child N.

Early weeks

3.26 Child N was born in September 2011. The delivery was uneventful and she was in robust health. There were six follow up contacts with midwives in the community, during which no significant problems were identified and the infant was noted to be thriving.

3.27 Health Visitor 1 made her primary birth visit (the first home visit to assess the needs of new born child and family circumstances) on 5 October 2011. This covered routine areas of advice about the child's health and the mother was signposted to a range of services. It was noted that the mother had 'some good support networks' but it was not recorded what that meant. The mother was advised to attend the local child health clinic and other services.

3.28 Aside from a minor medical complaint there were no significant professional contacts with Child N or the family during the remainder of 2011. The baby was taken to the 6-8 week health check which was noted to be positive. Routine immunisations were given.

Application for Prohibited Steps Order and subsequent court decisions: December 2011 – May 2012

3.29 On 15 December 2011 the parents attended a mediation session as part of an attempt to arrive at amicable divorce arrangements.

3.30 The notes of the session indicate that this was the first time that the parents had agreed contact arrangements. Until the New Year there would be two contact sessions per week (but flexibly arranged – presumably because of the holidays). Subsequently there would be two four-hour contact sessions per week at specified times at the father's home. Neither parent made allegations of domestic abuse in the session.

3.31 The mother was considering taking Child N to her country of origin to meet her family. At this point the father indicated his agreement to this provided that it was only for a month. The mother also stated that she was experiencing some financial difficulties, in particular funding the mortgage on the family home. She was to seek advice about her eligibility for state benefits. Consideration was to be given to the financial support that the father should provide.

3.32 Subsequently the mother spoke to a Community Staff Nurse (CSN1) who was a member of the Health Visitor's team to report her fears that the father 'may be thinking' about taking Child N out of the country. The mother referred to 'general' comments and threats made by the father, but there

were 'no physical threats' and 'nothing to go to the police with'. This had not been noted in the record of the mediation session.

3.33 CSN1 advised the mother of agencies who could offer relevant advice and consulted Health Visitor 1, who decided that no additional action was required.

3.34 On 1 January 2012 the mother phoned the police and reported that the father had been threatening and aggressive towards her at her home. The police attended and found only the mother there. There was no sign of injury or damage to property. Officers completed the same standardised information gathering exercise during which the mother offered the additional information that the father had previously threatened to commit suicide. The officers assumed that the father had been present and had left and gave the mother advice on how to make better contact arrangements. They did not attempt to see the father to verify the mother's account or offer advice.

3.35 Police records indicate that details of the incident were forwarded to '*all child agencies'* though those agencies were not listed. The SCR has confirmed that only the local authority received the notification.

> The Thames Valley Police management review has noted that in the circumstances (this was the third reported domestic incident in 8 months) it would have been wise to see the father in order to give him advice.
>
> With hindsight and in the light of all the information available from other agencies doing so might also have served to test out whether the incident had happened in the way that the mother had described (or even whether it had occurred at all). It would certainly have highlighted some aspects of the mother's account that were not consistent with the facts and with versions given to other agencies.
>
> It is not possible to be certain which agencies were notified but if an alert was sent to health agencies it is further evidence that the arrangements for alerting health agencies of domestic incidents were not reliable as this was the second of two alerts in this case which had not successfully become part of health service records. This is addressed in Section 4.4.

3.36 The local authority initially decided to take no action, but the decision was reviewed by a senior practitioner who decided that the case should be 'monitored' because of the baby's age and vulnerability. This meant that it was recorded on the file that should there be another domestic abuse referral enquiries would be made, even if it were not an incident that in its own right would normally merit that response. In making the decision not to seek to be actively involved the social care service is likely to have assumed that the health visiting service – which would have been in contact with Child

N – would have received a copy of the same notification, though this had not happened.

3.37 During the following month the mother took Child N to two baby groups at a children's centre, before ceasing to attend. On 20 January 2012 the father made an application for a Prohibited Steps Order (PSO) in order to prevent the mother from taking Child N out of the jurisdiction of the court.[8] His supporting statement claimed that the mother was preventing him from having the agreed contact. The application did not raise any safeguarding concerns or mention allegations of domestic abuse.

3.38 The court heard the application at a Directions Hearing on 23 January 2012 and granted the PSO. At this point Cafcass was notified of the proceedings and the requirement to undertake safeguarding checks prior to a scheduled full hearing. These were undertaken promptly. During the course of telephone contacts the mother advised a member of Cafcass staff that she had stopped the contact because of the heated arguments between the parents which she did not want Child N to witness.

3.39 The Cafcass officer categorised this as a case of possible domestic abuse and as a result initiated the enhanced checks required by family court private law proceedings practice guidance. These revealed the information held by the police and the local authority already set out in this report which Cafcass subsequently made available to the court. In doing so Cafcass made clear to the court the limited value of such checks when either party had lived in the UK for only a limited time.

3.40 According to information which she provided to Oxfordshire children's social care in May 2012 the mother rented out the former family home on 12 February 2012 as she could not pay the mortgage. She said that from that date she and Child N had moved to live with friends in Northamptonshire. It is not possible to verify this information and in the agency records there is no account of the mother living anywhere other than at her established address until May.

3.41 The next significant court date was on 4 April 2012. Prior to this the mother contacted her Health Visitor and (in effect) asked for a reference, stating that the father was alleging that she was not a fit parent and asking her for a report to the court. The advice of the Named Nurse for Safeguarding was that in a private law case the trust would not provide a report unless it was requested by the court. [9] The Health Visitor emailed the mother to tell her this.

3.42 At the hearing the court made Child N a party to the proceedings. The case was transferred to the Family Division of the High Court to be heard by a more senior judge, largely as a result of the international dimension to the

[8] Section 8, Children Act 1989. This enables the court to prohibit a person from taking any specified action in relation to the child
[9] A specialist child protection advisory post in the health trust

case. The court directed Cafcass to appoint a Children's Guardian to report on the merits of an application made by the mother to take Child N to her country of origin, the progress of contact and any other pertinent welfare issues. The report was to be filed by 4 July 2012.

3.43 Cafcass allocated responsibility for the work to a Family Court Adviser (FCA 3) the following day.[10] However she did not have the space in her caseload to begin work on it in earnest for some weeks. A solicitor was appointed by FCA3 to represent Child N's interests independently of the views of the FCA. Both remained involved in the case until the death of Child N.

3.44 At the court hearing on 4 April 2012 the judge ordered that contact should take place each week at a contact centre (which would provide a neutral venue, but no observation or assessment of the contact arrangements). The parents were asked to file statements for a future hearing; including proposals for contact should the mother take Child N to her country of origin.

The decisions of the court and Cafcass at this stage were consistent with the case law and practice guidance. The appointment of the FCA as the Children's Guardian being particularly relevant to a case with an international dimension.

It is important to recognise that neither party in the proceedings raised concerns about safeguarding in relation to Child N. The father was concerned that at certain points the mother's care of Child N was less than satisfactory because she had no permanent home; however his main concern about this was his belief that the mother was using this as a ploy to disrupt contact arrangements.

There is evidence from phone calls made to the child's solicitor of the Guardian planning her assessment so as to take account of the potential international complexities, the significance of Child N maintaining a relationship with both parents and the previous allegations of domestic abuse.

The case had been categorised as one which featured domestic abuse as a result of reports of low level incidents which might be indicative of a larger problem and so merited more detailed background checks. This was an entirely correct approach in the circumstances

Contact with agencies when the mother and child had no stable accommodation: 3 – 31 May 2012

[10] A Family Court Advisor is a Cafcass employee who provides advice to the court (sometimes in the form of a written report). FCA is a job title. In this case the FCA was appointed as a Children's Guardian. Children's Guardian is a legal term with defined responsibilities appointed by the courts. To simplify matters the member of staff concerned is subsequently referred to by the abbreviated job title FCA.

3.45 On 3 May 2012 the mother registered herself and Child N at a GP practice in Luton. Initial health screening was undertaken by the Practice Nurse who noted relevant medical information. The mother gave a local address and indicated that she was a single parent, staying in the town temporarily. There were no concerns about Child N and GP routinely alerted the child health database in order to notify the health visiting service. There was no further contact with this surgery and the patient was deregistered on 16 June 2012 when the mother registered at a new practice.

3.46 Between 14 May and 2 June 2012 the mother was reported to have moved with Child N between a number of different addresses and locations. The following paragraphs reconstruct events and contacts with professionals as they were known at the time to the professionals involved.

3.47 On 14 and 15 May 2012 the mother had telephone contacts with the social care service in Luton. She said that she was moving between different locations and planned to stay with a friend in Cambridge and that she would then be returning to seek accommodation in Oxfordshire. Her initial contact was with the Luton out of hours service and she did not keep appointments offered with the normal duty service the following day.

3.48 On 15 May 2012 the mother informed FCA3 that she had been sleeping in her car with Child N. She was homeless as she had been staying with her brother in Luton, but they had had a dispute. Her intention was to send for money from her family to buy a ticket to travel to her country of origin. FCA3 advised her to present herself at a police station and seek accommodation, but the mother said that she would be staying with a friend in Cambridge.

3.49 A Luton social worker (who had spoken to the mother on the phone but not met her face to face) discussed the circumstances with FCA3 who undertook to make a safeguarding referral to Oxfordshire children's social care. The referral was made on the morning of 16 May 2012 and copies were sent to the local authorities in areas where it was understood the mother had stayed or visited over recent days. It was completed on a Cafcass template for child protection referrals headed 'URGENT Referral for Child Protection Services under Section 47 of the Children Act (1989)'; however the content related to the lack of stable accommodation.

3.50 FCA3 also notified the court of her concern and considered asking the court to insist that the mother surrender her passport because of the perceived risk of her fleeing the UK.

3.51 During this time FCA3 was given different information by the parents about contact arrangements. The father said that there had been no contact for substantial periods and the contact that had taken place was unsatisfactory as the mother forgot to bring basic items that he needed for Child N. The mother said she also wished to avoid confusion and possible breach of the court order by confirming which venue should be used for contact.

3.52 At about midday on 16 May 2012 the mother took Child N to a children's centre in Luton where she was seen during a child health clinic. The health visitor had details of the GP registration in Luton referred to above. Height, weight and head circumference measurements were taken. No concerns were noted and the mother said that Child N had previously had her developmental check-up.

3.53 Later the same afternoon the mother presented at the Oxfordshire County Council social care office in Oxford. She described her recent stays with relatives and reported that she had stayed in her car the previous evening. The mother was told to go to the Banbury team office (which covered her previous home address) and to try to make temporary arrangements pending her tenants being given notice to quit the former family home. The mother later phoned the Banbury office and was advised to seek temporary housing. She agreed to present herself to the District Council office as homeless. The District Council had responsibility for housing assessments.

3.54 Oxfordshire County Council closed the social work contact a few days later on the grounds that the only concerns expressed had related to homelessness, over which the authority could not take further action. The District Council housing officer referred the mother to a women's refuge in Luton which decided not to offer her a place on the basis that there was no actual evidence of any imminent risk of domestic abuse.

> The social care management review has noted that the staff involved responded in a limited way by treating the contact with the mother as being exclusively about housing issues and not assessing any potential risks to Child N caused by the mother's mobility.
>
> The review recognises that this was the approach that staff generally feel a pressure to adopt and that this may create difficulties when there is a potentially vulnerable child involved. This is considered further in Section 4.6.

3.55 On 18 May 2012 the father phoned Thames Valley Police to express his concern about recent events and report that the mother had threatened that she would take Child N to her country of origin so that he would never see her again. The police established the mother's whereabouts and Hertfordshire police visited the hotel where she was staying to check on the child's wellbeing, reporting back that there were no concerns.

3.56 The mother next had contact with professionals at the family court on 24 May 2012. It is not clear where Child N and her mother spent the intervening eight nights. The mother later told Oxfordshire social care that she was staying with a friend in Northamptonshire and that she stayed for some time at the hotel. She subsequently admitted that she had never slept in her car, though she had come close to doing so. At the court hearing orders were made for the mother to surrender her passport and for weekly contact. The

father made clear his intention to apply for a Residence Order (which would mean that his daughter would live with him and that he would have control over the main decisions about her). FCA3 was instructed to address this issue in her assessment and report.

3.57 On 28 and 29 May 2012 there were a large number of phone calls between Oxfordshire children's social care, the FCA, housing services managed by a district council and a women's refuge in Northamptonshire in order to establish the whereabouts of Child N and her mother and to seek to provide suitable accommodation and advice to the mother. The mother refused the offer of a refuge place. The mother was offered but did not take up a further duty contact with the local authority social care service in Oxfordshire.

3.58 During this period the FCA and Child N's solicitor discussed whether it would be necessary to ask the court to make an order under Section 37 Children Act 1989 requiring the local authority to assess Child N's circumstances and the potential need for a Care Order to safeguard her.

Court decision to make an Interim Care Order

3.59 By 31 May 2012 the mother and Child N were living in privately rented accommodation in Northamptonshire. At a court hearing that day the judge made a direction under Section 37 Children Act 1989, instructing the local authority to undertake a detailed assessment of Child N's welfare. The judge viewed the mother as being a 'flight risk' due to her failure to hand over her passport. He determined that he had found her to be unreliable in her accounts and felt that the care of Child N had been inconsistent. He accepted at face value accounts of the mother and child sleeping in a car. Very unusually the judge also made an Interim Care Order, despite the fact that neither the local authority nor the FCA had sought such an order. He gave the local authority the power to remove Child N immediately if judged necessary.

3.60 Oxfordshire immediately asked Northamptonshire children's social care to make a welfare visit to check that Child N was not at immediate risk and notified various agencies of the need to prevent the mother from leaving the country. Oxfordshire also sought to find ways of preventing the mother from removing Child N from the country, which had been a major concern of the court. It established that none of the agencies concerned (such as the Border Agency) could 'flag' individual details in a way which would have prevented the mother from leaving the UK unless specific travel plans (such as a flight number) were known.

3.61 Northamptonshire social care service did not undertake the welfare visit because the local service decided that it did not have sufficient capacity and could not prioritise the task.

The Northamptonshire County Council review of this episode has found that whilst this judgement was properly considered it gave insufficient weight to

the potential risks to a child about whom the authority had no direct knowledge and was not justified by the other pressures on the service at the time. A visit should have been made.

3.62 Thames Valley Police did make contact with the mother and Child N later that day, though the mother refused to disclose where she was living. The next day two members of social work staff from Oxfordshire social care visited the mother in Northamptonshire after she disclosed her address. There were no immediate concerns about Child N and the mother signed a written agreement that she would remain in her current accommodation and participate in the assessment ordered by the court.

3.63 On 6 June 2012 the mother surrendered Child N's passport to her solicitor and registered with a local GP. The Oxfordshire children's social care Team Manager directed a Senior Practitioner to begin an assessment in order to present a report to the court hearing scheduled for 22 June 2012, providing specific guidance as to how to undertake it.

Contacts with children's centre and health services in Northamptonshire during June 2012

3.64 On 11 June 2012 Child N was seen by a health visitor at a drop in clinic. The mother said that she had recently moved to the area and gave details of her circumstances (i.e. that she had wanted to take her daughter to the mother's country of origin but this was being prevented by proceedings in the family court). The health visitor was satisfied with Child N's development and presentation and the mother's account of her feeding and behaviour and allocated her to the universal service (contacts would be determined by the mother and take place at the child health clinic). Enquires were to be made about a further immunisation linked to the mother's proposed travel plans.

3.65 On 15 June 2012 the health visitor was informed by the local children's centre that Child N had been made the subject of an Interim Care Order. The police had made a welfare visit and that – apart from financial worries – no immediate concerns had been identified. On her next working day (18 June 2012) the health visitor made contact with Oxfordshire social care and the allocated senior practitioner explained the reasons why the interim order had been made. She stated that Oxfordshire social care had no concerns about the parenting that was being provided by the mother. There had been concerns about the lack of stable accommodation and the mother had been strongly advised to find permanent accommodation, which she had now done.

3.66 The health visitor heard from Oxfordshire social care on 25 June 2012 that the court had decided not to make any further order that required the local authority to be involved and that Oxfordshire would confirm this in an update to Northamptonshire social care. The health visitor contacted the mother to

discuss the outstanding immunisation and she said that she would not continue with it at this point as she had not realised that she would have to pay for it. The health visitor confirmed that she had made an application for a financial grant under the Healthy Start programme. The health visitor's next involvement was in July 2012 when Northamptonshire social care undertook a child protection enquiry.

Local authority core assessment 31 May - 22 June 2012

3.67 The Senior Practitioner saw the father on 7 June 2012. This was the first face to face contact that he had had with the local authority. He gave background information about the parents' relationship, which had begun in 2007, stating that the marriage had broken down due to the mother's controlling and bullying behaviour and her dishonesty. His account was that he had separated from her during the pregnancy (early 2011) but remained supportive.

3.68 The account given by the father to the SCR in early 2014 was entirely consistent with this record.

3.69 The father's view was that the mother's behaviour had deteriorated in November 2011 because she had discovered that he was having a relationship with one of her neighbours and it was suggested that this person might play some role in Child N's life by child minding her. Since then contact had been very difficult with the mother cancelling visits at short notice and mediation had been unsuccessful. The father alleged that the mother had subsequently disregarded court orders and placed numerous obstacles in the way of him spending time with his daughter.

3.70 The father explained his understanding of the financial position and the support he provided. His view was that between his support and the mother's benefits there was sufficient money for the mother and child to live comfortably. He denied ever having behaved abusively towards the mother.

3.71 The worker was satisfied that Child N was genuinely at the centre of his concerns. As the cause of concern in the case was framed as being about 1) relationship difficulties between the father and mother and 2) there was no evidence that Child N was at risk of immediate harm, the social worker noted that the father had not been observed with his daughter so the quality of the relationship had not been assessed but recorded that she '*could see little advantage'* in the Interim Care Order remaining in place.

3.72 This constituted the initial assessment. The local authority decided at this point that there were no grounds for an application for the local authority to seek a Care Order and that the concerns could be resolved satisfactorily within the private law proceedings. This decision was made prior to the completion of the core assessment.

> The timing and implications of this decision are considered further in Section

4.3 which considers this assessment further.

3.73 At this point the social worker sought legal advice. Despite the social worker reporting that the mother's interaction with the child was 'brilliant' the County Council legal advisor confirmed that the local authority was required to complete the Section 37 report for the court.

3.74 During the course of the core assessment the social worker had contact with or received information from the following individuals and agencies:

- Children's Centre
- Health Visitor
- Contact centre
- The parents
- Citizen's Advice Bureau (CAB)
- A member of the mother's extended family

3.75 The Health Visitor informed her that when Child N was an infant the family had received a 'universal' service and that there had been no concerns.

3.76 The children's centre listed the activities that the mother and child had attended but as she had been using universal services, rather than a targeted individual support programme, there were no detailed records of contacts.[11] There were no records of any concerns at all about Child N.

3.77 The Children's centre Manager passed on information that had been provided to the centre by the CAB about the mother's financial difficulties; her housing problems; the mother's aspiration to take Child N to her country of origin and the support and advice that had been provided. It was reported that Child N was clean and well presented and that there was a 'beautiful bond' between the mother and her child. It was noted that the mother appeared to listen to advice offered.

3.78 Entries in records show the social worker trying unsuccessfully to phone other professionals who were for one reason or another not in their offices or at work. A number of pieces of information were obtained by the social worker on 21 June 2012, the day before the court hearing but after the written report based on the core assessment had been submitted to the court.

3.79 There was no successful contact with the GP surgery, though it is clear from the GP records now available to the SCR that there would have been nothing negative to report had contact been made. The relevant health records would also not have been at that surgery as they would not at that point have arrived from the mother's last GP in Luton.

[11] Between July 2011 and January 2012, the mother had taken Child N to: 2 parent craft group; 3 mediation sessions at Bicester Mediation Clinic; 2 baby groups; a baby weighing group and the "breast feeding café" (once). There had been one introductory visit to the family home which was a standard part of the universal provision.

3.80 The contact centre (which was run by a local church) stated that its role was not to provide an assessment and that it needed to remain 'neutral' in its dealings with the parents. However it had identified no concerns about the child or the contact.

3.81 The records show that the mother was not interviewed again because she could not attend appointments offered, though there were email and phone contacts. The social worker planned to conduct an 'observational assessment' of father and child together but this did not happen because the social worker had a period of leave and the father was unavailable on the days that the social worker suggested.

3.82 The core assessment was completed and authorised on 18 June 2012. It concluded that because she had moved so often the mother had failed to provide her daughter with a secure and stable environment. She had failed to comply with court directions and appeared not to be taking the court proceedings sufficiently seriously. Financial pressures if not managed would adversely affect Child N's basic care.

3.83 The assessment also highlighted the apparently strong emotional attachment between mother and child. It noted that the mother had cooperated with the social care assessment team and had prioritised Child N's needs. The father told social care that he believed that mother had moved around in order to create obstacles to him seeing his daughter and reported his fear that the mother would remove Child N from the country. He alleged that the mother was dishonestly manipulating professionals in order to get the outcome she wanted.

3.84 The overall assessment was that Child N's physical, health and emotional needs were being met whilst in her mother's care and that she was not at risk of significant harm.

3.85 On 21 June 2012 the social worker had a conversation with a man who was said to be the mother's uncle. He said that he had provided support since her brother had asked her to leave his home and that he had visited the mother and Child N. He confirmed that his niece took excellent care of her daughter and that he would contact the local authority if he had any concerns. He suggested that the father was placing undue pressure on the mother. He was firm in his opinion that there was no reason to remove Child N from the mother's care.

3.86 The findings of the core assessment were presented to the court on 22 June 2012. The local authority also reported the actions planned by Oxfordshire social care in order to share information with services in Northamptonshire (where the mother was now living) which would remain in touch with the family. The judge thanked the local authority for providing a thorough assessment in such a short time.

3.87 Oxfordshire social care staff wrote to the agencies in Northamptonshire and on 25 June 2012 Oxfordshire closed the case. The parents were told this.

The father expressed his dissatisfaction at the outcome because he felt that the mother had been dishonest and misleading.

3.88 The following day the FCA observed a contact session between Child N and her father. Her observation was that this had been very positive and there was clearly a good relationship between them. As a result the FCA filed a recommendation for the contact to be changed to a three hour, unsupervised session.

3.89 There was no significant professional contact with the family for the next four weeks.

Episode of possible abuse or neglect in Northamptonshire

3.90 On Thursday 26 July 2012 the mother's landlord reported to Northamptonshire social care that 2- 3 weeks previously she had left Child N alone in the flat without supervision; he also said that the baby had no cot and had bruises caused by falling off the bed. A telephone strategy discussion the same day between Northants Police and the local authority led to the decision that Northants social care would pursue this as a single agency investigation.

3.91 An urgent home visit was made during which the mother admitted that she had left the baby alone – but that it was for only a few minutes and the landlord had been in the property for the whole time. The episode was categorised as 'concerns substantiated' (as the event had been admitted) but the mother had promised not to repeat her behaviour. This was treated as an acceptable outcome in the absence of any other current concerns.

3.92 At no point was consideration given to the bruising mentioned in the referral.

3.93 The Northants social worker involved contacted Oxfordshire at the beginning of the following week seeking background information from the core assessment previously conducted, which was provided over the phone. This was recorded by Northants as offering positive views on the mother's parenting. The local authority also made contact with the Northamptonshire health visiting service and the local children's centre. The health visiting records refer to discussions about Child N being left alone 'for ten minutes' and falling out of bed. The health visitor noted that she had shared information from her notes with the local authority. She gave details of the GP and suggested that the social worker made contact.

3.94 As a result of the visit and the discussions with other professionals Northamptonshire decided to take no further action. Letters were written to the mother, the health visitor and to the Children's centre confirming this. No information about the reported incident was provided to Cafcass (which the authority knew from its earlier contacts had been involved).

The SCR is concerned that the investigation focused exclusively on the

episode when the baby had been left alone and did not address the reference in the referral to bruising. The contact with the health visitor refers to Child N 'falling out of bed' which strongly suggests that the landlord's explanation for the bruises had been accepted.

The mother admitted leaving the child alone and said she regretted it. There is no account given about whether the child had had bruises and if so how they had been caused. Even though this was said to have happened some days before the referral and even though the referrer gave an account of how he thought it had happened, it should have been recognised that the presence of bruising on an infant under the age of one (even one who could crawl and walk and so might have caused the bruises accidentally) was a potentially concerning presentation.

The authority has told the SCR that it cannot find a reason for this happening, other than the fact that it was not considered. The staff involved were experienced and knowledgeable and the office was not one that was unduly busy making it hard to explain that this was anything other than an oversight leading the staff to focus on just one of the presenting problems.

In the context of the review as a whole however this is an important and concerning episode, since this is the only point in the case history when there was any professional knowledge of a sign or symptom that might have been indicative of physical mistreatment of Child N while she was in her mother's care.

The SCR is also concerned that information about the outcome of this Section 47 enquiry was not made known to Cafcass (which may have found the information relevant in the private law proceedings) and Child N's father (who had parental responsibility).

The SCR has made a recommendation to Northamptonshire LSCB in relation to this episode.

3.95 The health visitor next tried to make contact with Child N and her mother on 19 September 2012. She found the rented accommodation empty and renovation work being carried out. She established from the children's centre that the mother might have moved back to her address in Oxfordshire. The health visitor was unable to contact the mother to establish her forwarding address so decided to pass details of the case and the records to her safeguarding advisor. She in turn tried to establish a forwarding address. She but could not do so as the mother had not by then registered herself or Child N with a new GP. She retained the records until she was contacted by colleagues from Oxfordshire in October 2012 (see paragraph 3.102 below)

Court hearings and further developments during the period 4 September 2012 – 26 November 2012

3.96 There is no record of further professional contact with the mother between 26 July and 4 September 2012, the date of the next court hearing.

3.97 At that point it was noted that the mother had moved back to the former family home in north Oxfordshire and that contact with the father in recent weeks had remained problematic. For example the mother had phoned the police when the father returned Child N fifteen minutes late after a contact visit.

3.98 The final family court hearing was listed for mid-December. This included allowance for professionals to be consulted who could offer advice about the position of the child should the mother be allowed to take her to her country of origin. However this hearing had to be postponed as some of the professionals could not attend.

3.99 On 30 September 2012 the father contacted Cafcass and reported that the contact arrangement seemed to be working better and his fears that the mother wanted to take Child N out of the country had diminished.

3.100 On 3 October 2012 a specialist safeguarding advisor in the Oxfordshire contacted her counterpart in Northamptonshire health visiting service and obtained information about the health visiting contact that there had been with Child N and her family when they had been in Northamptonshire.

3.101 On 12 October 2012 the mother spoke to a GP over the phone. She reported being low and depressed because of the court case and not being allowed to travel to visit her family. The mother described sleeping poorly, overeating and low motivation, but said she had no suicidal thoughts and was not thinking about running away with the child (as the court would prevent her from doing this). She was encouraged to make an appointment and the GP recorded his intention to contact the Health Visitor. There is no evidence in the medical record that the GP did discuss the family with the Health Visitor; however the Health Visitor did start to become involved from this point on because of information shared by colleagues in Northamptonshire.

3.102 On 15 October 2012 two Oxfordshire health visitors who had had contact with the mother spoke in order to review the position of Child N. This conversation detailed knowledge of the episode from Northamptonshire and confirmed that there were no other known concerns.

3.103 On 17 October 2012 the mother's allocated Health Visitor (who had also dealt with her before she moved away from Oxfordshire) made an unscheduled visit to the family following unsuccessful attempts to contact the mother by phone. The mother was seen. Child N was recorded as being asleep upstairs and reported to be well.

3.104 The mother stated that she was tearful about having to go to court and that she was not well enough to attend. She repeated her allegation about the father's reasons for marrying her and that she was upset that he was now

having a relationship with her neighbour. She was not prepared to attend the local Children's centre as her husband's partner attended there too. The Health Visitor recorded that the mother was 'very depressed' and offered to look into the services available at another centre to see if legal advice could be obtained. She advised the mother to see her GP to get a sick note for the court and the health visitor agreed to call back in a week's time.

3.105 The mother missed a scheduled court appointment on 19 October 2012 on the grounds that she was off work for two weeks due to stress. At this hearing it was noted that some progress had been made in understanding the legal position in the mother's country of origin. Advice received suggested that the mother would need to apply for an order, mirroring any order made in the family court in the UK, setting out the father's right to contact and the practical arrangement.

> Section 4.7 considers the international aspect of the case, taking account of the advice obtained by the court, the practicality of implementing it and the process for obtaining it.

3.106 On 24 October 2012 the mother attended an appointment at her GP surgery. She reported that things were 'much the same' as recorded in the previous phone consultation. She had been in touch with her Health Visitor and was keen on the idea of contacting the Talking Space psychological therapy service, though she had not done so yet. [12] She asked for medication on the grounds that this would lift her mood and was prescribed a standard anti-depressant medication.

3.107 The same day she took Child N to the child health clinic and referred herself to Talking Space. After an initial telephone screening interview the mother subsequently missed two appointments before attending one face to face appointment and then taking up one phone appointment. This contact took place over a period of six months.

3.108 On 29 October 2012 the mother saw a number of health professionals. Further contacts and referrals resulting from these appointments set the pattern of the mother's contact with professionals between this point and the death of Child N. The GP notes mistakenly state that on this day the mother was seen in 'psychiatry clinic' but it has been established that this was a mistaken reference to the telephone therapy and treatment service.

3.109 The mother had an initial assessment (carried out over the phone) with a therapist from Talking Space. She stated that she had been unable to cope (for herself or with Child N) since July 2012 when the court had barred her

[12] Talking Space is a community based therapy service using cognitive and behavioural approaches. Its purpose is to treat patients with minor mental health problems, particularly anxiety and depression. Much of the work of the service takes place by phone as this allows more clients to be seen, some service users prefer this and it improves take up of services.

from taking Child N out of the country. She described her former husband as emotionally abusive and that he had threatened to hit her and had broken ‘objects’. However he had never hit her. She described a low mood, lack of motivation and loss of control and the feeling that her partner was getting on with his life, whereas she was not. The father was described as ‘totally unreasonable’. She was hurt by the fact that he was having a relationship with one of her close neighbours.

3.110 The mother stated that she was currently taking an anti-depressant and that she had had a previous episode of depression when she had been made redundant. Her aims in treatment were to ‘gain back my self-esteem’ and cope with ‘emotional abuse’.

3.111 Following the consultation the mother was sent welcome letters and information about Talking Space and her GP was informed. She was signposted to Women’s Aid and the EVE Wellbeing Project.[13] The Oxford Health NHS Trust summary of this assessment was that it did not identify any specific risks (either to herself or to others) arising from the mother’s account of her circumstances and needs.

3.112 On the same day (29 October 2012) the Health Visitor saw Child N and her mother at the GP surgery. Child N was recorded as being well presented, a happy and articulate toddler. There were no concerns about her health or development and she was up to date with her immunisations. The mother also looked smart and seemed well. She said that she had financial worries and also a real concern that the father was attempting to gain custody of Child N.

3.113 The Health Visitor made a referral to the Children’s centre describing the mother as feeling ‘very low’. It was felt that she would benefit from access to the centre and the crèche, the Freedom Programme (which is a programme for women who have been victims of domestic abuse) and the opportunity to make new friends. A referral was also made for a service called ‘floating support’ (which offered welfare benefits and financial advice).

3.114 On 31 October 2012 health visiting notes from Northamptonshire were transferred to the local service.

3.115 On 5 November 2012 the court issued a penal notice in order to enforce the order for contact previously made. It also refused the mother’s request for adjournment of the final hearing date (at that time fixed for 26 and 27 November) due to her ill health, on the basis that the sick note she had supplied did not say that she was unfit to attend court hearings.

3.116 The same day Child N was taken to the crèche at the children’s centre. She subsequently attended on nine occasions during November 2012, and at no

[13] EVE is a voluntary organisation that offers to support to women affected by sexual abuse, domestic abuse and mental health concerns http://evewomenswellbeing.org/

point was there any concern about her appearance or behaviour or the mother's interaction with her.

3.117 On 6 November 2012 a centre worker visited the mother at home. This was a normal part of the centre's work to support referred families. The mother gave a similar account of her worries about her situation and her mood was described as being 'OK'. It was noted that the house was very bare and that Child N had no cot. Mother explained that she had been staying with relatives 'up north' and had had to sell furniture to pay her legal fees. The centre worker said she would get the mother a cot and confirmed the plan of support and activities described above.

3.118 On 7 November 2012 the mother saw her GP for a review. It was the same doctor who had seen her a week before. She reported feeling a lot better as a result of the positive impact of the medication, the psychological therapy service and contact with her Health Visitor. She also saw her Health Visitor with Child N at the GP surgery to provide an additional immunisation that was part of the normal health care regime in the mother's country of origin. The mother said she felt more in control than when they had last met and that she had seen her solicitor which was helpful.

3.119 On 14 November 2012 FCA3 visited the mother and child at home. She had no concerns. The mother informed her that the reason some contact sessions had been missed in September was that the father had been on holiday. There is no evidence that this assertion was checked.

3.120 The same day the mother asked her GP for a letter to the court explaining that she could not attend and the impact that the court case was having on her. The mother subsequently withdrew the request as on the advice of her solicitor she attended.

3.121 On 19 November 2012 the mother saw her GP again and reported continuing small improvements as a result of the support she was receiving from the children's centre and the Health Visitor.

3.122 On 22 November 2012 FCA3 filed a court report for the forthcoming hearing. This set out her view that Child N should remain in the care of her mother. She noted her concern about contact arrangements and how they would be maintained should the mother leave the UK, especially as the current (relatively straightforward) contact arrangements were not working successfully. FCA3 recommended that the parents should be directed to attend a Separated Parenting Information Programme (SPIP) in order to understand the impact that their behaviour might have on Child N. This service is provided by a separate organisation.

3.123 The planned court hearing on 26 November 2012 was not in a position to make a final order. Instead it required both parties to file updated statements and ordered disclosure to the court of information from the police and the mother's bank. On the advice of FCA3 the court asked the Office of the Head of International Family Justice to provide clarity about the possibility of

obtaining a court order to secure the father's contact. This was to be done by 8 February 2013.[14] The role of this body is considered in Section 4.7.

3.124 FCA3 interviewed both parents at the court. The father stated that he was seeking a Residence Order and wanted overnight contact in the meanwhile. The mother was opposed to this on the grounds that she was still breastfeeding. FCA 3 took the view that overnight contact was not in Child N's interest given her age and attachment to her mother.

3.125 The judge agreed with the recommendation to direct the parents to attend the SPIP. FCA3 was directed to file a report specifically to consider the issue of overnight contact with a further final report to be filed by 13 May 2013. A review hearing to decide the application for overnight contact was listed for March 2013 and the final hearing was listed for 13 May 2013.

3.126 On 28 November 2012 the mother cancelled her first face to face appointment with Talking Space saying that she was 'stuck in floods'. An alternative appointment was offered for 11 December and the mother was sent further paperwork and self-assessment questionnaires to complete.

Court hearings and other key events from December 2012 until the death of Child N

3.127 On 4 December 2012 the mother and Child N were seen at the child health clinic and the infant was observed to be thriving. The mother had a minor concern about 'noisy breathing' which she attributed to the father smoking during contact visits and having pets. Practical advice was given on this and the mother was offered a review with the GP if reassurance was needed.

3.128 The mother took Child N to the crèche at the children's centre. On 3 December 2012. She subsequently attended on six further occasions during December 2012, and at no point was there any concern about the child's appearance or behaviour or the mother's interaction with her.

3.129 On 12 December 2012 the mother attended the Freedom Programme.

3.130 On 10 and 19 December 2012 the mother had contact with the GP (on the first occasion by appointment and on the second by phone) about minor health matters and she was given advice. During the first consultation she claimed to be a nurse. No particular significance was attached to this.

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[14] This is a small team of members of the judiciary supported by civil servants http://www.judiciary.gov.uk/about-the-judiciary/international/international-family-justice According to its annual report it has 2 or 3 members of staff and received 253 referrals during 2012. A significant part of the workload of its judicial and professional staff is to attend international conferences and workshops, sometimes making presentations. The Annual Report for 2012 shows that during that year staff associated with the office spent over 40 days attending conferences in locations including Hong Kong, Bermuda, The Hague, Paris, Switzerland, Barcelona, Madrid and Nicosia. The report refers to assistance being provided by an overseas judge in relation to the country to which Child N's mother proposed to remove her.

3.131 On 20 December 2012 the mother had a telephone consultation with her worker at Talking Space. This appears to have been another rearranged appointment possibly due to the mother's attendance at the Freedom Programme on 12 December 2012. The mother reported the decisions made by the court and her disappointment that the court appeared to want to prevent her taking Child N to her country of origin. The therapist discussed the potential value of Cognitive Behavioural Therapy and sent the mother further material in relation to depression.[15]

3.132 There is no indication in any agency record as to how or where the mother and Child N spent Christmas 2012. The father told the SCR that at some point over the Christmas period he noted that there were lights persistently on at the mother's home when she had said that she and Child N were going to be away. He says that he phoned to local social care office to ask for advice about this. The local authority has no record of the contact which suggests that he could have been given informal advice which (given that he had not reported a specific concern which the local authority could have acted on) appears not to have been recorded.

3.133 On 7 January 2013 attended the GP for a review of her depressive symptoms. She again reported the positive effect of her medication and the GP noted the value of continuing it for at least six months. The mother also discussed other medical matters.

3.134 The mother had much less contact with services during January 2013. Child N attended the crèche on only three occasions. On the last occasion it was noted for the first time that Child N was upset when her mother left and was generally uninterested during the session. When this was shared with her mother she stated that Child N had been a bit more 'clingy' recently.

> Nothing in this was outside the range of normal age-appropriate behaviour and it was entirely appropriate that it was discussed with the mother in the way that it was.

3.135 On 18 January 2013 the mother missed another phone appointment with Talking Space. She was phoned and sent a text and letter to ask her to make contact within two weeks if she wanted to continue to be seen by the service. If not she would be discharged. Subsequently the mother contacted Talking Space on 15 February and attended a further appointment on 14 March 2013.

3.136 On the same day the father brought Child N to the GPs because of thrush on the child's vulva. He was noted to be concerned about this, but had 'no

[15] CBT is an approach which seeks to enable the patient to think about and understand their circumstances differently in order to enable them to try to implement different strategies for dealing with day to day problems.

concerns about abuse'. There had been an earlier similar presentation in August 2012. No treatment was recorded on either occasion.

> This can be a symptom of child sexual abuse, but also has benign causes in infants. There is no reason to believe that there was reason for concerns about sexual abuse in this case.

3.137 Child N was left at the crèche on five occasions during February. On the first – when she had not attended for over two weeks - it was noted that she took some time to settle.

3.138 On five occasions between 12 and 19 February 2013 the mother had contact (either by phone or urgent appointment) with GP practice staff in relation to Child N suffering from vomiting and diarrhoea. Her contacts with health professionals appear to have been routine and do not raise concerns.

3.139 On 19 February 2013 two workers from the local authority Early Intervention Service met with a worker from a charity known as Parents and Children Together (PACT) to discuss the possible involvement of the mother in a programme known as the Recovery Tool Kit. This is a 12 or 24 week educational programme to support victims of domestic abuse, who are no longer living with the abusive partner. A programme was due to commence the following day at the children's centre and a member of staff from PACT had assessed the mother as being suitable for the course.

3.140 The PACT service had at that time been commissioned by the District Council to provide services for victims of domestic abuse and had been put in contact with the mother by the local housing service. Subsequently the District Council awarded the contract for services to another organisation and the worker from PACT stopped attending the group. This worker did not provide the local authority workers with details of their assessment of the mother, leading to the belief that no assessment (or at best a very scant assessment) had been undertaken.

3.141 Subsequently the mother attended four programme sessions during February and March 2013 with her last attendance being on 13 March 2013. She missed two further sessions on 20 and 27 March 2013 (the fifth session having been focused specifically on the impact of domestic abuse on children). At that point it was reported that she would no longer be attending due to 'other commitments' (which were not defined).

3.142 The only unusual or noteworthy comments made by the mother at the group sessions were recorded on 6 March 2013 during the course of a discussion among the women about handing over children for contact sessions with violent partners. In contrast to other group members, who reported high levels of anxiety about this, the mother made it clear that she had no concerns and that if anything happened to her child during a contact visit it

would be the father's responsibility. During this session the mother also reported having met a new partner via the internet.

> The mother's involvement in domestic abuse services is discussed in detail in Section 4.4

3.143 On 21 February 2013 the Health Visitor saw the mother and Child N at the GP surgery. The mother said that she was still feeling 'very down' about going to court over the custody dispute. She said that she was still taking anti-depressants and attending the domestic abuse programme, which she was finding helpful. The mother claimed that the court was telling her to give up breastfeeding and the Health Visitor advised the mother of World Health Organisation recommendations to continue breast feeding until the age of two years.

3.144 The Health Visitor noted that the mother had no thoughts of self-harm or harming Child N, though she was very angry with the court and her husband. It was suggested that the mother write down all the things that were making her angry and take the opportunity to discuss them at the children's centre the following week. The Health Visitor obtained the mother's agreement that she could discuss her situation with the children's centre worker, but there is no recording to indicate that this discussion took place.

> It is not certain whether what the mother was saying about continuing to breast feed was truthful. There is no evidence that the court had discouraged her from doing so and it certainly could not prevent her. In fact FCA3 had been influenced by the mother's account of continued breast feeding to be cautious about granting overnight contact visits.
>
> At no point was there any contact between Cafcass and the health visitor or the other professionals who were in contact with the mother and Child N at this time. This is considered in detail in Section 4.7

3.145 The Health Visitor next saw Child N and her mother on 27 February 2013. At this stage the mother was noted to be much calmer and more positive about her situation and observed to be interacting happily and warmly with Child N. The mother reported her continued concern about being asked by the court to stop breastfeeding in order for the father to have overnight contact. However this had not been required and there had been no court hearing since the last Health Visitor contact. Again the Health Visitor did not know this.

3.146 On 1 March 2013 the father took Child N to the GP surgery and asked if he could have access to her medical records on the grounds that the mother was not keeping him informed about Child N's health. He made it clear that both parents were seeking Residence Orders in relation to the child. No

specific response was recorded. This visit coincided with the mother visiting the surgery and she was angry that the father was bringing Child N for appointments. The GP told her that the appointment had been for the father and that no details could be provided. Mother stated that she 'could not think clearly' because of the custody dispute and went home. This was the last significant GP contact with Child N.

3.147 In contrast to these contacts with health professionals in which negative feelings about the court process had been expressed, on 8 March 2013 at a court hearing all parties (including the mother who was legally represented) agreed to a planned overnight contact stay with the expectation that a second overnight stay would be agreed before the next scheduled court hearing.

3.148 At this hearing the mother reiterated her plan to take Child N to her country of origin and confirmed her intention to live with and marry a man she had met on the internet. FCA3 and the child's solicitor reiterated their opposition to Child N being removed from the UK until such time as there was an order in place to protect the father's right to contact. The final court hearing was listed for 17 June 2013.

3.149 On 14 March 2013 the mother had a telephone session with Talking Space. Standardised assessments were undertaken and the mother was asked questions about any thoughts or intention to harm herself or others. The therapist identified no concerns. The mother said that she continued to take the same medication.

3.150 Records indicate a session in which the mother spoke mainly about the practicalities of her current situation including progress with the court case. At this point the mother suggested that lawyers were establishing if there was a way for her to move overseas with Child N, which she preferred to do as she had 'no support here'.

3.151 She reported that there had been one overnight contact stay and that arranging contact can be 'a nightmare'. However they have two day stays per week and are working towards stays of two nights per week. The notes state that the mother 'gets on well with him (the father) and his partner and trusts God that it goes well'.

3.152 She described her relationship with a new partner, currently living in her country of origin.

3.153 The mother described feeling a residual anger towards Child N's father as he had 'abandoned' her during the pregnancy.

3.154 She spoke of having attended the domestic abuse programme sessions and reiterated some of the contents. She stated that this allowed her to 'let things go'; however she had lost all faith in the legal system.

3.155 The mother spoke of a possible business opportunity in London. The notes conclude by stating that her anger is the main destructive thing and that

there are times when she can get upset and not know 'what to do with it'. The therapist suggested some relaxation techniques, which the mother agreed to follow.

3.156 The mother's next telephone session with Talking Space took place on 11 April 2013. The same standardised screening assessments were used and again the mother denied any thoughts or intentions of harming herself or anyone else. Once again the session notes suggest that the mother spoke a lot and provided updates on her views on all aspects of her current situation. She appears to have stated that she was now able to be more accepting of her current circumstances; however she aspired to return to her country of origin, but feared the financial cost in legal fees of making the necessary arrangements. She reported that her new partner would be attending the next significant court hearing which was scheduled for 7 May 2013.

3.157 The mother agreed to continue practicing the relaxation techniques previously sent to her. A further appointment was made for the 10 May 2013 but was cancelled by Talking Space on the day of the appointment due to staff sickness. The appointment was rebooked for 17 May 2013.

3.158 On 3 May 2013 the parents notified FCA3 and the solicitor acting on behalf of Child N that they had agreed arrangements for the second overnight contact visit. The records show that the mother had asked the father to care for Child N whilst she was abroad for two (or according to one record three) weeks from 23 May. The interim contact arrangements appeared to have gone well so that Child N had been able to stay overnight with her father from Thursday morning until 8pm on Saturday.

3.159 FCA3 remained of the view that Child N should not be allowed to move abroad without safeguards in place to ensure contact would continue to take place with her father. Advice provided on the overseas legal issues had confirmed that there was no provision under child care law in the country concerned to adopt a foreign order so an application would need to be made afresh in that country. This is considered further in Section 4.7

3.160 On 10 May 2013 the FCA observed a further contact session between the father and Child N. She was satisfied with the outcome believing that there was evidence of warmth and a strong attachment between them

3.161 On 14 May 2013 FCA3 had supervision with her Service Manager and discussion about the final recommendation to be made to the court. The Service Manager advised FCA3 to make a firm recommendation in order to avoid further delay in what had become protracted proceedings.

3.162 Although there was evidence of growing cooperation between the parents over contact arrangements the report focused its deliberations on the applications that had been made to the court. The mother had a long standing application to remove Child N from the jurisdiction of the court in order to bring her up in her own country of origin. The mother proposed to form a new family unit with her new partner and his son (whom she had met

on the internet but who had never been to the UK or met Child N). The mother's legal representative had undertaken enquiries in order to establish how contact arrangements for the father might be arranged and secured via an order in the court in her country of origin.

3.163 The report set out the father's reservations that he feared that Child N would not be well looked after if she left the UK, that the mother would not facilitate contact and that he would not be safe if he travelled to visit his daughter. The report considered how contact arrangements might be secured, either through a court in the mother's country of origin making an order for contact, or the mother agreeing to bring Child N to the UK for contact and posting a substantial sum in the UK which would be forfeited if contact did not take place. Any orders made would not be mutually enforceable in the courts of the different countries because the country concerned was not a signatory to The Hague convention.

3.164 In contrast the father's application for residence was based on the assumption that he would live in the UK and allow contact with the mother. He envisaged his new partner playing a role in Child N's life.

3.165 After further reflection the FCA decided to recommend that the court should make a Residence Order in favour of the father. Her report recorded her assessment that 'both parents are equally capable of meeting Child N's needs' and that had the case not involved the mother's application to remove Child N from the jurisdiction of the court FCA3 would have recommended an order in which residence was shared by both parties.

3.166 FCA3 recorded her lack of confidence in the mother's willingness and ability to facilitate contact should she be allowed to take Child N to her country of origin. Her judgement was that Child N had a significant relationship with her father which would be jeopardised if she moved to live with a new family in a different country.

> This recommendation in favour of the father and the process by which it was arrived at are discussed in Section 4.7. This also considers the issue of how best to tell parents in a contested case that Cafcass has recommended a change in residence.

3.167 On 14 May 2013 FCA3 completed her report and emailed it to the father (who was representing himself) and to the solicitor acting for the mother to share and discuss with her. The mother's solicitor forwarded the Cafcass report to the mother by email. On 15 May 2013 the father alerted the police to the possible flight of the mother because she had failed to take Child N to a scheduled contact handover. Subsequently it was established that she had left the UK that evening.

3.168 The following day Child N was found dead in the family home.

4 EVALUATION OF THE SERVICES PROVIDED FOR CHILD N AND HER FAMILY

4.1 Introduction

Working assumptions about the circumstances of Child N's death

4.1.1 In conducting its work the SCR has not had the benefit of 1) definitive information about the cause of Child N's death 2) a detailed understanding of the circumstances in which it occurred or 3) clear evidence about who – if anyone – caused it. These are unusual circumstances in which to conduct a SCR. Whilst it is not the function of the SCR to investigate or to determine any of these matters the SCR has had to take account of possible explanations of events in order to direct its enquiries.

4.1.2 Given the information that is known about the circumstances of the death set out in Sections 1.4 – 1.5 of this report the SCR's work has therefore proceeded on the basis that it is likely that Child N's mother was implicated in some way in her death. There is no evidence to suggest that the father had any involvement and at the time of writing there is no evidence to implicate anyone else.

4.1.3 Whilst this assumption has no legal standing it is difficult to see how the SCR could have proceeded on any other sensible basis. The evaluation of services in this section of the report therefore focuses in part on whether there was evidence – in her interaction with the child, with the father or with professionals - that the mother might have posed a risk of serious harm to the child and if there was, how the agencies responded.

Focus of the evaluation

4.1.4 This section of the report addresses the aspects of practice that offer the most important opportunities for learning and service improvement, as follows:

- 4.2 Whether there was evidence that the mother might pose a risk of serious harm to Child N and if so what action was taken?
- 4.3 The pattern of agency involvement with Child N and her parents during the period under review and the nature of the assessments that were undertaken
- 4.4 Assessment and provision made in relation to allegations of domestic abuse
- 4.5 Assessment and provision made in relation to the mother's mental health
- 4.6 Assessment and provision made in relation to homelessness
- 4.7 The role of Cafcass in private law cases where the residence of children is disputed
- 4.8 The work of agencies with fathers and other male carers

4.9 The response of agencies to ethnicity, religion and cultural factors

4.1.5 Each section of the evaluation refers back to specific episodes described in Section 3 of the report.

4.1.6 In relation to each aspect of practice the report evaluates whether the findings are significant in relation to the outcome for Child N and in wider service provision for vulnerable children.

4.2 Was there evidence that the mother might pose a risk of serious harm to Child N?

Introduction

4.2.1 This section of the report summarises the findings of the SCR about whether overall professionals had grounds to be concerned that the mother might have posed a serious risk to her child.

Episodes when there was potential concern about the quality of care that was being provided for Child N by her mother

4.2.2 During her pregnancy Child N's mother made contact with the social care service at the hospital where she was receiving antenatal care to say that she was considering relinquishing the unborn child for adoption. After meeting with a member of the hospital social work team and being told about the sort of financial and practical support that would be available she changed her mind. This episode is described in detail in Section 3.16 – 3.21 above and evaluated in Section 4.3. Neither the mother's presentation nor her account of her feelings could have been viewed as being an indication of any serious risk to her future child.

4.2.3 On three occasions between April 2012 and January 2013 the parents separately reported domestic disputes (rows, arguments, threats and past threats). These were treated by agencies as falling within the definition of domestic abuse and responded to as such. As a result Cafcass and the court treated the private law proceedings over Child N under the guidelines for domestic abuse cases and accordingly made additional local authority and police checks on the parents which highlighted these episodes. However neither parent ever formally made allegations about reported domestic abuse in the court proceedings. In late 2012 - 2013 the mother continued to refer to historic domestic incidents in which her husband had threatened her and she attended services for women who had suffered domestic abuse in north Oxfordshire.

4.2.4 There has never been corroborative evidence of domestic abuse and it remains unclear whether 1) the reported incidents took place 2) how serious they were and what impact if any they had on Child N and 3) if there were incidents, who the perpetrator was. Many professionals who worked with the mother have subsequently expressed serious doubts as to whether she was a victim of abuse, though none recorded doubts or challenged her accounts

at the time. Some considered that she was more likely to have victimised her husband.

4.2.5 The responses of professionals to these reported episodes are evaluated in Section 4.4. There is no indication that Child N was at risk of harm as a result of domestic abuse.

4.2.6 In May 2012 (when Child N was 8 months old) her mother had no stable accommodation and stayed temporarily with a family member and then with a number of friends. She said at the time that she had slept in her car with the baby though she subsequently reported that this was untrue. The child's father believed that the mother was moving frequently in order to frustrate his attempts to have the contact ordered by the family court. As a result of the instability the court made Child N the subject of an Interim Care Order and ordered the local authority to undertake an assessment. This episode is evaluated in Sections 4.3 and 4.6.

4.2.7 There is no indication that the mother's presentation or her account were indicative of any serious risk and once the mother found stable accommodation observations made by professionals of Child N with her mother indicated that the baby was being well cared for and thriving.

4.2.8 Between October 2011 and the death of Child N the parents were involved in protracted court proceedings over the residence of their child. One member of staff from Cafcass had contact with the parents and was able to observe Child N on many occasions over this period. With the exception of the period of instability due to the mother's housing problems – when she was concerned - this professional identified no signs or symptoms of abuse or neglect. Indeed along with all of the other professionals involved she always observed and recorded that Child N was well cared for, by both parents, almost always in a happy mood and meeting all of her expected developmental milestones.

4.2.9 Between October 2012 and May 2013 the mother spoke to her GP and a therapist about feelings of depression and anxiety, linked in the main to the custody dispute. The GP prescribed anti-depressant medication, which was regularly reviewed. The mother made use of face to face and telephone therapy and treatment services. Her symptoms were within the range of commonplace and moderate presentations and she appeared to respond well to these interventions (which are evaluated in detail in section 4.5 of this report). At no time did there appear to be any indication that these problems might impair the mother's capacity to parent Child N or cause professionals any concern.

4.2.10 In July 2012 Northamptonshire social care received a report that Child N (who at that time 10 months old) had bruises from falling off the bed and had been left alone in the mother's bedsit. Northamptonshire visited the mother, observed Child N and asked other professionals if they had concerns. The mother admitted briefly leaving her child alone but claimed that the landlord

had been on the premises at the time. She undertook never to do this again. Northamptonshire social care overlooked the need to investigate the account of bruises caused by falling off the bed and so did not examine Child N to see if there were bruises or ask her mother about this aspect of the report.

4.2.11 At this distance it is impossible to be certain whether or not this was significant. Child N was mobile at this point and so could have fallen or been bruised accidentally. However any report of bruising in a child under the age of one is of potential concern and the reported concerns should have been investigated and tested. Given the subsequent history it is important to note that this was the only point at which any concern about a symptom of possible physical assault was ever noted. It is also a concern that the outcome of this episode was not reported to the father or to Cafcass.

<u>Overall assessment</u>

4.2.12 Unless the bruises to Child N described in the episode referred to above were inflicted deliberately, there was no evidence known to professionals who were working with the family that the mother might pose a risk of serious harm to Child N. In fact the opposite is true. Even though the mother experienced practical and emotional difficulties at some points and there were occasions on which some professionals found the mother demanding and difficult to work with, the unanimously held view of professionals who had contact with Child N was that she was in good health, extremely well cared for and flourishing.

4.2.13 This was the professional assessment during the period under review and nothing has emerged in the collation of evidence since the death of Child N which has shown evidence of risks that were missed at the time to contradict this picture.

4.2.14 It was a view shared by the father who told the SCR that he ‘never, ever worried’ about the way in which she looked after Child N.

4.2.15 There may of course have been aspects of the mother’s behaviour or events in her earlier life history that – had they been known – might have would have pointed to potential risks. But if they existed they were not known. Section 4.3 of the report recognises that professionals had opportunities to ask for more information about the background and life histories of both parents and did not do so. The reasons for this are explored below.

4.2.16 In the circumstances it is not possible to see how professionals working with the mother could have predicted that she would harm her child or have taken any action – that would have been justified by the circumstances – that would have prevented it.

Wider research and practice experience

4.2.17 The SCR has also considered whether there is wider research or practice experience that would have highlighted potential risks to Child N and therefore should have been taken into account.

4.2.18 Research about the killing of children in the context of custody disputes and domestic abuse has identified that this is a very serious risk but a very rare one. The only major study of the phenomenon covers a 10 year period and identified 29 cases.[16] However even detailed knowledge of this research – which is well known in Cafcass – would not have led to specific concerns about this case. All of the perpetrators in the study were men and all of these cases occurred where there had been serious domestic abuse (of which there is no evidence in this case).

4.2.19 Cafcass has recently published an overview of the organisation's involvement in SCRs over the period 2009 – 2013 and a detailed analysis of more recent cases.[17] This provides useful additional information about children who have been killed or seriously harmed in the context of disputes about residence or contact or care proceedings. The study notes the very low proportion of private and public law cases in which the organisation is involved in which there is a child death (approximately 1 per 3800) and again describes a picture in which in the overwhelming majority of deaths there was previous evidence of risk factors such as domestic abuse (90%); substance misuse (78%); neglect (38%) mental health problems (33%) or physical abuse (33%).

4.2.20 The report recognises that there are cases in which children are killed without there being any previous indication of risk and notes that this is '*a useful reminder that fatal abuse does not always occur within the context of recognised high risk indicators'*. Identifying this as a problem does not mean that there is a solution. Whilst highlighting that children can be killed in cases where there are no known indicators of heightened risk (i.e. in 10% of the deaths) this also serves to underline the fact that it is close to impossible to successfully identify risk in every case.

4.2.21 The circumstantial evidence about Child N's death indicates that it was an extremely unusual and rare event. This makes it naturally less likely that anyone would conceive that it was a possibility. Even if this had happened no one has suggested a way in which the tiny number of such events (approximately 1 event in every 3800 cases) could be screened or assessed to identify every possible risk. If such a method were devised it would probably be so time consuming and expensive and have such an adverse impact on the operation of the courts that it would never be implemented.

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[16] Hilary Saunders (2004) *Twenty-nine child homicides: Lessons still to be learnt on domestic abuse and child protection*, Women's Aid

[17] Cafcass (November 2013) Learning from Cafcass Individual Management Reviews (IMRs) - Case Dynamics: Executive Summary

4.2.22 This raises the question of whether wider research should be conducted given that the findings cited above have a very specific focus and may not be comprehensive in its coverage. The knowledge held by Cafcass will not be comprehensive as serious harm may have occurred in the course of custody disputes in which the organisation was not involved or after it has ceased to be involved.

Issues raised by the father of Child N.

4.2.23 The father of Child N has raised a number of concerns about the conduct of agencies in relation to the child's mother. In particular:

1) He feels that the failure of the mother to comply with court orders (even when there were penal notices) should have been dealt with more firmly.
2) Recommendations from Cafcass should just be sent to the judge, rather than all the parties.
3) The Section 37 report conducted by the local authority should have included more visits and especially unannounced visits to the mother
4) He should have been told that there had been social care involvement in Northamptonshire

4.2.24 These matters are referred to in the remaining sections of the report. The SCR shares the concerns of the father in relation to the final two. However it remains the view of the SCR that even if all of these matters had been addressed differently they would not either individually or in total have substantially altered the picture that everybody involved had of the care that Child N received from the mother. Nor are they likely to have altered the outcome of events.

Identified areas for improvement

4.2.25 The remainder of this report needs to be understood in the overall context of the finding that Child N's death could not have been foreseen. In reviewing their involvement with the child and her parents contributing agencies have understandably identified errors in practice and individual actions which might fall short of the standard that agencies normally deliver or aspire to. Such episodes will be found in all cases, including many in which there has been a positive outcome for the child.

4.2.26 The SCR identifies some weaknesses in systems and practices. However there is no evidence that any of these placed Child N at risk or led to a failure to identify risk. The burden of all the evidence is that – with the exception of the brief period when she was homeless – the mother's care of Child N was good and usually that it was very good.

Breaking bad news in court cases where residence and other aspects of the care of children are disputed

4.2.27 The Police investigation suggests that Child N may have died shortly after the mother's solicitor informed her by email that Cafcass intended to

recommend that the father should be granted a Residence Order. However the final decision rested with the court which would hear other evidence and opinion and it was by no means certain that the court would accept this recommendation.

4.2.28 It is not possible to know whether this news triggered the events that led to the death of Child N. However Cafcass has taken seriously the possibility that it might have. As a result it has given further thought to the question of how all of those in the family justice system might in future break unexpected bad news to parents where the court is considering or has decided to order a change in residence for a child when this has been disputed. Section 4.7 considers this further and it is the subject of a recommendation to Cafcass.

4.2.29 This may be the subject of wider learning for all professionals. It may for example now be widely assumed that it is reasonable to impart potentially disturbing news via an email, where there is no scope to judge or respond to the recipient's reaction, rather than face to face. It is hard to turn this into a practical recommendation, but it is something that all professionals might usefully reflect on.

4.3 The nature and quality of the assessments undertaken

Introduction

4.3.1 This section considers the quality of the following assessments and the resulting service provision:

- Antenatal service assessment of health and social risk factors
- Pre-birth initial assessment by local authority social work staff
- New birth health assessment by the Health Visitor
- Local authority Section 37 / core assessment in June 2012

4.3.2 The following assessments are evaluated separately:

- Assessments in relation to alleged domestic abuse (Section 4.4)
- Assessments in relation to mental health (Section 4.5)
- Cafcass assessments (Section 4.7)

Antenatal assessments

4.3.3 The antenatal assessment of health and social risk factors took place at the hospital maternity service early in the pregnancy. The mother did not delay referring herself. The management review provided by the health trust indicates that the assessment covered all of the expected areas. The midwife identified some medical risk factors which were addressed by referring the mother for consultant-led medical care. No social risk factors were identified at that point.

4.3.4 Since circumstances can change during the course of a pregnancy the trust management review has recommended that it would be beneficial if, in

future, midwives repeated the assessment of social vulnerability factors later in the pregnancy. The trust has also noted that there was very limited contact with the father during the pregnancy, who might have provided an additional source of information. The trust has undertaken to carry out further work in order to consider how it can involve fathers better. The SCR endorses both of these recommendations. The question of the father's involvement is considered further in Section 4.8 of this report.

4.3.5 The mother referred herself to the hospital social work department in May 2011 initially stating that she wanted to relinquish her child at birth. Having been informed about the kind of practical and financial support that would be available she reported in a subsequent discussion that she wanted to keep the child. The social worker who saw her was aware of the police notification of a row between the parents.

4.3.6 It appears that this contact with the mother was categorised as an initial assessment of need in relation to the unborn child, but was viewed by the professional involved as a counselling contact with the mother. No further background information was sought because by the time of the mother's second contact the presenting problems had been resolved. The assessment was that the mother had been panicked by the prospect of becoming a single parent but had become more positive and confident and was now completely committed to preparing for and keeping the child.

4.3.7 The social care management review has noted that this contact was unusual in two respects. First, it was a self-referral. Second, it was unusual for a mature woman with a healthy foetus to seek advice about relinquishing the child at birth. It comments that this should have led the staff involved to be more curious as to the circumstances and background.

4.3.8 Taking a wider view it is easy to understand why this contact was viewed as being a less significant piece of work in relation to the range of tasks undertaken in a busy paediatric and medical social work service. In most local authority areas this case would not have met the threshold for allocation to a worker for assessment. In many it would not have come to the attention of a social worker at all as the local authority does not have an active presence in antenatal services.

4.3.9 The staff involved considered whether to share information about the contact with the antenatal service but decided not to do so on the basis that this had been a minor episode. Whilst this was a considered decision the SCR is clear that even on the basis of the information known at the time, it was not a correct one. A short note summarising the contacts should have been shared with the antenatal service in order to inform future contacts by the midwives. Had this happened it would not have changed the interventions that were made because the mother subsequently kept all of her antenatal appointments and complied with suggestions for care without causing anyone any concerns.

The Health Visitor new birth assessment and subsequent contacts

4.3.10 The Health Visitor and other members of the community health team had three face to face contacts with the mother and Child N during the first eight weeks of her life, in keeping with the normal arrangement to provide a universal child health service. There were no concerns at all about Child N's health or development.

4.3.11 During the course of the contacts the mother's current social circumstances were explored and she was signposted to relevant support services. No information was obtained about the mother's background, which was seen as being less relevant than her current circumstances.

4.3.12 The assessments undertaken met the health trust's expectations, given the fact that there were no current difficulties or concerns in relation to Child N. Possible concerns about domestic abuse were explored, but the mother was clear that this was not currently relevant.

4.3.13 Almost a year later (October 2012 onwards) the same health visitor had a short series of contacts with Child N and her mother after they moved back to Oxfordshire. Again there were no concerns about the safety, health or development of Child N. At this time the Health Visitor was covering some additional work as the second Health Visitor in the locality (who worked part time) was not at work.

4.3.14 The focus of activity at this point was on the reported impact of the court proceedings on the mother's mood and mental health. Once again there was no concern that this was having a negative impact on the health or development of Child N.

4.3.15 The Health Visitor referred the mother and child to the local children's centre and to the Freedom Programme (for support around domestic abuse), financial and legal advice and advised her to see her GP about her reported depression and anxiety. The reasons for referring the mother to the Freedom Programme (given that she had not reported current or recent domestic abuse) were not recorded.

4.3.16 The Health Visitor had four further contacts with the family between October 2012 and February 2013. During this time she discussed the family with the children's centre but she had no contact with the other professionals she knew to be involved i.e. Talking Space (mental health psychological therapies) or the GP. This is not surprising given that the Health Visitor was covering the work of a colleague and that she did not have pressing or unresolved concerns to discuss. The Health did not know that Cafcass was involved, though she did know about the private law proceedings.

4.3.17 In its individual management review the health trust recommends that there should be greater information sharing between health visitors and other

professionals involved. It indicates that staff in community health services should have a greater awareness of the role of Cafcass in private law proceedings that involve young children.

4.3.18 The SCR endorses this approach recognising that the extent to which professionals can share information about their involvement with families will always be shaped by the time they have available, their judgement of the value that it will add and competing priorities. This mirrors a recommendation made that Cafcass should provide more comprehensive information to the agencies represented in the LSCB about its role and responsibilities in private law cases.

Potential use of the Common Assessment Framework

4.3.19 In principle the Common Assessment Framework could have provided a means of coordinating help for the mother and child. This was not used because the mother was separately cooperating with individual agencies and there did not seem to be the need for meetings or shared assessments to coordinate the help that was being provided.

4.3.20 Given the presentation of the family and the lack of any concern about the health and development of Child N it is not surprising that none of the professionals involved felt that there was a need to undertake a CAF. There is no reason to think that if one had been undertaken it would have altered the pattern of service provision made or offered any greater protection to Child N.

Social care core assessment in June 2012

4.3.21 Oxfordshire social care undertook a core assessment in order to inform the report required by the court when it made an order under Section 37 Children Act 1989. This required the local authority to investigate the child's circumstances with a view to determining whether it should (a) apply for a care order or for a supervision order with respect to the child; (b) provide services or assistance for the child or his family; or (c) take any other action with respect to the child.[18] Unusually the court made an Interim Care Order at the same time (without either Cafcass or the local authority proposing or seeking the order).

4.3.22 The local authority presented its Section 37 report, based on the core assessment, at the court hearing on 22 June 2012. The judge was complimentary about the quality of the report and grateful that it had been prepared so quickly. Based on the reassurance that it provided the judge decided that Child N was not at risk of significant harm and that there was no need to make an order to remove Child N from her mother's care.

4.3.23 Sections 3.59 – 3.80 set out the steps taken by the local authority social worker to prepare the report, including a range of contacts with

[18] Children Act 1989, Section 37. http://www.legislation.gov.uk/ukpga/1989/41/section/37

professionals and family members. During the period under review Child N's mother was living in Northamptonshire

4.3.24 It is clear that the major concern of the local authority was to establish whether there were grounds to remove Child N from her mother's care. It was quickly determined that there was no reason to do so and that the legal criteria for removal were not met. The assessment then focused on the recent history of the family and the standard of care being provided to Child N. It addressed the fact that the mother had moved several times and the impact of this on her daughter. The mother was left in no doubt about the need to maintain stability of accommodation for Child N and made a commitment to stay in her current accommodation in Northants.

4.3.25 The management review prepared by the local authority noted some weaknesses in the assessment undertaken. For example there was no detailed consideration given to the concerns reported by Cafcass about the mother's mood being 'up and down'. Little information was gathered about that the parents' family histories or the mother's support network or to understand in more detail the reports about alleged domestic abuse. It noted that the mother appeared to have ended the problem of unstable accommodation but it did not establish why this had come about in the first place. In addition there was no specific consideration given to the cultural or international aspects of Child N's circumstances, bearing in mind that her parents came from different countries, were of different racial origin and different religions, the potential impact of these factors might have been of concern.

4.3.26 These criticisms rely more on a comparison between this core assessment and the 'ideal' standard that the local authority aspires to, rather than setting out why the core assessment had these shortcomings.

4.3.27 The circumstances in which this assessment was carried out led to its very specific scope. The report was narrowly focused on the question of whether a Care Order was required and whether Child N needed to be removed from home. This was established through observation of the parents and child and seeking corroborative information about the current care of the child from other professionals who were involved. Once the chief purpose of the report had been accomplished little further background information was sought.

4.3.28 There was no doubt that from the local authority viewpoint the circumstances of the case as they currently presented fell far below the level that would normally have been required to merit an Interim Care Order. Had it not been for the court order the local authority would have been unlikely to have initiated a core assessment at all.

4.3.29 Nor were there grounds at that point to remove Child N from her mother's care and place her with her father. The threshold to remove an infant who

had only ever been cared for by her mother and was still (according to the mother) breast feeding would rightly have been extremely high.

4.3.30 At the time the mother and child were already living in another local authority area and the mother had given an undertaking to remain there. This meant that the case would probably not be the long term responsibility of Oxfordshire. The local authority believed that a fuller assessment would be undertaken by Cafcass and presented to the court before any lasting or final decision would be made about the long term welfare of Child N. It believed that there would be ample opportunity for others to evaluate in much more detail the child's needs and the capacity of each of her parents to meet them.

4.3.31 The assessment was required and undertaken within a very short timescale. This was dictated by the level of concern that the FCA and the judge had felt at the time of the hearing on 31 May 2012. Looked at from a different perspective it could equally be said that the report was more superficial than it might otherwise have been had the judge not needed to make a decision about whether Child N needed immediate protection.

4.3.32 It is very likely that all of these factors would have influenced the mind set and judgement of the social worker undertaking the assessment. They would also have shaped the judgements made by managers about the level of detail required on issues that the court had not asked the local authority to address, particularly when set alongside the needs of other cases and workload for the individual and the team.

4.3.33 Child N's father told the review that there should have been more visits to the mother and more unannounced visits. In an ideal world the SCR has some sympathy with this view, however there is nothing to suggest that had this been done anything else the findings of the assessment would have been different.

4.3.34 When the court received the report on 22 June 2012 the judge thanked the local authority for presenting the report such a helpful report so quickly, as it addressed the immediate concerns that he had had when ordering it.

4.3.35 In all the circumstances it is right to recognise that this report should have been more analytical, asking more questions about the family backgrounds of the parents and seeking more information about the mother's environment and support. Its shortcomings were understandable and a product of the unusual circumstances that led to it being prepared.

4.3.36 The local authority has made a recommendation making clear its expectations for the quality of core assessments and noting the need for managers to be more challenging of the scope and rigour of these assessments in future. The SCR endorses this approach.

The overall pattern of assessment and service provision

4.3.37 The assessments undertaken by agencies were very specific in their focus and oriented to particular tasks and services. Knowledge about the family captured in assessments did not accumulate as the case history progressed. Assessments were not informed by the family history or the outcome of previous assessments.

4.3.38 This is a frequent finding in SCRs where a large number of agencies are involved. It is a feature of the way that many agencies expect their staff to operate. Except for local authority core assessments it is rare for professionals to gather significant amounts of information from other agencies when undertaking their assessments. Often they do not probe for background information or seek information about what other agencies have been involved and what services have been provided.

4.3.39 Unless there are serious concerns about a child's health or welfare there is little coordination of work by agencies except when it is undertaken by the local authority. This case followed that pattern. Agencies came into contact with the family at specific points in order to undertake certain tasks and no one felt that the circumstances merited action to coordinate the input made by different agencies.

4.4 Assessment and provision made in relation to allegations of domestic abuse

Introduction

4.4.1 This section of the report considers the allegations made in relation to domestic abuse and the response of professionals. It focuses on two areas:

- The response of agencies to reports of less serious incidents of domestic abuse
- Service provision made to the mother.

It is not the responsibility of the SCR to determine whether there was domestic abuse.

4.4.2 The police received three allegations of possible domestic abuse, two during the pregnancy and one shortly after Child N was born. The allegations made by the mother were about incidents best described as 'rows' and there was no allegation of physical assault. The father's allegation about the mother was made in order to pre-empt and protect him from false allegations he feared would be made by the mother.

4.4.3 There was no corroborative evidence of any domestic abuse. Whenever allegations were put to the father he denied having abused the mother and in turn alleged that the marriage had broken down because of her aggressive and unreasonable behaviour. He firmly maintains this position.

4.4.4 Some professionals who knew the mother did not have the impression that she behaved in a way that indicated that she had been a victim of abuse, though they accepted her word that she had. No one sought to corroborate

the accounts given and no one involved attempted to speak to both parties together about the allegations.

4.4.5 When the parents were seen together (through mediation and parenting services associated with the court applications) the allegations were not mentioned.

4.4.6 The family court was aware of the allegations of abuse because the mother mentioned them to Cafcass at an early point. The court took the allegations seriously though neither party sought to bring evidence of allegations into the court, where they could have been tested. The court did not feel that they reached the threshold where a fact finding was required to determine what, if anything, had happened.

4.4.7 The mother repeated her allegations to her health visitor and mental health therapist and she was referred to local support services. During early 2013 she attended group support meetings, though again no steps were taken to corroborate her accounts. The mother stopped attending the group meeting two months before the death of Child N, saying that attendance was not a priority.

Initial responses to allegations of domestic incidents

4.4.8 The incidents of alleged domestic abuse that might have affected children or pregnant women were taken seriously. In the main they were responded to in line with local procedures and protocols, even when they were of a less serious nature and there was no firm evidence to support or corroborate them. For example the police attended promptly and took the expected steps to record and respond to alleged incidents.

4.4.9 Agencies receiving information generally ensured that it was recorded and considered properly. Social care considered the need for an initial assessment and judged (correctly given the circumstances) that the referrals did require an intervention. In one instance a social care manager decided because of the accumulation of incidents that the authority would respond positively to the next incident, even if it was not itself a serious one. Given the number of incidents and the age of the child this was a measured and sensible reaction.

4.4.10 District Council housing services responded by making offers of temporary accommodation, pending a fuller assessment of the circumstances.

4.4.11 However the management reports provided by agencies have identified a number of ways in which the response to domestic abuse reports which did not fully comply with local procedures and expectations. In two instances it was not possible to find confirmation that information had been passed by the police to health agencies (whereas the same information had been sent to social care). In one instance it appeared likely that this was because it had been shared but not recorded or filed by the ante natal service. In the second the evidence that information had been sent was less clear.

4.4.12 The police management review identified one incident where it would have been better if the offers concerned had spoken to both parties in order to given them both advice and to corroborate the accounts. In another instance it was found that further consideration should have been given to investigating historic allegations as possible crimes.

4.4.13 Taken together these were minor shortcomings, which had been addressed through the individual management reports and lead to a number of recommendations which are set out in Appendix 5 of this report. None of these are considered to be significant in relation to the overall findings of the SCR.

4.4.14 The SCR has noted that local agencies and partnerships have gone to great lengths to make systems for sharing information about domestic abuse as reliable as possible, including the systems in the antenatal service. This incident confirms how hard it is to achieve that. Since the events under review, additional systems to track domestic abuse notifications have been introduced in the antenatal service. These should lead to greater reliability.

4.4.15 Discussion in the SCR panel has identified a wider concern about the very large number of referrals which are currently shared between referrers (most often the police) and other agencies. This has led to the danger that systems for risk assessment have become overloaded. Agencies wish to take this opportunity to consider collectively whether current arrangements are as effective as they could be, especially at the lower level of risk.

4.4.16 The SCR notes that in 2014 Oxfordshire agencies will collaborate in the introduction of a multi-agency unit to screen and evaluate referrals and contacts.[19] The review has therefore recommended that in the design and implementation of the MASH attention should be paid to the arrangements for sharing and responding to incidents of alleged domestic abuse so as to ensure that there is an effective response to cases where there are a number of minor incidents. Agencies will need to ensure that thresholds are at a level which protects children whilst at the same time ensuring that agencies are not overloaded with information about relatively minor incidents.

<u>Services provided to the mother because she was believed to be a victim of domestic abuse</u>

4.4.17 A number of professionals who worked with the mother felt it was unlikely that she was a victim of domestic abuse, or that if there had been abuse the mother may have instigated it. Nevertheless her allegations were taken at face value by all of the professionals who dealt with her and she was referred to attend an educational and support group.

[19] Nationally such arrangements are commonly referred to as a multi-agency assessment hub or MASH

4.4.18 The initial assessment of her suitability for the group was carried out by an organisation called PACT, though when asked for details of the assessment by the local authority nothing was provided. The main commissioner of the service was the District Council, as part of its housing and community safety responsibilities. However the service was de-commissioned during the period under review. The mother attended briefly and suddenly stopped doing so, indicating that the group was not a priority for her.

4.4.19 The SCR is concerned that information was not shared between the original service provider and the local authority when it took over the service. This is a matter that should have been built into the contract and monitored to ensure that it occurred. The relevant partnership will be asked to remind commissioners and providers of this.

4.4.20 It is also a concern that services are currently commissioned in a way which would allow for a woman to attend a group work service (which then appears not to have met her needs especially well) on the basis of a very limited assessment without any reference to corroborative information from other agencies to establish if she had actually been a victim of abuse.

4.4.21 This points to the need for professionals to be more curious about the details of events, to share information about allegations of abuse with one another and to seek corroboration of their nature and seriousness.

4.4.22 However this approach also presents a potential difficulty. It would not be right to ignore allegations and in accepting accounts at face value professionals feel that they are properly guided by research that shows that victims find it hard to disclose abuse and tend to under-report it. It is inevitable that in any sample of people who claim to be victims of domestic abuse there will be some false positives. Possibly this is a risk that has to be taken and not a major concern in the overwhelming majority of cases.

4.4.23 This points to the need for a recommendation to the agencies that commission domestic abuse services to take account of the need for professionals to obtain a more detailed account of the incidents of domestic abuse and its impact on children before making referrals for services, while at the same time not losing sight of research about the prevalence and nature of domestic abuse.

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

Provision made for the mother

4.5.1 The health visitor was aware of the mother's self-reported symptoms of depression and anxiety and advised her to consult her GP and the primary care mental health service.

4.5.2 The mother was seen by her GP and by the Talking Space service, which provided evidence-based psychological therapies. The GP provided medication and reviewed it periodically. The therapy and treatment service undertook regular standardised assessments and counselling either over the phone or face to face.

4.5.3 There is no evidence that the mother had any significant mental health problems. Her accounts of mild symptoms of anxiety, depression and loss of self-worth were consistent with the experience of many people going through contested divorce cases where the residence or contact arrangements for children are disputed. The standardised assessments point to low level / moderate concerns and suggest that there was some improvement over time as a result of the interventions offered.

4.5.4 At no point was there any concern that the mother's mental health problems were impacting negatively on her capacity to care for Child N, less still that they posed any risk to her. There was no evidence that signs and symptoms of more serious problems were missed.

Information sharing between professionals

4.5.5 At no point did the professionals who were aware of these difficulties share information with one another about their work with the mother. This would have been useful and easily done and should be part of normal working practice when a referred patient is responsible for the care of potentially vulnerable children.

4.5.6 The Oxford Health NHS Trust management review has made a recommendation to address this in relation to Health Visiting and Talking Space which the SCR endorses. When a person with small children has accessed a service for mental health problems, GPs should naturally be part of arrangements to share information about progress and any concerns.

4.6 Assessment and provision made in relation to homelessness

4.6.1 In May 2012 the mother was referred to Oxfordshire County Council because she had reported that she had no permanent accommodation and the Family Court Advisor was concerned about the welfare of Child N. The mother presented to the Oxford social care office (where she was seen by a

housing worker and a member of the social work team) and was referred on to the District Council in the area where she had previously lived in north Oxfordshire. The workers involved did not feel that the mother was in need of accommodation but that if she had been and had she also been responsible for the care of a child, funding for short term accommodation would have been made available while a fuller assessment was carried out.

4.6.2 The approach taken in this case was justified by the circumstances. Nevertheless the local authority management review sets out concerns about the wider picture in which '*many of the workers who were interviewed stated that having the 'housing' or 'homelessness' label resulted in what was referred to as a 'blanket approach', namely: to outline the duty local authorities have in relation to homelessness; to explore options of staying with friends/family; to advise the family to refer themselves to the homelessness section of their local District Council. The housing options that are at CSC's disposal are very few, and funding is limited.* In such circumstances '*providing money or housing is a last resort*'.

4.6.3 Taken together with the large volume of work dealt with by assessment teams there is always a pressure in what are defined to move through and close 'housing' cases.

4.6.4 The local authority management review recommends that there is a need for clearer guidance to staff as to how to deal – jointly with housing colleagues – with families in more complex situations including those who have experienced multiple moves. The SCR endorses this proposal.

4.7 The role of Cafcass

Introduction

4.7.1 Cafcass was involved with Child N and her family from January 2012 (when it received a copy of the application for a Residence Order from the father) until 14 May 2013 when the FCA filed a report prepared to assist the final court hearing which was scheduled for mid-June 2013.

4.7.2 The responsibility of Cafcass in Child N's case was twofold. In all contested private law cases involving children Cafcass will undertake checks with the police and the local authority, in line with guidance.[20]

4.7.3 At the hearing in April 2012, the judge made Child N a party to the proceedings because of the potential complexity of the case (i.e. the concern about allegations of domestic abuse and the international dimension to the case). As a result Cafcass was directed to appoint a Children's Guardian to report on the merits of the mother's application, the progress of contact and future arrangements and any pertinent welfare issues.[21] The role of the organisation is to advise the court, taking account of the welfare checklist in Section 1(3) of the Children Act 1989 as well as any other matters required by practice directions, required by the judge or raised by the parties.[22]

4.7.4 Cafcass prepared a comprehensive individual management review for the SCR which finds that in its work Cafcass complied fully with its internal procedures and with family court practice directions. However the case raises wider professional issues for Cafcass and others working in the family court system dealing with private law applications about children. These are set out in the following paragraphs.

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[20] This is described in the Cafcass individual management review as follows:
1) Screening – obtaining information from the police and children's services 2) Risk identification – making an initial assessment of risk based on screening and separate interviews with both adult parties and 3) Reporting of this initial work to the court's first hearing.

[21] See footnote 10

[22] Section 1(3) of the Children Act 1989

a) The ascertainable wishes and feelings of the child concerned (considered in light of his age and understanding);
b) His physical, emotional and/or educational needs;
c) The likely effect on him of any change in his circumstances;
d) His age, sex, background and any characteristics of his, which the court considers relevant;
e) Any harm which he has suffered or is at risk of suffering;
f) How capable each of his parents and any other person in relation to whom the court considers the question to be relevant, is of meeting his needs;
g) The range of powers available to the court under the Children Act 1989 in the proceedings in question.

Working arrangements between Cafcass and other professionals

4.7.5 In private law cases Cafcass will always make standard checks with the local authority and the police. Those checks will be enhanced (more detailed and thorough) in cases where concerns about domestic abuse have been identified. However Cafcass does not automatically access and report on the full range of information that might be available to other professionals and agencies that are in contact with the child. It will only contact others - such as health professionals – if it is apparent that they have information that is relevant to the issues that Cafcass is required to address or if the court directs that specific information is obtained.

4.7.6 During the course of SCR panel discussions it was established that this was not apparent to members of the panel. It is reasonable to conclude that it is also very unlikely to have been known to professionals who were involved with Child N who might have had information that could have assisted the court. For example information held by the GP, the mother's Health Visitor and the Talking Space service about the mother's depression and anxiety was never known to Cafcass or to the court. As a result the FCA did not form the view that the mother had any mental health problems, beyond the stresses and strains likely to be present when a parent is involved in a dispute over plans for the child's future.

4.7.7 In this case knowledge of the mother's reported symptoms of mental health problems was unlikely to have affected the recommendations made by Cafcass in its report to the final hearing. The mother's problems were minor and there was no evidence that they had impacted negatively on her care for Child N. If anything, knowledge of the mother's contact with professionals is likely to have reinforced the assessment that it was in the interests of Child N to live with her father.

4.7.8 However the current approach might create a risk in other cases, where for example there are mental health concerns about a parent that are not known to the other parent and not apparent to the court or to Cafcass.

4.7.9 This needs to be addressed from both sides. It may not be necessary, possible or proportionate for Cafcass to undertake a more comprehensive set of agency checks in all cases, however the agency should consider how it can ensure that within the framework of guidance laid down by the court, its staff can become more proactive in seeking information from agencies other than the local authority and the police.

4.7.10 It would also be beneficial if professionals in other agencies were more widely aware of the normal approach taken by Cafcass in obtaining information from other agencies. In some cases this might lead professionals to be more proactive in finding out whether Cafcass was involved and providing information to the organisation. In order to facilitate this Cafcass has agreed to adopt a recommendation that it will begin to make systematic presentations to local safeguarding boards in order to

assist in making professionals in other agencies more aware of its role (and of any limitations in that role). That work is under way.

Decision making leading to the decision to recommend a Residence Order in favour of the father and the approach taken when informing parties of the proposal for a change of residence in a contested case

4.7.11 The report for the proposed final hearing was filed by Cafcass on 14 May 2013.

4.7.12 At that point the agency records suggest that cooperation between the parents was increasing and working in Child N's interests. For example the parents had successfully negotiated longer contact including overnight stays which were reported to have worked well. The mother had overcome some of her suspicions and fears about the father to the extent that she had asked him to care for Child N for two or three weeks while she travelled to her country of origin. This may of course just have been because she could not take Child N out of the UK so it suited her for the father to have the child.

4.7.13 Although there was evidence of growing cooperation between the parties, the final hearing was scheduled to consider the applications before the court (details of these have been set out in Sections 3.154 – 3.162 above) rather than the recent changes in the parents' behaviour.

4.7.14 In the face of severe practical difficulties and some reasonable and obvious objections from the father, the mother would need to overcome a number of substantial hurdles in order to achieve her ambition of taking Child N to live in her country of origin. In hindsight these difficulties appear almost insurmountable but it is not clear how well the mother was being advised and whether she was aware how unlikely it would be for her application to be successful.

4.7.15 It is not hard to see why the FCA chose to recommend that the court should make a Residence Order in favour of the father. This was in keeping with the case law and principles that the court would be required to follow. Because there were so many unknowns and uncertainties attached to the mother's proposal to take Child N to Africa granting a Residence Order to her father appeared to be the least risky option.

4.7.16 However there is nothing to indicate that this was the preferred option for the FCA until the final supervision session with her Service Manager. Nor is there evidence that the FCA had discussed this possibility with the mother, prior to her solicitor sending her the report containing the FCA's recommendations.

4.7.17 Earlier in the proceedings the mother had been warned by the judge that if she did not cooperate fully with the required assessments, consideration would be given to granting residence to the father. It may have been clear to the mother that if she persisted in her intention to take Child N overseas she

risked losing the right to have her daughter live with her. However this is not clear from the material seen by the SCR.

4.7.18 At this point the mother was represented by a solicitor. However for the reasons set out in Section 1.13 he has not contributed to the SCR. It is therefore impossible to judge how well he prepared the mother for the Cafcass recommendation or whether he had concerns about its potential impact on her or her child.

4.7.19 A recommendation or court order for a full change of residence in a disputed case is inevitably distressing for the party ruled against. Whilst the number of such recommendations is relatively small Cafcass has recognised the need for further detailed consideration to be given to the question of how the findings of reports recommending a change in residence should be made known to parents in these cases.

4.7.20 Regardless of the role of Cafcass it would be reasonable to assume that a parent's advocate would explain the decision and enable the parent who faced losing custody of a child an opportunity to consider his or her options. It would always be natural for Cafcass to be more concerned about the potential reaction of a parent who was not legally represented, or had a history of threatened or actual violence.

International aspects

4.7.21 Legal consideration of Child N's circumstances was made more complex because of the international dimension. The country to which the mother proposed to take Child N is not a signatory to the relevant sections of The Hague Convention (which seeks to achieve agreements on aspects of law between different countries, including family law). As a result a legal order made in the UK would not automatically be mirrored and could not be enforced through the court system in the country where Child N would have been living.

4.7.22 At the hearing in July 2012 the court ordered that the child's solicitor obtain information about the legal system in the mother's country in order to determine whether an order made in the UK could be enforced there. After some delay it was confirmed (in October 2012) that this was not possible and the onus was then placed on the mother's solicitor to establish how a separate court order could be obtained in the overseas court to do this.

4.7.23 On 26 November 2012 the court invited the Office of the Head of International Family Justice to provide more definitive advice on this matter by 8 February 2013. It is not clear when this body was contacted or what action if any it took. In May 2013 the court considered sending further information to this body, but it appears not to have done so before the death of Child N.

4.7.24 At the time of the preparation of the Cafcass report to the final hearing the court did not have the benefit of reliable, neutral or comprehensive advice

on the international aspects of the case to enable it to chart the best course of action. It is not clear whether in these circumstances the responsibility of Cafcass is to seek out a viable, practical solution or whether the onus is on the parties to make proposals.

4.7.25 In her report for the final hearing the FCA suggested (as one possible solution) that if Child N was taken to her mother's country of origin the mother should be asked to post a surety with the court in London which would be forfeited if orders setting out contact arrangements were breached. The report indicates that this was a solution that had been implemented in another case. It is not clear whether this had been discussed with the mother before the report was written or whether in practice it would have been possible to implement.

4.7.26 Alternatively the mother had been encouraged to apply for an order in an overseas court granting contact rights in favour of the child's father (who did not live in and was not a citizen of that country). It remains unclear how it could ever have been practical for the mother to do this or how in practice the father might enforce the order if the mother failed to comply with it. Overall the proposed steps and measures may have appeared to those involved to have carried some hope of success but it is extremely difficult to believe that they would have worked in practice.

4.7.27 The inability of the parties and the court to resolve this issue contributed to confusion and delay. Child N was too young to be aware of the uncertainty and in fact her parents appeared to be working better together as time passed. However in other cases this sort of delay and uncertainty might not be in the best interests of a child.

4.7.28 Cafcass has legal advisors who it says could have assisted by providing advice on international issues, but it did not seek their advice in this case. Reliance was placed on the parties to propose solutions.

4.7.29 The judiciary at present relies on the Office of the Head of International Family Justice.[23] This is a tiny body which according to its Annual Report has two or three members of staff and received 253 referrals during 2012. The Annual Report provides seven case studies demonstrating its contribution but beyond that it is not clear what role was played in relation to the 253 referrals or how many of them were successfully resolved as a result of the information and advice provided.

[23] http://www.judiciary.gov.uk/about-the-judiciary/international/international-family-justice Its judicial and professional staff devote a considerable amount of time in promoting international collaboration through attending and making presentations at international conferences and workshops. The Annual Report for 2012 shows that during that year staff associated with the office attending conferences in locations including Hong Kong, Bermuda, the Hague, Paris, Switzerland, Barcelona, Madrid and Nicosia. According to the annual report a judge in the country to which Child N's mother proposed to remove her '*has continued to provide the Office with invaluable assistance throughout 2012*'.

4.7.30 Given the growing numbers of international private cases being brought before the courts (an inevitable consequence of international migration and the greater diversity of the UK population) there appears to be a need for Cafcass (and possibly others in the family court system) to learn wider lessons from this and to devote more resources to the problems created by disputed cases with an international dimension.

4.7.31 The SCR has therefore recommended that Cafcass should consider how it should strengthen its own capacity to work in international private law. It should also discuss the issues raised by this with the President of the Family Division in order to consider whether the judiciary and the private law system as a whole is properly equipped to deal with the likely need to manage international family law cases.

4.8 The work of agencies with fathers and male carers

4.8.1 The management reviews prepared by individual agencies found the involvement of the father to be an area of weakness in the practice of the midwifery and health visiting services.

4.8.2 The health visiting service had all of its contacts with the mother and did not seek to establish the father's views or role, nor to corroborate of challenge the mother's account by speaking to the father. The antenatal service had a small number of contacts with the father, but did not record his presence or views.

4.8.3 This is a common problem likely in this instance to have been exacerbated by the fact that this was treated as an 'unproven' case of domestic abuse where current professional culture is not to seek to check facts and allegations.

4.8.4 The engagement of fathers is identified in the community health management review as an area of potential learning, given that recent government guidance places stress on identifying fathers, assessing their involvement in the family and encouraging greater involvement with children and services. [24]

4.8.5 Guidance sets very high expectations about the involvement of both resident and non-resident fathers highlighting the value of direct communication with fathers, assessment of fathers and arranging appointments at times when fathers can attend. At present there is often a gulf between the guidance produced by government and its implementation.

4.8.6 It is recognised that there are particular practical difficulties in applying this approach in midwifery, not least because midwives are also expected to exclude male partners from part of the antenatal assessment while they ask required questions about domestic abuse.

4.8.7 If it is to be successful the work to engage fathers requires a significant development in culture, expectations and working practice. Guidance and training may be beneficial because it is clear that many practitioners find it hard to know how to broach the issue of father's involvement with mothers and to find out more about fathers in a way which does not appear to be intrusive. It is recommended that health trusts need to provide a much more comprehensive approach. This could include: issuing clear guidance; offering training; and monitoring the extent of engagement with fathers and the effectiveness of contacts.

4.8.8 Staff will need to be consulted so that there is a shared understanding of why this aspect of practice is so difficult and to have an opportunity to contribute their own ideas. Many of the ideas suggested in national guidance (such as offering appointments when it suits fathers) will clearly

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[24] Department of Health (2009), *Healthy Child Programme – pregnancy and the first five years of life.*

have resource implications and trusts need to decide at a senior level whether they are prepared and able to ask staff to prioritise this area of activity.

4.8.9 Both the health agencies referred to have agreed to adopt the recommendation that they revisit their current strategies for the involvement of fathers in service provision, examine their success and make further recommendations for action.

4.9 **The response of agencies to ethnicity, religion and cultural factors**

4.9.1 The ethnicity of family members was potentially of significance, as the parents came from different ethnic, cultural and religious backgrounds.

4.9.2 With the exception of the concern that Cafcass had in relation to the international aspects of the family's situation (described in the Section 4.7) there is no evidence from notes and records that agencies paid attention to the potential significance of factors such as ethnicity and religion, the extent of the support that family members had in the UK or the potential for conflict between them over this.

4.9.3 It appears that the mother was viewed as being Westernised and therefore treated as if she were English. It is recognised that she was very forceful in her dealings with professionals and that she did not make it easy for professionals to seek background information or explore issues such as this.

4.9.4 For there to be such a shortfall in practice in a case where the ethnic and religious background of the parents may have had a significant impact should be a concern for the safeguarding board and member agencies. The SCR will therefore recommend that the LSCB revisits its current thinking and strategy on this issue in order to identify ways in which service provision can better reflect the needs of the changing population of Oxfordshire.

5 Summary of findings and recommendations

Overall assessment of the provision made for Child N and other family members

5.1 A central concern of the SCR has been to establish whether there was evidence that the mother might have posed a risk of serious harm to Child N and if so whether professionals took the right action. The following paragraphs summarise the findings of the review in relation to this.

5.2 There were a small number of episodes during Child N's life when there was potential concern about the quality of care that was being provided by her mother. However none of these could have led professionals to anticipate that her mother presented a risk of serious harm to her.

5.3 During her pregnancy Child N's mother made contact with the social care service at the hospital where she was receiving antenatal care to say that she was considering relinquishing the unborn child for adoption. Neither the mother's presentation nor her account of her feelings could have been viewed as being an indication of any serious risk to her future child.

5.4 On three occasions between April 2012 and January 2013 the parents separately reported domestic disputes (rows, arguments, threats and past threats). These were treated by agencies as falling within the definition of domestic abuse and responded to as such. There has never been corroborative evidence of domestic abuse and there is no indication that Child N was at risk of harm as a result of domestic abuse. The SCR has identified some minor shortcomings in the way in which agencies responded to the reports of domestic abuse, but they have no bearing on the death of Child N.

5.5 Between October 2011 and the death of Child N the parents were involved in protracted court proceedings to obtain a Residence Order in relation to their child. One member of staff from Cafcass had contact with the parents and was able to observe Child N on many occasions over this period. With the exception of the period of instability due to the mother's housing problems – when she was concerned - this professional identified no signs or symptoms of abuse or neglect. Indeed along with all of the other professionals involved she always observed and recorded that Child N was well cared for, by both parents, almost always in a happy mood and meeting all of her expected developmental milestones.

5.6 When Child N was 8 months old her mother chose to rent out the family home and as a result had no stable accommodation. As a result of the mother's behaviour the family court made Child N the subject of an Interim Care Order and ordered the local authority to undertake an assessment. Whilst there were some gaps in this assessment there is no reason to believe that the circumstances at that time merited removing Child N from her mother or making her subject to a child protection plan. Once the mother found stable accommodation observations made by professionals of Child N with her mother indicated that the baby was being well cared for and thriving.

5.7 Between October 2012 and May 2013 the mother spoke to her GP and a therapist about feelings of depression and anxiety, linked in the main to the

dispute. The GP prescribed anti-depressant medication, which was regularly reviewed. The mother made use of face to face and telephone therapy and treatment services. Her symptoms were within the range of commonplace and moderate presentations and she appeared to respond well to these interventions. At no time did there appear to be any indication that these problems might impair the mother's capacity to parent Child N or cause professionals any concern.

5.8 In July 2012 Northamptonshire social care received a report that Child N (who at that time 10 months old) had bruises from falling off the bed and had been left alone in the mother's bedsit. Northamptonshire visited the mother, observed Child N and asked other professionals if they had concerns. It is impossible to be certain whether or not this was significant. Child N was mobile at this point and so could have fallen or been bruised accidentally. However it is a concern that this report was not investigated properly. It is the only incident during which any concern about a symptom of possible physical assault was ever noted.

5.9 Taking the history as a whole there was no evidence known to professionals who were working with the family that the mother might pose a risk of serious harm to Child N. In fact the available evidence suggested the opposite. Even though the mother experienced practical and emotional difficulties at some points and there were occasions on which some professionals found the mother demanding and difficult to work with, the unanimously held view of professionals who had contact with Child N was that she was in good health, extremely well cared for and flourishing. Although he was in conflict with the mother over Child N the father told the SCR that he had no reason to believe that Child N's mother would ever deliberately harm her.

5.10 In the circumstances it is not possible to see how professionals working with the mother could have predicted that she would harm her child or have taken any action – that would have been justified by the circumstances – that would have prevented it.

5.11 It is known, though very rare, for children to be killed in the course of a dispute about contact or residence. There are also no pointers in the wider research on this topic which would have highlighted risk in this case. When children are killed as part of such a dispute it is almost always by the male protagonist and almost always where there has been a history of violent domestic abuse, neither of which applies in this case.

<u>The wider implications for services to safeguard children and proposals for further action to improve the safeguarding of children</u>

5.12 Agencies with safeguarding responsibilities could neither have predicted Child N's death nor taken action to prevent it. However the review has identified a number of areas in which services could be improved. Whilst there is no reason to believe that the minor weaknesses identified had any impact on the outcome for Child N they should be addressed as they highlight potential areas of vulnerability in services which might impact negatively on other children and their families.

5.13 The SCR has made the following recommendations arising from the analysis and findings in Section 4 of this report. Recommendations made by individual agencies which arise from the learning from their separate internal reviews are set out in Appendix 5.

Standard of Section 47 Investigation in Northamptonshire

1. Northamptonshire County Council should undertake regular scrutiny of the conduct of Section 47 enquiries so as to ensure that the response of the local authority and the police service fully addresses all of the referred concerns.

Multi-agency management of risks arising from domestic abuse

2. Oxfordshire LSCB and the member agencies involved in the design and implementation of the proposed MASH attention should ensure that it provides an effective arrangement for dealing with incidents of alleged domestic abuse, including cases where there is a sequence of apparently less serious incidents. The response to cases should be effective and matched proportionately to the likely risk to children and vulnerable adults.

3. Oxfordshire LSCB should ensure that agencies that commission and provide domestic abuse services take account of the need for professionals to obtain relevant factual information about incidents of domestic abuse and its impact on children before making referrals for services, while at the same time not losing sight of established research about the prevalence and nature of domestic abuse.

Recommendations for and relating to the work of Cafcass in private law cases

4. Cafcass and OSCB should review the current programme of presentations on the roles and responsibilities of Cafcass to ensure that they address the learning from this SCR and also meet the needs of both operational staff and strategic managers in member agencies.

5. Cafcass should undertake a review of the way in which it presents the recommendations of reports in private law cases in which it is recommending a change of residence (or other potentially challenging recommendations) in contested private law proceedings

6. Cafcass should consider how best it can strengthen its ability to work in complex international private law cases, taking account of the growing international mobility of families and the growing number of cases coming before the courts.

7. Cafcass should seek to enhance the capacity of the family court system to deal with complex international private law cases taking account of the growing mobility of families and the growing number of international cases coming before the courts through discussion with 1) relevant members of the judiciary and 2) local Family Justice Boards

Engagement of fathers and other male carers in service provision

8. Health trusts working with families in Oxfordshire should revisit their current strategies for increasing the involvement of fathers and other male carers in their services in order to test their effectiveness and review approaches as necessary.

Service provision to children and families from minority ethnic populations

9. Oxfordshire LSCB should review how it monitors and challenges member agencies over their policy, procedures and practice in relation to children and families from minority ethnic groups in order to ensure that all aspects of the planning and delivery of services reflect the needs of the changing population of Oxfordshire.

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Appendix I

SCR REVIEW TEAM MEMBERSHIP

SCR Panel Independent Chair:	Paul Kerswell
Agency:	**Designation:**
Oxford Health NHS Foundation Trust	Acting Head of Nursing Children and Family Services
Children's Social Care & Youth Offending Service, Oxfordshire County Council	Deputy Director
Children's Social Care, Oxfordshire County Council	Safeguarding Manager
Education & Early Intervention Service, Oxfordshire County Council	Deputy Director
Legal Services, Oxfordshire County Council	Head of Law and Governance
Thames Valley Police	Detective Chief Inspector
Oxford University Hospitals and Oxfordshire Clinical Commissioning Group	Designated Doctor Safeguarding
CAFCASS	Head of Service for Avon, Gloucestershire, Wiltshire and Thames Valley.

Appendix II

List of documents and material considered by the SCR review team

Individual Management Reviews
Children and Family Court Advisory and Support Service (Cafcass)
Oxfordshire Clinical Commissioning Group (formerly NHS Oxfordshire)
Oxford Health NHS Foundation Trust
Oxford University Hospitals NHS Trust
Oxfordshire County Council Children's Social Care and Early Intervention Service
Oxfordshire County Council Legal Services
Northamptonshire County Council - Children, Families and Education Directorate
Thames Valley Police
Chronologies of brief involvement
Luton Borough Council – Children and Learning Department
Cambridge Community Services NHS Trust (in relation to the health visiting service in Luton)
Luton Clinical Commissioning Group

Appendix III

Principles from statutory guidance informing the SCR methodology

1. The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.
2. Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
3. Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

In addition Serious Case Reviews should:

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

Appendix IV

Policy guidance and research references

HM Government (2013) Working Together to Safeguard Children

HM Government, LSCB Regulations 2006

HM Government (2010) Working Together to Safeguard Children

Charles Vincent (2010) Patient Safety (second edition) Wiley-Blackwell BMJ Books

DASH- CAADA Risk Identification Checklist
http://www.caada.org.uk/marac/RIC_without_guidance.pdf

Annual report of the Office of the Head of International Family Justice
http://www.judiciary.gov.uk/about-the-judiciary/international/international-family-justice

Hilary Saunders (2004) Twenty-nine child homicides: Lessons still to be learnt on domestic abuse and child protection, Women's Aid

Cafcass (November 2013) Learning from Cafcass Individual Management Reviews (IMRs) - Case Dynamics: Executive Summary

Children Act 1989 http://www.legislation.gov.uk/ukpga/1989/41/section/37

Department of Health (2009), Healthy Child Programme – pregnancy and the first five years of life.

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Appendix V

Recommendations arising from individual agency management reviews

Rec No.	Agency	Rec
1	**Thames Valley Police**	Thames Valley Police to include guidance in the new Domestic Abuse Standard Operating Procedure regarding the importance of contacting the other party in domestic abuse incidents.
2	**Thames Valley Police**	Thames Valley Police to circulate guidance to all front line staff explaining the importance of considering making contact with the other party in domestic abuse incidents as part of a 'Positive Action' response.
3	**Thames Valley Police**	Thames Valley Police to remind front line staff of their duty to record and investigate any disclosures of a crime on a DOM5 form.
4	**Thames Valley Police**	Thames Valley Police to ensure that front line staff understand that Positive Intervention in relation to domestic incidents includes when the victim perceives that an incident is domestic related and that their concerns should be fully investigated and positive action taken.
5	**Thames Valley Police**	Thames Valley Police to instruct front line staff to consider whether there are any safeguarding issues evident in 'Fear for Personal Welfare' incidents and ensure that they are recorded on CEDAR.
6	**Thames Valley Police**	Thames Valley Police to remind staff within the Protecting Vulnerable People Referral Centres to record all actions in CEDAR.
7	**Thames Valley Police**	Thames Valley Police to evaluate the effectiveness of local policing area domestic abuse initiatives in relation to standard graded victims and consider the viability of rolling them out across the whole of Thames Valley Police.
8	**CAFCASS**	Learning and themes from the Cafcass IMR to be disseminated throughout the agency.
9	**Children's Social Care**	Ensure consistency of practice so that self-referrals are managed in the same way as referrals from other sources and proceed to assessment where necessary
10	**Children's Social Care**	Senior Managers should assure themselves that C&F Assessments include an understanding of wider environmental factors and analyse the impact on the risk to the child.

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Rec No.	Agency	Rec
11	**Early Intervention Service**	Review the quality of referrals received by children's centres and the use made of the Common Assessment Framework (CAF) both at the referral stage and when a family's situation becomes more complex.
12	**Early Intervention Service / CAFCASS**	Cafcass and EIS to ensure good practice with families in private proceedings, especially where both parents are (potential) users of the same hub or children's centre.
13	**Police / Children's Social Care / Health**	The system of domestic abuse notification should be reviewed and taken into account in the design of the Multi-Agency Safeguarding Hub in order to: • Ensure that the risks to children and families are assessed in a timely way and that there are appropriate and consistent responses from agencies, including the children of 'standard risk' victims. • Ensure that resources are used efficiently across agencies without over-reliance on children's social care.
14	**OSCB**	Domestic Abuse training should ensure that 'listening to what victims say' is not interpreted as accepting statements at face value without probing, assessment or challenge.
15	**Legal Services**	International law and port alerts , knowledge of emergency action procedure when there is a risk of abduction, to be added as team training event for the Child Care Solicitors.
16	**Legal Services**	Child Care Team to be reminded of responsibilities to properly scrutinise adequacy of Court Reports and particularly S37 Reports.
17	**Legal Services**	Child Care Team to ensure cultural, religious, racial and other characteristics properly considered and addressed in Court Reports.
18	**Legal Services**	Diarise reminders if Social Workers complete S37 Reports with NFA required in private law proceedings and if there are issues to inform CAFCASS.

Rec No.	Agency	Rec
19	**Clinical Commissioning Group**	GP records should represent a summary of primary care provision for a patient • GPs must actively contribute to planning and agreeing communication arrangements with other relevant co-professionals to ensure this happens. • The GP practice must have a clear communication process with Health Visitors and other co-professionals to ensure that the GP is kept up to date with all issues and actions for the patient. • Formal arrangements such as being a "Looked After Child" must be notified to GP Practices and recorded in patient's GP notes. GPs must ensure they have in place a clear system that this happens and is kept up to date.
20	**Oxford University Hospitals NHS Trust**	The OUH midwives need to ensure that vulnerability is assessed on more than one occasion to maximize the opportunity to identify any concerns, vulnerability or risk
21	**Oxford University Hospitals NHS Trust**	The maternity service needs to give further consideration on the best way to assess and record the involvement of and interactions with the father in pregnancy.
22	**Oxford Health NHS Foundation Trust**	To improve information sharing between the Talking Space and the health visiting service in relation to patients with children under five to ensure a shared understanding of a parent's mental health and any impact on the child is assessed and a shared plan of support is in place.
23	**Oxford Health NHS Foundation Trust**	RIO rules/documentation guidelines to include guidance for health visiting staff on the documentation of father's details and their role within the family and to be monitored via the annual documentation audit.
24	**Oxford Health NHS Foundation Trust**	Health visiting services to ensure that recording of domestic abuse enquiry and maternal mental health is completed by practitioners and monitored via audit.
25	**Oxford Health NHS Foundation Trust**	To provide updated information to Trust staff on the private law court process and role of CAFCASS.