Shropshire Safeguarding Children Board

Serious Case Review Report relating to

Child E

Contents

Section 1: Introduction

1.1 What this review is about

1.1.1 This serious case review (SCR) concerns a child known, for the purpose of this review, as E.

1.1.2 Shropshire Safeguarding Children Board (SSCB) agreed this case met the criteria laid down in Working Together 2015 for an SCR to be conducted.

1.1.3 The brief circumstances of this case are as follows; E's parents separated shortly after his birth and contact and residency had been determined by the Court following the breakdown of their relationship. E lived with his mother, her partner and his half sibling. His eldest half-sibling would visit the family home to see E. He also spent time with his father, his wife and his paternal half-sibling although this contact had been stopped by mother three months prior to E's death. In September 2017, E was found deceased at the maternal family home. His mother, who was also at the property, was found with critical injuries and was transferred to hospital where her injuries were treated. Subsequently E's mother was arrested and charged with his murder. E's mother was found guilty of murdering E who was 7 years old at the time of his death and was sentenced to life imprisonment.

1.1.4 E was found dead on the day that his parents were due to attend a Directions Hearing in the private law proceedings that had been initiated by father to address contact and residence issues. The Directions Hearing would have addressed E's interim contact with his father pending a final decision by the Court on contact and residency matters. E's father had made an application to Court in response to mother stopping contact between father and E in June 2017.

1.2 Why this review was conducted

1.2.1 The Independent Chair of the SSCB agreed with a recommendation of the Learning and Improvement sub-group that this case should be the subject of an SCR; under the requirements of the Local Safeguarding Children Boards Regulations 2006 Section (5)(1) (e) and (2).

1.2.2 The statutory basis for conducting an SCR and the role and function of a Local Safeguarding Children Board is set out in law by: The Local Safeguarding Children Board Regulations 2006, Statutory Instrument 2006/90.
Regulation 5 requires the Local Safeguarding Children Board (LSCB) to undertake a review where –

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

1.2.3 Guidance for LSCBs on conducting an SCR is contained in Chapter 4 of Working Together 2015[1]. This version of Working Together was used when deciding upon the SCR process, as it was the most current at the time decisions were taken around the review process (published in March 2015).

1.2.4 An SCR establishes the role of services in the life of the subject child and provides a rigorous, objective analysis of what happened and why, so that important lessons can be learnt, and services improved to reduce the risk of harm to children. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

1.3 How this review was conducted

1.3.1 Author and Review Panel

1.3.2 The author of this report was Liz Murphy, who is a qualified Social Worker, and independent of all agencies that work to safeguard children and young people in Shropshire. She has extensive safeguarding experience including reviewing cases and service provision to support improvements in how services are provided to children and their families.

1.3.3 A review panel was established. Meetings were held at regular intervals and the panel was consulted about the scope of the review. In addition, Panel Members contributed to the analysis contained in this report. The panel included a senior manager from each of the key agencies.

1.3.4 The Terms of Reference

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

1.3.6 This review focuses on the period from January 2014 to September 2017. This period was selected following a SCR Panel meeting and is of a sufficient range to include the relevant engagement that E had with agencies in Shropshire. Whilst this period was the basis for the review, contextual and relevant information falling outside of this period was also included.

1.3.7 The review was conducted in a way which:

- recognised the complex circumstances in which professionals work together to safeguard children;

[1]Working Together to Safeguard Children March 2015 - https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

- sought to understand precisely who did what, and the underlying reasons that led individuals and organisations to act as they did;
- sought to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight;
- was transparent in the way data is collected and analysed;
- made use of relevant research and case evidence to inform the findings.

1.3.8 Agencies that are involved in child safeguarding are required to follow the statutory guidance laid down by government. The guidance is called Working Together to Safeguard Children. It contains all the processes that agencies are required to follow. Working Together has been through several iterations. This review benchmarks against the statutory guidance contained in Working Together 2015.

1.3.9 Methodology

1.3.10 The methodology agreed by the Shropshire Safeguarding Children Board (SSCB) review panel is based on a model consistent with the requirements of Working Together 2015. It ensures that:

- a proportionate approach is taken to the SCR;
- it is independently led;
- professionals who were directly involved with the case are engaged with the review process;
- families are invited to contribute.

1.3.11 Chronologies and Agency Reports

1.3.12 Agencies were asked to compile a report detailing their contacts with E, resulting in a combined chronology of events. In addition, each agency was asked to provide a report that described the contact they had with E and his family. Agencies were asked to identify key learning for their agency and to describe how they will embed this learning into day to day practice. All the agencies that were asked for a report provided the information requested. In cases where further clarification was required, agencies responded in an open and transparent way.

1.3.13 Learning Event

1.3.14 A learning event with front line practitioners is an essential part of the process. In the learning event, front line staff and managers that had had contact with E were brought together for discussions around themes that had been identified from the chronologies and reports. This provided a view of their engagement with E that enriched the information provided by agencies and ensured that all the relevant facts were recorded.

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

1.3.16 Whilst the details of discussions that took place were recorded, the comments made by the staff involved were non-attributable. For many front-line practitioners, this was the first opportunity for them to discuss with other professionals their engagement with E and his family; it was pivotal to the learning from these traumatic events.

1.3.17 Family Engagement

1.3.18 Family members were invited to contribute and the views of those that did have informed this report.

1.3.19 Parallel investigations

1.3.20 The timing of this review was managed by SSCB so as not to undermine the criminal investigation that was conducted by West Mercia Police and resulted in E's mother being convicted of his murder. E's death has been referred to the Coroner. It is understood the Coroner will review his decision to hold an inquest upon completion of this review.

1.3.21 How this report has been structured

1.3.22 Following the introduction, Section two provides a summary of agency involvement with E and his family whilst Section three provides a summary of the key learning from research into filicide. Section four analyses the key themes, identified by the author in conjunction with the review panel and frontline practitioners, and explains **WHAT** happened and **WHY**. Section five summarises the key findings of the review. The recommendations in Section six have been developed from these findings taking account of the work carried out by agencies since these events occurred.

1.3.23 This report has been written so that it can be read by the public.

1.3.24 In this report, the following initials represent the main subjects:

E – subject of this review
ME – mother of E
FE – father of E
Family Member 1 – Maternal half sibling
Family Member 2 – Paternal half-sibling
Significant Adult 1 – Mothers partner

Section 2: Summary of agency involvement with E and his family

2.1 This section sets out the contact that agencies had with E and his family. It begins with a picture of E so that the reader has an insight into the child that E was. This information is provided by the family members who contributed to the review and E's school.

2.2 What was E like?

2.2.1 E spent time living with both his parents, their partners and his half-siblings. His parents separated when he was just a few months old and his residence and contact arrangements had subsequently been determined by the Court.

2.2.2 E is described as an active child with a great sense of humour. His interests included riding his bike, go-karting, skateboarding or sledging. He also enjoyed playing computer games, watching films, making pizza and lots of bubbles when having a bath. Family trips and holidays were also an important part of E's life.

2.2.3 E was considered to be a thoughtful and hardworking pupil who always liked to do his best. He liked talking to adults and asked lots of questions about history or programmes he had watched on television. Academically, he was at the expected level for this age and was working above the expected level in mathematics. E is described as chatty and confident when talking to his peers and adults as well as considerate and kind towards others. On occasions, E displayed indicators of distress in school and both parents shared examples with professionals of, either comments they heard E make, or behaviour they observed which would also suggest that on occasions, E was experiencing distress.

2.2.4 Professionals who attended the learning event commented that in their view, E should be considered a resilient child as given the level of parental conflict he was exposed to, further indicators of the impact of this on his emotional well-being could have been expected. This suggests that whilst being exposed to parental conflict, E had at other times received good quality care and nurturing from the adults in his life.

2.3 Summary of agency involvement

2.3.1 E was born in January 2010 and lived with ME and FE. Health visiting services provided a high level of support to ME in E's first year of life with 18 face to face visits taking place prior to February 2011. E was last seen by a Health Visitor in February 2011 when he was aged 2; he was never seen by school nursing services.

2.3.2 In E's early life, ME accessed a range of early help services including a group for mother's experiencing post-natal depression, a group for victims of domestic abuse as well as Home-Start[2].

2.3.3 In April 2010, ME saw her GP because of low mood. She was prescribed medication and seen on several occasions in the future about her emotional well-being/low mood.

2.3.4 In June 2010, ME contacted the Police to report an argument between herself and FE. ME reported to the Police that FE had left the family home with E in his pushchair. ME reported the incident as she was concerned about E's welfare as FE had been drinking and was upset. E & FE were quickly located by Police and they were found with ME's sister across the road from the family home. This incident was classified as a 'standard' risk domestic abuse in adult by Police and records indicate that both parties were recorded as "Domestic Abuse Undetermined". A further 6 'standard' risk domestic abuse incidents were reported to the Police over the coming years. They were usually reported by ME however, FE also made reports. The nature of the reports focused on a range of issues; child contact, verbal disagreements and parenting style.

2.3.5 In July 2010, ME and FE separated and ME describes the separation to professionals as not very amicable.

2.3.6 In November 2010, FE applied to Court for contact. CAFCASS completed safeguarding checks and did not identify any ongoing role for themselves. ME & FE completed a parenting programme and hair strand testing for alcohol. The Court ordered unsupervised contact between E and his father from May 2011 onward.

2.3.7 In April 2011, E started pre-school close to FE's home and attended 2 days a week (the days he was resident with FE). E left this preschool in July 2014.

2.3.8 In December 2013, ME was given a new tenancy via a local Housing Association. A new tenancy visit was conducted in January 2014 and no additional support needs were identified.

2.3.9 In January 2014, FE reported concerns to the GP. He stated he had observed bruising on E's legs in the past. E was examined and no evidence of bruising was found. The GP made a safeguarding referral to COMPASS. COMPASS is the single point of contact for receiving enquires and referrals regarding the welfare or protection of children in Shropshire.

2.3.10 In March 2014, FE reported the same concerns to the pre-school. The school sought advice from the Early Help team (based within COMPASS). The Early Help team advised that there was no need for a referral at this

[2] Home -Start is voluntary sector organisation that recruits and trains volunteers to provide friendship, emotional support and practical help to families with at least one child under five years of age.

stage and that the information had been registered by the GP in January 2014. The pre-school informed the review that the Early Help team commented that FE may be trying to build some sort of case against ME or he may have even inflicted the injuries himself. It would appear from the records that the Early Help team were under the impression that Court proceedings were ongoing at this time.

2.3.11 In April 2014, FE made a referral to Children's Social Care. He reported the historical and more recent bruising as well as an allegation made by E of sexual abuse by a family member. This did not progress as a referral and instead the outcome was to write to both parents with guidance on acrimonious relationships and advise FE to contact the GP or Police if he had further concerns. FE also shared his concerns about physical and sexual harm with the pre-school who in turn shared the information with the Early Help team.

2.3.12 In May 2014, and on the advice of his solicitor, FE reported his concerns of physical and sexual harm to the police. Police visited E to conduct a safe and well check. They found no evidence of visible bruising and considered E to be a happy little boy. The information was shared with Children's Social Care and Police Family Protection Unit. The incident was filed with no further Police action.

2.3.13 In May 2014 and on the same day that the Police conducted the safe and well check, ME contacted the Police to report FE was harassing her. She also made an allegation of a non-recent sexual assault against FE although did not wish to make a formal complaint.

2.3.14 At the end of May 2014, the GP contacted Children's Social Care to report concerns both ME & FE had reported to him. Children's Social Care have a record of the contact made following the concerns raised by FE however, there is no record in Children's Services records of the contact made by the GP in respect of the concerns raised by ME. ME's concerns centred around FE making alleged derogatory comments about her character and parenting to E. At this time, the GP was concerned that the parental relationship was causing emotional harm to E. GP records indicate that Children's Social Care considered the allegations to be based on the 'ongoing dispute' between parents.

2.3.15 In June 2014, ME told the Health Visitor that E was being cruel to his pets and that he was having increased temper tantrums and some angry outbursts directed at a family member. Furthermore, ME shared that E was sleeping poorly and was having regular nightmares. ME shared this information with Children's Social Care and information provided to the review indicates the Health Visitor also contacted Children's Services. The outcome of ME's contact with Children's Services was to sign post to the Family Information Service. This advice is similar to what is recorded in health visiting records as to the outcome of their contact with Children's Services which supports the position that the Health Visitor had contacted Children's Social Care about this information.

2.3.16 In September 2014, E started primary school.

2.3.17 Between Autumn 2015 and July 2016, ME was supported by a range of early help services after she self-referred to a Children's Centre. Services delivered include the Power to Change programme, The Me, My Child and Domestic Abuse programme and E attended a group work programme called Helping Hands. These programmes were provided by a specialist domestic abuse service. In addition, an early help worker from the Children's Centre worked with both ME and E. In October 2015, E completed a Webstar (a tool designed to assist practitioners to identify a child's needs) which indicated low happiness when with FE and some feelings of being unsafe when with ME. A total of 14 home visits were conducted to ME and E was seen on 4 occasions at home and on 7 occasions in school.

2.3.18 In October 2015, ME shared concerns with school that E was being mentally abused and wanted to be sure E's contact with FE was safe and secure. School made a referral to Children's Services. Children's Services have no record of this contact.

2.3.19 In November 2015, FE applied to the Court to vary the contact order. CAFCASS completed safeguarding checks and identified no ongoing role for themselves. These proceedings concluded in February 2016 with a Child Arrangement Order which stipulated the arrangements for contact between E and FE, including during the school holidays. The information provided to CAFCASS by the Local Authority to inform the safeguarding checks did not include the allegations of sexual abuse made by FE in 2014.

2.3.20 In April 2016, family member 2 was born.

2.3.21 In July 2016, early help services (Children's Centre) close their involvement with the agreement of ME.

2.3.22 In September 2016, the GP makes an urgent referral for ME to the Community Mental Health Team. ME had thoughts of self-harm and suicide and was suffering from depression due to a number of factors: custody dispute, relationship breakdown with current partner, bereavement/loss and job worries. ME was admitted to a short stay local mental health crisis provision for five days. This provision was used as an alternative to hospital admission.

2.3.23 ME subsequently self-referred to an NHS Wellbeing service. She had, since E's birth, been referred to this service on 3 previous occasions and failed to engage. From October 2016 – March 2017, ME accessed 18 face to face therapy appointments. It is considered that the wellbeing service was the appropriate response to ME's emotional wellbeing issues. The focus of this intervention was ME's relationship breakdown with significant adult 1 and her relationship with her own mother. There was a very limited focus on her relationship with FE and no focus of the impact of her wellbeing on E. By the

end of the intervention, there was evidence of positive improvement in ME's depression and anxiety scores.

2.3.24 In September 2016, ME attended for a carer's assessment in relation to her caring responsibilities for family member 1. The assessment did not explore other caring responsibilities that ME had i.e. E.

2.3.25 In June 2017, ME calls the Police to report FE had refused to return E home. ME was very upset and during the call said "nothing stopping me stabbing the c**t. I want him dead. It would save him having to grow up with that". Police visited both ME and FE and determined that there was no breach of the Contact Order as it was FE's weekend to have contact. ME has shared that this was the trigger for her decision to subsequently stop contact. She reported that she feared if she did not address what she perceived as FE's non-compliance with the Court Order, FE would not adhere to the Order in the future.

2.3.26 This contact with the Police was recorded as a standard domestic abuse incident and discussed at the local domestic abuse triage meeting where following a multi-agency discussion, it was agreed that this incident should be responded to as a level 1 incident in terms of the SSCB levels of need as set out in the thresholds document i.e. recorded for information. At this time, local practice was for the Police to record this information. In response to the findings of the Ofsted inspection in 2017, Children's Social Care now also record this information on their systems.

2.3.27 Later in June 2017, FE called Police to advise that his solicitor had informed him contact had been stopped by ME. FE raised concerns for E's mental health and wellbeing and 6 days later, Police followed up with a safe and well visit. The Police concluded that FE's call was malicious, and FE was using the Police to harass ME. Both ME and FE subsequently contacted Children's Services and school to report concerns about each other and E. FE's initial contact to Children's Services at this time repeated the allegation that E had said he was being sexually abused by a family member. During this period, FE made 3 contacts in total to Children's Services and once notified that the Local Authority were closing the case, FE contacted Ofsted to express his concerns that the Local Authority appeared prejudiced towards men and were not prepared to investigate allegations of neglect and sexual abuse. A senior officer provided a rationale to Ofsted for the Local Authority's decision which was that there was no evidence from the Police or school that E was suffering harm.

2.3.28 At the end of June 2017, FE contacted the NSPCC Helpline. As a result of FE's contact, NSPCC made a referral to Shropshire Council in a timeframe that was in accordance with their internal guidance. Some of the information reported by FE to NSPCC was not contained in the referral made by NSPCC and whilst most of this information had previously been shared with Children's Services by FE, he did share some new information with NSPCC and in particular that he considered that ME had undiagnosed mental health difficulties. In addition, information about an occasion when FE shared

information with E about ME's manipulation of their contact was not included in the referral. FE also informed NSPCC of the lack of response by Children's Social Care and Police to the allegations of sexual abuse that he had reported to them. Whilst the NSPCC referral was received by Shropshire Council in June 2017, there was no response provided to this referral.

2.3.29 Early in August 2017, FE made an application to Court to enforce the Child Arrangements Order made on 16th February 2016 and for E to live with him. CAFCASS conducted safeguarding checks and on this occasion, the information provided by the Local Authority detailed the allegations of sexual abuse made by FE in 2014. CAFCASS recommended a Section 37 report and were concerned that E was caught up in the middle of issues between parents and the associated impact of allegations and counter allegations made by ME and FE on him. At the end of August 2017, the Court ordered a Section 37 report and directed that the safeguarding letter prepared by CAFCASS was shared with the Local Authority. The Local Authority did not receive a copy of the safeguarding letter. Children's Social Care subsequently received the request for a Section 37 report on 8th September 2017; once the referral was received the case was passed to the relevant case management team for allocation.

2.3.30 In early September, ME self-referred to a local domestic abuse service and subsequently she attended a face to face appointment. She expressed her concerns about attending the court hearing scheduled for later that month.

2.3.31 About a week before E was killed, ME attended E's school and shared that she was feeling anxious and that no one was listening. ME consented to school making a referral to Children's Social Care to explore support available for mother. During the contact with school, ME stated that the 'only way to end it all would be a shotgun and shovel". In response to the contact from the school, Children's Social Care confirmed that ME had completed the Freedom programme and advised that the case had already been passed to the relevant case management team and was awaiting allocation. The call was not returned by the allocated team. At the same time as ordering a Section 37 report, the Court also directed that FE should have one supervised contact session with E in September 2017 however this did not take place.

2.3.32 Two days prior to E's death, ME contacted the GP by telephone and reported that E had said he wished he was dead so that he wouldn't have to see FE. ME asked that E was protected from the emotional abuse she was alleging. The GP made a written referral to CAMHS (via COMPASS). The referral requested that CAMHS urgently assess E and detailed the issues between the parents in relation to contact. The referral was assigned to a CAMHS practitioner who reported that it was returned to COMPASS to be reassigned to Children's Social Care due to safeguarding concerns, however, it is understood the referral remained sitting on the CAMHS practitioner's desktop. On the same day, the GP also contacted Children's Social Care by telephone to refer his concerns in respect of E. This contact

was passed to the relevant case management team and shared by email with the duty worker. This call was also not returned by the allocated team.

2.3.33 In the telephone call with ME, the GP advised her that she should consult the GP practice regarding her own health. This was because throughout the telephone consultation, ME presented as anxious.

2.3.34 E did not attend school on 21st September 2017. The school did not attempt to contact E's parents to establish the reason for his non-attendance. Later that day, a call to the emergency services was made by Significant Adult 1 to report that he had found E dead at the family home. Paramedics and Police attended the scene and paramedics confirmed E's death at 18:34hrs.

2.3.35 ME was subsequently convicted of E's murder and jailed for life with a minimum sentence of 18 years. Information gathered by the Police during the criminal investigation into E's death suggests that ME had told members of the community in the week preceding E's death that she would be in prison by the following week. ME had also written letters to family members' weeks prior to E's death that indicated her intention to harm both herself and E. These letters were discovered after E's death.

Section 3: Learning from research

3.1 To inform the review the author has reviewed the findings of a study into filicide in the context of separation, divorce and custody disputes[3]. This research analysed 128 filicide killings between 1994 – 2012 and draws on other research that has been carried out in this field. Key findings from the study are:

- Relationship breakdown is the most conspicuous and significant characteristic of the filicide cases in the study;
- Depression is the most common mental illness in parents in both filicide and child abuse cases;
- Mental illness is an important contextual background for marital, separation and divorce conflict and/or in residence or contact disputes and can exacerbate any of those conflicts and disputes;
- The prevalence of mental illness among female perpetrators of filicide is significantly higher (75%) in contrast to male perpetrators (19%);
- That children have to be rescued from 'something awful' is quite common in the thinking of many filicide perpetrators;
- Apart from infanticide and neonaticide, the 4-7-year age group seems to be a particularly vulnerable one in filicide killings;
- Domestic violence is a common feature in cases of male filicide;
- The state of the perpetrators relationship with their (ex) partner/spouse at the time of the filicide killing is a key issue;
- Most filicide killings are preceded by and are wholly dependent upon an exceptionally high degree of premeditation and deception on the part of the perpetrator;
- The frequency of revenge as a motivator is exceptionally high but given the context in which the killings take place that may not be surprising i.e. mutual animosities and recriminations between parents;
- A shift in the balance of power, control and influence a perpetrator once exerted in a relationship can be a predominate feature in some cases. In some cases, a partner may lose power, control or influence as a consequence of external factors that have nothing to do with the relationship e.g. unemployment or poor physical or mental health;
- Public and private law proceedings can be a dangerous time, a time of enhanced risk for all concerned;
- The risk of parents taking some drastic action on or near the day a court is due to make decisions, will be higher if the court hearing has been proceeded by weeks, months or years of bitter wrangling between the parents, or if there has been frequent involvement by social workers unhappy with the care of a child, or when there has been recurring domestic abuse, and the issuing of non-molestation and other types of restraining orders. The final decision of a court may leave a parent seething with rage and a desire for revenge or retaliation;

[3] Filicide – suicide. The killing of children in the context of separation, divorce and custody disputes. Kieran O'Hagan 2014

- 44 out of 128 perpetrators in the study were female; some studies conclude that the majority of perpetrators are men whilst there are probably just as many which find that the majority of perpetrators are women. There is another strand of research which finds that the numbers of mothers and fathers who kill their children is roughly equal. Research on the gender of filicide perpetrators is therefore inconsistent at best and more often contradictory.

3.2 It is important to state that the features described above are correlated with filicide rather than being causal. Many of the features are fairly common occurring risk factors in child welfare cases and therefore have low predictive value for filicide which is indeed a rare event. As a result, their significance is often only apparent with the benefit of hindsight. This helps to explain the significant challenge that agencies face in identifying the cases that could end in filicide from those that don't and reflects the views of some of the family members who contributed to the review that there was nothing else agencies could have done to make a difference to the tragic outcome for E.

Section 4: Key themes

4.1 The Terms of Reference for this SCR agreed that the review would focus on the following question "What is the learning in relation to how services respond to the needs of children of separated parents, where contact and residency are decided by the Court?"

4.1.1 The SCR Panel agreed the priority themes that emerged from their collective considerations of agency reports. Priority findings are identified because they create risks to other children, young people and families in future cases because they undermine the reliability with which professionals can do their jobs. Priority findings therefore provide useful organisational learning to underpin improvement.

4.2 Priority Finding 1 Safeguarding referral pathway – (including open unallocated cases). (This finding is relevant to all children and young people and not just those children of separated parents)

4.2.1 A range of professionals reported concerns about the safety and wellbeing of E from January 2014 up to 2 days before his death. The review has identified a lack of clarity about the safeguarding referral pathway across the professional network.

4.2.2 When a referrer calls Shropshire Council Children's Services, call handlers based in the First Point of Contact (FPOC) receive the call. Previously, including at the time of E's death, referrals to CAMHS were made via FPOC with one of two CAMHS nurses then deciding as to whether to accept the referral. These referrals were recorded on Children's Social Care records rather than in CAMHS records. In December 2017, a separate front – door was created by the responsible health trust to receive CAMHS referrals and from this date, referrals to CAMHS have been recorded by the responsible health trust thereby creating a more robust system of governance for referrals to CAMHS than was in place when the GP made a referral to CAMHS in respect of E.

4.2.3 When a call is made to FPOC about a child's welfare or safety, current practice is that the call handlers will transfer a safeguarding referral to the Initial Contact Team (ICT) who then determine if the threshold for a statutory social work service is met. If the caller wishes to book an Early Help Consultation, FPOC will arrange this consultation and if the caller is unsure about the level of their concern, FPOC transfer the call to the Early Help team who explore the options of making a safeguarding referral or seeking an Early Help Consultation to determine which service in COMPASS is best placed to respond to the concerns.

4.2.4 The SSCB thresholds document published in March 2017 requires practitioners to complete a Multi-Agency Referral Form (MARF) when they have identified the need to make a referral to Children's Social Care i.e. complex/significant needs have been identified. Good quality MARFs will make it easier for staff in COMPASS to understand the intentions of the

referrer and the nature of their concerns for the child. The version of the SSCB thresholds document that was in place between April 2013 and March 2017, made no reference to the need for a written referral for cases being referred to Children's Social Care and the review has found that during this period, there was not a culture of submitting written safeguarding referrals. As a result, phone call was the method of 'referral'. According to the version of the SSCB thresholds document that was in place up to March 2017, FPOC would receive calls and either:

- Arrange for a consultation to be provided by an Early Help Advisor (a senior social worker). This consultation would be offered within 2 working days and its purpose was to assist the caller consider their options and manage risk appropriately,
- Transfer calls regarding concerns that a child is at risk of suffering significant impairment to their health or development or is suffering or at risk of suffering significant harm to the ICT where a decision would be made about whether the threshold was met for social work intervention. The SSCB threshold guidance stated that to secure this response, the caller would need to advise they wished to make a child protection referral.

4.2.5 An analysis of the contact and referrals made by professionals to Shropshire Children's Social Care has been completed and has established that professionals and in particular, the GP and school made what they believed to be safeguarding referrals however, these were not received or processed as safeguarding referrals by Children's Social Care. The fact that up until March 2017, the phrase 'child protection referral' was a requirement for a case to be processed as a referral to Children's Social Care by FPOC, coupled with the fact that there was no expectation of a written referral up until March 2017, provide an explanation as to 'why' this has occurred. Discussions with agency report authors and front-line practitioners at the learning event confirm that there is still a lack of clarity and understanding about the referral pathway to Children's Social Care and furthermore that MARFs are not routinely being completed by practitioners who consider that a child meets the criteria for a social work service. The lack of written referrals to Children's Social Care by the school and GP in September 2017 provide evidence that the use of MARFs is not fully embedded in Shropshire.

4.2.6 There are also examples were professionals have contacted COMPASS (GP in May 2014 to report concerns shared by ME, Health Visitor in June 2014 to report concerns shared by ME and school in October 2015 to request support for E) that are not recorded in Children's Social Care records. Children's Social Care report that regular audits and inspection by Ofsted have more recently provided assurance that there is a robust system in place to record contacts. The lack of the recording of the NSPCC referral made in June 2017, along with some information provided to this review about the practice of recording contacts on closed cases, indicates the need to confirm arrangements for recording all contacts received by Children's Social Care. This work is being progressed as part of the review of the local referral pathway to Children's Social Care and Early Help that has commenced because of the learning from this review and will also include

embedding a system to provide written feedback to those who make referrals to COMPASS.

4.2.7 As referenced earlier, NSPCC made a referral to Shropshire Children's Social Care in June 2017. Initially, the Serious Case Review Panel thought that the referral had not been received by Shropshire Council, however, it has been established that the referral was received on the date it was sent. At the time of this referral, Children's Social Care already had an open contact in respect of E. The NSPCC referral should have been linked to the open contact and its content considered as part of the Local Authority's decision making as to whether E met the threshold for a social work service. The NSPCC referral was moved into a folder in the receiving email account by an Early Help social worker and the open contact was closed later the same day by a senior social worker in the ICT which meant that the NSPCC referral was never linked to E's records. This provides an explanation as to why it was never actioned. In terms of the information that was not included in the referral, NSPCC have advised the review that they will use the Quality Assurance Process for the Helpline to monitor that all relevant and significant information is included in referrals made to Local Authorities.

4.2.8 The referrals made by school and the GP in the days leading up to E's death were received by Children's Social Care. The GP made a written referral to CAMHS (Via COMPASS) and a safeguarding referral by telephone to Children's Social Care. Similarly, the school made a safeguarding referral by telephone. At this time, the case had been opened in the relevant case management team because the request for the Section 37 report had been received from the court. These referrals were accordingly transferred to the team with case responsibility. Neither telephone call was returned by the Case Management team although the call from the GP was passed to the duty worker.

4.2.9 In exploring why this happened, the Local Authority report that the team manager was off sick, and, at the same time, an Ofsted inspection of Children's Social Care was taking place which impacted on the capacity of the service manager and other team managers within the service and resulted in the case not being allocated in a timely way. The Local Authority reports that it was exceptional for cases not be allocated and the practice norm was for the case to be allocated and a child to be visited within 7 working days following a referral. ME has shared as part of her contribution to the review that the lack of contact from Children's Social Care following the S37 report being ordered by the Court increased her anxiety as she was anticipating an opportunity to share her concerns in a timely way. Shropshire Children's Social Care have introduced changes to address the service failures they have identified in responding to safeguarding concerns on open, unallocated cases and these are:

- A team manager protocol has been created and a robust management cover system has been implemented in the case management service. The protocol outlines the roles and responsibilities across teams when another team manager is off work due to sickness or annual leave.

- Training will also be provided to administrators to clarify their responsibilities in respect of concerns reported on open cases from professionals

4.2.10 The Independent Reviewer notes that in a previous SCR published by SSCB in November 2015, the findings included that there was confusion about reporting arrangements for agencies when there are concerns about children with an allocated social worker who is unavailable particularly when their manager is also absent. In addressing the learning from this review, it is recommended that SSCB review how they have previously addressed the need for the professionals involved in the safeguarding system to understand how to secure and provide a response in relation to concerns in respect of open cases where an allocated worker is unavailable. This is to ensure that awareness and practice becomes embedded.

4.2.11 <u>Priority 2 Managing allegations/concerns in respect of children of separated parents</u>.

4.2.12 As previously described, a range of professionals reported concerns in respect of E as did ME and FE. None of the contacts/referrals made resulted in a decision that the case met the threshold for a social work assessment.

4.2.13 The nature of the concerns reported by parents either directly, or indirectly (via professionals), included historic bruising, allegations of physical neglect which were not corroborated by professionals who were in regular contact with E, or allegations of statements made by E to either parent that were not shared or repeated to anybody else. The nature of the allegations, coupled with the fact that domestic abuse incidents reported to the Police were classified as 'standard' and at that time not recorded on Children's Social Care records, plus the lack of tangible evidence of serious impairment to E's physical health and wellbeing provide an explanation as to why referrals were responded to in this way i.e. the threshold for Children's Social Care intervention was not readily apparent in many of the referrals.

4.2.14 The dynamics of the family will have also influenced the professional response and there were also examples of ME either intentionally or unintentionally manipulating professionals. Examples include:

i) ME telling her Health Visitor in 2014 that the Police who had visited the day before in response to allegations made by FE had told her they were confident the allegations by FE were malicious. ME added that she felt the motive for these allegations was the disagreement over contact arrangements. The Police report of this incident records that ME deemed the report to be malicious due to the ongoing custody issues.

ii) ME telling a domestic abuse service in September 2017 that she experienced domestic abuse from FE when he was misusing alcohol and E was 6 years old i.e. within the previous year. This information contrasts with previous reports of domestic abuse as parents had

separated several years ago. In E's 6th year, the only domestic abuse incident reported to the Police was by FE.

4.2.15 FE was likely to be seen as manipulating professionals due to what was perceived as him elaborating on his initial reports, contacting multiple agencies and repeating previous allegations. What should be noted is that when reporting his concerns in April 2014, which included allegations of sexual abuse, FE was recorded as being extremely emotional and said, "he did not know if anything was wrong or if it was just in his mind", adding that "E has a lively imagination and he wondered if E had imagined things". He went on to say that he would be concerned if ME was told about the referral and said that he did not know what was worse, that his child continued to be abused or that he made an unfounded referral. This does not suggest that FE was motivated to make a malicious allegation. FE went on to say that his reason for not reporting these concerns previously was concern about ME's reaction and her ability to turn things back on him; this comment suggests that ME was able to exercise a degree of power and control over FE.

4.2.16 A common national challenge that helps provide an explanation as to how safeguarding referrals in respect of children of separated parents are managed is that they are often seen as a feature of the parental conflict, particularly for cases involving private law applications. Instead, they need to be seen as distinct issues that should be addressed in the same way as a safeguarding concern for a child who is not involved in private law proceedings. Evidence that safeguarding allegations/concerns were seen as a feature of the parental conflict in this case include:

i) Advice to pre-school that "FE may be trying to build some sort of case against ME" (February 2014)
ii) Comments to GP that mother should consider applying for emergency order via a solicitor to suspend contact from father (May 2014)
iii) Querying FE's motive for raising a continuous pattern of concerns once contact had been stopped (July 2017)

4.2.17 Those in attendance at the learning event identified that there is a need to "rescript the starting point" when dealing with allegations made in respect of children of separated parents. This is to enable professionals to objectively consider the safeguarding needs of the child as they would for children not involved in private law proceedings. Paternal family members have asked the following questions of the professional response: "Where was that little boy?" and "Who understood what E wanted?". They identified that professionals should practice with a "healthy level of suspicion" and be open to the possibility that "perhaps what this parent is saying is true". If this happened, they consider it would place the child at the centre of professional practice.

4.2.18 Whilst many of the allegations made by parents or professionals did not readily evidence the threshold for statutory children's social care intervention there were three that clearly did:

1) Allegation of disclosure of sexual abuse by E in April 2014 reported by FE (Reports of concerning behaviour exhibited by E were also shared by ME with Health Visitor around this time);
2) Referral by school in September 2017 which included concerns about mother's wellbeing and information that she had had thoughts of harming others;
3) Referral by the GP in September 2017 about E's emotional wellbeing, including a report that E had said he wished he was dead.

4.2.19 An explanation as to why referrals (2 and 3) were not progressed has been provided elsewhere (see 4.2.9). Children's Social Care accept that their response (to conduct agency checks) in respect of the allegations made by FE in April 2014 was not reflective of the concerns being shared. The decision not to conduct an assessment appears enmeshed with the view that the allegations were a feature of the parental conflict as the rationale for this decision was that FE had returned E to his mother despite the suspicion of abuse and FE had not reported the allegations of sexual abuse to the Police or GP. FE informed the review that he adhered in full to the requirements of the Court Order as he feared that if he did not ME would stop contact. Information from the pre-school corroborates this perspective as in April 2014, FE told the pre-school that Children's Social Care had questioned why he returned E to ME's care if he had concerns. During this discussion, FE was upset and advised the pre-school that he did so as he feared that he would be arrested for breaching the Court Order if he did not. This information provides an insight into why FE returned E to ME's care.

4.2.20 On the advice of his solicitor, FE, approximately one month later, reported these concerns to the Police who in turn reported them to Children's Social Care. Neither the Police nor Children's Social Care acted in respect of the allegations of sexual abuse at this point. The Police agency report author correctly raises the question as to why there was no strategy discussion held between the agencies to ascertain if there was to be any additional action taken, and whether this would be as a single or joint agency investigation. The lack of a multi-agency assessment at this time was a missed opportunity to understand the needs and experience of E. There were further missed opportunities to identify the lack of joint Police and Children's Social Care response to the allegations of sexual abuse at the point when Ofsted contacted the Local Authority to share the concerns that FE had raised and when NSPCC referred their concerns to the Local Authority.

4.2.21 With regard to CAFCASS' response to concerns raised by E's parents, it has been identified by the CAFCASS agency report author that the allegations made by both parents when information was being gathered on behalf of the court in December 2015 warranted further assessment than was carried out at the time to determine the level of risk to E. Whilst CAFCASS identified that further information was required by the court e.g. copies of the Police logs, there was no consideration as to who would assess and analyse this information before final arrangements could be made. A more in-depth assessment at this time, by way of a Section 7 report, would have informed the professional understanding of the severity of any risk and enabled a

more child focused assessment to ensure that any recommendations made to the court would safeguard E from emotional and any other kind of abuse, and that the arrangements agreed were in his best interest. Had this more in-depth assessment been completed, it would have included seeing E. CAFCASS decision making at this time should therefore also be considered a missed opportunity to understand E's lived experiences.

4.2.22 In responding to the various allegations made by ME, FE and professionals, the focus was on identifying evidence of physical harm or neglect, and in the absence of tangible evidence of these forms of abuse, it was determined that E was not experiencing significant harm or impairment to his health and development. This approach fails to recognise the emotional impact of parental conflict on children and for E, it also failed to recognise the lack of joint investigation into the allegations of sexual abuse. Practitioners in attendance at the learning event identified that the impact of parents 'battling' over their children should be universally viewed as a negative experience for any child. E's behaviour at school sometimes evidenced the emotional distress he was experiencing; and the direct work he completed with the family support worker in 2015 -16 is perhaps most revealing of his reality. E completed MyLife booklets in relation to life at home with ME and another in relation to life at home with FE. There were a lot of similarities across both booklets and when asked by the Family Support Worker why his answers were so similar in both booklets, he said *"I just want to make everyone happy".* Practitioners at the learning event suggested that a Family Group Conference approach could perhaps be used to support children living in these circumstances with the aim of parents being both supported and challenged to make changes to their behaviour. In the near future, a project called Inspiring Families, aimed at working with families in conflict, is being piloted in Shropshire; the findings from this initiative will assist agencies to evaluate how future services could be developed to support children exposed to parental conflict.

4.2.23 <u>Priority 3 Working with fathers</u>

4.2.24 The lack of engagement with fathers has been an endemic problem in safeguarding and child protection and is exposed repeatedly in all child abuse inquiries preceding Serious Case Reviews, particularly in the Tyra Henry, Kimberley Carlile and Jasmine Beckford reports; in child abuse literature (Farmer and Owen 1995[4], O'Hagan 1997[5]) and in SCRs. Brandon et al's biennial analysis of SCRs (2009)[6] commented 'information about men was very often missing'. In a more recent analysis of SCRs, Sidebotham et

[4] Farmer, E. and Owen, M. (1995) *Child Protection Practice: Private Risks and Public Remedies: As Study of Decision-making, Intervention and Outcomes in Child Protection Work*, London: HMSO.
[5] O'Hagan, K.P. (1997) 'The problem of engaging men in child protection work' *British Journal of Social Work, 27*(1): 25-42
[6] Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C. and Black, J. (2009) Understanding Serious Case reviews and Their Impact: A Biennial Analysis of Serious Case Reviews 2005-07, London: Department for Children, Schools and Families

al (2016)[7] identify professional cultures within some agencies which potentially mitigate against effective safeguarding. An example of such a professional culture that they highlight is engagement with fathers.

4.2.25 Examples where agencies did not engage with FE have been identified by agency report authors:

i) No evidence of any engagement with FE by the health visiting service despite the expectation that Health Visitors are expected to be inclusive of fathers when supporting families;
ii) No evidence of contact with FE regarding the MyLife work carried out by the family support worker during the period of their involvement

4.2.26 Examples of what the SCR Panel described as an "unconscious bias" against FE have also been identified:

i) The questioning by Children's Social Care of FE's motives for reporting safeguarding concerns;
ii) The Police response to domestic abuse incident in June 2017, whereby the referral made by the Harm Assessment Unit shows FE as 'person referred' and ME as 'alleged perpetrator' however, the DASH victim assessment was completed in respect of ME, yet she had made threats to seriously harm FE;
iii) E's admission to hospital at ME's request in April 2014 when FE, who had attended with E, was reassuring to hospital staff that he would be able to provide the recommended treatment at home and wanted to take E home;
iv) Evidence of a partisan approach by primary care practitioners e.g. one practitioner described FE as "clearly manipulative" when in fact they had never met him;
v) The review has been made aware that schools do not send routine information e.g. email updates to the "non-resident" parent unless the non-resident parent requests this information. FE was viewed as a "non-resident" parent for E by school. Whilst FE had requested to receive updates about E, he questions whether he received all relevant information e.g. being informed about E's absences from school.

FE informed the review that the decision by the Court in August 2017 to reduce the frequency of contact between E and FE and require it to be supervised is another example of "bias" in the system. Paternal family members do not consider that this decision took into account that FE had made the application to Court as a response to ME's breach of the Child Arrangement Order.

4.2.27 FE's experience of services fits with the examples of "unconscious bias" described above as he reports that he was treated differently by professionals because he is a male and because professionals accepted

[7] Sidebotham, P., Brandon, M., Bailey, S., Belderson P., Dodsworth, J., Garstand, J., Harrison, E., Retzer, A. and Sorensen, P. (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, London: Department for Education.

ME's allegations of domestic abuse without exploring the available evidence or seeking his perspective and experiences of his relationship with ME and most importantly, his concerns for E. The impact of how FE was treated by professionals was that he always felt like he was "on trial" as a parent.

4.2.28 O'Hagan[1] suggests that the lack of engagement with fathers may be "culturally embedded, habitual and instinctive". The SCR Panel identified that in cases where allegations of domestic abuse have been made, professionals can be "pre-programmed" to accept the word of the female without exploring what evidence is available to support the allegations. In this case, there was also no recognition or consideration of whether FE was a victim of domestic abuse or how ME was able to control him and influence his behaviour. An example of how professionals failed to consider that FE could be a victim of domestic abuse can be seen in September 2017 when the school make a referral to Children's Social Care for support for ME when she had shared that she had thought of harming father. The initial response from the Local Authority was to clarify that ME had attended a course for victims of domestic abuse. In all cases, professionals need to be able to recognise male victims of domestic abuse and that individuals can be both a victim and a perpetrator of domestic abuse.

4.2.29 Challenging and changing cultures is far from straight forward and requires deep understanding of the issues, creative thinking, and engagement with practitioners and management to understand why it is so challenging to routinely engage fathers effectively. O'Hagan[1] concludes that reversing this practice will have a dramatic effect on the quality of assessment, and in determining the degree of risk to which children are exposed.

4.2.30 <u>Priority Area 4 Section 37 referral pathway</u>

4.2.31 In August 2017, CAFCASS recommended to the court that a Section 37 report should be made. Section 37 reports can be recommended or directed by the Court where it appears that it may be appropriate for a care or supervision order to be made in respect of the children subject to the court proceedings. Section 37 reports are completed by the Local Authority's Children's Social Care Service who undertake an investigation to consider whether they 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 the family;
c) Take any other action with respect to the child.

4.2.32 In August 2017, the Court directed Children's Social Care complete a Section 37 Order which was to be filed on 25th October 2017. A direction was also made for the safeguarding letter to be shared with the Local Authority. The Local Authority received the request for a Section 37 Order seven working days after the Court hearing. As previously stated, once this request was received, the case was transferred to the relevant case management team for allocation.

4.2.33 The CAFCASS worker who completed the safeguarding checks and produced the safeguarding letter identified that E would be impacted by the allegations and counter allegations that were a feature of his parent's conflict. In terms of context, allegations and counter allegations are not remarkable in the Work to First Hearing stage of CAFCASS work however, the CAFCASS worker was worried that Children's Social Care were not pursuing the concerns. In recommending a Section 37 report, the CAFCASS worker was reassured this paved a way for somebody to see E and assess the risks including E's emotional health which was a particular concern for the CAFCASS worker.

4.2.34 At this time, E's case was closed to Children's Social Care and as stated earlier; the request for a Section 37 report was not received until seven working days later although the concerns will have been identified by CAFCASS a couple of weeks prior to this date i.e. when gathering information to complete the safeguarding letter. The safeguarding letter was not received by Children's Social Care although the Order made stipulated that this should happen. Internal CAFCASS guidance currently sets out that when recommending a Section 37 report, CAFCASS officers should generally agree this course of action with the Local Authority. This did not happen in E's case and the Local Authority were therefore not sighted on the assessment of E's welfare that CAFCASS had completed.

4.2.35 Discussion in the learning event identified an inconsistent approach and delay in CAFCASS informing the Local Authority about any Section 37 reports they may recommend to the Court as well as requests for Section 37 enquiries being sent to Children's Social Care, including safeguarding letters not being shared with the Local Authority. A review of the last 10 requests for a Section 37 report received by Shropshire Council confirms this position, although it is important to state that CAFCASS may not have been involved in all the cases reviewed at the point that the Section 37 report was ordered by the Court.

4.2.36 When a CAFCASS worker recommends a Section 37 report, it is because they have identified a concern about the child's safety and wellbeing and consider that the Local Authority should be asked to consider whether it should be taking further steps to protect the child. In response to the learning from this review, CAFCASS have agreed to review their Work to First Hearing guidance so that it is a requirement for the CAFCASS Officer to notify the Local Authority when recommending a Section 37 report and also for them to consider whether to make a safeguarding referral if there are matters of significant harm that will not be addressed within the timeframe of the Section 37 assessment.

4.2.37 Discussions with CAFCASS indicate that their perspective is that when a discussion with the Local Authority takes place about a case, they consider that they have shared information in relation to concerns about a child and the Local Authority should then determine how to respond to this information. CAFCASS currently have a Child Protection Policy which requires their officers to make a child protection referral if they have concerns that a child

is at risk of significant harm. There is no guidance in the Child Protection Policy for how CAFCASS officers should refer safeguarding concerns below the "significant harm" threshold. It is considered that the absence of a clear pathway for CAFCASS officers to make referrals below the threshold of "significant harm" creates the potential for misunderstanding about the purpose of contact by CAFCASS officers with the Local Authority. Given that safeguarding concerns in respect of children of separated parents can often be seen as a feature of parental conflict, it is particularly important that there is clear and mutually understood process.

4.2.38 To address the potential for miscommunication between the two agencies, CAFCASS Child Protection/Safeguarding Policy should also require their staff to make a safeguarding referral if they have concerns that the child is a "child in need". A "child in need" is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled". This approach would be consistent with statutory guidance and would also mitigate against the potential delay that children, like E, can face in having any safeguarding needs identified by CAFCASS assessed by Children's Social Care.

4.2.39 <u>Priority 5: Whole Family Focus (This finding is relevant to all children and young people and not just those of separated parents)</u>

4.2.40 The lack of focus on the whole family is a reoccurring finding of SCR with Sidebotham et al (2016)[5] finding a lack of 'thinking family' in order to better understand the needs and experiences of children in their analysis of Serious Case Reviews published during 2011-14.

4.2.41 ME accessed a range of services in her own right including in respect of her mental health and emotional wellbeing. Mental health is not, in and of itself, harmful to children; it may, however, present risks in some situations, for example through delusional thoughts or self-harming thoughts or behaviour, or when combined with other parental risks. Parental mental ill health has been recognised as a potential risk factor for child maltreatment and, the presentation of an adult with mental health problems who has contact with, or caring responsibilities for children provides opportunities for further assessment and intervention to mitigate risk. It is therefore, crucially important that professionals, including GP's and mental health workers, consider the risks and implications of any mental health problems for children living in the family.

4.2.42 A couple of days prior to E's death the GP had positively identified ME's emotional presentation as a concern and advised ME to seek support. There were other occasions when professionals did not consider the implications of ME's mental health needs on E including:

i) ME's admission to the crisis unit in September 2016;

ii) No exploration of childcare responsibilities and impact of ME's anxiety and depression on E by Primary Care Well-Being Service in September 2016;
iii) No consideration of the impact of ME's current mental health on E during October 2016 – March 2017 when ME was accessing therapy;
iv) Omission of information about concerns for ME's mental health in the referral made by NSPCC in June 2017

4.2.43 Between September 2016 and March 2017, early help services were involved with ME and E. There is no evidence that the Family Support Worker attempted to or had any contact with FE even though the concerns raised by ME related to E's contact with FE and the time he spent at FE's home. The lack of engagement with fathers has been explored elsewhere in this report; its impact was to minimise professional understanding of E's needs and experiences or in the words of the paternal family "to cut half his family out". In addition, whilst some of the professionals providing early help support to ME were aware of her long-standing emotional wellbeing needs, they did not engage with the relevant professionals to understand her needs and how these were being managed.

4.2.44 A comprehensive family assessment or chronology would have increased professional understanding of the family's history and informed the intervention. The impact of the lack of such an assessment and chronology meant the work offered was largely directed by the word of ME. Developments within Early Help services have been made to promote whole family engagement including the introduction of a whole family consent form which prompts and enables consultation with other agencies and family members. In addition, and as a matter of good practice, it is now a requirement across Local Authority Children's Services (Early Help and Children's Social Care) that interventions are informed by a family chronology to ensure that the whole family story is considered.

Section 5: Summary of review findings

5.1 This section summarises the key findings from the review to inform the recommendations that are made in the next section. In advance of setting out key findings, it is important to stress that the system challenges identified in this or any SCR, can have no responsibility for the perpetrator's motivation or their actions. Responsibility for the death of any individual rests firmly with the perpetrator.

5.1.1 A lack of clarity regarding the safeguarding referral pathway to Children's Social Care has been identified and in particular, professionals understood they were making safeguarding referrals however they were not received as such by the Local Authority. One factor influencing the response by the Local Authority to those 'referrals' will be the previous version of the SSCB thresholds document which stated that for referrals to be passed to ICT, the referrer had to state they wished to make 'a child protection referral'. In addition, and prior to March 2017, referrals were to be made by telephone rather than in writing. Whilst MARFs were introduced in March 2017, these have not yet been embedded across the partnership and there is therefore further work to do in respect of embedding a clear process for making safeguarding referrals as well as increasing understanding of the stages of decision making in the referral pathway. Children's Social Care have also identified a need to review how referrals that are received electronically are linked and added to a child's records.

5.1.2 Many of the referrals made by ME or FE did not evidence the threshold for Children's Social Care intervention had been met. However, on 3 occasions, referrals were made either by FE or professionals that should have resulted in a service being provided by Children's Social Care (April 2014 (FE), Sept 2017 (School) and September 2017 (GP)).

5.1.3 NSPCC made a referral to Shropshire Children's Social Care which was not acted on by the Local Authority. The NSPCC referral did not fully reflect all the information that had been reported to them. Whilst it cannot be known whether a response to this referral by Children's Social Care would have resulted in them taking action, the Independent Reviewer considers this to be unlikely largely because the Local Authority response to the safeguarding concerns raised was to view them as a feature of parental conflict.

5.1.4 The absence of a team manager who had oversight of cases in the relevant Case Management Team, including those requiring allocation, and the demands of the Ofsted inspection, provide some explanation as to why the case was not allocated once the report for a Section 37 report was made. There was a system for a Duty social worker to respond to issues in respect of unallocated cases in the Case Management Team however, this did not result in a response to the two referrals from the school and GP passed to the Case Management Team in September 2017 by FPOC. The review has noted that a finding from an SCR published by SSCB in November 2015 was "agencies are unclear about who to contact when there are urgent concerns on open cases and the allocated social worker is unavailable". That review

identified that there was a potential that this was a relevant issue for all children who are open to Children's Social Care and have a social worker. In this case, whilst E did not yet have a social worker, the issue about urgent concerns being dealt with on open cases is the same as that identified in 2015. SSCB should therefore take action to assure itself of the arrangements to respond to urgent concerns on open cases including how well these arrangements are understood by all agencies.

5.1.5 Family dynamics, and either the intentional or unintentional manipulation of professionals by ME, will have impacted on their response and influenced their perception of the validity of the concerns being raised by FE. In addition, professionals who had contact with both parents have described how they both said unpleasant things about each other resulting in an impression they were deliberately adversarial. This discord will therefore have contributed to the likelihood of professionals forming a view that the allegations stemmed from the parental conflict.

5.1.6 It is not uncommon for the safeguarding system to view safeguarding concerns/reports as a feature of parental conflict, particularly in cases involved in private law proceedings and this practice is not unique to Shropshire. When this happens, safeguarding concerns are inappropriately considered as matters to be resolved by the Court.

5.1.7 The review has found a combination of factors influenced the response to the safeguarding concerns that were raised:

i) Nature of allegations made by FE and ME e.g. historic allegations of bruising that meant there was no current corroborative evidence;
ii) A focus by professionals on identifying physical evidence of neglect or physical abuse at the exclusion of considering of the risk, or indicators, of emotional abuse and sexual abuse.
iii) A scepticism amongst the workforce about FE's motivation for reporting concerns;
iv) The lack of a clear system to respond to urgent concerns on cases open to Children's Social Care.

5.1.8 Professional scepticism about FE's motivation for reporting concerns is likely to have been influenced by the culture of working with fathers that prevails within the multi-agency safeguarding system. Again, this practice is not unique to Shropshire. A pattern of non-engagement with FE across some services or the questioning of his motivation has emerged alongside a practice norm of accepting ME's allegations of domestic abuse whilst not recognising or exploring the risk of domestic abuse for FE. His lack of involvement in the early help intervention prevented a more holistic and comprehensive understanding of the nature of family relationships and dynamics and most importantly their impact on E.

5.1.9 The pathway for notifying the Local Authority for requests for Section 37 enquiries/reports has been considered as part of the review and delays and inconsistency found. When such requests are received from the Court, the Local Authority does not necessarily receive all the relevant information, as

was the case for E, which is likely to impede the response provided by the Local Authority.

5.1.10 CAFCASS have internal guidance that addresses when and how referrals should be made when there are concerns that a child is at risk of significant harm however there is no similar guidance when "child in need" concerns have been identified. The lack of clear pathway for making such concerns creates the potential for miscommunication between CAFCASS and the Local Authority and given that safeguarding concerns in respect of children of separated parents are often seen as feature of parental conflict, it is important that there is a clearly understood process amongst CAFCASS and the Local Authority as to how these concerns are referred.

5.1.11 Like many other SCR's, the review has identified an insufficient whole family focus in many of the interventions that were provided, and, there is learning in respect of how professionals considered the impact of ME's long-standing mood disorder on the care of E. In E's case, Children's Social Care were not aware of ME's mental health needs until after E's death. A further and again common finding, from SCRs is that there was a lack of understanding of E's lived experiences. Whilst E's views were obtained through early help services, there were other important opportunities for these to be better understood by professionals. A family member (other than ME and FE) who it is considered was able to talk objectively to E about his parents shared that he loved ME and FE and wanted to see them both. This view is based on their discussions with E and illustrates that E was able to share his wishes and feelings.

5.1.12 During the course of the review, a number of strengths in the safeguarding arrangements in Shropshire have been identified that will have a positive impact on future similar cases. These include:

- Availability of specialist support for male and female victims of domestic abuse;
- Provision of College of Policing Vulnerability training for all frontline West Mercia Police Officers;
- Introduction of ECINS as a recording system for services provided by Early Help Workers. This system can be accessed by over 800 external users including schools, health, housing and voluntary and charitable organisations including Domestic Abuse Services;
- Training for Social care staff on child sexual abuse;
- Training for Early Help workers in whole family assessment, consent and whole family action plans;
- Pilot of Inspiring Families project to work with families in conflict;

5.1.13 The above strengths are in addition to the learning that agencies have identified within their agency reports which has or is being implemented. The recommendations set out at Section 6 are designed to further enhance the safeguarding response provided by Shropshire services to children of separated parents where contact and residency are decided by the Court.

5.1.14 In concluding, professionals working with children of separated parents, where contact and residency are decided by the Court should be supported to:

- Practice with objectivity;
- Engage with both parents and explore their perspectives;
- Have a healthy level of professional scepticism and be open to considering what a parent is saying might be true (as opposed to viewing allegations of abuse or neglect as a feature of parental separation/conflict);
- Recognise and address the emotional impact of parental separation and private law proceedings on children's emotional well-being;
- Respond to any safeguarding concerns as they would for a child who is not involved in private law proceedings.

These actions will serve to place children of separated parents at the centre of the professional response.

Section 6: Recommendations

a) SSCB to clarify, and subsequently audit the application of the referral pathway and decision-making process for referrals to Early Help and Children's Social Care. This should include the use and quality of written referral forms and feedback to referrers.

b) SSCB to seek regular assurance that:
   i) Professionals understand how to refer urgent concerns in respect of cases open to Children's Social Care;
   ii) Children's Social Care provide a timely and child centred response to this information.

c) SSCB to provide the multi-agency workforce with the knowledge and understanding of
   i) the impact of protracted private law proceedings on children's emotional wellbeing;
   ii) the factors to be considered and assessed in circumstances whereby separated parents make allegations about the welfare of their children
   iii) the features of filicide cases.

d) To test the impact of recommendation (c) SSCB to conduct a multi-agency audit of the services provided to children referred to Children's Social Care whose parents are separated and where private law proceedings have taken place. The audit should consider the completion of whole family assessments and the response to safeguarding concerns and allegations of domestic abuse.

e) SSCB to work with Local Family Justice Board (LFJB) and CAFCASS to review the notification process for Section 37 reports to ensure timely and consistent arrangements.

f) CAFCASS to update their Child Protection Policy to include when and how safeguarding referrals (child in need) should be made.

g) SSCB to engage with multi-agency frontline staff as well as parents/carers to explore their experiences, and any barriers, to working with fathers. The findings of this work should be considered and acted on by SSCB.

h) SSCB to create learning opportunities for the multi-agency workforce to come together and reflect on their approach to providing a whole family focus; including how they consider the impact of parenting capacity on children.

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