

SERIOUS CASE REVIEW

Executive Summary – Highly Confidential

Purpose

This report is a summary of an independent Serious Case Review commissioned by the Royal Borough of Kingston-upon-Thames Area Child Protection Committee following the death of Baby A, a resident of Kingston-upon-Thames.

This independent report was commissioned in line with Chapter 6 of the Government Guidance “Working Together to Safeguard Children” 2005.

Baby A died as a result of a brain injury.

It is believed, from medical and forensic evidence that she died as a result of a non-accidental injury. Two adults are currently in custody pending trial. One is charged with her murder.

This baby and her parents’ relationships are complicated. A time line and genogram are attached at Appendix A to help simplify the story.

1 BACKGROUND

- 1.1 Baby A is the first child of Ms B. Her birth was a normal delivery and she was a healthy baby developing normally.
- 1.2 Ms B is a 20 year old black African woman from Zimbabwe. It is believed that she entered the U.K on 24 December 2000. She applied for permission to remain in the UK to study in 2001. This was refused and Ms B remained illegally. She has no legal status in the U.K. There is little further information known about her background.
- 1.3 Baby A’s father is a 28 year old black African Caribbean man. His relationship with Ms B ended during her pregnancy and Baby A never lived with her father. There is no further relevant information known about Baby A’s father.
- 1.4 While pregnant with Baby A, Ms B began a relationship with Mr C, and began living with him. Mr C is a black African Caribbean man from Dominica in his late thirties. He has given different dates of birth to different agencies. It is believed he has leave to remain indefinitely in the U.K.
- 1.5 Mr C was previously known to the Police, Social Services and Health Services in respect of domestic violence to his previous partners, and in relation to child protection issues regarding his son.

- 1.6 Mr C was married at one time and this relationship ended as a result of his violence. There were four occasions when police were called to domestic violence incidents.
- 1.7 Mr C then began a relationship with Ms D in 2001 and their son E was born in 2002. The couple allegedly separated in 2003. This relationship was also violent. The violence continued after the couple separated and the police were involved in ten incidents of violence between September 2001 and May 2005.
- 1.8 Ms D was also a black African woman seeking asylum in this country. There is confusion regarding her date of birth as she gave different dates of birth to different agencies.
- 1.9 There were also significant child protection concerns in relation to E, not only in respect of domestic violence perpetrated against Ms D but also with regard to three incidents reported by Ms D where E allegedly suffered injuries whilst in the care of Mr C. The first incident had no date specified but alleged that E had a bruise on his face and Mr C had said that E had fallen off a sofa. The second incident was dated 14.11.02 and alleged that E had unexplained scratches to his cheeks. The third incident was dated 30.11.02 where E was found on the bed with blood in his mouth and on him. E was subsequently seen by a GP who confirmed that there was a split in the fraenum of his upper lip. Mr C, when questioned, reported to the police that he had fallen on E.
- 1.10 As a result of these allegations and the medical opinion that E's torn fraenum was a non-accidental injury, Children's Services social workers obtained a written agreement from Ms D and Mr C stating that Mr C should have no contact with E.
- 1.11 A Child Protection Conference was convened and E's name was placed on the child protection register and Children's Services' social workers worked with the family. Ms D allegedly stayed living separate from Mr C. After 8 months E's name was removed from the register because all agencies involved believed that there was:
- Continued positive progress
 - No further unexplained injuries to E
 - Good relationship between E and his mother Ms D
 - Mr C was having weekly supervised contact

Social work support continued for a further 14 months when the case was closed.

- 1.12 During this period Ms D had contact with RBK Housing Services regarding her housing situation. There was correspondence between RBK Children's Services and RBK Housing Services which included references to a violent ex-partner and previous child protection concerns but Mr C's details were not given to the Housing Services. Neither were housing staff invited to or attended any child protection conferences regarding E.
- 1.13 At same time after Mr C stopped living with Ms D he established a relationship with Ms B, baby A's mother. He was present at baby A's birth and was considered by hospital staff to be Ms B's partner. No problems were identified and baby A was discharged home.

- 1.14 Ms B and baby A were visited regularly at home by health professionals. Mr C was present on some of these visits. Appropriate advice and support was given and there were no apparent reasons for concern regarding baby A's development, physical care or concerns regarding the relationship between Ms B and Mr C.
- 1.15 Health professionals had no reason to connect Ms B's partner with the allegedly violent partner of Ms D who had given rise to child protection concerns.
- 1.16 On 31st January 2005, Ms. B as a single applicant made a homelessness application to RBK Housing Services which was refused on the same day, as she was ineligible. From 31st January 2005, to 29th April 2005, RBK Housing Services was dealing with a separate approach from Mr. C with Ms. B as a couple. Although they gave incomplete information RBK Housing Services knew from this second approach that Mr. C was part of the household with baby A. RBK Housing staff were not aware of the child protection history held by their colleagues in Children's Services regarding Mr C.

During this time, on three occasions Ms B made contact with RBK Children's Services.

There was a statutory notification from RBK Housing Services to Children's Services requesting an assessment in the light of Ms B's housing situation and ineligibility.

Ms B made contact by telephone in relation to her accommodation needs and requesting financial assistance.

Advice was given. It was assumed by Children's Services that Ms. B was not homeless as her mother lives nearby. No further action was taken.

At no point were Children's Services aware that Mr C was Ms B's partner.

- 1.17 On 9.5.05 Mr C presented himself at Kingston police station stating he had tried to kill his ex-partner Ms D. During this attack Mr. C had sustained injuries. Mr C was arrested for attempted murder and taken to hospital to attend to his injuries. En-route to the hospital Mr C stated that he had left a baby alone at a flat; he gave police the details of where the mother, Ms B, worked. Police contacted Ms B and accompanied her to her home where baby A was found in her cot. Baby A was not breathing and had no pulse.
- 1.18 Baby A was taken to Kingston Hospital where sadly attempts to resuscitate her were unsuccessful. She was pronounced dead at 17.20 on 9.5.05. The post mortem revealed that baby A had died due to a recent head injury; it also revealed old injuries to the arm and brain. It is believed that baby A's death was as a result of non-accidental injury.
- 1.19 Mr C has been arrested and charged with: Murder of baby A; Causing or allowing the death of baby A; Cruelty to baby A; Assault occasioning actual bodily harm to E. Ms B has been arrested and charged with: Causing or allowing the death of baby A; Cruelty to baby A; Interfering with witnesses. Both are remanded in custody and a trial date has been set for March 2006.

2 ANALYSIS AND LEARNING POINTS

- 2.1 The review does not identify any major failings on the part of staff in complying with current policy and practice that would have altered the outcome of the case.
- 2.2 However it does raise issues and identify areas where practice needs to be improved.
- 2.3 One of the major areas of concern highlighted by the review is that of information sharing between agencies within the Royal Borough of Kingston-upon-Thames (RBK).

A significant amount was known to a number of agencies in respect of Mr Cs' history of domestic violence and child protection concerns. This was in respect of past relationships (Police) and most notably with regard to Ms D and their son E (SSD, Police, Health Visitor, GP) and the potential risk he posed. However, this information was not accessed in relation to the contact that agencies had regarding Ms B, Mr C and baby A.

- 2.4 The second major area of concern raised by the report is the poor quality of recording by some Children's Services staff during 2002 and their early involvement with Ms D and her son.

Children's Services records during this period lack detail and clarity as to what actions were or were not taken and the reasons behind these decisions.

- 2.5 A further area requiring attention regarding Children's Services is the issue of clarity regarding the level of concern or risk which triggers social work involvement.
- 2.6 Domestic violence was a significant feature throughout this case. This highlights the importance of all agencies, when working with vulnerable women, pro-actively asking questions about partners details and about the risk of domestic violence.
- 2.7 The significance of domestic violence and its connection to child abuse is now well documented in research. The local agencies did not have a system in place which would have highlighted the significant history of domestic violence surrounding Mr. C and his relationships with vulnerable women. Had a system which collated information on the perpetrators of domestic violence been in place, this could have influenced child protection planning.

3 RECOMMENDATIONS

- 3.1 When a serious case review is commissioned, all agencies also provide their own management reports with recommended actions. This independent review agreed all the recommendations already made and made three additional ones. The recommendations are listed, separated into different agencies.
- 3.2 The internal management reviews undertaken by the individual agencies have identified recommendations that this Review would fully support and considers appropriate in responding to the learning points identified in Section Two.

3.3 Children's Services RBK

Children's Services RBK in its review identified the following points in relation to the involvement with Ms. D and E:

- 3.3.1 The Context within which staff were working from 2002-2004 was one of staff shortages, temporary agency staff and temporary managers. This situation was prevalent across London at that time.
- 3.3.2 In April 2004, the council introduced a comprehensive recruitment strategy to address the issue and significantly reduce the number of agency staff.
- 3.3.3 It was also recognised that a succession of agency temporary managers within the Initial Response Team did not provide the desired level of support and challenge required for child protection work.
- 3.3.4 As a result the division restructured in 2005 to create one bigger and more robust Safeguarding Service from two previous social work teams – the Initial Response Team and the Family Support Team.
- 3.3.5 The current structure has one very experienced team manager and there are currently only three agency staff and no vacancies. Recent recruitment means that all three temporary staff will be replaced by permanent staff by February 2006.
- 3.3.6 This structure, with experienced management and few temporary staff, will strengthen supervision arrangements.
- 3.3.7 Since December 2003 Children's Services have extended their child protection monitoring arrangements to ensure that all strategy meetings are fully recorded and logged. A signed copy of every police consultation form, strategy discussion record and core group minutes is reviewed by the child protection service manager and any concerns or omissions immediately followed up.
- 3.3.8 This Review notes the action already taken by Children's Services.
- 3.3.9 The RBK Children's Services Management Review in relation to the lessons learned from the work with Ms D and E made the following recommendations:
- I. Training in child protection and assessment will highlight the vulnerability of families with no legal status in this country. Existing staff will be made aware as a result of this review.
 - II. The case file audit process will be reviewed to ensure complete and accurate recording of all casework activity.
 - III. The Domestic Violence Policy for the council as a whole will be reviewed in the light of the new legislation – Adoption and Children Act 2002.
 - IV. The need for social workers to obtain objective evidence of what parents tell them in the context of child protection work will be emphasised throughout the department. This will be incorporated into all training on assessment and raised

as a supervision issue for all managers. Child Protection Conference chairs will be alerted to this issue.

V. The implementation of an electronic Information Sharing and Assessment (ISA) system will ensure that “dangerous adults” are identified, and identified as a risk if they appear in subsequent families

VI. A synopsis of this case along with lessons learnt and the recommendations and action plan will be made available to all social care staff within the directorate and to key colleagues across the council.

3.3.10 This Review supports the recommendations and has no further recommendations to make.

3.3.11 RBK Children’s Services’ Management Review identified the following points in relation to the involvement with Ms B and Baby A:

3.3.12 During this period the functions of the Initial Contact Centre (ICC) were evolving and changing to take account of the Information Sharing and Assessment requirements. The co-ordinators were managing “first contacts” to the social work service while at the same time developing an information sharing and assessment system for vulnerable children. In these circumstances the co-ordinators were required to make a judgement between those cases that required a statutory social work service and those that could be supported in some other way or by some other agency.

3.3.13 As part of the Council’s implementation of Information Sharing and Assessment (ISA) requirements it has entered a development partnership with Liquid Logic (IT Solutions Company) to develop an electronic system that will:

- a) Ensure systematic information gathering, checking and cross referencing at the first point of contact
- b) Flag individual who are known to pose a risk to children or young people
- c) Link to the council’s and other partners’ databases and client record systems to facilitate improved identification and referral of children who may be vulnerable

3.3.14 Pending the introduction of this system arrangements have been put in place to ensure that housing colleagues check all new entrants (in the categories a - c below) to their system against the local authority’s existing Children’s Services’ database. Two dedicated ICC co-ordinators have been identified to research any families where a previous or known concern has been identified.

- a) Ineligible households *
- b) Victims of domestic violence
- c) Intentionally homeless households *

3.3.15 Interim arrangements are now in place to ensure that all those households referred under Section 213A of Homelessness Act 2002 are considered by the social work team for an Initial Assessment.

3.3.16 This Review notes the action already taken by Children’s Services.

3.3.17 The RBK Children’s Services Management Review in relation to the lessons learned from the work with Ms B and Baby A made the following recommendations:

- I. Liquid Logic ISA system will be implemented by April 2006. Interim arrangements for sharing information between Children’s Services and Housing are in place from January 2006.
- II. Further training in child protection and assessment for the ICC co-ordinators will highlight the vulnerability of families with no legal status in this country.
- III. ASKK (Kingston’s Information Sharing System) Training will be provided for all Housing Officers
- IV. The protocol with the Housing Services in respect of the section 213A referrals Social Services under the Homelessness Act 2002 will be revised, specifying the

assessment arrangements and assistance to be provided by Social Services under the relevant legislation (e.g. Children Act 1989, National Assistance Act, Community Care legislation etc.)

3.3.18 This Review supports the recommendations and has no further recommendations to make.

3.4 **Housing Services RBK**

Housing Services RBK in its Review identified the following recommendations:

3.4.1 A joint protocol plus training be developed in respect of the section 213A referrals Housing is required to make to Social Services under the Homelessness Act 2002 specifying the assessment arrangements and assistance to be provided by Social Services under the relevant legislation (e.g. Children Act 1989, National Assistance Act, Community Care legislation etc.)

3.4.2 A protocol plus training be developed for Housing Staff to email Social Services the household details of all families presenting to Housing for the first time including, where possible, the names of estranged father/s of children in the household and any former partners. Given the scale of this task with approximately 1,000 new approaches to Housing from families each year, priority to be given initially to:

- a) Ineligible households *
- b) Victims of domestic violence
- c) Intentionally homeless households *
- d) Other cases where there are particular concerns or extra vulnerability factors.

* These cases are also subject to Section 213A referrals

The protocol would need to specify the timescales within which Social Services will respond, with specified same day response times for emergencies. The protocol would need to be reviewed in light of the introduction of the ASKK information sharing system.

3.4.3 An audit of the household details of all families accommodated by the Housing Service will be conducted jointly by Housing and Children's Services to identify any known individuals. Given the scale of this task with approximately 5,000 families accommodated, the following priority order for implementation should be followed:

- I. Families in temporary accommodation
- II. Families in secure Council tenancies
- III. Families nominated by the Council to Housing Association tenancies
- IV. Families in Council leasehold properties
- V. Families nominated by the Council to shared ownership Homebuy properties.

3.4.4 To assist this process a list of known individuals posing a risk to children be disseminated to housing staff dealing with families, together with guidance on the arrangements for referrals to Social Services in the event of a known individual presenting to Housing. Initially this may need to be an updated hard copy list, but in due course an electronic list or checking system could be introduced.

3.4.5 This Review supports the recommendations and has no further recommendations to make.

3.5 **Metropolitan Police**

The Police in its Review identified two recommendations:

- 3.5.1 The Borough Commander should explore innovative ways to increase the funding of the Domestic Violence Crisis Intervention Worker and thus extend the working hours.
- 3.5.2 The Child Abuse Investigation Team must put in place a system to ensure doctors' and specialists' reports are registered and brought to the attention of the officer in the case.
- 3.5.3 The Police Review also made a comment in respect of the failure to act pro-actively in trying to locate and arrest Mr C on the night of 8.5.05 and the failure to notify the Community Safety Unit. The Review states: "There has been personal learning for the officer that dealt with this incident. I have also spoken with the Superintendent who will ensure that the above learning is disseminated to all the operational teams at Kingston. Under these circumstances I make no further recommendation."
- 3.5.4 With respect to issues relating to recording practices the Review considers that there are still ongoing initiatives within the Metropolitan Police that should address these and therefore there is no need for a further recommendation.
- 3.5.5 This Review supports the recommendations and would also propose that police investigate all incidents of NAI to children, in line with police policy, and that a parent's reluctance to press charges should never be a reason not to pursue an investigation. Clear and compelling reasons should be recorded where this does not take place. These should be noted at Strategy meetings and Child Protection conferences.

3.6 **Kingston Hospital NHS Trust**

Kingston Hospital NHS Trust in its Review identified three recommendations:

- 3.6.1 The policies relating to the history taking of women presenting for maternity care should be reviewed in light of the fact that neither of the women involved in this case were proactively asked about the risk of domestic violence. Every reasonable effort should be made to elicit this information from all women and if this is not possible a record must be made of this fact. Those women identified as being at risk should be discussed at the monthly meeting already held with Midwives and other agencies.
- 3.6.2 The education programme on Domestic Violence (DV) should be reviewed and developed for all midwifery and Accident and Emergency (A&E) staff. This should include a link to Child Protection issues so that staff are able to develop an awareness of the potential risk to children where there is a history of DV in the family.
- 3.6.3 A review of DV policy in A&E should take place to ensure appropriate action is taken to refer to Children's Services and advice given to victims. Victims of DV should be proactively asked whether they have children and this should be flagged up with the Named Child Protection Nurse.
- 3.6.4 This Review supports the recommendations and has no further recommendations to make.

3.7 **Kingston Primary Care Trust**

The Kingston Primary Care Trust (KPCT) in its Review of the Health Visiting Services makes the following two recommendations in respect of the involvement with Ms B and Baby A:

- 3.7.1 It is acknowledged that information regarding the fathers of babies/children may not always be recorded as fully as that of the mother. Therefore a recommendation to highlight in the KPCT Record Keeping Policy/Training to include the importance of the fathers or partners' information being recorded with as much detail as possible.
 - 3.7.2 KPCT will continue to work in partnership with ASKK and the information sharing agreement.
 - 3.7.3 This Review supports the recommendations and would also propose in respect to the involvement with Ms D and E that all health visitors and GPs are aware of the need to inform Children's Services immediately when any Child Protection concerns are raised and to ensure that records reflect the action taken. Where there is a delay in passing on information the reasons for this should be clearly recorded.
 - 3.7.4 The final recommendation is in relation to the Kingston Primary Care Trust:
 - 3.7.5 A reminder to all GPs of their duties in respect of Child Protection issues and the completion of reports under Chapter 6 of the revised) Government Guidance: "Working Together to Safeguard Children".
- 3.8 This Review considers that the above recommendations cover the issues raised re: developing practice; compliance with existing policies and procedures; staff training and education; and the deficits in the electronic system for identifying adults who pose a risk to children

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Local Children's Safeguarding Board

May 2006

Appendix A

Time Line	
Baby E born, child of Mr C and Ms D	31.07.02
1 st complaint of domestic violence from Ms D accusing Mr C	September 2002
Ongoing domestic violence	
1 st report of three injuries to E allegedly caused by Mr C	December 2002
Mr C charged and bailed to live separately from Ms D	January-June 2003
Couple separated. Child Protection Conference. E's name on child protection register	
Domestic violence incidents continue between Mr C and Ms D although couple have separated	June 2003 – February 2005
Social work support continues, Mr C had supervised contact with E	
Social work case closed	February 2005
Ms B met Mr C. Ms B was already pregnant with another man's child	
Mr C and Ms B living together	December 2004
Baby A born	23.12.2004
No child welfare concerns	January – May 2005
Couple contact agencies regards housing issues.	January – May 2005
Baby A dies	09.05.2005