Child Safeguarding Practice Review Overview Report in respect of

‘Stephen’

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Acknowledgements

As lead reviewer and author of this report, I would like to acknowledge the help and support of the Child Safeguarding Practice Review panel, the independent scrutineer, the Chair of the Child Safeguarding Practice Review sub-group, and staff from the Independent Safeguarding Partnership Service. I am indebted to those who completed a chronology of their agency's involvement with Stephen and his family members, and those who contributed to this report through the virtual practitioner conversations. The challenges of delivering services during the Covid-19 pandemic, alongside contributing to a review of this nature, are acknowledged. I would also like to thank Stephen's father, and the father of Stephen's half-siblings, who shared valuable insights regarding the importance of practitioner understanding of the role of men in the family and household, and in ensuring fathers' involvement in the lives of their children.

Governance

I declare that I have found no conflict of interest in completing this review, and that I am independent to Cambridgeshire and Peterborough Safeguarding Adults and Children Partnership Board and partner agencies. The report has been commissioned by, and written for the Board, and overseen by a multi-agency child safeguarding practice review panel of local senior managers and practitioners from the following agencies:

- Cambridgeshire Constabulary
- Cambridgeshire Children's Social Care
- Cambridgeshire and Peterborough Clinical Commissioning Group
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust
- North West Anglia NHS Foundation Trust
- Cambridgeshire and Peterborough Independent Domestic Violence Advisory Service
- Cambridgeshire Education Directorate

Additional support has been provided by the Lead of the Integrated Front Door and Assessment Service (Children's Social Care), the National Probation Service and the CRC Deputy Director and Head of Cambridgeshire Local Delivery Unit (BeNCH).

In preparing this report for publication, the details of the child and their family, as well as the individuals providing care to them, have been anonymised in accordance with statutory guidance and best practice.

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17th March 2022

Executive Summary

A local child safeguarding practice review (CSPR) was commissioned following the death of a 12-week-old male infant, Stephen, who had suffered serious abusive head trauma. Post-mortem, evidence was found of historical injuries, including fractures, reflecting physical abuse over time. Mother's partner (who was not Stephen's biological father) has been found guilty of his murder and of causing the earlier injuries. An important finding of the review is a recognised change in family dynamics when this individual, a known perpetrator of domestic violence, joined the household. Stephen had older half-siblings. At the time of his death, children's social care services were completing a child and family assessment. This followed police call outs and referrals from neighbours and others concerned about the welfare of the children and their mother.

The sequence of events leading up to Stephen's death are complex, and a range of agencies were involved, or had information about mother's partner, not all of which was shared in a timely way. Some inaccuracies in recording were made that had an impact on the perceived level of risk within the family. In addition to the involvement of police and children's social care, services were also provided by primary care (GP), maternity, health visiting, education (including pre-school), housing, probation, and MIND mental health support. Professional dialogue between involved practitioners and agencies was found to be somewhat limited. Such communication may be critical in adding context, clarity and expertise to data provided through a trawl of records.

The review was overseen by a multi-agency CSPR panel. Panel meetings and consultation with practitioners and managers was managed via virtual means due to Covid-19 restrictions. The progress and improvements in child safeguarding practice that were shared is testament to reflection and learning that has already taken place locally. This review highlights, and builds on, these developments.

Four 'practice episodes' are identified. These expose cross-cutting themes that contribute to the learning and recommendations and reiterate the enduring message from other reviews for the need for authoritative child-centred practice. The first practice episode reflects the importance of establishing and recording paternity, and of 'professional curiosity' and enquiry regarding the background, role and status of men in the household; the second relates to the checks and balances in managing the multi-agency response to domestic abuse and the need for agencies to share information regarding concerns about children in the household in a timely way; the third highlights systemic issues in recording infant weight and in recognising signs of Stephens 'faltering growth'; the fourth practice episode recognises a pattern of 'parental resistance' to engagement with practitioners, with a concomitant need for authoritative practice.

As reflected in the literature, the review acknowledges the 'unpredictability' of death and serious harm in child safeguarding practice. It also notes the risks to children who may be 'on the boundary' of the child protection system. In this case, the risk to Stephen and his half-siblings was recognised, but the risk was balanced by protective factors and an approach that sought to work collaboratively with the family. The review finds that the initial responses to concerns of domestic abuse and the welfare of the children (i.e., the offer of early help) were not sufficiently robust. This is because the known risks at this time included

mother's pregnancy, the involvement of family and neighbours in raising concerns, the young age of the siblings, and the, then, new partner's history and criminal convictions as a perpetrator of serious domestic abuse. The multi-agency safeguarding hub (MASH) partners' response also lacked robustness in interrogation of the partner's background, and in the provision of an indicative response in the application of the Domestic Violence Risk Identification Matrix (DV-RIM) framework.

The offer of early help was not taken up by the family. Had a statutory child and family assessment been commenced at an earlier stage, this would have enhanced multi-agency working, provided key insight into the daily lived experiences of the children, and a clearer view of whether Stephen and his siblings were 'children in need' or 'children in need of protection.' Critically, there would have also been a timely opportunity to support the family in addressing the known risk from the partner, including the application of the domestic violence disclosure scheme.

Recommendation One: *The Board seeks assurance as to the way in which agencies record and update the details of family/household members. This may include completion of a genogram (or equivalent record of family make-up) and recording of current address/addresses. The recommendation applies to those providing services to children and to adults who are parents/carers. Such services should be required to demonstrate compliance with their wider responsibilities in child safeguarding. Consideration should also be given as to whether a change in intimate partner during pregnancy be added as a risk factor to section two of the pre-birth protocol in its next revision.*

Recommendation Two: *The Board requires the National Probation Service to ensure that services commissioned to support offenders' rehabilitation activity requirements (RAR) are provided with relevant information about the nature of the offending, risk management, and the expected outcome of their involvement. Information sharing includes the evaluation of progress in achieving the goals of the RAR.*

Recommendation Three: *The Board seeks assurance that concerns, and referrals, are not processed based on a hierarchy of referrer (giving less weight to concerns from neighbours or family members). The response should be proportionate to the reported lived experiences of children and others potentially at risk within the household.*

Recommendation Four: *The Board requires Cambridgeshire Constabulary to provide assurance that stated improvements to internal system checks ensure correct allocation, grading and sharing of DASH/F101 notifications with other agencies are in place, with evidence of impact. Partnership agencies should also seek to progress and support improvements in the management of domestic abuse notifications to ensure the identification and prioritisation of high-risk cases.*

Recommendation Five*: The Board requires Children's Social Care to provide assurance that children are both seen, and spoken to, within the expected protocol and timescales of a child and family assessment. Those with parental responsibility who are not resident in the family home should be made aware of agency involvement and enabled to contribute to the assessment.*

Recommendation Six: *The Board requires health partners to report on progress in the embedding of improvements in growth monitoring of infants, with evidence of impact through quality assurance of practice.*

Recommendation Seven: *The Board undertakes quality assurance activity to assure members that the work it has undertaken to enhance practitioners' understanding of authoritative practice has been embedded and resulted in a positive impact on practice.*

Contents

1.0 Introduction and background

1.1 This report sets out the findings of an independently led local child safeguarding practice review (CSPR) commissioned by the Cambridgeshire and Peterborough Safeguarding Adults and Children Partnership Board ('the Board'). The review concerns Stephen, a White British baby boy, who died in hospital at the age of twelve weeks, having sustained serious abusive head trauma.

1.2 Clinical investigations and post-mortem examination revealed the presence of multiple rib and other fractures, some of which were in the stages of healing. This reflected physical abuse over time. Stephen's mother's male partner (who was not Stephen's biological father) has been found guilty of his murder, and of causing the earlier injuries to him. The purpose of this review is to learn from the case and to identify improvements that may be made in provisions for safeguarding and promoting the welfare of children.

1.3 Stephen was the baby brother to half-siblings, who attended pre-school/primary school. At the time of his emergency admission to hospital, children's social care services were completing a child and family assessment[1]. The decision to undertake the assessment followed police call outs and referrals from neighbours and others concerned about mother and her partner's 'constant arguing and screaming' and the 'children crying'. The concerns, which arose over a period of several months, dated from the time that mother's partner became part of the family and 'things changed' for the children in the household.

1.4 Mother's partner had a significant history of a pattern of abusive behaviour towards intimate partners and ex-partners and criminal convictions resulting from his controlling, coercive and violent behaviour. His victims appear to have been vulnerable women, with children (including unborn children) who were also placed at risk. The children of one previous partner had been subject to child protection planning because of his presence in the family. An assessment by a responsible officer was that this man posed a medium risk to known women and children.

1.5 Stephen's mother seemingly began the relationship with the partner when she was already pregnant with Stephen. At that time, he was completing a period of probation and was receiving services from a community rehabilitation company [BeNCH]. As part of his rehabilitation activity requirements, he was directed to attend a local MIND wellbeing service for one-to-one mental health support and access to an emotional control [anger management] programme. From the outset of the relationship, this individual portrayed himself to professionals and others as being 'dad' to Stephen. Mother concurred with this.

1.6 When mother's partner joined the household, he was being treated by the GP for depression and anxiety. He had been assessed as not being fit for work because of these conditions. This meant not being able to undertake unpaid work in the context of his community sentence. Substance misuse was disclosed to the GP at his appointments. Despite assertions to others, including his responsible officer and MIND worker, that he was 'bi-polar', clinical colleagues contributing to the review found no evidence in the medical records of a formal diagnosis or treatment for this psychiatric disorder. He had, however,

[1] S.17, Children Act 1989 (A Child and Family Assessment is also known as a Single Assessment.)

been diagnosed with attention deficit hyperactive disorder (ADHD), for which he received medication.

1.7 When the statutory assessment process began, a police disclosure relating to the partner's criminal history was shared with children's social care. Links were also made with other social care records concerning his history of domestic abuse. The risks that this partner presented had been previously shared with agencies at five multi-agency risk assessment conferences (MARAC). In short, the arrival of this partner, and his status and presence in the household, changed the dynamics, put the children and their mother at risk of significant harm, and ended with the tragic death of Stephen.

1.8 The broader family context indicates adversities in the lives of the mother and her partner, including during their own childhoods. In addition to evolving concerns about domestic abuse, other known 'risk factors' for child maltreatment were somewhat evident in the family. These include mental health, substance misuse and financial difficulties. Despite these factors, positive parental care of Stephen was observed and recorded by universal services. Crucially, there had been no historical safeguarding issues identified in the care of the older siblings; mother was seen to be a good parent.

1.9 The time-period for the review is from mother's booking for maternity services for her pregnancy with Stephen, until his emergency admission to hospital. The reviewer requested detailed chronologies of practitioner involvement with the family during that time and, where relevant, agencies also provided additional background information. This information was considered alongside the 'agency returns' that contributed to the earlier rapid review undertaken in line with national guidance (HM Government, 2018a).

1.10 Whilst consideration of the practice of lead statutory agencies is critical to the CSPR, it is important to note at the outset that Stephen's untimely death occurred in the context of service provision from other agencies with a role in safeguarding and promoting the welfare of children i.e., primary care (GP services), maternity services, health visiting services, education (including pre-school), housing services, the community rehabilitation company and MIND.

1.11 The complexity of the child protection system and the circumstances in which practitioners work together is recognised in statutory guidance. This local child safeguarding practice review takes a systemic approach to learn from Stephen's case and to identify improvements that can be made in policy, provision, and practice to help to prevent similar incidents in the future. The improvements and recommendations may be of wider national interest. The terms of reference for the review can be found in Appendix One.

1.12 Consultation with front line practitioners is long since recognised to be an essential requirement of systems methodology (Association of Chief Police Officers and Crown Prosecution Service, 2014). Panel were advised that any such consultation wait until the criminal trial had been completed, as several involved practitioners were to be called as witness. This contributed to an unavoidable delay in completion of the review.

1.13 The Covid-19 pandemic precluded face-to-face practitioner events strongly favoured in undertaking a review of this nature. Following consultation with other independent

reviewers, and directions from the local CSPR panel, a series of eight virtual[2] 'practitioner conversations', lasting 90 minutes and supported by panel members, were held. A total of 24 participants from key involved agencies took part. The aim was to enable free-flowing conversation, with guided discussion points circulated in advance. A copy of these can be found in Appendix Two.

1.14 The progress and improvements in local child safeguarding practice that were shared in the meetings is testament to the reflection and learning that has already taken place locally. This review highlights, and builds on, these developments. As such, practitioners, and their managers, are co-creators of the learning and will be key facilitators of the continuing improvement journey.

1.15 Stephen's mother was made aware of the commissioning of the CSPR and had expressed a desire to contribute. Various favourable text-based messages were shared with the author, but ultimately telephone calls went unanswered. A key worker has been identified to provide mother with feedback on the progress and findings of the review. However, the fact that her views could not be ascertained, nor a face-to-face meeting arranged (due to the pandemic), are regrettable and an important omission in the report.

1.16 Contact was made with Stephen's father and with the father to his half-siblings. Both men shared valuable insights regarding the importance of practitioner understanding of the role of men in the family and household, and in ensuring fathers' involvement in the lives of their children. It is Stephen's father's wish that the learning from this review will help to prevent further infant deaths in the future.

2.0 Narrative Chronology: Stephen's story

2.1 Baby Stephen was born at term, by normal delivery, following what appears to have been a straightforward pregnancy. His birth weight was just below average for a term male infant. Mother's partner and maternal grandmother were present for the birth. Despite not being his biological father, Stephen was given the partner's surname. His death, at the age of twelve weeks, occurred in the context of the known risk (as above) that this partner presented to the family.

2.2 When mother booked for her maternity care at 12 weeks of pregnancy, she initially provided the name of a different male partner as the father. This was subsequently changed on the hand-held maternity notes to reflect her new relationship. This change is believed to have been made around the 28th week of pregnancy. It was normal practice, at that time, for expectant mothers to complete biographical information on these records. Paternity has since been established through genetic testing.

2.3 In the 25th week of pregnancy, mother's partner, who was subject to a probation order, reported to his responsible officer (community rehabilitation company) that he was in a new relationship (with Stephen's mother). A note was made on his records of the need to find out more about this relationship when the officer next saw him. A week later, despite

[2] Via MS Teams

the pregnancy, the presence of mother's other young children in the household, and a record that he had recently shared news of 'his baby' (and subsequently the due date) with a MIND worker, the responsible officer was told by mother's partner that there were no children involved.

2.4 Approximately six weeks prior to Stephen's birth, police were called by a neighbour, who reported hearing mother and her children screaming. Mother's partner initially resisted engaging with police, reporting that he had 'a problem with the authorities'. Mother was noted as being pregnant. Police officers entered the premises and found the children were refusing to go to bed, and that a new puppy in the household had heightened tensions. Mother described the incident as being a verbal argument and that the couple 'had been arguing a lot lately'.

2.5 A DASH assessment[3] was completed and attending officers, who had checked police systems for the partner's previous history, identified the risk as medium. A police domestic violence notification (known locally as the F101) was sent to the children's school, children's social care and health partners (GP, maternity, and health visiting services). Consent was sought from mother for her information to be shared.

2.6 The neighbour was spoken to by police officers. They reported that the noise and arguments had escalated since mother's partner had moved in, and that the household was 'much different to the atmosphere that they had been used to'.

2.7 School were aware that mother's partner had previously been a perpetrator of serious domestic violence, as he had had an earlier relationship with another parent of children at the school. Those children had been subject to child protection planning because of his abusive behaviours. The designated safeguarding lead (DSL) asked staff to be vigilant in monitoring Stephen's half-siblings. They also spoke to mother about the concerns who said that the neighbours were 'being malicious'.

2.8 Four days after the initial call out, police were called to the home of a member of mother's extended family and their partner, who reported that mother and her partner had made threats against them and caused criminal damage to their property. They also expressed concerns about mother's children. Police declared a public order offence, but this was deemed as not being in the public interest to pursue. Practitioners have described a dysfunctional relationship between mother and this family member.

2.9 The next day, children's social care, who had contact with the extended family member due to the service's involvement with their own children, noted the relative's reported concerns as follows; that mother's partner was slapping the children, that he was threatening to kill [the family member] and was a perpetrator of domestic abuse in his current, as well as previous relationships.

2.10 A multi-agency safeguarding hub (MASH) enquiry followed. This found that mother had told school she was happy with her partner and the children were 'fine', although the eldest had told a teacher that he 'didn't like it' when mother's partner shouted. A DV-RIM[4]

[3] Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment Tool
[4] Barnardo's Domestic Violence Risk Identification Matrix

was completed to assess the risk to the children and this was judged to be at scale one (moderate level of risk to children).

2.11 The outcome from the MASH enquiry was to recommend 'early help' support. A worker tried, but failed, to contact the family to offer this service. As a result of no contact, the case was closed as 'no further action' (NFA). Later that week, the police DASH assessment completed following the call out noted above (2.4) reached other agencies, including children's social care. The 'medium risk' identified by the DASH did not change the outcome of NFA.

2.12 The health visitor undertook an antenatal visit at home as per the *Healthy Child Programme.* At this point she had received the police notification, but not the completed DASH form. The health visitor got in touch with MASH who mentioned two referrals had been made but did not disclose the details. The health visitor had a conversation with mother about the anonymous referral to children's social care, obtained her consent to share information, and followed up the visit with a call-back to the MASH team.

2.13 Mother, who was nearly 36 weeks pregnant at this point had attended an antenatal appointment with the midwife earlier that day. The midwife discussed the concerns with mother who said this was a 'malicious' report, probably from [relative] as they were 'always falling out'.

2.14 Shortly afterwards there was a further (second) call out by the police service in response to a neighbour's concern about fighting between mother and her partner, and the wellbeing of the children in the household. Mother was reported to be accusing her partner of having an affair due to her pregnancy. As part of their domestic violence action plan, police added a marker to the address to identify a medium risk of domestic abuse to mother and children. Just over three weeks later, Stephen was born.

2.15 When Stephen was a week old, a neighbour made an anonymous referral (via housing) to children's social care. The neighbour was concerned about the children being physically abused, neglected, and left unsupervised. They also reported shouting and aggression from mother's partner towards the children. MASH report that their attempts to contact mother by phone and email failed. As the concerns were noted to be 'similar to' those received previously, a letter was sent offering support through the early help process, with NFA by children's social care.

2.16 Prior to undertaking the 'new birth visit', when Stephen was 13 days of age, the health visitor contacted children's social care for an update. She was informed that they had made numerous attempts to contact mother, that she was not responding to their calls, and they were wanting to put a family support worker in place. As they had been unable to make contact, they had not been able to gain permission to share information. The health visitor was advised to make another referral if there were concerns at the new birth visit.

2.17 The health visitor was also contacted by the midwife, who expressed concerns about Stephen's half-siblings being left with the extended family member and partner mentioned above (see 2.7). This is because this couple were deemed to be unsuitable carers, due to child safeguarding issues that had led to the removal of their own children.

2.18 The health visitor undertook the new birth visit in line with the expectations of the *Healthy Child Programme.* The midwife had earlier recorded a small weight gain. This placed Stephen on the 25th centile (his birth weight was between the 25th and 50th centile).

2.19 Stephen's maternal grandmother was also present for this visit. Mother reported that 'father' and the other children were with the relative and partner, as above. The health visitor challenged this because of the carers' own history. Grandmother was reported to have been angry with the health visitor for raising this challenge, but subsequently joined mother in acknowledging the concerns.

2.20 The health visitor reminded mother about multi-agency working and professional communication. Mother assured the health visitor that she would email children's social care back in response to their request for her to contact them. The health visitor arranged to visit the family at home in a week.

2.21 A week later the health visitor weighed Stephen. This reflected a normal weight gain for an infant of his age over the seven days, albeit with him remaining on the 25th centile. A positive report of Stephen 'looking well, beautifully and appropriately attired in clothing fit for the season' was made. A warm and reciprocal relationship with his mother was also recorded.

2.22 'Dad' [mother's partner] was reported to have stayed in the kitchen but was 'polite and welcoming' to the health visitor. The heath visitor asked mother if she had contacted children's social care; the reply was that she had now received a letter from them stating that there would be no further action. On enquiring, mother reported to the health visitor that she was not in a controlling relationship.

2.23 In mid-September, when Stephen was just over four weeks of age, police were called four times during a Saturday night (between midnight and 04:15). Initially this was to respond to reports of mother being attacked in the street and calling for help, and then again as the arguments continued as the couple returned home. The police report that mother's partner was 'very anti-police and aggressive, before walking off'.

2.24 Mother, who had been physically injured, refused to complete the DASH paperwork and said that her partner sometimes 'has problems with his mental health and was bi-polar'. The children were said to be with [family member]. Police visited the family member's address, and all four children were seen, and noted to be 'alive and well'. A standard risk police notification was completed.

2.25 In the morning, neighbours contacted children's social care emergency duty team and the police with their continued concerns about mother and her partner 'constantly arguing and screaming and the children crying'. At this juncture social care report that they 'now have' criminal records on mother's partner, and other social care records. A further DV-RIM assessment was undertaken, and this was graded as scale three (serious level of risk to children). The outcome was for the family to be allocated from MASH to the assessment team for a child and family assessment.

2.26 Information was sought from the health visitor and the school. The health visiting information was provided by a duty health visitor who reported the positive findings from the named health visitor's recent visit as recorded on the records. The school reported good

attendance and ‘immaculate presentation’ of the children. They also noted that the eldest sibling talked about [the sibling] and their mother ‘being slapped’ by mother’s partner.

2.27 The named [i.e., family’s] health visitor was made aware by her colleague that a child and family assessment was being commenced by children’s social care because of further domestic abuse concerns, the young age of the baby and ‘dad’s’ previous history of domestic violence. The health visitor informed me that she did not receive a police notification of the protracted incident, the details of which were not disclosed by the MASH team.

2.28 School, however, do report receiving a copy of a police domestic abuse notification the following day. The deputy designated safeguarding lead spoke to mother who said that this was a ‘small row’ with no physical contact. School followed this up with contact with MASH who advised that the case had been opened for a child and family assessment.

2.29 When the social worker visited to commence the assessment, mother, supported by grandmother, refused to give permission for the practitioner to speak to the children alone. Mother and her partner reportedly downplayed the concerns. Partner was described by the social worker as ‘acting in a controlling manner’.

2.30 A housing officer also visited the home to discuss anti-social behaviour. They observed a baseball bat over the front door. When asked about this, mother replied ‘it’s just what [partner] does.’ The housing officer had linked mother and her partner to an address where a known drug dealer was shouting for mother’s partner to come out, as he owed money to them.

2.31 The social worker sought agreement from the team manager to approach the siblings’ father for permission to speak to the children alone, effectively over-riding mother’s wishes. Mother did give permission for her medical records, and those of her children, to be released to children’s social care. The GP practice was aware that mother’s partner was part of the household but did not release his medical information at this time, as his consent had not yet been given to do so. Mother’s partner was recorded by children’s social care as being the biological father of Stephen.

2.32 The social care chronology notes that nearly three weeks after the agreement for the child and family assessment, further details on mother’s partner’s criminal history of domestic violence and abuse towards a previous partner were received from the police.

2.33 When Stephen was seven and a half weeks of age, the health visitor undertook a home visit to carry out an assessment of Stephen. His weight was noted in the e-records to be 37.5kgs. This was assumed by the chronology author to be a decimal point error, and a reading of 3.75kgs was suggested. This recording is disregarded for the purpose of the review, as the health visitor’s written record has been sourced.

2.34 The police have provided a copy of pages from the ‘red book’ (parent-held child health record) which is now in their possession. This records the weight as being 4.32 kgs at the home visit. The head circumference at this time was recorded as 37.5cms and this is seemingly what was erroneously entered on the weight chart. Whilst an increase on the previously known weight, a weight of 4.32 kgs placed Stephen just under the 9th centile at this time.

2.35 The health visitor noted that Stephen's growth and development were 'appropriate', with Stephen 'fixing and following, smiling, and turning to familiar voices'. The HV addressed 'dad's' rough handling of Stephen when undressing him for weighing, but also noted 'parents' appropriate interaction, warmth, and sensitivity to his needs. Mother told the health visitor that her previous partner had subjected her to domestic abuse and that the children 'had not seen their father in months'.

2.36 The school became aware that the children were again spending time with unsuitable carers (as above), and informed children's social care. They also reported that one of the siblings had arrived at school very cold, dressed in a soaking wet coat. The headteacher spoke to mother about this and asked staff to monitor the children as the incident had been out of character as the children were 'always well-presented and well-equipped ordinarily'.

2.37 The social worker undertook a further home visit to discuss the concerns from school and housing. Mother was distressed that the older siblings' father was being involved and agreed for the children to be seen, and spoken to, at school. The social worker discussed domestic abuse and mother was recommended to do a Clare's Law disclosure[5]. Mother said that her partner suffered from bi-polar disorder. He had been asleep in another room but came in and signed the consent form for his medical records to be accessed.

2.38 Stephen attended the GP practice for his first immunisations; 'both parents' were noted to have accompanied him. A small blister had been seen on his upper lip, which had 'burst'; this was deemed to have been a 'sucking blister' and the assessment was overseen by the practice safeguarding team, who were aware of the s.17 assessment.

2.39 When Stephen was nine weeks old, he was apparently weighed at the Child Health Clinic. This weight/visit to the clinic is not recorded in the red book; but had been noted on the chronology as being 3.75 kgs in the clinic record. This would have reflected a loss and placed his weight as being just below the 0.4 centile. It is possible that this recording was also made in error.

2.40 A few days after the clinic visit Stephen was seen for a routine six to eight-week GP check (he was just over nine weeks of age at this time). His physical examination was reported to have been normal and there were 'no [parental] concerns'. The medical records note that he was not weighed or measured at this check 'as this had been done by the health visitor two weeks previously', and the weight was recorded by the GP as 9lbs 8oz (4.32kgs) as per the entry in the red book at that time. The GP noted the weight and head circumference as being on the 9th centile.

2.41 Mother also saw the GP for her postnatal check. She discussed having 'lots of stressors' as neighbours had referred the family to children's social care services. However, she also told the GP that she was 'not worried as she thinks there are no problems', but that it was playing on her mind. She added that she 'feels guilty' about the effect of the referral on her children. The GP diagnosed depression and issued a prescription. When asked about relationships at home, mother described her partner as 'supportive'.

[5] Clare's Law is the Domestic Violence Disclosure Scheme that enables any member of the public to ask the police if their partner poses a risk to them. It also enables a close friend or family member to make enquires.

2.42 The social worker saw the siblings alone in school, as agreed by mother, and noted that the eldest looked 'absolutely terrified and close to tears'. This contact took place some six weeks after the assessment commenced. The social worker believed that the children may have been warned not to talk to them. They also recorded that none of the children seemed anxious when asked about, or discussing, mother's partner.

2.43 The pre-school manager (safeguarding lead) disclosed to the social worker that the youngest sibling 'does come out with comments about mummy crying and people shouting out of the blue when she is playing'. This information was seemingly not discussed with mother or written on the child's pre-school safeguarding file.[6]

2.44 The following day (which was the same day that Stephen was admitted to hospital), the pre-school manager commenced a log of concerns, as follows; that the youngest sibling had been upset on the last four times they attended pre-school, that they were taking longer to settle in than previously, that they had been wearing the same outfit for three to four weeks and was unclean. This was noted as a change, as this child was usually well presented. A plan was made to inform the social worker.

2.45 The other children were recorded to be late for school that morning; this was also seen to be unusual as their punctuality and attendance were normally good.

2.46 That afternoon, Stephen was taken by ambulance to hospital, fatally injured. There is evidence from the GP records (which include a transcript of mother's call to the practice) that there was a delay in his mother and her partner seeking medical help. It was noted that mother collected the other children from school (early) before calling an ambulance, despite the presence of her partner in the household, and the urgency of the situation being made clear by the GP.

Stephen's siblings

2.47 Stephen is the child at the centre of the child safeguarding practice review. However, it is pertinent to make some additional reference to the lived experiences of his older half-siblings. Prior to the arrival of mother's partner in the household, it appears that no serious concerns about the family had been raised by those who knew them; either as service providers, or as members of the local community. School reported well-mannered, well-presented, and polite children, with parents who engaged well with the school.

2.48 Neighbours' growing anxiety about the siblings, and changes in the children's presentation and behaviour at school after mother's partner joined the household have been noted above. Although outside of the timeline of the review, the author of the education chronology added the voice of these children through reported disclosures made to education staff following their baby brother's hospitalisation and subsequent death.

2.49 One sibling told school staff that they were told by mother and partner 'not to trust the social', and that their mother had told them 'not to tell the truth, or the social would take [them] away'. They also shared that mother's partner told them that school would not do anything if they told them what was happening at home, adding that school was 's***'.

[6] This is being addressed by the Early Years Lead for the County following action taken by the education chronology author.

2.50 Stephen's siblings additionally provided a vivid description of mother's partner's verbal aggression towards their baby brother, and of his violence towards their mother, to them, their pet dog, and of causing harm to himself. Some six weeks after Stephen was hospitalised and the children moved to a safe place, the youngest sibling was continuing to express anxiety that the person they had begun to call 'dad', was going to 'come and get me'.

3.0 Key practice episodes

3.1 The child safeguarding practice review process enables the bringing together of information (from a range of sources and perspectives) to aid in an understanding what happened and why, to learn from the case, and to apply the learning to improve outcomes for children in the future. Identification of key practice episodes informs the learning. In this case, the key practice episodes identified include establishing and recording paternity, responding to reports of domestic abuse and concerns about the children, Stephen's pattern of faltering growth and the evidence of parental resistance to engagement with practitioners.

3.2 Although 'episodes' are identified, these are often linked and expose some cross-cutting themes that contribute to the learning and the recommendations for improving the child safeguarding system that follow. This also reflects the enduring messages from other reviews, for the need for authoritative child-centred practice (Brandon *et al*., 2020).

Establishing and recording paternity

3.3 The review has identified that from the outset of the relationship between Stephen's mother and her new partner, this individual was presented to agencies and practitioners as being the putative father of Stephen. The original name (of the biological father) provided by mother at her booking appointment, was documented in maternity records, but altered on the hand-held maternity notes. Once born, Stephen was given mother's partner's surname, and an embedded belief that he was the biological father prevailed.

3.4 The fact that mother's partner was presenting as, and was believed to be, Stephen's father is a significant finding. Research on child homicide references the 'clear danger' that may be presented by a non-biological carer (Wilczynski, 1997). A change of partner in pregnancy is a pivotal event. Such changes should engender professional curiosity about the role and status of men in the household.

3.5 The community midwife did not meet Stephen's biological father in person at any appointments, including the home booking. She recalls meeting mother's partner subsequently but had no reason to suspect that this was a different male partner. Maternity colleagues informed me that changes were often made by clients on the hand-held notes, most typically changes of contact numbers. The change of partner's name was not noted until the case became subject to review.

3.6 Stephen's biological father was seemingly not part of his life; nor, it is understood, was he able to see him prior to his death. The estranged father of his half siblings was not informed of emergent concerns about his children or involved in the assessment process. A

clearer understanding of men in the family and household by all involved agencies may not only have better protected Stephen, but also offered an opportunity to explore the potential role of his father (and the father to his siblings) in the children's care, welfare, and protection, particularly at the point of statutory assessment. As Brandon *et al.* (2020) note:

'Lack of professional curiosity or interest in fathers and partners not only leaves women and children vulnerable it can also leave fathers feeling alienated, forgotten and their role in bringing up their children dismissed.' (p.69)

3.7 An opportunity to explore paternity, and potential risks, occurred when mother's partner disclosed to his MIND worker that 'he was going to be a dad soon', later sharing the due date of 'his' baby. This disclosure was made around the time he reported the new relationship with Stephen's mother to his responsible officer at the community rehabilitation company, albeit disclosing that there were 'no children involved', and not sharing the news of the pregnancy.

3.8 Mother's partner's attendance for MIND mental health support reflected a rehabilitation activity requirement (RAR) in the context of his period of probation. The service informed me that after self-referral, he attended an initial assessment and two subsequent individual sessions. He was recorded as missing other appointments, and this resulted in his discharge from the service. It also negated his eligibility for the borderline personality disorder (BPD) peer support group that he was planning to attend[7].

3.9 Despite the RAR, the MIND worker and responsible officer did not liaise directly with each other. The MIND service was aware mother's partner was on probation. They understood (from the partner) that this was for criminal damage to canal side property. The service was unaware he had been judged as presenting a medium risk to known women and children. This raises a potential concern for the safety of female workers, as well as impacting on the service's safeguarding responsibilities.

3.10 Mother's partner's probation ended approximately one month prior to the first police call out, and two months prior to Stephen's birth. A responsible officer, supported by their manager (a senior probation officer), confirmed he had progressed satisfactorily through his period of probation. This was evidenced by his self-reporting, compliance and engagement with the service, and the fact that there were no further/alleged offences or police call outs during this time. The CRC were not aware that he had only partially engaged with the MIND service.

3.11 As acknowledged by the CRC, best practice is to complete a formal termination review at the end of a sentence, with the responsible officer recording whether they consider the service-user's risk of re-offending and risk of harm have reduced, increased, or remained the same. This would normally triangulate feedback from other agencies. Had there been communication between CRC and MIND this may have prompted a discussion about the pregnancy and new relationship and a call to children's social care before the period of probation ended. This would have also highlighted the fact that rehabilitation activity requirements had not been fulfilled.

[7] Partner's claim to suffer from BPD, similarly to his claim to be 'bi-polar', has not been clinically diagnosed.

3.12 The use of a genogram [family tree] or other means of recording family and household make-up can help to establish the presence of children (including unborn children) and to record putative paternity. This should inform initial assessments, as well as an ongoing understanding of the dynamics of relationships within families, and the identification and management of risk presented by a new boyfriend/father figure. However, the risks presented by deliberate attempts to deceive are acknowledged. The recommendation to record family and household make-up applies to all agencies who have safeguarding roles and responsibilities, including those whose primary client is the adult/parent in the family.

The response to domestic abuse and concerns about the children

3.13 The change in family dynamics when mother's partner joined the household is one of the most important findings of this review. This change was perhaps best described by concerned neighbours, to an extent by a family member, and later by the siblings' school. The building of the chronology exposes the events, the risks, and the opportunities to improve the response to domestic abuse and concerns about the children.

3.14 The police officer who attended the first call out for domestic abuse, recorded as a verbal argument, was described by senior officers as exercising good judgement in completing a DASH assessment, as well as an F101 notification. The DASH assessment, which was circulated to agencies, gave the risk of domestic abuse as 'medium' and shared mother's partner's history of 15 previous police call outs involving an ex-partner and noted he had 'previous convictions for assault.'

3.15 The 'flow chart' used to manage the DASH process states that where risk is judged to be medium, police records for the victim and perpetrator are searched for any child protection or domestic abuse history. The research, carried out by civilian staff, was not [at the time] shared with partner agencies. A system-check to review the circumstances and risk assessment was in place. The review of any domestic abuse history ascertains if the parties have been heard at previous MARACs. (As noted earlier, mother's partner, through perpetration of violence in a previous relationship, had been discussed at MARAC on five occasions.)

3.16 A few days following the first known incident, police again attended the family home after a neighbour reported 'fighting between the occupants.' Mother was accusing her partner of having an affair, due to her pregnancy (with Stephen). The police put a domestic violence action plan in place (DVAP). This meant that there was a marker flag on the family's address to identify the vulnerability of mother and her children, and to name mother's partner as the perpetrator. The marker is normally associated with high-risk cases.

3.17 Further concerns about domestic abuse and the welfare of the children were raised by an extended family member. A MASH enquiry was undertaken. Children's social care had linked mother's partner with another family who had had previous engagement with the service. However, the checks, and balances, in managing the agency response to domestic abuse and concerns about the children did not result in further protective action being taken at this time (for example, to raise the threshold from 'early help' to a potential for statutory

intervention[8], to raise the risk of domestic abuse to 'high', and/or to consider re-referral to MARAC).

3.18 The review thus finds that the initial responses to concerns of domestic abuse and the welfare of the children (i.e., the offer of early help) were not sufficiently robust. This is because the known risks at this time included mother's pregnancy, the involvement of family and neighbours in raising concerns, the young age of the siblings, and the, then, new partner's history and criminal convictions as a perpetrator of serious domestic abuse. Further concerns from neighbours raised shortly after Stephen's birth (see 2.15) did not change the agency response from the 'early help offer', despite the additional stressor of a new baby in the family. Whilst continued attempts were made to contact mother, including sending a letter, the case was 'NFA' (no further action).

3.19 The multi-agency safeguarding hub (MASH) partners' response lacked robustness in interrogation of the partner's background, and in the provision of an indicative response in the application of the Domestic Violence Risk Identification Matrix (DV-RIM) framework. This finding must be seen in the context of a need to process and manage a high volume of police notifications and DASH assessments, with limited resources. Critically, the decisions were not challenged by other services party to the information on the initial police notification and DASH and working with the family at this time.

3.20 When Stephen was four weeks of age, four episodes of domestic violence were reported over the course of one night (see 2.23-2.25 above). Police attending the initial episode may not have been aware of the DVAP, as the events were taking place in a public setting and not at the marked home address. However, officers subsequently attended the address. The view of the police panel member is that although Stephen's mother refused to engage in a DASH, officers should have raised a 'medium risk' DASH because there had been three incidents attended by police within 90 days.

3.21 School were sent a standard police notification[9] of the overnight incident, which stated this was a 'verbal argument' (albeit physical injuries to mother were subsequently noted). The health visitor was made aware that there had been 'a further domestic abuse incident' (but not the details) through a call from a MASH worker to the duty health visitor. This is the point at which children's social care commenced the statutory child and family assessment.

Stephen's pattern of faltering growth

3.22 The family were not known to children's social care prior to mother's partner's arrival in the household. Parental relationships with school and health services had been largely positive. Practitioners from universal services (education and health) had witnessed mother's care of her other children, who were seen to be well-presented, with good punctuality and attendance at school.

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[8] *Effective Support for Children and Families* Cambridgeshire and Peterborough Safeguarding Children Partnership Board (2018)

[9] This is due to the grading of the incidents as per 'Operation Encompass'; only school receive a notification for standard risk.

3.23 Stephen's mother and her partner engaged with antenatal and post-birth home visits from maternity and health visiting services. When Stephen was just over three weeks old the health visitor noted a warm and reciprocal relationship with his mother, and that he was 'looking well, beautifully and appropriately attired in clothing fit for the season'. Mother and her partner also took Stephen to the baby clinic to be weighed, he received his first course of immunisations, and was taken to the GP for a 'six-week' developmental review.

3.24 Integrating such findings reflects the expectation that child safeguarding practice balances protective factors with emergent risk before invoking procedures that may entail compulsory intervention in family life. This was evident in this case. However, there is the ever-present risk that positive findings may contribute to professional optimism that all is well.

3.25 Of potential significance, is the fact that mother booked late for her maternity care, reporting that she had done a positive pregnancy test six weeks previously. The booking was completed by a midwife at home, in the 13th week of pregnancy. Mother then attended all her scheduled maternity appointments. Late booking may be an indication of risk to the mother and/or the unborn child (National Institute for Health and Care Excellence, 2010). Current guidance from the NHS is that booking should normally take place before 10 weeks of pregnancy[10].

3.26 The chronology reflects the ongoing contacts with universal health service practitioners. Here, it was concerning to find evidence that Stephen's reported weights were indicative of a pattern of faltering growth. This is demonstrated by the references in section two (above) to the drops in the centiles in the first nine weeks of his life.

3.27 When Stephen was seen by the GP, aged nine weeks, for the 'six-to eight-week' developmental check, he was not weighed or measured. The stated reason for this was that his weight and his head circumference 'had been done by the HV two weeks previously'. At this point, the welfare of Stephen (pre-birth and post-birth) and his half-siblings had been discussed at the in-house practice safeguarding meetings on four occasions and an alert [icon] added to the records. The practice was aware that a social worker was undertaking a child and family assessment.

3.28 In the context of an otherwise normal physical examination, no concerns about Stephen's growth or development were identified by the GP or raised as a concern by mother. This appointment was the last time Stephen was seen by a health professional prior to his emergency admission to hospital 10 days later. Stephen's pattern of faltering growth was not identified at this appointment, or in the earlier contacts with health professionals. This is important because, in the absence of an organic cause, his slowness in gaining weight/weight loss may have reflected the presence of physical injuries or neglect.

3.29 A recent paper by Laurent-Vannier *et al*., (2020) highlights a common retrospective finding of 'sentinel injuries' in infants who later sustained abusive head trauma. The paper acknowledges that most of these babies were seen by health professionals during this time,

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Your first midwife appointment - NHS (www.nhs.uk) (accessed 3/01/21)

but that such injuries were generally not identified. Whilst we now know that Stephen had already suffered non-accidental bone fractures at the time of his routine health appointments, identification of these covert injuries would have required specialist x-rays (a skeletal survey) undertaken as part of a child protection medical. The emergent pattern of faltering growth raises the question of whether there was a window of opportunity for a referral to a paediatrician in the context of known safeguarding concerns, including domestic violence and abuse.

Parental resistance to engagement with practitioners

3.30 Early in mother's new relationship with her partner, there were emergent indicators of 'parental resistance' to engagement with practitioners (Tuck, 2013). This was borne out in non, partial, or disguised compliance, and in deflecting or minimising practitioners' concerns. This behaviour is best seen and judged cumulatively as a pattern, rather than by individual events. It is entirely possible that these behaviours relate to a controlling, coercive and violent relationship, but the evolving evidence reflects an increasingly risky situation for the children and their mother.

3.31 Parental resistance is seen throughout the timeline for the review. Mother's partner had poor compliance with his ADHD medication regime (as demonstrated from a GP review of his prescriptions). He failed to engage fully with his RAR during his period of probation. When he joined the household, he was reported to absent himself from professional visits and described as being 'resistant', but also recorded as being both 'polite and welcoming'. When police attended the call outs for suspected domestic violence, 'he had a problem with the authorities' before being 'very anti-police and aggressive' and walking away. When the social worker commenced the child and family assessment, mother's partner was described as 'confrontational' and 'controlling'.

3.32 Mother chose not to accept the early help offer, despite 'numerous attempts' to contact her by phone and email. This early indicator of parental resistance may have reflected her vulnerability (and that of her children) from the outset of her new relationship. As Brandon *et al*. (2020) note, overwhelmed parents may not have the emotional capacity or material resources to be able to take up the services offered. [11] Her behaviour was also evasive at times; for example, refusing to complete a DASH assessment after the protracted overnight domestic abuse incidents. On several occasions she excused her partner's behaviour as being due to him having 'problems with his mental health' and being 'bi-polar' to detract from the presenting risk (N.B. such an excuse does not lessen the risk or impact for a victim or their children).

3.33 The police call outs were described to other agencies as being 'due to neighbours being malicious' and of it 'being a small row'. Mother had told the school that she was happy with her new relationship. When asked by a housing officer why there was a baseball bat by the door, mother's apparent response was 'it's just what he [partner] does.' Reflecting the findings of another local review, ('Child K'), this was a mother who was able to reassure professionals that all was well (Cambridgeshire Safeguarding Children Board, 2015).

[11] Whilst the refusal is of note, families are not compelled to accept this intervention.

3.34 When the child and family assessment commenced, mother refused to give permission for Stephen's siblings to be spoken to alone and became distressed when the social worker mentioned asking the children's father for permission to do so. It is notable that maternal grandmother was seen to collude with her daughter when challenged; and then conceding to the professional view. Whilst there was subsequently an agreement for the children to be seen by the social worker at school, they were noted to look 'absolutely terrified and close to tears' prompting the practitioner to hypothesise that they had been warned not to talk to them. The children's later disclosures confirm this seems to be so.

3.35 The children were seen at the social worker's initial home visit and described as 'chaotic but well-presented.' Children's social care reported that the delay in speaking to the children alone was in part due to the issue of gaining parental consent, with a half-term school holiday adding to this delay. This meant that the assessment was not completed in the expected timescales. Normal practice is to speak to the children, alone, within five days of the commencement of the assessment.

3.36 The conversation mother had with a GP at her postnatal check is illuminating. Here the involvement of children's social care was shared with the GP in the context of anxiety and depression. Having put the blame on neighbours' reporting, mother indicated that she was 'not worried as she thinks there are no problems', that she 'felt guilty' about the impact of social care's involvement on the children, and that her partner was 'supportive'.

3.37 Mother's response to the GP has been discussed with practitioners from primary care. An important consideration is that mother's relative's children had recently been subject to proceedings and been removed. However, there was agreement that the disclosure may have presented an opportunity for an authoritative discussion on mother's own safety and that of the risks to her children in the context of the statutory assessment and known risk from domestic abuse (Department of Health and Social Care, 2017).

3.38 This was also an opportunity for the practitioner to suggest to the mother that the input of children's social care be viewed as a positive for the protection and welfare of her children, rather than being punitive. This finding has resonance with Brandon *et al.*'s (2020) suggestion that opportunities for protective actions by statutory agencies are curtailed by a perception that assessment equates with blame and creates a barrier to collaborative working.

4.0 Discussion

4.1 In their first annual report, the Child Safeguarding Review Panel (2020) note the 'shocking' (p.27) level of violence that has led to deaths of, and serious injuries to, infants under the age of one year. This has led to the commissioning of a national review that focuses on the motivation and behaviour of male perpetrators of this form of abuse.

4.2 Mother's partner, who was not Stephen's father, had a significant history of a pattern of abusive behaviour towards intimate partners and ex-partners, and criminal convictions resulting from his controlling, coercive and violent behaviour. His previous victims appear to have been vulnerable women, with children (including unborn children) who were also

placed at risk. As recognised by concerned neighbours, when mother's partner became part of the family, 'things changed' in the household.

4.3 The tragic death of Stephen adds to the toll of cases that reflect the level of violence noted by the Child Safeguarding Review Panel. We now know that this baby had suffered serious injuries before the catastrophic head injury that ultimately killed him. Stephen's death has had a devastating impact on his family and has caused great sorrow to those who provided care during mother's pregnancy and in the short weeks of his life.

4.4 The review has highlighted key practice episodes in this case that lead to specific recommendations for the Cambridgeshire and Peterborough Safeguarding Children Partnership. There is evidence of embedding improvements in practice locally, reflecting learning from this case, as well as from other reviews and developments (see below). The Board will be seeking assurance that these improvements are secure and having impact.

4.5 Opportunities for further learning and improvement to support robust, evidence-based, authoritative practice and inter-agency working are recognised through the process of child safeguarding practice review. This includes sharing good practice in this case.

4.6 Examples of good practice include the opportunities taken by health professionals to 'ask the question' regarding domestic abuse; the school's designated safeguarding lead's direction for vigilance in observing the well-being of the siblings; the recognition by the social worker of mother's partner's 'controlling' and 'confrontational' behaviour; and the urgency of the need for Stephen to be taken to hospital, as clearly articulated by the GP. There is also evidence of managerial oversight and supervision of safeguarding practice within health and social care services.

4.7 Authoritative practice is reflected in the actions of the health visitor on receipt of the police notification, and subsequent DASH assessment, following the first call out. This practitioner liaised with children's social care before and after undertaking a planned antenatal visit, where a frank and open discussion was held with mother about the concerns. Consent for information-sharing was also sought and given. This practice should be commended and modelled elsewhere.

4.8 In line with good practice, the risk analyses undertaken in response to the first known episode of domestic abuse balanced risk and protective factors. The protective factors included the health visitor's observation of the house being 'warm and clean' and another child being 'well-presented'. The initial school reports were also positive. The absence of historical safeguarding concerns within the family is an important finding.

4.9 The fact that 'things changed' when mother's partner joined the family is key. The response to neighbours' escalating concerns about the children was not sufficiently robust, reflecting previous findings from a national study that 'insufficient weight is given to concerns raised by neighbours' (Brandon *et al*., 2020:70) and the 'hierarchy of referrer' described in a more recent review (Shropshire Safeguarding Partnership, 2021). Agencies appear to have accepted mother's explanation of neighbours' reports being 'malicious', that the arguments were verbal, and that her partner was supportive.

4.10 Had a statutory child and family assessment been commenced at an earlier stage (and/or there had been consideration of the application of the multi-agency pre-birth protocol) this would have enhanced multi-agency working, provided key insight into the daily lived experiences of the children, and a clearer view of whether Stephen and his siblings were 'children in need' or 'children in need of protection.' Critically, this would have provided a timely opportunity to support the family in addressing the known risk from the partner, including the application of the domestic violence disclosure scheme.

4.11 The reviewer heard evidence to suggest limitations in professional dialogue and sharing of concerns between involved practitioners and agencies. This includes exchanges between statutory partners in the MASH. Other examples include communication between the CRC and MIND; children's social care and health partners; and the timeliness of pre-school reporting and recording of concerns. Such communication may be critical in adding context, clarity and expertise to data provided through a trawl of records (referred to in the chronology as 'agency checks'). As recognised in government guidance:

'Professional judgement is the most essential aspect of multi-agency work which could be put at risk if organisations rely too heavily on IT systems.' (HM Government, 2018b:14).

4.12 Chronology authors, panel members and practitioners have considered whether, at the point of transfer to the assessment team, it may have been more appropriate to consider a s.47 child protection enquiry, rather than a s.17 child and family assessment. Making a definitive judgement on this is challenging, with potential hindsight bias an important confounding factor.

4.13 As the Child Safeguarding Review Panel (2020) acknowledge, when there are child safeguarding concerns there is 'unpredictability' (p.6) of deaths and serious harm. Most families with multiple risk factors do not harm their children; and some children are harmed in families with no known risk factors. However, the risks to children who may be 'on the boundary' of the child protection system are also recognised (Brandon *et al*., 2020:14). The decision to undertake a child and family assessment was in keeping with the outcome of the second DV-RIM assessment.

4.14 The serious risk to the children was thus recognised, but the risk was balanced by protective factors and an approach to work collaboratively with the family. Furthermore, mother's partner was understood to be Stephen's father, a full disclosure of his criminal background had not yet been shared, indications from health services were that baby Stephen was essentially 'doing well', and school reports on his siblings' well-being were initially largely positive.

4.15 However, as the period of assessment progressed there were, as recognised by the social worker, continuing indicators of 'parental resistance', and the subsequent delay in speaking to the siblings alone. 'Further details' on mother's partner's criminal record (see 2.32) were shared by the police[12]. When the social worker visited the school, pre-school staff expressed some serious concerns about the youngest sibling. These factors may have led practitioners to consider 'step-up' to s.47, but it was at this point that Stephen was

[12] Arguably these could have been elicited through the MASH enquiry – see 3.20.

grievously injured, and events intervened. Agencies subsequently took appropriate actions to safeguard and protect the welfare of his siblings.

5.0 Progress and improvements

5.1 Discussions with CSPR panel members, practitioners and managers has highlighted evidence of learning and improvements in practice locally, reflecting learning from this case, as well as from other reviews and local developments. This section provides a summary of key improvements within the system.

5.2 Maternity staff are now more able to be made aware of changes to partner/putative father details through a new maternity e-records systems as changes to this information can only be made by the midwife (the system is known as K2 Athena/My pregnancy). The system for managing copies of DASH assessments and police notifications has been improved within maternity services, and this means that community midwives, as well as hospital-based staff, have more timely awareness of women who may be at risk from domestic abuse.

5.3 Domestic abuse, safeguarding and child sexual exploitation are current strategic priorities for the Cambridgeshire Constabulary. The service report they were 'confident that they were now in a better place' regarding response to domestic abuse incidents and ensuring the welfare of victims and children in the household. Leadership is provided through the 'protecting vulnerable people' department, and a domestic abuse delivery group seeks to enhance service delivery across the organisation.

5.4 There are plans for a 'vulnerability focus desk' in the two geographical divisions. These will enhance the support and supervision of frontline practice as part of ongoing developments. Supervisory oversight of all cases, including those deemed to require no further action, is now in place. Officers are equipped with an App, 'We Protect', to assist in their duties.

5.5 The designated paediatrician for child safeguarding has introduced improvements in clinical practice for infant growth monitoring. This follows the learning and practitioner reflection from Stephen's case, as well as the case of 'Jack' (Cambridgeshire and Peterborough Safeguarding Children Partnership Board, 2020). The improvements include a review of the systems used to record, share, and evaluate children's measurements within the parent-held, clinic and GP electronic health records.

5.6 There has been investment in new equipment, and access to a smartphone App. The App is essentially an 'aide memoir' that uses data from the Royal College of Paediatrics and Child Health (UK/WHO) to improve accuracy of recording measurements and helps to guard against accidental errors. Consideration is also being given to the use of the *Ardens* 6–8-week baby-check template in primary care.[13]

5.7 Children's social care services have revised and aligned their systems and processes across Cambridgeshire and Peterborough. This means that the current

[13] 6-8 Week Baby Review: Ardens Healthcare Informatics (accessed 5/03/21)

framework for undertaking child and family assessments places a greater emphasis on multi-agency planning at the outset of an assessment, and clarification of the contribution of agencies and professional expertise in the process.

5.8 The safeguarding children partnerships board provides multi-agency safeguarding training for all professionals who work with children and families across both Peterborough and Cambridgeshire. A current programme of work is in place to support professional learning and improvement in 'working with parents who are difficult to engage'. This includes professional briefings following CSPRs (where there is evidence of parental disguised compliance or confrontational behaviour) and training for practitioners in helping to support families through strategies for positive change.

6.0 Learning points and recommendations:

6.1 The fact that mother's partner was presenting as, and was believed to be, Stephen's father is a significant finding of this child safeguarding practice review. His arrival, status, and presence in the household, changed the dynamics, put the children and their mother at risk of significant harm, and ended with the tragic death of Stephen. A change of partner in pregnancy is a pivotal event. Such changes should engender professional curiosity and enquiry regarding the background, role, and status of men in the household.

6.2 In their review of serious cases featuring domestic abuse, the NSPCC (2020) highlight the importance of the verification of information about the composition of a household. Practitioners should keep this information up to date. Respectful enquiry and the completion of a genogram (or equivalent record of the family structure and relationships) address this finding. A recommendation is made:

Recommendation One: *The Board seeks assurance as to the way in which agencies record and update the details of family/household members. This may include completion of a genogram (or equivalent record of family make-up) and recording of current address/addresses. The recommendation applies to those providing services to children and to adults who are parents/carers. Such services should be required to demonstrate compliance with their wider responsibilities in child safeguarding.*

Consideration should also be given as to whether a change in intimate partner during pregnancy be added as a risk factor to section two of the pre-birth protocol in its next revision.

6.3 The review found that the MIND worker and responsible officer did not liaise directly with each other. The MIND service was aware mother's partner was on probation, but not the nature of the offence. The fact of mother's pregnancy was reported to the MIND worker, but this information was not shared with the community rehabilitation company. Mother's partner's rehabilitation activity requirements were not met.

Recommendation two: *The Board requires the National Probation Service to ensure that services commissioned to support offenders' rehabilitation activity requirements (RAR) are provided with relevant information about the nature of the offending, risk management, and*

the expected outcome of their involvement. Information sharing includes the evaluation of progress in achieving the goals of the RAR.

6.4 The checks and balances in managing the agency response to domestic abuse and neighbours' growing concerns about the children did not result in timely protective action being taken. This includes the timely sharing of information from police partners. Two recommendations are made:

Recommendation Three: *The Board seeks assurance that concerns and referrals are not processed based on a hierarchy of referrer (giving less weight to concerns from neighbours or family members). The response should be proportionate to the reported lived experiences of children and others potentially at risk within the household.*

Recommendation Four*: The Board requires Cambridgeshire Constabulary to provide assurance that stated improvements to internal system checks ensure correct allocation, grading and sharing of DASH/F101 notifications with other agencies are in place, with evidence of impact. Partnership agencies should also seek to progress and support improvements in the management of domestic abuse notifications to ensure the identification and prioritisation of high-risk cases.*

6.5 Children's social care reported that the delay in speaking to the children alone was in part due to the issue of gaining parental consent to do so, with a half-term school holiday adding to this delay. This meant that the assessment was not completed in the expected timescales. Normal practice is to speak to the children, alone, within five days of the commencement of the assessment. A recommendation is made:

Recommendation Five*: The Board requires Children's Social Care to provide assurance that children are both seen, and spoken to, within the expected protocol and timescales of a child and family assessment. Those with parental responsibility who are not resident in the family home should be made aware of agency involvement and enabled to contribute to the assessment.*

6.6 Stephen's pattern of faltering growth was not identified as a concern by health professionals. In response to this finding (and learning from another local review) a programme of improvements in growth monitoring of infants has already been instigated. A recommendation is made:

Recommendation Six: *The Board requires health partners to report on progress in the embedding of improvements in growth monitoring of infants, with evidence of impact through quality assurance of practice.*

6.7 The review found evidence of 'parental resistance' to engagement with practitioners. This was evidenced in non, partial, or disguised compliance, and in deflecting or minimising practitioners' concerns. A recommendation is made:

Recommendation Seven*: The Board undertakes quality assurance activity to assure members that the work it has undertaken to enhance practitioners understanding of authoritative practice has been embedded and resulted in a positive impact on practice.*

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Appendix One: Terms of Reference

1. How were risk and protective factors identified, assessed, and managed within the family?
2. What actions were taken by practitioners and agencies to ensure that concerns were shared appropriately, and within the available frameworks, to attempt to mitigate any risk?
3. How did practitioners and agencies that had contact with the family, work together to safeguard the children?
4. How well did practitioners and agencies understand the role and relationships of men within the household?
5. Can you identify any areas you consider to be good practice?
6. Does learning and improvement from this case resonate with other pertinent local (and national) reviews?
7. What recommended improvements can be made by local partners in safeguarding children policy, procedures, and practice in relation to this case?

Appendix Two: Guided discussion points for practitioner conversations

Safeguarding in agency/organisation

Broad discussion on how safeguarding and promoting the welfare of children works in your organisation, and with other local organisations/agencies. What is working well? Less well? Are you aware of any changes in practice or policy in the last year or so? (including pre-Covid-19)?

How are families/individuals helped to access your service? What might prevent them from doing so?

How is your role in safeguarding supported? Supervision? Management oversight? Learning opportunities?

Case

Tell me about your role & contact with family, length of time, frequency of contact, which family/household members.

How would you describe your relationship with the family/household members?

What was your understanding of the structure of the household when you started working with the family? How was this evidenced? (e.g. genogram/family tree). Were you aware of any changes to the family/household structure during your contact/service provision?

What were the aims of any assessments that you were undertaking? How did this inform/link to planned outcomes for the children/adults in the household? What did progress/success look like at the time? What helped/prevented you achieving this?

Were there any points at which you felt a different approach may be needed to ensure the children and their mother were safe and well? Did you speak to anyone else about this? (If so who/which agency).

Given your knowledge of the DA incidents (from the police notifications), how did this impact on your contact with the family? Was there any signposting to sources of help (e.g. IDVA)

What do you think the learning from this case might be; for your practice/for your agency/for the ways in which agencies work together in your locality?

Are you aware of any changes that have already been made as a result of this case?

Is there anything else that you would like to add?

Thanks.

Support post-meeting.

Next steps.