Cambridgeshire & Peterborough Safeguarding Children Board

Serious Case Review
Overview Report in respect of

Eleanor

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1 Introduction

The subject of this review, Eleanor, was born in March 2016. She was 19 months old when she was the subject of a serious assault perpetrated by her natural father, when he struck her in the face several times causing serious injuries.

Police were informed by the grandparents and attended the home address where they arrested the father for assault, and the mother for neglect.

Subsequent medical examination revealed that Eleanor had suffered a series of significant and serious historical injuries.

Both Eleanor and her sibling, then aged 2 years and 6 months were taken into protective care and subsequently made subject of care proceedings.

Both Mother and Father were given custodial sentences for assault and neglect.

2 About the author and independence

The author is independent of all the organisations involved in this review. He was an experienced Safeguarding Senior Police Officer having managed police and multi-agency safeguarding teams over a number of years.

He has investigated offences of child abuse and has worked extensively in multi-agency teams with Local Safeguarding Children Boards, Clinical Commissioning Groups and the voluntary sector.

He has been involved as contributor, commissioner and author in Serious Case, Safeguarding Adult, and Domestic Homicide Reviews.

3 Terms of reference / Scope including time-frame to be covered

The subject of the review is Eleanor, aged 19 months at the time of the offence committed against her.

The time frame for the review starts on 1st February 2015. Whilst this date is before Eleanor was born, the date is relevant as it is the first time that the family came to the attention of agencies. The finishing date for the review is the date of the assault on Eleanor and the arrest of her parents.

Agencies that contributed to the review were also asked to consider any other information that impacted, or was likely to impact, on the safeguarding of the children.

In addition to generic issues of whether agencies worked effectively together to safeguard Eleanor, agencies were asked to consider certain areas when undertaking their review and analysis.

- Was language or culture a barrier for the family to access services or support?
- Were there any indicators that the family required support or that there was any risk to the children?

- Did agencies that had contact with the family work together effectively to safeguard the children?

4 Methodology

Working Together 2015 allows local safeguarding children boards to determine their own processes for review. The Case Review Sub-Group of the Cambridgeshire Safeguarding Board decided that the review would be undertaken by a facilitated professionals and practitioners event.

A scoping exercise was conducted to understand which agencies should be consulted and included.

Each identified agency was asked to research their information, and where necessary interview key staff, and to prepare a chronology which would help to inform the information sharing and discussion event.

The below agencies were involved in the information sharing and discussion event.

- Overview author and facilitator
- Cambridgeshire County Council Children Services
- Cambridgeshire Community Services NHS Trust
- Cambridgeshire and Peterborough Clinical Commissioning Group
- Cambridgeshire Constabulary
- Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- Cambridgeshire and Peterborough Safeguarding Board

5 The family

Eleanor had one older sibling, who was born in 2015, making them just under 1 year older than Eleanor.

Eleanor's mother was born in April 1991 and therefore 26 years of age at the time of the assault on Eleanor.

Eleanor's father, was born in June 1988, and therefore was 29 years of age when he perpetrated the assault on Eleanor.

Mother and father were not married. It is believed that they moved to the United Kingdom in 2014.

The maternal grandmother lived in Eastern Europe but the mother does have a sister in the United Kingdom, and although in contact with her, she did not see her regularly.

The paternal grandmother lived within the local area but it is not known to what extent the family had contact with her.

Neither mother nor father spoke English.

As will be seen there was little contact by agencies with the family, and whether by design or due to their own circumstances the family seemed to be 'off the radar'. This was in part due to the children being pre-school age.

6 Involvement of family in the review

Notification of this review was made to both mother and father. Both were invited to be interviewed but neither agreed to this and therefore their perspective to the challenges that they felt they faced are not reflected.

The maternal grandmother was contacted and initially agreed to be interviewed for the review but at a later stage declined.

7 Background

It is believed that mother and father came to the UK in 2014. The father has his mother and half-sister living in the local area. Mother has a sister in the United Kingdom with whom she had regular contact. Her parents still reside in Eastern Europe. It is apparent that for around a month, mother's sister looked after Eleanor and her sibling on the basis that mother and father had to work.

Since the assault has come to light, mother has disclosed that there was regular domestic abuse perpetrated on her by father. This took the form of physical assault and behaviour to control her such as monitoring her social media accounts, and is said to have started during the pregnancy with Eleanor. This abuse is denied by father. It is likely that some of the abuse was witnessed by the sibling.

Also post the assault on Eleanor, father has disclosed a history of his own mental ill health. The extent of this is not known as any treatment would have taken place in Eastern Europe prior to his arrival in the UK (2014). Father also disclosed that for one year prior to the assault he was using cannabis on a daily basis.

8 Chronology of key events

In 2015, Eleanor's sibling was born at Queen Elizabeth Hospital. There was an initial concern that the mother was not engaging but she subsequently attended an ante natal appointment and explained that she was moving to a Cambridgeshire District Council area, although no address was given. There were no other concerns and no agencies were further involved.

In March 2016, Eleanor was born at Queen Elizabeth Hospital. There were no issues at birth, Eleanor was a healthy weight and a usual referral was made for the universal level of health visiting service.

A standard letter was sent to initiate the health visitor care, this letter was sent in Eastern European and at this early stage potential language barriers were recognised as an interpreter was booked for the visit.

In March 2016, Father attended the the local council's One Stop Shop. There he spoke with an Eastern European member of staff and stated that he was in rent arrears and likely to be

made homeless. The records held by the District Council are poor due to a change in recording systems. It is not clear whether at this stage the father had made it clear that he had a new born child. At this time the family were living in private rented accommodation where the arrears had accrued.

In March 2016, the District Council received a housing application from mother and father. This application had been assisted by staff at the One Stop Shop. All of the District Council's housing stock is outsourced to a housing association. The housing association wrote to mother and father and stated that due to their rent arrears their application would be removed until they could show that the rent arrears had been cleared. This and all other housing communications appear to have been sent in English.

Mother failed to attend the Health visitor appointment in March 2016. The health visitor contacted the midwife and was informed that mother had attended a clinic a few days earlier and had been advised to see her Doctor as Eleanor had a rash in her groin. Mother had stormed out of the clinic. The midwives had been concerned and had tried to visit the family over the weekend but received no reply. They had also left messages on the phone using a language line interpreting service. It was agreed by the health visitor and midwife that the police would be asked to undertake a safe and well visit.

In March 2016, the police attended the home address of mother and father. Initially they received no reply despite repeated knocking but remained in the area to speak to neighbours. As they did so father emerged from the address and police were able to gain access. They saw both Eleanor and her sibling, who appeared well cared for and in good health. Father changed the sibling's nappy and mother fed Eleanor whilst the police were at the address. The police checked cupboards for food and noted that there were age appropriate toys present. The police saw that there were letters present indicating that the family was in debt and father was not working. The parents were advised to visit their Doctor with Eleanor as soon and possible. The police subsequently submitted the appropriate safeguarding documentation and passed the information back to the midwife who shared the result with the health visitor.

During the police visit mother and father explained that there had been confusion over the appointments as the letters had been sent in English, which is known not to have been the case. In March 2016, the health visitor made a successful visit to the home address, Eleanor was seen but not seen undressed as the house was said to be cold. The interaction with the parents was conducted through a telephone translating service. A record was made that since the police visit the parents were engaging more.

A CAF[1] was considered at this point but deemed unnecessary as the right interventions were in place. Mother was advised about local assistance available and how to obtain food bank vouchers. It is known that mother attended the Community resource on three occasions in April where she received assistance with claiming benefits and access to food vouchers.

[1] CAF – Common Assessment Framework - is the process to identify children who have additional needs, assess needs and strengths and to provide them with a co-ordinated, multi-agency support plan to meet those needs.

In March 2016, following a referral by maternity services the case was discussed at the Local Allocations and Referral Meeting (LARM). On the basis that the family were now accessing support, the decision of LARM was that the case was referred back to universal services.

In April 2016, Mother and father received notification that the property they were living in would be repossessed and there was a hearing listed at Norwich County Court with a date set for May 2016. It is known that at this Court date an order was made in relation to the property and the family were due to leave on or around 30th May 2016. The District Council state that a housing officer attended this hearing with father but there is no record of this.

In April 2016, there was another visit made by the health visitor, this had been re-arranged to allow an interpreter to be available. Eleanor was seen and noted to be making good progress. The house was recorded as being clean but cold. Mother stated that she had not been able to access the GP post-natal review as it was difficult with two children, but she had now obtained a twin buggy and that would make getting out easier. There were no concerns noted.

During May to July 2016 mother accessed appointments with her Doctor on three occasions for immunisations and health checks. There were no concerns recorded except a rash in the left armpit which mother was told to return with if it did not clear up.

It is known that father attended the One Stop Shop again in May (date not known) and the Eastern European member of staff sent emails to the Housing department stating that the family, with two young children, would be made homeless on 30th May 2016. A housing officer is believed to have tried to make contact with the family but was unsuccessful. There is no record of a homelessness application being pursued.

Between July and December 2016, there was no contact by any agencies with the family. It is known that the children did go and stay with an aunt in the United Kingdom but the dates for this are not known.

The next contact with the family was in December 2016. On this occasion mother contacted relatives on social media and made a number of allegations against father. These included the fact that she had been assaulted and stabbed by father. The location of the family was not clear, and it was due to extensive police enquiries that the family were located to a converted office premises in Cambridgeshire.

Police established that there had been no assault as claimed by mother, she admitted to making this allegation up as she was fed up with father as they had been arguing. Mother had no visible signs of injury. Both children were seen, Eleanor was asleep, and her sibling was being fed by father. Mother disclosed that Eleanor had injured her head, but it is not clear how. Police noted there was no visible injury to Eleanor. The police did not undertake a Domestic Abuse Risk Assessment (DASH)[2] but did complete a safeguarding referral. This

[2] Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH, 2009) Risk Identification and Assessment and Management Model

included the fact that the premises, whilst having power and water, were not considered appropriate for a young family to be living in.

The Safeguarding referral from police was received by Children Social Care (CSC). It was noted that there had been no DASH undertaken. The concerns over the accommodation and possible injury to Eleanor's head were also noted. The Multi-Agency Safeguarding Hub (MASH) attempted to contact the family by phone with no success but the CSC District Team agreed to offer support to the family although the case did not meet their usual threshold criteria.

Two unsuccessful visits were made to the newly obtained address to see the family, on each occasion there was no reply. The first was in February 2017, by the health visitor and the second in the February 2017, by the health visitor with the family worker. A decision was made to refer the case back to CSC due to concerns over the surroundings. It is apparent that enquiries were also made with the landlord and a neighbour. The neighbour stated that he had seen the sibling but was unaware of a second child. The health visitor also made a referral to the MASH and was advised to undertake another visit.

In March 2017, a health visitor called CSC to obtain an update but was informed that she could not be given the information as she was not the referring health visitor.

Between the end of March and April 2017 the health visitor and family worker attempted numerous contacts with the family by phone, calling at the address and interrogating social media. The police did undertake a visit in March 2017 but were unable to gain entry. Thereafter there was a debate between agencies on the threshold of the case. The police did not feel that the circumstances warranted forcing entry to the premises. In April 2017, the MASH closed the case and wrote to the family to inform them. The letter was not translated.

In April 2017, the case was closed to Early Help. The landlord stated that the family were believed living with an aunt but not known where. The health visiting service were informed that the case was closed, and the health visitor placed an alert on the GP system should contact be made to the GP.

In September 2017, Suffolk Police were contacted by Eleanor's paternal grandfather with serious concerns for Eleanor. Enquiries with the family traced mother, father and the children to another address.

Police attended and found that Eleanor had an injury to her eye. Father was arrested and both Eleanor and her sibling were taken to hospital. Hospital staff found that both children were hungry and were unclean. The sibling had decaying teeth and he was described as having delayed speech. The house was found to be unclean and there was a lack of food.

A full and forensic medical examination of Eleanor revealed a large number of healed injuries, including full fractures. The injuries were:-

- Healed fracture to left wrist
- Healed fracture to left collarbone

- Fracture to right hip
- Burns to finger tips
- Numerous marks all over her body.

Expert medical opinion stated that the injuries were substantial enough that any person giving reasonable care to Eleanor would have been fully aware of the injuries to her. The medical opinion is that the healed fractures were somewhere between 4 to 12 weeks old in September 2017. It is estimated that they occurred between July 2017 and September 2017. It cannot be determined if the fractures occurred on the same occasion or separate occasions within this timeframe.

Expert medical opinion further stated that there was no medical reason for these injuries to Eleanor and in their view they were inflicted intentionally. These injuries would have caused Eleanor significant pain. The punches that Eleanor suffered to her head were capable of causing significant permanent damage and she is fortunate that this does not appear to be the case at this time.

9 Analysis of involvement

Was language or culture a barrier for the family to access services or support?

Both mother and father were not English speakers and had only been in the UK since 2014, these factors would undoubtedly present a challenge for them to fully integrate and avail themselves of services. That said, the potential for these barriers were recognised by professionals at an early stage.

There is evidence that from the outset of mother's pregnancy that letters were translated into Eastern European and where appointments were made either interpreters or language interpreting phone services were used. This early recognition use of the services has to be seen as good practice.

During the discussion event for this review it was recognised that achieving the interpreting services presented a challenge. The only recorded occasion where communication was not translated is when the case was closed by the MASH in April 2017. Whilst this is unfortunate it is unlikely that the letter reached the family as there was no known address at this time.

The letters sent by the District Council and the Housing Association were in English. These involved important issues for the family and were not likely to have been understood. Father did attend the One Stop Shop and was able to speak with an Eastern European speaker, but the records are poor and it is not clear what support in relation to housing the family were given. The fact that there were looming court proceedings in relation to rent arrears is likely to be another reason why mother and father were reticent to engage with agencies. It is fair to say that the issues of record keeping, translation and communicating with customers, for whom English is not their first language, have all been addressed by the District Council since this review started.

Although the Eastern European community is well established within this part of Cambridgeshire, there are marked differences culturally, not only between the traditionally

based communities, but also with other European cultures and nationalities that have taken up residency in the area. Other reviews involving the Eastern European community have noted that this community in particular tend to reside principally together.

There is a recognised distrust of authorities and much of this is a cultural issue. This also has a profound effect on the use of services, as many will avoid engagement with statutory agencies. Comparatively speaking the policing within Eastern Europe is also somewhat at odds with 'policing by consent' or the expectations that British people have of the police in the UK.

This distrust, or perhaps lack of understanding of the cultural differences, can be seen in this case. When mother disclosed domestic abuse, it was after the assault on Eleanor and during assessment by Children Services. When asked why she had not sought help previously she stated that she believed that this would immediately put her children at risk of being taken by the authorities.

Mother and father were seen by professionals as being unwilling to engage with universal services at the outset of Eleanor and her sibling's births. This engagement seemed to improve after the police had been asked to undertake a safe and well visit. This lack of engagement may have been due to the cultural lack of understanding or mistrust of what the agencies in the UK were able to assist with.

Assistance and signposting was offered to the mother to a local community resource which, among other things, supports persons coming into the area who do not have English as first language. Mother did avail of this service, but only briefly to seek specific assistance with benefit application and food vouchers.

It would appear that mother and father relied mainly on their family network. This was difficult for the mother as her parents were in Eastern Europe and her sister lived some distance away. Father had the support of his mother who lived closer. Unfortunately, it has not been possible to understand better what degree of impact this limited network of support had on the family.

Were there any indicators that the family required support or that there was any risk to the children?

There is no indication that there was a known or potential risk to the children recorded by any agency at any stage. Just before the sibling was born there was a concern that the mother was not engaging with services fully, a CAF was considered, but ultimately not put in place, as mother started to engage appropriately.

The same situation existed when Eleanor was born, there was concern over the mother's engagement after she had left a GP appointment and failed to keep another appointment. This was robustly followed up by the midwife in communication with the health visitor. After a police visit had been undertaken again the engagement of mother improved. The lack of engagement was explained by mother as a breakdown in communication and given the language barrier this explanation was not unacceptable.

There is good evidence of consideration of risk with the case being referred to and discussed at the LARM. Both children were seen on visits in March and April 2016 and no concerns were noted. Eleanor was not seen undressed on either occasion, as the house was described as cold. Although the significant historical harm appears to have occurred after this time, this would have been a good opportunity to fully examine Eleanor.

When the police were asked to carry out a safe and well visit in March 2016, the visit was thorough. They made comment on the surroundings and age appropriate toys. They advised on seeing the GP and noted that there were signs that the family may be in debt. They followed this up by passing all information back to other agencies.

During May to July 2016 Eleanor was seen on three occasions in the surgery for routine appointments. No concerns were noted or expressed. Professionals did recognise that the mother may require additional support and signposted her to community services to assist with benefits and food vouchers.

The family did not come to notice again until December 2016, when the mother reported domestic abuse. Police had to make extensive enquiries with the extended family to locate the mother, father and the children in converted office accommodation. It was apparent that the reports that had been made by the mother were not all correct but there had been a domestic situation at the address, with the children present.

Whilst the action by the police at the address was thorough and followed up with a safeguarding referral, no DASH risk assessment was undertaken. The assessment may have led to the initiation of other services such as an IDVA and a wider recognition of the presence of potential domestic abuse in the relationship. It may also have impacted on threshold decisions made by other agencies.

The police after this visit did highlight that the premises in which the family were living were not suitable surroundings for young children.

Although the case, as far as agencies were aware, did not meet the threshold for other than universal services there was the unusual step taken for the case to be opened to the Children Services District Team. This has to been seen as good practice, as was the way in which professionals then tried to work together to support the family, which is discussed in more detail below.

A main concern for the family was suitable accommodation. The fact that they were located in less than ideal, converted office premises underlines their struggle in this area. Obtaining housing records has been difficult in this case with both the District Council and Housing Association having changed their recording systems. But this is an important area to try to understand.

It is known that the family were in private rented accommodation up until May 2016. During this time they accrued rent arrears of around £3000. Proceedings were taken to remove them from this property. They sought advice and were assisted with a housing application in March 2016, just after the birth of Eleanor.

After a matter of days they were informed that the application was withdrawn due to the arrears and could not be reinstated until the rent arrears were cleared. The housing departments have no records of a homelessness application being pursued by the family and therefore their case was closed. It is believed that a housing officer tried to support the family but there is no record of this.

This effectively left the family homeless and without housing support. It is likely that the family resorted to relying on family before resorting to the private rented sector again. Whilst the housing providers had no duty to make a referral under the Housing Act, consideration could have been given to the general circumstances that the family faced and the likely risk to the young children. These circumstances could have given rise to consideration of a referral being made to Children Services.

Did agencies that had contact with the family, work together effectively to safeguard the children?

There is evidence throughout this relatively short case of professionals working really well together, appropriately sharing information in most instances, and some doing more than may have been expected of them.

When there was a failure to attend a health appointment, this was immediately followed up by the health visitor with a discussion with the midwife. They decided that a visit should be undertaken by the police to check if the children were safe and well.

Within a very short time the police visited the address, when they received no reply they were persistent and spoke with neighbours. This persistence paid off as the father was seen to emerge from the address - it is thought in the belief that the police had left the area. The police were able to go into the address, check on the children and surroundings and then report back on their visit.

In December 2016, following the reported domestic abuse incident, the case, although not fitting the threshold for acceptance by the District Team, was accepted by them. The health visitor and family worker tried on numerous occasions to visit the family. They showed good professional curiosity by speaking with neighbours and the landlord. They left messages, wrote letters in the family language and sought to check social media to try to trace and speak to the family. All the indications were that the family had moved away.

The police were again contacted and undertook a visit but there was no reply. There was some discussion at the professional's event as to whether the family at this stage should have been treated as missing. It was felt that there was information that the family had moved away and therefore this was not an option at the time.

There could have been consideration given to contacting the wider family network to get more information on the current whereabouts of the family. This route had been used to trace the family in December following the report of the domestic incident and may have given the current address for them.

During the course of the enquiries to trace the family someone from the health visiting service called Children Services to get an update on the case and was told that they could not be given information as they were not the person who made the referral. This is the only instance where poor information sharing can be seen in this case.

In April 2017, the case was closed. On closure the health visitor took the step of putting a marker on the family records to be alerted should the family seek support from the GP. This again shows good practice and a desire to ensure that all areas were considered.

It is during this period of absence from agencies that the expert medical evidence would suggest that the significant harm was caused to Eleanor. The fact that Eleanor's injuries were so serious meant that contact with any service, particularly health would have led to discovery of the injuries. It is likely that during this period, until police were called in September, that the mother and father deliberately evaded the attention of all services.

10 Learning from this case

One of the learning points that should be taken from this case is what can be achieved when services work closely together and share concerns in order to manage potential risk. The health visitor and midwife communicated well and involved the police to assist them when they could not contact the family.

Another area which should be highlighted is the desire by professionals to 'do the right thing' even when a case may not fit the given criteria. There was a good demonstration of professional curiosity, with numerous attempts to contact a family, who obviously did not want to be reached, when there was little evidence or information to raise this case above many others. This case should be used to re-enforce with professionals the benefits of following their professional instinct and judgement.

The involvement of the housing departments of both the District Council and Housing Association is difficult to accurately gauge due to the limited access to reliable records. What can be said is that there was information that a vulnerable family were likely to be made homeless and there was no consideration of making a safeguarding referral or seeking their consent to access support from other services. It would appear that 'front facing' staff may not routinely receive safeguarding training.

The District Council has, since the start of this review, considered these areas and where necessary amended or enhanced their practice.

Recommendations

1. **The CPSCB should use the good practice identified in this case in training and briefing to underline the benefits and strengths of agencies working closely together and effectively sharing information.**
2. **The CPSCB should be assured that Cambridgeshire Constabulary conduct DASH risk assessment in all incidents of alleged domestic abuse.**
3. **The CPSCB should use its influence in other strategic areas to ensure that agencies have access to translation services.**
4. **The CPSCB should seek assurance from District Councils and Housing Associations that their staff receive appropriate safeguarding training, and they comply with policies and procedures around appropriate safeguarding or Early Help referrals for children and families.**