



Wolverhampton Safeguarding Children Board

SERIOUS CASE REVIEW

Child G

Lead Reviewer

Nicki Pettitt

**Second Reviewer and Report
Author**

Karen Perry

CONTENTS

1. Reasons for conducting the Serious Case Review and methodology	page 2
2. The story of the family	page 4
3. Analysis	page 9
4. Good practice	page 16
5. Recommendations	page 17

1 Reasons for conducting the Serious Case Review and methodology

- 1.1. This Serious Case Review is in respect of a child aged 2 years 9 months, who presented to the Emergency Department at the local hospital on the evening of 21st November 2016. Child G was pronounced dead in the early hours of the following day. Child G had a number of injuries ranging in age and severity.
- 1.2. In June 2017 Mother's Partner was convicted of murder¹ and sentenced to life imprisonment. Mother was convicted of allowing the death of a child² and sentenced to 3 years and 4 months. Child G's only sibling, who was 7 years old at the time that Child G died, was made the subject of care proceedings.
- 1.3. The following learning was identified;
 - When women disclose previous domestic abuse, an assessment of future risk is better informed if practitioners obtain details of the nature of the abuse and record the name(s) of the alleged perpetrators
 - When parents are no longer with an abusive partner, tenacity and creativity may be required to engage them to prevent repeat victimisation
 - People vulnerable to domestic abuse, their families and the practitioners who support them, would benefit from understanding the application and limitations of Clare's Law and how to make use of it
 - There are benefits to practitioners having a better understanding of the implications of "no right to remain" and "no recourse to public funds" on the lives of the families they work with
 - It is important for practitioners to have an understanding of the role of specialist staff
 - Practitioners need an awareness of local specialist voluntary organisations for families with undocumented status, and the value of involving them

¹Murder is an offence under Common Law

² S5 Domestic Violence Crime and Victims Act 2004

- Gaining an understanding of what parent's faith means to them might enable more holistic and effective support for families. Practitioners do not consistently have the confidence to do this
- Holistic assessments should include asking "who else is involved with you and your family?" and recording this in a form that is accessible and easily updateable, for example using an Ecogram³
- Written plans and Team Around the Child (TAC) meetings for ALL Children in Need, including those only judged to be so by virtue of destitution, would support co-ordinated and systematic interventions
- When conducting assessments and reassessments of vulnerable families, practitioners may find that including internet and social media checks would enhance and triangulate information given by parents
- Accurate recording of specific details and effective arrangements for transfer of records when families move or involvement transfers between services would better safeguard vulnerable children

- 1.4. The Independent Chair of Wolverhampton Safeguarding Children Board (WSCB) agreed that the criteria for a Serious Case Review⁴ was met in this case. This report will be published on the WSCB website.⁵ The WSCB will also ensure that learning is widely disseminated. Details in this report regarding what happened focus only on the facts required to enable the learning to be identified. The footnotes should be read alongside the main text and includes the author's comments as well as references to relevant research, legislation and guidance.
- 1.5. This review considers agency involvement with the family from 1st February 2013 to 21st November 2016.⁶ The WSCB undertook this review using an independent Chair and separate Author, a panel of safeguarding leads representing key agencies⁷ in Wolverhampton, and Croydon and a lay member of WSCB with knowledge of the local churches. Panel members were independent of the case. The panel met 5 times and had the benefit of specialist briefing and consultation support from AFRUCA⁸ and a regional representative from the Home Office. Both the Panel Chair and Author are independent of WSCB and its agencies.⁹
- 1.6. Mother, Child G's father, Maternal Grandmother and a church friend were spoken to as part of this review. The purpose of speaking to them was to inform them of the review, and to establish if any additional learning could be obtained from asking them about the

³ A diagram showing an individual's social and personal relationships

⁴ Working Together 2015 states a serious case review should be held for every case where abuse or neglect is known or suspected and either a child dies or is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child

⁵ Working Together 2015 states that SCRs should be available on the LSCB website for a year, then by request thereafter

⁶ Information outside these timescales has been included where appropriate to aid understanding and learning

⁷ Mostly from local agencies but with representation from the local authority hosting the NRPf team (Croydon)

⁸ Africans Unite against Child Abuse (AFRUCA) is a charity which was established in May 2001 as a platform for advocating for the rights and welfare of African children following the high profile deaths of children in the UK. The main focus of their work is prevention and early intervention.

⁹ The lead reviewer in this case is Nicki Pettitt, an independent social work manager and child protection consultant who is an experienced chair and author of SCRs, learning reviews, and multi-agency case file audits. The second reviewer and author of this report is Karen Perry, an experienced ex local authority senior manager of services for children who need protection and/or care.

way that partner agencies worked with them during the timeframe of the review. Comments made by family and friends are included in the report at the most relevant point.

- 1.7. The first stages of the review involved compiling a multi-agency chronology, and Independent Management Reviews (IMRs) which identified the single agency learning. Practitioners and first line managers, and then IMR authors, contributed to the SCR at meetings held in June 2017. They have also provided clarity, comments and challenge to this overview report following the meetings. Their input has been invaluable.

2 The story of the family

- 2.1. Child G has one older sibling who will be referred to in this report as Sibling. The parents of the children are referred to as Mother, Child G's Father and Sibling's Father. Other family members will be referred to by their family relationship e.g. Maternal Grandmother. Mother's Partner refers to the man who murdered Child G, who was Mother's Partner for two short periods; around the time of Child G's birth and his death.
- 2.2. Child G was part of a family of Caribbean and African heritage. He has been described by those who knew him as a smiley, happy toddler with a good appetite who enjoyed hugs. Child G was an independent child who engaged well with adults. He liked music and to watch Mr Tumble on television.¹⁰
- 2.3. Mother was a single parent, who was close to Maternal Grandmother, who lived in London. Feedback from the professionals who knew Mother and the children suggests that they did not stand out as particularly vulnerable. Mother arrived in England as a child in 2003. She came from the Caribbean with her sister to visit Maternal Grandmother, who had arrived two years previously. The two children settled with Maternal Grandmother and her younger children in London. Subsequently, in 2008, Maternal Grandmother made an unsuccessful attempt to obtain "leave to remain" for herself, Mother and Mother's Sister.¹¹ Mother's status was of an undocumented migrant with no recourse to public funds (NRPf), which means no entitlement to welfare benefit or social housing, no ability to hold a driving license, open a bank account, go to college or university or gain employment.¹²
- 2.4. As young adults, Mother and Sibling continued to live with Maternal Grandmother, with financial support from local charities. In autumn 2012 Mother started living with Child G's Father. Approximately 8 months later, Mother made separate allegations that Child G's father had assaulted her and abused Sibling¹³. Mother and Sibling were provided with emergency accommodation. The police and local authority (Croydon) made enquiries and concluded that the allegations made were fabricated. Within a couple of weeks, it was known that Mother was pregnant with Child G¹⁴, and 4 months after the allegations were made involvement was passed to Croydon's No Recourse to Public Funds Team (NRPFT), as the family were only assessed to be in need by virtue of destitution. The NRPFT provided accommodation and money for basic necessities.

¹⁰ Mr Tumble is a Cbeebies (children's television) character.

¹¹ The application was not progressed due to the fee not having been paid. This was a feature in other subsequent applications made by Mother and Sibling's Father, and not unusual for such applications according to information from the Home Office.

¹² Coram Children's Legal Centre (2016) "[This is my home; securing permanent status for long-term resident children and young people in the uk](#)"

¹³ The allegation re Domestic Abuse was not followed up by children's social care as Mother would not press charges and the alleged abuse of Sibling took precedence

¹⁴ It is not known whether Mother knew this at the time of making the allegations

- 2.5. Mother, Maternal Grandmother, the Children's Fathers and Mother's Partner were all involved in varying ways in Christian religious worship in London. When Mother was 4 months pregnant with Child G, she was subject to an "exorcism ritual" by a pastor linked to a London church. This was reported online by a journalist of a national paper who described it as being intended to break a curse on her that was handed down by her ancestors, to prevent the curse being passed on to her children. No agency saw this report at the time. Both at the time and since, Mother reported feeling better afterwards. She and the other family members interviewed described it as being "prayed over", or a deliverance, rather than an exorcism.
- 2.6. As with her first pregnancy Mother had very little ante-natal care.¹⁵ This is concerning due to the health risks identified through her previous pregnancy.
- 2.7. The Fathers of both Children had periodic contact with them. This appears to have been restricted when Mother's Partner moved in about 2 months before Child G died.¹⁶
- 2.8. In early 2014 Mother and Sibling were provided with accommodation in Wolverhampton¹⁷, a few weeks before Child G was due to be born. Mother returned to London to be near Maternal Grandmother for the birth and presented at hospital for booking at 37 weeks. The address given was that of Mother's Partner, in another part of London.
- 2.9. After Child G's birth, the ward sister requested advice from the safeguarding midwife due to concerns about lack of antenatal care and an unclear social history. The safeguarding midwife contacted Croydon council. She established that Sibling was not subject to a Child Protection Plan (CPP) as had been indicated by Mother, that her immigration status was "awaiting decision from the Home Office"¹⁸ and obtained details of the support being received from the NRPFT. Subsequently another midwife made a multi-agency referral (MARF) to the local Children's Services; there is no record of this in the local authority concerned.
- 2.10. During a conversation about the discharge process a day later, Mother informed the midwife that she did not want to go home as she was in pain. Records indicate that Maternal Grandmother had phoned the ward requesting that Mother was not discharged to her Partner's address. When Maternal Grandmother and Great Aunt visited later they told another midwife that Mother's Partner was controlling and that Mother had told them she was scared of him and didn't want to be at his address.
- 2.11. The midwife observed that Mother was tearful when Mother's Partner visited that evening; therefore, the midwife told Mother in the presence of Mother's Partner that she would need to stay overnight as medication was not available. Later Mother confided to the midwife that she didn't want to go with her Partner, as he was controlling and seemed obsessed with her, had "given up his family for her" and she felt he had a mental health problem. Accordingly, at Mothers request, she was discharged to Maternal Grandmother's

¹⁵ An illegible referral from London midwives to Croydon Children's social care in Dec 2013 mentions that Child G might be exposed to Domestic Abuse but there are no details and no record of a response.

¹⁶ Child G's Father describes a rather higher level of contact and financial support than reported by Mother. However, both are agreed that his contact with Mother and Child G was stopped in September 2016

¹⁷ Participants at the practitioners meeting suggested this was because accommodation is cheaper than in London, and that a number of families were being transferred out of London boroughs to Wolverhampton in 2014

¹⁸ She had made no application despite being told to by the NRPFT social worker

address. Mother's Partner came to the ward the following day to see her, no information was shared.

- 2.12. The discharge summary containing information about the involvement of the Croydon social worker, alleged domestic abuse by an ex-partner and that the new partner¹⁹ was controlling and obsessive was sent to the community midwife and GP, but are not contained within Mother's health records. A midwife also phoned a Croydon Duty NRPFT social worker regarding the discharge arrangements, she stated that the message left included the concerns about the new partner, although this is not recorded in the Croydon records.
- 2.13. The NRPFT social worker had spoken with Mother by phone while she was in hospital to explain the inadvisability of being discharged with a new baby to live with a partner she hardly knew, and followed this up with a visit a week later. Mother and Grandmother repeated the reasons for Mother not wanting to be discharged to her Partner's home; there was a discussion about choice of partners. Mother's Partner did phone her a few times while at Maternal Grandmother's and they had intermittent contact by social media subsequently, but did not meet again until the summer of 2016.
- 2.14. Mother and the children moved into their tenancy in Wolverhampton in March 2014 when Child G was a few weeks old. Unfortunately, the allocated NRPFT social worker had left so they did not receive a visit until June 2014.²⁰ Mother gave false information that the children were registered with a GP and up to date with their immunisations. Mother also said that they were being supported by a local church in Wolverhampton. The NRPFT did not inform Wolverhampton Children's Services of their involvement and the family's presence in the city until November 2014 – well over 6 months after the family settled in Wolverhampton. Neither then²¹, nor at the point of a subsequent referral approximately 6 months later²² did the NRPFT share a copy of Croydon's assessment or Wolverhampton Children's Services request a copy.
- 2.15. During the summer of 2014 Mother made her first contact with the Home Office in her own right, to make an application for "leave to remain" for herself and Sibling.²³ Mother applied for remission of the fees on the grounds of being destitute. The fee waiver was not granted as insufficient evidence of destitution was provided.
- 2.16. In September 2014 Sibling was admitted to a local primary school. School staff sent Mother a parental information pack and asked her to provide basic biographical information about Sibling and her family. This was never received, despite a further letter, and involvement of the school parent officer in 2016.²⁴

¹⁹ Neither were named in the discharge summary, nor the electronic record although the booking record includes the name of Mother's Partner

²⁰ Usual NRPFT practice would be to visit within a week of moving to a new area– but the family's previous social worker had left, a new one was not in post immediately, and mother was moving about between Wolverhampton and London

²¹ Referral 1 directly to Children's Centre that Mother may need help with immunisations and understanding routines Since Jan 2016 all early intervention and safeguarding referrals go through Multi-agency Safeguarding Hub (MASH)

²² Referral 2 involved a standard inter local authorities letter stating family had been placed and were receiving financial support and no role for Children's Social care. Suitable lateral checks were completed.

²³ As Child G was not a British citizen, it is unclear why Child G was not included. The Home Office were not aware of his existence.

²⁴ School staff now go through form with parent/s to complete any gaps in information passed on from admissions team

- 2.17. After discussion at an early intervention meeting at the local Children's Centre, the family were recognised as being new to the area and potentially socially isolated. The same day a family support worker from the Early Intervention Service made a home visit, and then contacted the health visitor, who made a prompt transfer-in visit. Co-incidentally, also present at that visit was the social worker from Croydon NRPFT and someone from the local church. Mother told the health visitor that she had an appointment to register with a GP and get the children immunised.²⁵ She also disclosed she had suffered historical domestic abuse²⁶ and requested support from a local agency. The health visitor made a referral to a local children's centre for support from a domestic abuse charity and to the Freedom Programme.²⁷ She made referrals regarding a couple of typical health issues for babies of this age and she informed the NRPFT social worker that the cot was too small for Child G and needed to be replaced to reduce the risk of cot death.
- 2.18. Mother and the children attended the GP surgery for registration and medicals on the second time of booking.²⁸ Over approximately the next 18 months there was ongoing activity to encourage Mother to have Child G immunised. There were a number of face to face discussions, and phone and letter reminders after Child G was not brought to appointments, mainly led by the health visiting staff, but also the NRPFT social worker, the GP surgery and a Family Support Worker (FSW). There was also follow-up by the GP regarding the minor health concerns discussed at the transfer-in visit.
- 2.19. The Early Help FSW made a second visit some 8 weeks after the first. The cot had not been replaced, so the FSW agreed she would follow this up by obtaining a cot and safety equipment. Mother agreed to an Early Help Assessment.
- 2.20. In December 2014 Mother visited the local children's centre and reported feeling overwhelmed and isolated. The Freedom Programme was discussed with her, but she did not attend an introductory session the following week.
- 2.21. In mid-January the Early Help Family Support Worker (FSW) made a further visit; to support Mother with budgeting skills and inform her that they were on a waiting list for a cot. The FSW made a further visit one week later to encourage engagement with the children's centre groups and to deliver the cot which was supplied by a local charity. A discussion was also had about the Freedom Programme. Whilst domestic abuse was mentioned in the history included in the Early Help Assessment, it was not included in the plan of action.²⁹
- 2.22. In April 2015 Mother finally agreed that Child G could have his immunisations if the health visitor would accompany her, and stated that she would take Child G to an outpatient appointment for a routine health issue. Neither appointment was achieved.
- 2.23. The same month the Home Office amended the fee waiver policy, so Mother's application was eligible for reconsideration, and she was given a further opportunity to submit

²⁵ Given mother had lied to social worker before, the health visitor and social worker went to check at the GPs surgery

²⁶ She gave no details and this first quite intense visit was not the time to ask given lack of any immediate risk

²⁷ This was the first referral for support with domestic abuse none of which were effectively followed up by mother or professionals

²⁸ At the meeting held during this review, practitioners stated that from their own experience it is not unusual for people who have "over-stayed" to be reluctant to register with GPs – as they assume information will be shared with the Home Office

²⁹ Plan included action on budgeting, and accessing children's centre for parenting and social isolation

evidence on destitution.³⁰ Supporting evidence from both London and Wolverhampton churches was not submitted by Mother until some months later. The fee-waiver was rejected during 2015 due to insufficient evidence of destitution, but removals activity³¹ had not progressed significantly at the point of Child G's death.

- 2.24. In May 2015 Child G was brought to the GP surgery for his first set of immunisations (8 months after this was first raised with Mother) accompanied by a friend from church. The health visitor recorded an intention to contact the NRPFT social worker about a stair-gate, but she delivered this and a highchair 4 weeks later. Child G was brought for the second set of immunisations, but not for the third set.
- 2.25. Between May 2015 and April 2016 Child G was seen twice by the NRPFT social worker during home visits in September and October 2015.³² Both times Mother falsely said she was involved with the children's centre, which appears not to have been checked. The NRPFT social worker made no further visits until July 2016, when Mother was again told to make a fresh application to the Home Office.
- 2.26. In April 2016, the GP reviewed Child G's case notes³³, identifying concerns about Child G not being fully immunised and there being no record of Child G's birth, which raised a potential concern about Private Fostering or Adoption. The GP made a referral to MASH and checks were made with the health visitor, Sibling's school, police, probation, and housing, but not with the NRPFT. The Wolverhampton Multi-Agency Safeguarding Hub (MASH) concluded there were "no safeguarding concerns"³⁴ and the health visitor agreed to follow up the concerns about lack of immunisations. Feedback from the MASH to the GP about the outcome of the referral was provided by letter about 4 weeks later and only after an email request by the GP.
- 2.27. The health visitor promptly contacted Mother by phone. Mother indicated she was willing for Child G to have the immunisations if someone else was with her. The health visitor contacted the church friend who attended as previously.
- 2.28. In June 2016, the school raised concerns about Sibling's frequent lateness, an example of apparently walking to school unaccompanied³⁵ and Mother's expressed difficulties in managing her behaviour at home. After two unsuccessful attempts the FSW made one visit, with no further involvement, as school attendance had improved and Mother demonstrably felt more confident in managing Sibling's behaviour and was receiving helpful support from the local church and the school parent worker³⁶. The FSW remembers the visit and stated during this review that it was a hot day and Child G was playing happily in an all in one vest. His limbs were clearly visible and the FSW saw no evidence of any injuries. The FSW did not see Sibling alone or make contact with the NRPFT team or the church, and felt there was no need for an Early Help Assessment.

³⁰ People cannot be removed from the UK while any applications are outstanding

³¹ Opportunity for the person with no right to be in the UK to leave voluntarily or through enforcement action

³² It is unclear why visits were not more frequent. Usual NRPFT practice would be to visit a family 2-3 monthly, the precise frequency is usually agreed in supervision.

³³ The GP practice routinely conducted 3 monthly reviews of vulnerable children with a health visitor, now the safeguarding GP also has a mid-point meeting with the health visitor.

³⁴ they did not recognise the potential significance of there being no record of a child's birth

³⁵ Mother's explanation of her running ahead was later accepted

³⁶ Also the view of the NRPFT social worker who visited around the same time

- 2.29. The children were brought by Mother to the GP surgery for “health checks” which she said had been advised by ‘social services’.³⁷ Despite a number of requests by the health visitor, Mother never brought Child G to his 2-year-old developmental check.
- 2.30. In mid-September 2016 Mother successfully requested a few days absence from school for Sibling, ostensibly so they could attend an appointment at the Home Office regarding her immigration status.³⁸ This was the first occasion that the school were aware of the child’s NRPFT status.
- 2.31. During her time in London Mother emailed the offices of the NRPFT and informed them that she no longer needed financial support as her Partner (who she did not name) and his parents would support and accommodate her and the children. A week later she contacted NRPFT again to enquire about ceasing support as her new Partner (now known to be Mother’s Partner) had proposed to her publicly in church and she stated that they would be moving back to London to live with him. Mother was advised to put her request in writing³⁹ and further advised that the NRPFT would need to visit the address to check its suitability for her children. The NRPFT did not ask the name of Mother’s Partner.
- 2.32. During September 2016, two anonymous letters (sent together) were received by the Home Office, complaining about Mother’s continued stay in the UK and making allegations that she was working illegally, but also noting that she had a new Partner. No action was taken and the letters were filed on the wrong file.
- 2.33. In the autumn term, as the school felt Mother might benefit from support in general, their Parent Worker became involved. During the term staff at Sibling’s school had occasional sightings of Child G, including with Mother’s Partner who, it was said by Mother, made visits to the family when his work in London permitted. In fact, it would appear that Mother’s Partner had effectively moved in with the family in September.
- 2.34. At the end of November 2016 Mother’s Partner called an ambulance to the family home where Child G was found to be in cardiac arrest. On examination in hospital, and after his death, Child G was found to have peritonitis due to a perforated bowel (allegedly caused by blunt force trauma) and a complex fracture of the skull. Child G also had a bite mark on his chest, pressure injuries to some finger nails and toe nails and many scars, including likely belt marks, varying in size and age on his limbs and torso.

In summary:

- 2.35. Prior to the injuries that caused Child G’s death, apart from the reluctance to ensure immunisation, and lateness to school, there had been no particular concerns about the care of either child. The only non-universal help provided in Wolverhampton was in respect of Early Help for assistance with routines and behaviour, and practical help such as the food bank and safety equipment. When observations about the children’s presentation are recorded these are consistently along the lines of the children being generally happy and developing normally or “no concerns”. This was confirmed by practitioners at the meeting held during this review.

³⁷ Participants at the practitioners meeting thought this was probably as a result of a recent visit by a social worker from NRPFT.

³⁸ There was no appointment. The application for a fee waiver had recently been reviewed and was refused for a second time

³⁹ Mother sent an email to the NRPFT social worker at the end of September confirming she would shortly be moving to Essex and supported in future by her partner and his parents.

- 2.36. Mother's Partner appears likely to have come back into her life at some point during the school summer holidays of 2016 (during a visit to London to see Maternal Grandmother). Mother's Partner is a violent man whose belief in the value of physical chastisement in bringing up boys resulted in tragic consequences for Child G.

3 Analysis

Domestic Abuse

- 3.1 On the two occasions when Mother expressed concerns about current domestic abuse, in 2013 and 2014, she was supported to find safer accommodation. At the time of Child G's birth, midwives recognised the risks of "coercive control"⁴⁰ even though this had been relatively recently included in the legal definition of domestic abuse⁴¹ and not yet been proposed to become a specific crime.⁴²
- 3.2 The response to prevent repeat victimisation was less effective however. Research shows that women who have been subjected to domestic abuse are vulnerable to two kinds of repeat victimisation; by the same person or by future partners.⁴³ It may be that the protective factors at the time of Child G's birth, which included that the relationship was relatively new, that Mother had confided in Maternal Grandmother, and that Mother was moving to Wolverhampton, were considered to outweigh the risks of repetition, as no-one seems to have considered obtaining consent to refer to the police or domestic abuse services.
- 3.3 Mother subsequently disclosed a "history of domestic abuse" to different practitioners after she moved to Wolverhampton. No-one asked what she meant nor recorded the alleged perpetrator's names. There was an over-reliance on the "Freedom Programme"⁴⁴ as being the solution. When Mother did not attend the Freedom Programme, this was not effectively followed up and no alternatives were delivered. Given she had no current partner, this was probably partly due to a focus on what were understandably seen as more immediate (health) issues. Nonetheless the FSW did consider using the "Empowerment Star"⁴⁵ with Mother but this was not achieved either, possibly due to the FSW going off sick and the proposal not being explicit in the Early Help action plan. The cover provided for the sick leave focused on the outstanding practical issues only. Had the MASH contacted the NRPFT on receipt of the referral from the GP they would have established where Child G was born, and possibly the circumstances of discharge, which would have indicated Mother's potential vulnerability in relationships with partners.
- 3.4 No-one seems to have considered informing Mother and Maternal Grandmother about "Clare's law" for their future reference.⁴⁶ During the review it became apparent that, by the time of the renewal of Mother's relationship with Mother's Partner, had she requested

⁴⁰ Term coined by Evan Stark 2007, for detailed discussion and risk of escalation from control to violence see Stark E (2012) "Re-presenting Battered Women; Coercive Control and the Defence of Liberty" in Violence against women: Complex Realities and New Issues in a Changing World . Les Presses de Universite du Quebec

⁴¹ <https://www.gov.uk/guidance/domestic-violence-and-abuse> March 2013

⁴² Section 76 Serious Crime Act 2015, specific legislation proposed December 2014

⁴³ http://www.ucl.ac.uk/jdibrief/analysis/repeat_victimisation

⁴⁴ <http://www.freedomprogramme.co.uk/>

⁴⁵ <http://www.outcomesstar.org.uk/about-the-star/>

⁴⁶ The Domestic Violence Disclosure Scheme (DVDS), often referred to as "Clare's Law", was being rolled out across all 43 police forces in March 2014. This permits disclosure of information about offences or other behaviour which might pose a risk in a current intimate relationship– <https://www.gov.uk/government/publications/domestic-violence-disclosure-scheme-pilot-guidance>

information the Multi-Agency Risk Assessment Conference (MARAC)⁴⁷ might have deemed it appropriate to disclose two previous reports of intimidating domestic arguments reported by two different partners and a recent caution for assault against another partner.

- 3.5 When Mother's Partner resumed his relationship with Mother again a few months before Child G's murder, the connection with his previous behaviour towards her was not made. The NRPFT were intending to follow up this new relationship after Mother stated an intention to discontinue financial support, but did not ask his name. The midwives had detailed the concerns in the discharge summary but neither this nor his name was available on Mother's health records.
- 3.6 Nonetheless, whilst it is now evident that Mother's Partner is a very violent man, there is no suggestion that the severe level of violence against Child G could have been predicted from his history. It is also recognised that, following Mother's move to Wolverhampton, until the murder of Child G, no-one identified or received reports of any significant concerns about his presentation with or behaviour towards Mother or the children.⁴⁸

Learning; domestic abuse

Learning	Rationale
When women disclose previous domestic abuse, assessment of future risk is better informed if practitioners obtain details of the nature of the abuse and record the name(s) of the alleged perpetrators	<p>There is a high general level of awareness amongst practitioners of the harm caused by Domestic abuse.</p> <p>People who have experienced domestic abuse are vulnerable to repeat victimisation by the same or a future partner.</p> <p>Gaining a detailed understanding of the nature of the abuse and the impact on the individuals affected (including children) would enable more effective personalised support.</p>
When parents are no longer with an abusive partner, more tenacity and creativity may be required to engage them to prevent repeat victimisation. While a referral to the Freedom programme may be of benefit, other interventions alongside this should also be considered.	<p>Knowing alleged perpetrators names would enable practitioners to intervene more effectively if relationships are resumed.</p> <p>Effective assessment and engagement requires the time and skills to develop confiding and trusting relationships-supporting practitioners to develop skills and confidence in delivering individual support would assist in overcoming the barriers to engagement</p>
People vulnerable to domestic abuse,	

⁴⁷ The MARAC is a multi-agency risk management meeting where professionals share information on high risk cases of domestic violence and abuse and put in place a risk management plan.

⁴⁸ Family members and friends had some concerns about how he had isolated Mother, his "disrespectful behaviour" towards family and friends and his taking over of care of Child G but nothing significant enough to report as a safeguarding concern.

<p>their families and the practitioners who support them, would benefit from understanding the application and limitations of Clare's Law and how to make use of it.</p>	<p>Greater awareness of Clare's law amongst practitioners and the general public would empower potentially vulnerable people to seek information at the first signs of concerns – although it is important to recognise that there are limits on what the police can disclose, and that information will only be available if concerns have been reported to the police.</p> <p><i>See recommendation 4</i></p>
--	--

Understanding of needs of people with an immigration status and No Recourse to Public Funds (NRPF)

- 3.7 Mother arrived in the UK with Maternal Aunt in 2003 on a visit, and did not leave within the 6-month timescale. As a child, she then essentially remained invisible to the Home Office until Maternal Grandmother made an application for her to remain in 2008, when Mother was 17. Because no fee was paid, Maternal Grandmother was asked to resubmit the forms. She didn't do so before Mother was an adult and because of gaps in Home Office procedures at that time, Mother essentially disappeared from view again until 2013, when enquiries were made to the Home Office, by the police, after Mother had made the allegation that sibling had been abused. At this point Mother was told by a Croydon social worker to make an application to regularise her status. She did not do so for another 12 months. Changes in procedures and gaps in the information she provided continued the uncertainty about her and her family's future (no right to remain, but no active steps towards removal either).
- 3.8 Until 2013, Mother had been supported financially by Maternal Grandmother. From 2013, once Croydon had conducted an assessment⁴⁹ and the family's NRPF status became clear, they were provided with accommodation including utilities, plus food vouchers and cash which amounted to £65 per week for herself and two children⁵⁰. The fathers of both children provided limited and periodic financial support, as did friends, but mother told the author she felt constantly short of money, and had to resort to borrowing money from people she did not know well.⁵¹
- 3.9 Mother's comments about the professional and informal helpers involved with her were that she appreciated approaches that were kind, courteous and thoughtful, and assistance which involved practical help, emotional support and explanations. Most of the people she came into contact provided some or all of those things. She did not like approaches which she saw as bossy or which involved asking her very personal questions when her children were nearby. Almost immediately after financial responsibility transferred from Croydon children's social care to the NRPF, the family were moved to Wolverhampton because accommodation was cheaper and more readily available. All members of the family interviewed had concerns about this as she was moving away from

⁴⁹ Under S17 of the Children Act 1989

⁵⁰ The payments are made in respect of the children and amounted to considerably less than a similar family in receipt of benefits would receive. (Since the period covered by this review Croydon have significantly increased the amount of financial support provided to families) Persons with no right to remain are not permitted to work.

⁵¹ This was also partly because of difficulties budgeting

family and friends. Relatives of sibling's father were able to put her in touch with the local church in Wolverhampton.

- 3.10 The accommodation was not ideal for a young family, being up a flight of stairs, and without a large enough cot for Child G or appropriate safety equipment.⁵² Although the deficits in equipment were identified by the health visitor on her first visit some 6 months after the family had arrived in Wolverhampton, these items were not provided for another 3 months. The NRPFT social worker did not visit until 3 months after Mother's arrival in Wolverhampton (which may have contributed to Mother feeling "abandoned"). She took Mother's statement that she had registered with a GP on face value and only by chance met the health visitor on a future occasion. Wolverhampton Children's Services (WCS) were not formally sent written notification of the family's arrival by the NRPFT until the summer of 2015⁵³. No-one considered referring the family to the local Refugee and Migrant Centre. This may have been of benefit to tackle Mother's social isolation as well as her undocumented status; Mother told this review that the specialist voluntary organisation in London that had helped her previously wanted her to seek more local support.
- 3.11 At the practitioners' meeting specialist participants shared their experience that people with undocumented status tend to try to stay "under the radar". Therefore, persons without the right to remain are potentially vulnerable to exploitation. Some may also have some reluctance to engage with services if they assume that other agencies share information with the Home Office. However, practitioners working with Mother saw her more as disorganised than avoidant, and when Mother felt unsafe, or that she or her children needed health care, she sought help.
- 3.12 Practitioners generally had not understood the role of the NRPFT social worker, nor had they formally checked Mother and children's immigration status. When Mother asked permission to take Sibling out of school to visit the Home Office the school did not understand the potential implications of their immigration status. During the meeting with the practitioners there was an appetite from non- specialist staff to better understand the needs, vulnerabilities and necessary survival tactics of people with no right to remain/NRPF, especially as it is likely that London boroughs will continue to place families outside London including, potentially, in Wolverhampton.

Learning; understanding needs of families with an immigration status and NRPF

Learning	Rationale
There are benefits to practitioners having a better understanding of the implications of no right to remain and NRPF on the lives of the families they work with.	Practitioners were aware of individuals with no right to remain/no recourse to public funds but they tend not have a good understanding of the typical lived experience. Families are inherently vulnerable due to their uncertain

⁵² Under the contract Croydon had, the housing provider should have ensured adequate sleeping arrangements and provision of safety equipment as part of the service commissioned by NRPFT – this provider no longer has a contract with the NRPFT.

⁵³ There was said to be no current role for Wolverhampton Social Care, and a request that Croydon be contacted if any concerns were raised about the family. Appropriate checks with relevant agencies were completed.

	status and not being able to fully participate in the communities they live
It is important for practitioners to have an understanding the role of specialist staff.	Practitioners awareness of the role of the NRPF social worker was low – this is a shared “explain and ask” responsibility for all practitioners which would improve the effectiveness of multi-agency working
There are benefits to practitioners having a better awareness about local specialist voluntary organisations for families with undocumented status, and giving consideration to the value of involving them.	Mother had been receiving advice and support about her immigration status from an agency in London, who thought she should seek more local support. Mother was not aware of the Refugee and Migrant Centre See recommendations 1,2 & 6

Assessing the implications of religious faith and beliefs

- 3.13 All the adults in this family had strong religious beliefs. While Maternal Grandmother and Mother have some beliefs about spirit possession, to the extent that Mother underwent what a journalist described as an exorcism when she was about 4 months pregnant, there is no evidence that Child G was subject to violence by Mother’s Partner because of these kinds of beliefs. None of the practitioners involved in this case were aware of the exorcism until after Child G had died.
- 3.14 Practitioners at the meeting were aware of the involvement of the church, especially in Wolverhampton, and gave a clear view about why they thought this was positive for this family. For example, the church she attended regularly provided practical support (fetching shopping, support for immunisations, meals, food parcels and transport), emotional support to Mother, and fun activities for Sibling. Two other churches provided her with food parcels. Mother was particularly grateful for the help she received from the congregation and staff of the church she attended regularly. This was more intensive and ongoing than from anyone else in Wolverhampton, and which she only received due to family connections between London and Wolverhampton churches.
- 3.15 Practitioners were also alert to the possibility that church involvement might not always be positive. They felt they would have been confident to follow up any concerns and they knew local examples of specific churches where involvement might have adverse implications for families in terms of, for example, discouraging access to medical care. However, a number of practitioners felt uncertain about how to go about exploring what an individual’s faith meant to them, and how this impacted on their lifestyle and parenting. This could mean missed opportunities for providing better support through church involvement, as well as missing potential risks of practices that might harm children.

Learning; assessing the implications of religious faith and belief

Learning	Rationale
Gaining an understanding of what a	The support Child G’s family received from the

<p>parent's faith means to them might enable more holistic and effective support for families. Practitioners do not consistently have the confidence to know how to go about this.</p>	<p>church she attended was positive and beneficial. Practitioners were alert to the possibility that church involvement might not always be positive. However, they were not consistently confident about how to go about exploring the impact of faith on lifestyle and parenting. This could mean missing opportunities for supporting families as well as assessing risk.</p> <p>See recommendation 5</p>
--	---

Assessment, Planning and Recording

- 3.16 The Croydon Children's Services conducted an assessment on Sibling in 2013 after Mother made the allegation of domestic abuse and abuse of Sibling. This was never reviewed or updated in the 3 years that the NRPFT were involved with the family. It was also never shared with Wolverhampton Children's Services, as would have been good practice. Despite some evidence of potential vulnerabilities which could have been explored in more detail, for example Mother's ability to maintain her own household, it was a "light approach" by virtue of the only identified need being destitution. Accordingly, it didn't result in a written Child in Need Plan, nor were there any multi-agency "Team Around the Child" (TAC) meetings. These would have been of particular benefit once the family moved to Wolverhampton. The existence of a plan would have given the opportunity to systematically follow up actions not done either by practitioners or Mother, including ensuring the children were registered with a GP.⁵⁴ The convening of a TAC meeting by the NRPFT social worker (or any other practitioner) would have ensured practitioners met one another, improved understanding about respective roles and responsibilities, identified any discrepancies in the information provided by Mother and improved co-ordination of visits to and services for the family. Improved co-ordination of visits is beneficial for agencies as well as families, as it promotes more efficient use of resources.
- 3.17 No practitioner was aware of the 'exorcism' video until there was media attention following Child G's death. An internet search⁵⁵ during an assessment after September 2013 may have identified the video, which could have provided an opportunity to reflect on whether there were any potential implications for Child G. Practitioners told reviewers that they do not do checks routinely on the internet or in social media. Some services make such checks on social media for specific reasons (NRPFT for fraud, and MASH for concerns relating to social media, both via specific accounts to overcome standard prohibitions on work computers). Other services, for example health visiting and Early Help, do not have such accounts, so are unable to do these checks.
- 3.18 There are a number of instances where records were incomplete, insufficiently specific or not effectively transferred when Mother moved.

⁵⁴ There is no legal requirement to register with a GP, but not to register a child would not be seen as good parenting

⁵⁵ Such checks, including on social media, in other cases could, for example, contradict denials of contact with dangerous ex-partners

Learning; Assessment, Planning and Recording

Learning	Rationale
<p>Holistic assessments should include asking “who else is involved with you and your family?” and recording this in a form that is accessible and easily updateable, for example using an Ecogram</p>	<p>Practitioners were not generally aware who were involved with the family. Asking about this would have identified all sources of support and gaps.</p> <p>Because these children were only regarded as “in need” by virtue of destitution this was treated with a light touch and no formal “child in need plan” was produced and nor were there any TAC meetings. Therefore, intervention was not well co-ordinated or systematic enough, and led to drift.</p>
<p>Written plans and Team Around the Child (TAC) meetings for ALL Children in Need, including those only judged to be so by virtue of destitution, would support intervention being well co-ordinated and systematic.</p>	<p>Checks on the internet and social media can provide publicly available information about lifestyle and relationships to inform assessments.</p>
<p>When conducting assessments and reassessments of vulnerable families, practitioners may find that including internet and social media checks would enhance and triangulate information given by parents.</p>	
<p>Accurate recording of specific details and effective arrangements for transfer of records when families move or involvement transfers between services would better safeguard vulnerable children.</p>	<p>The vulnerability of children in transient families is well known and compounded if poor recording makes it harder to see relevant history and issues.</p> <p>See recommendation 7</p>

Good Practice

3.19 It is important for serious case reviews to identify and promote good practice, and in this case there were a number of examples, which include:

- Midwifery staff sought safeguarding advice about a newly delivered mother who had had limited antenatal care in unclear social circumstances
- Midwifery staff enabled safe discharge of Mother and Child G, away from her controlling partner
- The NRPF social worker explained to mother the inadvisability of being discharged to live with a new partner with a new baby and followed this up with a phone call to Maternal Grandmother to make sure Mother was with her
- The NRPF social worker and the HV went together to the GPs surgery to check what mother was telling them
- The early intervention meeting at the Children’s Centre identified a potentially vulnerable family new to the area

- The health visitor identified the historic domestic abuse and made a referral to the Freedom Programme
- The health visiting service made prompt visits when requested by other agencies (transfer in and follow-up from referral to the MASH)
- MASH staff proactively made checks with other agencies when they received a written notification from Croydon which included a request to be told of any concerns
- The GP reviewed the records in April 2016 and chased the outcome of the resulting referral to MASH
- When Mother mentioned wish for support with immunisations, the health visitor went with her to the appointment and contacted member of church that had supported her to get Child G immunised previously
- The NRPF social worker took opportunities to check the house for anyone else who might be living there
- The NRPF social worker asked Mother to put her request to cease support in writing and stated a requirement for a social worker to visit the address she was proposing to live at
- The school proactively involved their parent worker to provide support
- The GP and health visiting staff were mindful of the learning from a recent Serious Case Review about the impact of a specific church on take up of healthcare services; they found out which local church Mother was involved with
- The local church provided support which was appreciated by Mother and seen to be beneficial to the whole family
- Sibling was protected effectively after Child G's injuries were discovered

4 Recommendations

The individual agency reports have made single agency recommendations. Wolverhampton Safeguarding Children Board has accepted these and will ensure their implementation is monitored.

To address the multi-agency learning, this Serious Case Review identified the following recommendations and questions.

For Wolverhampton Safeguarding Children Board:

1. Wolverhampton Safeguarding Board should consider how best to draw to national attention the inconsistent application of Section 17 duties under the 1989 Children Act for families with no recourse to public funds.
2. The Wolverhampton Safeguarding Children Board should consider contacting the Independent Press Standards Organisation (IPSO) to draw their attention to the article about Mother when she was pregnant. This would be with a view to asking IPSO to review their expectations of journalists and editors when they encounter material which raises potential child protection issues.

For Wolverhampton and Croydon Safeguarding Children Boards:

3. The Wolverhampton and Croydon Safeguarding Children Boards should ensure that any “No Recourse to Public Funds” protocols used by agencies in their areas incorporate all the learning from this Serious Case Review.

For all Safeguarding Children Boards who have contributed to this Serious Case Review, that they:

4. Consider how best to improve services to protect victims of domestic abuse from repeat victimisation:
 - a) Ensure practitioners understand the importance of enquiring about the nature of the historical domestic abuse and the name(s) of the alleged perpetrators
 - b) Ensure practitioners are aware of a range of strategies, tools and services to personalise support and engage families.
5. Consider how best to improve the confidence of practitioners in seeking information about what a parent’s faith means to them, and how it impacts on their lifestyle, well-being, and parenting. This would better enable recognition of the positive support faith groups provide, alongside better understanding and management of any risks.
6. Consider how best to ensure that:
 - a. Practitioners (including staff in schools) acquire a better understanding of the needs and vulnerabilities of families who do not have leave to remain, and
 - b. Families with no recourse to public funds gain better access to universal services and targeted support, where appropriate, including that provided by the voluntary sector.
7. Consider how best to enable practitioners to access and use relevant internet and public facing social media content to enhance their assessments. This should include policy and practice guidance.