



*Working Together
to Safeguard Children*



Executive Summary And Recommendations

(Extracts from the overview report commissioned by Milton Keynes ACPC and Bedfordshire LSCB and written by Annie Callanan)

***Incorporating: Milton Keynes Council
Milton Keynes Primary Care Trust
Milton Keynes General NHS Trust
Thames Valley Police**

Key-

DL- the child

DH- Mother of DL

NH- DL's Mothers Partner

AH- Mother of NH

TB/R- NH's former partner

Executive Summary and Conclusion

- 1.1 When DL was born, on the 18th November 2001, his mother, DH, was 18 years old and living with her father, DL's maternal grandfather.
- 1.2 Although there is some evidence that DH was supported by DL's father, by the time DL was 16 months old, DH had moved into the home of AH, NH's mother. She and DL moved from there to share a flat with a young woman, who DH alleges, was using 'crack' (cocaine)
- 1.3 From that address DH moved for a short while into Hostel accommodation and was accepted on the housing register on the basis of a letter from her father confirming that she and DL had been asked to move from her family home.
- 1.4 Prior to DH's relationship with NH Health Visitors and GPs did not express concerns about her capacity to parent. However there had been some early concerns about her overfeeding DL when he was in the first months of life and it is clear from the evidence that DH had not always been in contact with Health Visitors. When she moved to settled accommodation in Dunstable the GP did not alert his colleagues to her arrival on the GP Practice List.
- 1.5 DH was therefore not someone who was known to the authorities in Bedfordshire.
- 1.6 NH however, was known to the authorities. He was known to Social Services because he had been involved, two years previously, with a family where the children were observed to be terrified and shaking when asked about him and where their mother, TB/R, denied the violence that was taking place. Social Services and the Police in Bedfordshire had taken a decision in 2002 that dog handlers should be used if the TB/R children needed to be removed and that the Police should always be present during visits if NH was in the household. Social Services and Education noted a marked improvement in the well being of those children when NH left the family home and moved on.
- 1.7 NH was also known, through his own self reporting, by his GP, Mental Health Services and by Probation Services, to have serious anger management problems.
- 1.8 He was flagged on the Bedfordshire Police PNC system as being dangerous, a fact that was shared with Bedfordshire Social Services within days of the first anonymous referral to Social Services in July 2004 which alleged racial attacks and physical abuse, by NH against DL. That referral also alleged that DH 'shouts' at DL. That latter allegation was never investigated and, when Social Services did visit, NH was not interviewed, although assumptions were made that one of the two men present at DL's home was NH.

- 1.9 Within days of that first allegation, having accepted DH's assurances that the allegation was untrue and failing to ask her about the allegation against her, the Team Manager, who was the Key worker in the TB/R case, closed the case.
- 1.10 Five days following the closure of the case DH was told about NH's convictions and his tendency towards aggression. She replied that this was controlled with medication and because she loved him he would change. No alarm appears to have been raised about how her attitude, based on little or no experience of trying to achieve such an outcome, was putting herself and her child at grave risk of harm.
- 1.11 Bedfordshire Social Services did not take the case through its own Child Protection Procedures and the other agencies involved, both the Police Authority and Health Services, did not challenge Social Services on the closure of the case or take their own action to initiate a Case Conference.
- 1.12 On two more occasions Bedfordshire Social Services received anonymous referrals alleging escalating racial attacks and physical abuse against DL. On the second occasion, DH was once more interviewed and NH was not. Her assurances, that the alleged racism and abuse did not take place and that DL's injuries were caused by two separate, unrelated accidents, were accepted.
- 1.13 On the third occasion, when DL was observed by Health Visitors to have an untreated dog bite, and DH to have bruises on her face, Bedfordshire Social Services organised a medical.
- 1.14 DH told the Health Visitor and Early Childhood Advisor that DL had been bitten by an anonymous dog. DL told the Early Childhood Advisor that he was bitten by 'daddy's' dog. That information was passed to, and recorded by, Bedfordshire Social Services. DL also told his Pre-School Nursery and the Community Paediatrician that he had been bitten by the family i.e. NH's dog. Despite this and the fact that Social Services had also received another anonymous referral which alleged that NH had trained his dog to attack DL along with further allegations of racial abuse and physical abuse, when the Community Paediatrician, with little evidence, decided that his injuries were 'not deliberate' Social Services, once again, did not follow their own Child Protection procedures. And once again, Health Visitors continued to feel so concerned about NH's presence in the household that they had implemented the Lone Worker Policy and were visiting in twos, but they failed to either request or call a case conference.
- 1.15 When DH and DL presented at the Bedfordshire Social Services offices in September 2004 with cuts and abrasions they were taken to Luton and Dunstable Hospital for check-up. The events following that action were, once again, to exacerbate rather than reduce the risk to DL. An inexperienced Police Officer took a statement from DH who alleged that NH had attacked her when she intervened to prevent DL being

injured. That Police Officer failed to follow Bedfordshire Police procedures and did not log the assault on DL as a crime, the assault on DH was not passed to the Domestic Violence Unit. The assault on DL never reached the Child Protection Unit.

- 1.16 DH and DL were seen separately at the hospital and their cases not linked. They were discharged, into the 'care of a Social Worker' and the Hospital's own Child Protection procedures were not followed up.
- 1.17 DH took DL, with the knowledge of Bedfordshire Social Services, to an unknown address with a relative and had plans to fly to stay with her mother, DL's maternal grandmother, on Jersey the following day. After that time Bedfordshire Social Services responded to DH's request for support in finding new housing as a housing issue. They did not take steps to follow their own Child Protection Procedures and alert the authorities in Jersey or subsequently, in Milton Keynes that DH and DL were moving to those areas. Had they done so, and provided a comprehensive report on the outstanding issues, it is very likely that Milton Keynes Children's Services would have realised that DH was, by the time she reached Milton Keynes, staying with NH's brother and sister-in-law.
- 1.18 Further, the request for help with housing due to 'Domestic Violence' which referred to child protection issues was made by Bedfordshire Social Services to Milton Keynes Homelessness section. Milton Keynes Homelessness section were not asked specifically to do anything with this information and assumed, wrongly, that Bedfordshire Social Services would make a referral to Milton Keynes Social Services. Because of this wrong assumption Milton Keynes Homelessness section did not alert Milton Keynes Social Services about either the outstanding and unresolved child protection or the domestic violence issues related to DL or DH. Thus the failure to protect DL from harm that resulted from the mismanagement from the case in Bedfordshire was exacerbated in Milton Keynes.
- 1.19 When DH went to Bedfordshire Police in October 2004, to withdraw her statement, made in September 2004 alleging that NH had attacked both herself and DL, another opportunity was lost to protect her and her son from harm. The Dunstable address on the statement was assumed to be current; the assault against DL was not recorded or logged so it was not discussed and; there appears to have been no discussion about how she might protect herself from an individual the Police knew to be dangerous, should the decision be taken to pursue him. Again, the case was not referred to the Domestic Violence Unit.
- 1.20 When Bedfordshire Police made enquiries at NH's mother's home in on 23rd December 2004, both his mother and DH contacted his previous Probation Officer to seek advice about how the statement might be withdrawn.

- 1.21 On 31st December 2004 DH succeeded in getting a friend to meet her in Milton Keynes to take her to Bedfordshire Police to withdraw the statement and ask the Police to stop looking for NH. The friend refused and DH went back to her home.
- 1.22 Later that evening, she dialled 999 and asked for Police assistance in relation to an incident of Domestic Violence. The call was terminated at DH's end. When she was called back, to tell her that the Police would attend, DH told them the problem had been an ex-boyfriend who had left. She gave the Police a name which was not NH.
- 1.23 The Police attended and DH told the Officers that her 'ex-boyfriend' had left. They asked to see DL and satisfied that although he was upset he looked unharmed, they left.
- 1.24 The next time DL was seen was by the Ambulance Service who responded to a 999 call on the morning of the 1st January 2005. On admission to Milton Keynes Hospital, DL was found to be in a state of rigor mortis and, at 08.20 am, he was pronounced dead.
- 1.25 The likely cause of death was considered, by a Consultant Paediatrician and a Specialist Registrar Paediatrics to be an intestinal blockage. Although a nurse raised on two occasions, both with the Paediatricians and with the Milton Keynes Police who attended at A&E, the presence of bruising on DL's body, this was considered to be within the norm of what could be expected on a child of DL's age.
- 1.26 Both DH and NH were being treated by hospital staff as DL's parents, when, given his mixed race, this was clearly extremely unlikely. Neither hospital staff nor the Police asked who DH and NH were or what their relationship to DL was. This is the most basic information required when a child is admitted to hospital. Both Adults were fully dressed, despite telling clinical staff that they had been awake at 1am at 3am and had woken that morning to find DL not breathing. Neither had called the emergency services or a GP during DL's illness and, crucially in this Reviewers opinion, DH was noted, by nursing staff and by the Police, to have bruising on her face and her arms.
- 1.27 Had the clinical staff and the Police taken time to consider all of the information they had access to and to discuss their concerns and reservations about the cause of death, then it could and should have been considered likely that it was not due to natural causes.
- 1.28 The danger of the failure to take time and consider all of the evidence was clearly that DH could have been sent home from Milton Keynes Hospital with NH and if he is, as charged, guilty of the murder of DL, then she was the only witness.
- 1.29 When DH subsequently accused NH of causing DL's death the Police were re called to the A&E Department and, on the evening of the 1st

January 2005, NH was charged with the murder of DL and ABH against DH.

- 1.30 The systems failures in this case began when the first referral to Bedfordshire Social Services did not result in the allegations being investigated properly and the case being progressed through the Child Protection Procedures. Had that happened, the information available and already known to all the agencies about NH and DH would have been pooled, assessed and analysed and decisive action could have been taken to safeguard DL from further harm. Those systems failures endured throughout the time DL remained in Bedfordshire and following his move to Milton Keynes.
- 1.31 This case demonstrates clearly the need to understand racial abuse and harassment, to take racial attacks on all vulnerable people, especially children seriously and to ensure staff in all agencies understand their role in responding to reports of racial attack and in positive reinforcement of a child's minority ethnic background.
- 1.32 It also highlights the need to respond in an informed way, to the issue of Domestic Violence, the impact of Domestic Violence on children and on women and the need to take action to work with women who are, for whatever reason, in denial about what is happening to them and to their children.
- 1.33 The response to DH, who consistently denied Domestic Violence, has raised questions within some agencies about why she, (and other women) do not accept the help they are offered. The response to Domestic Violence is, however, complex and varied.
- 1.34 TB/R (NH's ex-partner) told me precisely how many times NH had been in prison. She also told me that being in prison made him 'angrier' and that, throughout the period of his sentence for attacking her ex-husband she 'had to' go to his mothers on a daily basis so that he would know where she was. She lied to Social Services throughout her relationship with NH. She told me that she was terrified of him and she was terrified of Social Services. However she believed him capable of carrying out his threats, to kill her children in front of her and then to kill her, if she did talk to the authorities. Lying to Social Services to protect herself and her children was the least risky of the options she believed were available
- 1.35 The response of women generally is extensively documented in a variety of literature. Some research into how hostages 'bargain' and 'collude' with their captors in order to remain alive have been explored as a method of understanding why women react with denial. The "Stockholm Syndrome", is the response of hostages who will begin to work with their captors in order to anticipate any sudden changes of mood which may trigger an aggressive or dangerous response and to keep aggression from escalating.

- 1.36 Added to this, the reality for many women in situations of Domestic Violence is that men who are perpetrators are not just taken away when the incident occurs; they are frequently set free and return again and again. Faith in the authorities' capacity to protect women can be undermined by women's own direct experience of repeated and escalating violence and abuse.
- 1.37 The links between Domestic Violence and Child Abuse are well documented as are the links between Domestic Violence and Mental Health. The Department of Health Report Into the Mainstream, Strategic Development of Mental Health 2003 states that;
- “At least 750,000 children a year witness domestic violence.” And
“Nearly three quarters of children on the “at risk” register live in households where domestic violence occurs.”
- 1.38 The same report also states that
- “Women who experience domestic violence report more depressive symptoms, are at a greater risk of suicide and make greater use of mental health services than women in the general population”
- 1.39 The lessons from this case are about the vital importance of clear communication, the importance of the implementation of the existing Child Protection Procedures by all of the agencies at all levels and the need to recognise the connection between racial abuse and harassment, domestic violence and child abuse, to analyse all of the evidence and to take systematic and robust steps to ensure the health and well being of vulnerable children.

Recommendations

2 Bedfordshire County Council Social Services

- 2.1 Social Services should take action to ensure that Statutory Child Protection Procedures are fully implemented and deployed in each and every case where concerns, from whatever source, are raised about the care and protection of a child.
- 2.2 Social Services should ensure that all staff deployed to work on cases involving child protection, from the initial referral and throughout the case work, are properly trained, supervised, managed and supported in all activities.
- 2.3 Social Services should take action to ensure that all information held in Social Services and other agencies data bases is accessed, fully analysed and deployed in the assessment of risk to children and families.
- 2.4 Social Services should ensure that legal advice is sought in cases of Child Protection where there is any question about whether to progress a case through the Child Protection procedures.
- 2.5 Social Services and the Police Authority should establish an agreed Protocol for sharing information on offenders following requests for PNC checks.
- 2.6 Social Services and Health Visiting staff should receive training in;
 - Working with aggressive individuals
 - Responding appropriately and in a service user centred manner to Domestic Violence
 - Understanding severe mental health problems, such as schizophrenia and how such illness may effect the individuals behaviour
 - Understanding personality disorders and how an individual with, for example, a psychopathic personality disorder will behave towards other people and the need for expert supervision and advice when working with such individuals
 - Working with children and families from minority ethnic communities
 - Working with racial abuse
- 2.7 Social Services and the PCT should establish cross sector quality assurance and monitoring mechanisms to provide evidence that Child Protection Procedures are implemented effectively and take immediate corrective action when gaps are identified that undermine the statutory responsibility to safeguard children.

3 Bedfordshire Police

3.1 Bedfordshire Police should take action to review implementation, in front line services of training, awareness, application of Policies and Procedures, of Supervision and Management in:

- working with Child Protection Procedures
- working with Domestic Violence
- working with children and families from minority ethnic communities

3.2 The Police Authority should review the Domestic Violence Policy to incorporate policy guidance on working with minority ethnic communities beyond the provision of interpreters.

4 Bedfordshire and Luton Community Mental Health Services

- 4.1 Bedfordshire and Luton Mental Health Service should ensure that clear decisions are taken about what kind of services are provided to service users with personality disorders who are reported, or self reporting as being aggressive. That information should be shared with all appropriate agencies involved with the individual.
- 4.2 Mental Health Services should ensure that when service users with a history of violent crime undergo a risk assessment the assessment should include questions about what kind of aggressive behaviour the individual is manifesting and how that behaviour is affecting those around them. Any concerns about the impact of such behaviour should always be passed to the appropriate agency.
- 4.3 Mental Health Services should communicate the outcome of treatment to GPs together with information about what services were not provided and the rationale for non provision of the requested services.
- 4.4 Mental Health Services should offer further appointments when appointments are cancelled and alert GPs to services user cancellation of appointments and the likely impact on the user of failing to follow through treatment.

5 Bedfordshire Heartlands PCT

GPs and Health Visitors

- 5.1 The PCT should ensure that GPs always alert Health Visiting Services to children who are registered with their practice.
- 5.2 The PCT should ensure that all staff are aware of their statutory duties under the Child Protection Procedures; are sufficiently trained, skilled and experienced to carry out those duties and are properly supervised and managed.
- 5.3 The PCT should put in place mechanisms for effectively monitoring all responses to child protection concerns and ensure that all staff allocated to work with children living in situations where there is risk are appropriately prepared, monitored and supervised particularly unqualified health visiting staff and students.

6 *Community Paediatricians*

- 6.1 Community Paediatricians should develop a clear protocol for referrals received from Social Services. Such protocols should allow the case to be put in context; the referral should be explicit about what the Community Paediatrician is being asked to do and describe clearly how the outcome of the medical examination and diagnosis, together with supporting evidence, will be fed back to the proper authorities.
- 6.2 Community Paediatricians should establish an approach to gathering all of the evidence available in making an assessment, recording the evidence and using it in reaching a conclusion.
- 6.3 Community Paediatricians should review training in Child Protection, Domestic Violence and Race Awareness.

7 Luton and Dunstable Hospital NHS Trust

- 7.1 The A&E Department should ensure that all cases of Child Abuse and Domestic Violence are logged using the Trust's Child Protection and Domestic Violence Procedures so that victims are provided with adequate follow-up and support on discharge.
- 7.2 The A&E Department should ensure that cases involving both Child Abuse and Domestic Violence are assessed together and that the outcome of examinations are recorded, where appropriate photographs are taken, and that information is provided to GPs and Health Visitors.

8 Milton Keynes Council

- 8.1 All staff in the Housing Department should receive training in the recognition of child abuse and their roles and responsibilities in working within the Council's Child Protection Policies and Procedures.
- 8.2 All staff in the Housing Department should receive training in the content and application of the Council's Policy on monitoring ethnic origins of services users, the rationale behind that policy and its use in supporting children and families from minority ethnic backgrounds and supporting the development of ethnically sensitive services.
- 8.3 All staff in the Housing Department should receive training in the recognition of Domestic Violence and in responding sensitively to the needs of women and children who are surviving such violence.
- 8.4 The Housing Department should develop existing systems to ensure that Health Services are made aware of the presence of children whose parents are receiving housing options advice and through that process are moving into the Milton Keynes area.
- 8.5 Interagency procedures should be established to ensure that all cases of suspicious death of a child that occur within the Borough are notified to the Head of Children's Services via robust and well informed on call systems linked to Emergency Social Work Teams.

9 Thames Valley Police

- 9.1 All Officers deployed to investigate the sudden death of a child should have training in Child Protection, Race Awareness and Domestic Violence Policies and be conversant in the application of those policies and procedures.
- 9.2 Thames Valley Police should establish a system to log calls on Domestic Violence so that the information is available, traceable and can be flagged, in the shortest possible time to Officers attending cases where there has been non-accidental injury or the sudden death of a child.
- 9.3 Thames Valley Police should establish a system for requesting details on all individuals accompanying or caring for a child who has been injured in suspicious circumstances or has died suddenly. These details should be checked on the Police National Computer as part of the initial fact finding process alongside the deployment of investigating officers.
- 9.4 Thames Valley Police should review the policy on Sudden Infant Death to include children above the age of infants.

10 Milton Keynes General Hospital and PCT

- 10.1 All staff in A&E should receive training in Child Protection, Domestic Violence and Race Awareness and be deployed according to their skills and expertise, to strengthen child and vulnerable adult protection systems, whatever the individual roles within the hospital team are.
- 10.2 All staff in A&E should be aware of the need to maintain vigilance to the reality of the presence of child abuse and Domestic Violence and the need to always ensure that time is taken to properly assess all of the evidence whilst continuing to respond with compassion and care to the parents and relatives of a child who has died.
- 10.3 The Hospital Trust should ensure that full information on the names and addresses of the adults accompanying a child who is injured in suspicious circumstances or who has died suddenly are passed to the Police for checking.
- 10.4 The Hospital Trust should always check the Child Protection Register in all cases of sudden child death.

11 General

- 11.1 Social Services, Health and the Police Authority should, in every case, alert authorities in other areas when a child or children move from the Bedfordshire area and there are outstanding child protection and Domestic Violence concerns.
- 11.2 Specific and detailed information should be shared with the authorities where the child moves to, however temporarily, together with requests for specific action to ensure the child is safeguarded from further abuse.
- 11.3 All agencies should review their child protection procedures, under the auspices of the Safeguarding Children's Board and establish effective mechanisms to share information and provide an effective child protection service.