Hampshire Safeguarding Children Partnership

HAMPSHIRE SAFEGUARDING CHILDREN PARTNERSHIP

Multi-Agency Review of 'Lucy'

Background

Baby Lucy was a twenty-month-old girl at the time of the incident. She has a brother who is a year older than her.

The Hampshire Safeguarding Children Partnership Learning and Inquiry Sub-Group considered the circumstances of the incident, detailed below, at a meeting. It was decided that a partnership review would be conducted, comprising of an analysis of partner agency scoping documents and a multi-agency practitioners' workshop. This latter event was held on 26 September 2019.

Baby Lucy's mother and father are both known to agencies. They were known to Children's Services (CSD) as children due to suspected neglect and poor parenting. As adults they were known to agencies for substance misuse, domestic abuse and criminality. CSD were initially involved with Lucy's brother who was placed on a child protection (CP) plan before birth due to the risk posed by the father. This extended to Lucy when she was born, and subsequently CSD issued proceedings to the court and care orders were granted in March 2018. At this time, the parents had separated, and mother was stating that she wanted no contact with the father. Given this, the family court decided that both children should remain living with mother. Father's contact with the children was only to be under supervision. The court knew, at this time, that mother had obtained a non-molestation order against father. This remains in place and father has been arrested in relation to breaching it on several occasions.

In May 2019, Lucy was attacked by the father's dog whilst both children were at his home, unsupervised. She suffered serious injuries which were initially described as 'life-changing' – but a physical recovery is now anticipated. Despite denials by mother, the strong suspicion is that she left the children at the house with father shortly before the attack.

In the weeks before the dog attack both police and CSD had concerns that the parents had resumed a relationship – but this was always denied by mother. No **evidence** could be found of a resumption of the relationship.

The review

The workshop was attended by practitioners from police, probation – in the form of the Community Rehabilitation Company (CRC), CSD and Health including a health visitor manager. The meeting was chaired by two senior manager leads from police and CSD, neither of whom had any recent involvement in the case. The discussion was wide ranging. Whilst notes are available, this report focusses on the key questions that were identified and aims to give them context.

1. What is professionals' level of understanding of integrated offender management (IOM) and how individuals are managed under the framework? What opportunities for information sharing exist between IOM and non-participating agencies?

Since the beginning of 2019, Police and Probation (in this case CRC) have jointly managed a cohort of persistent domestic violence perpetrators in the community. IOM involves regular contact, risk

assessments and information sharing between the two lead agencies. The CRC role is to support perpetrators in addressing their offending behaviours and signposting them to support for their needs. The police role is to catch and convict should they continue to offend.

Learning Point: It was apparent that other agencies were not aware of the IOM programme nor the rich source of information that both agencies could provide. Reciprocally, IOM agencies were not aware of the involvement of health visitors with mother, nor of the fact that the children were in contact with their father. Police also have neighbourhood teams who could be tasked to gather intelligence and information on local people of interest.

2. Are professionals aware of the differences, and the potential differences in approach, between CP plans and care orders where the child is placed at home and not with a foster family?

Both children were on a CP plan initially and then, as the result of a family court hearing, placed on care orders living with mother. As the care orders were in place, the CP plans were removed.

Learning Point: The consequences of this change of legal status were not widely understood by agencies. It is not clear whether agencies have mechanisms to record that children looked after placed at home are vulnerable children in the way that they would for children subject to CP planning. Some felt that their agencies would see this as a lowering of concern and control over the children as they had been removed from a CP plan. Consequently, a less qualified member of staff, or fewer staff might have been assigned to the case than was appropriate.

Learning Point: Concerns were also raised around the ability or accuracy of agencies' IT systems in recording the difference between children on CP plans and those on care orders placed at home.

3. Did professionals' level of understanding of CP plans and care orders at home affect the way information was viewed and shared?

There was a sparsity of awareness of other agencies' roles when in contact with such families and a lack of open lines of communication to share relevant information. There was confusion as to the notification process to agencies of CSD when conducting child in care planning and what their information requirement was or what meetings should be attended.

4. What is the multi-agency understanding of non-molestation and restraining orders, and the opportunities and consequences for professionals working with cases where they apply?

Learning Point: Professionals from all agencies had little understanding of the purpose, effect, and scope of such orders and how information they held could assist with their enforcement.

Recommendations:

- There is a need for multi-agency awareness training around the role of IOM, and the effect of non-molestation and restraining orders.
- Professionals from all agencies need a greater understanding of how some children can be subject to care orders but continue to live with a parent and the associated levels of risk.
- Agencies need to review their IT systems to assess if the appropriate information is recorded or can be recorded for children on CP plans and those on care orders but placed at home.

- CSD will review their process for notifying and involving other agencies of children on care orders at home, to ensure that all relevant agencies are informed of the risks and plans in place and are sharing information adequately.

Report completed by:

Colin Mathews, Serious Case Reviewer - Hampshire Constabulary

Kieran Lyons, Service Development Lead - Hampshire County Council

Publication Date: 24 January 2022