HARINGEY LOCAL SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW
Executive Summary

Family Q

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EXECUTIVE SUMMARY

1 INTRODUCTION

1.1. Circumstances leading to the review

1.2. In December 2009, police were called to an address in Haringey. There they found the body of a woman. A police investigation commenced which led to her husband being arrested and subsequently charged with her manslaughter. Present at the time of the assault were their four young children.

1.3. There was a long history of domestic violence between the children's mother and father. Both had been involved with a number of agencies, including criminal justice organisations, over the preceding years.

1.4. Chapter 8 of 'Working Together 2010' sets out the circumstances in which a Local Safeguarding Children Board (LSCB) should consider undertaking a Serious Case Review. They include when:

- *a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect; or*
- *a child has been seriously harmed as a result of being subjected to sexual abuse; or*
- *a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004.; or*
- *a child has been seriously harmed following a violent assault perpetrated by another child or adult:*

***and** the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes interagency and/or inter disciplinary working.*

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1.5. The purpose of a Serious Case Review is to:

- *establish what lessons are to be learnt from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;*
- *identify what those lessons are both within and between agencies, how and within what time scales they will be acted upon, and what is expected to change as a result; and*
- *improve intra-and inter agency working and better safeguard and promote the welfare of children*

1.6. The death of the children's mother led to the instigation of a domestic homicide review by the Metropolitan Police. Upon examination of the information presented the Independent Chair of Haringey Local Safeguarding Children Board (LSCB) agreed that a serious case review would be undertaken. Ofsted were informed that the Haringey LSCB would seek to engage Haringey Safeguarding Adults' Board in the process in order to maximise learning across children's and adults' staff groups.

2 THE SERIOUS CASE REVIEW PROCESS

2.1. Haringey LSCB set up a Review Panel to oversee the process of the review in February 2010. Graham Badman, Independent Chair of the LSCB, undertook the role of chair. An independent author, Brian Boxall, was appointed to write the Overview Report. The Panel met seven times between April and November 2010, when the final review was signed off by the LSCB. It included a specialist advisor on Domestic Violence. A three month extension was granted to the statutory six month timescale for completion of the review, in order that family members could be enabled to contribute.

2.2. The Serious Case Review Sub Group agreed the Terms of Reference for this review:

1. Each agency was asked to produce a chronology of their involvement with any member of the family during the specified period and to consider the following:
2. Were there any issues in communication, information sharing or service delivery between services?
3. Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
4. What were the key relevant points/opportunities for assessment and decision making and effective intervention in this case in relation to the children and family? What was the quality and timeliness of decision making and do assessments and decisions appear to have been reached in an informed and professional way? What was the quality of multi-agency risk assessments?
5. What did each agency know about the history of each of the parents? Consider whether both the mother's and father's experiences in the light of their childhood and previous relationships was appropriately identified, acted upon and has any relevance.
6. Was the impact of domestic violence on each of the children recognised, and was appropriate action taken to respond to the needs of the children in the light of what was known by the agency about domestic violence that was occurring in the household? Did each agency have systematic processes in place to ensure compliance with statutory responsibilities to safeguard children in the context of domestic violence, including appropriately targeted training?
7. What training has been provided in adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children?
8. Were practitioners aware of "what it was like to actually be that child"; sensitive to the needs of the children in their work; and knowledgeable both about potential indicators of abuse or neglect and what to do if they had concerns about a child's welfare?
9. Did the agency contribute to the Multi Agency Risk Assessment Conference (MARAC) process in relation to this case? What was the impact of the MARAC process in responding to the needs of this family?
10. Did actions accord with assessments and decisions made? Were opportunities for effective intervention, such as s.47 investigations, taken? Were appropriate services offered/provided and/or relevant enquiries made, in light of assessment?
11. Did practice since October 2009 show the impact of any lessons learned from Haringey's 2009 Serious Case Reviews?
12. Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?
13. Was there sufficient management accountability for decision making? What was the quality of supervision? Were senior managers or other organisations and

professionals involved at points in the case where they should have been?

14. Evaluate the impact of any organisational change over the period covered by the review and establish the capacity of front-line services for effective response.

The scope of the review was agreed as 1st January 2005 to 1st January 2010 to reflect the period during which there was clear escalation in incidence of domestic violence. Authors were also asked to highlight events that occurred prior to 2005 if they considered them to be relevant.

2.3. Individual Management Reviews (IMRs) were initially requested from:

- LA Children & Young People's Service;
- Metropolitan Police;
- General Practice;
- Children's Community Health Service managed by Great Ormond Street Hospital for Children NHS Trust,
- Whittington Hospital NHS Trust;
- Barnet Enfield and Haringey Mental Health Services;
- Schools & Early Years settings;
- London Probation Trust;
- HM Prison Pentonville;
- Epic Trust-HARTS service;
- LA Housing Service (including Hearthstone & Homes for Haringey);

A Health Overview IMR was produced to synthesise the findings of the five IMRs from health agencies and evaluate the practice of all involved health professionals . A further IMR was subsequently provided by Pentonville Prison Healthcare. Enfield Local Safeguarding Children Board also supplied a report. Recommendations for further action identified in IMRs are being addressed by all agencies. The authors of the IMRs were appropriately independent as they had not been involved with the family at any time.

This executive summary highlights the key issues identified by the serious case review and areas for further learning across the partnership.

2.4. **Parallel Processes**

The Metropolitan Police undertook a Domestic Violence Homicide Review. The review was made available to the Serious Case Review Panel. A criminal prosecution was also undertaken and concluded during the review process.

2.5. **Family Involvement**

Members of the family agreed to be interviewed as part of the serious case review. Their contribution was invaluable as it ensured increased understanding from the family's perspective.

3 SUMMARY OF AGENCY INVOLVEMENT

3.1. Family Background and history prior to 2005

Mother

3.2. There is very little known about her background before 2005 other than she had lived locally all her life. Prior to meeting father she had a daughter who was born in 1989. Mother was white British with no recorded disabilities.

Father

3.3. Father is also white British. He has stated that from the age of two years until the age of 18 he was in the care of a Local Authority. During this time he reported that he was in 23 care placements. He was previously married and had a daughter from this marriage. He stated that he had a further two relationships prior to meeting mother; both relationships produced children.

3.4. Between 1988 and 1995 father had 13 recorded presentations to Mental Health Services and three admissions for alcohol detoxification and/ or treatment of his mental health disorder. He had a diagnosis of alcoholism and personality disorder. He never registered with a GP.

Contextual Information pre-Review Period 2005-2009

3.5. It is not clear when mother and father first met, but there is evidence from police and health records that mother had been subject to violence at the hands of father for at least 10 years before 2005.

3.6. Twice in January 2004, mother attended the local police station and alleged that father had punched and throttled her until she passed out. Father was arrested and charged. Mother subsequently withdrew the allegations.

3.7. Two children were born in this period, in 2001 and 2003.

Review Period 2005 - 2009

3.8. During 2005, police attended the home address on multiple occasions resulting in father being arrested three times. On a number of these occasions it was mother's eldest daughter who contacted the police. She was nearly 15 years old at the time.

3.9. Between 2005 and 2009, there were a total of 14 referrals/notifications to children's social care, 13 of which were notifications from the police. On only four occasions was the completion of an Initial Assessment considered and only two of these assessments were completed.

3.10. One of the police notifications was very detailed. It listed the number of incidences of domestic violence since 2003 and specified concern that the children were present. However the level of risk was identified as low and 'no further action' was taken.

3.11. In 2008, mother attended her local GP. She disclosed that her partner had assaulted her. She had cuts and bruises to her head. She said that the children had been present at the time. She stated that it had also happened many times in the past. She stated that the police were involved. The GP did not send a referral to the Children and Young People's Service, assuming that the police would have done so.

3.12. In early 2009, father pleaded guilty to assault on mother. He was sentenced to 48 weeks imprisonment suspended for two years. He was required to take part in a Probation-run Integrated Domestic Abuse Programme (IDAP).

3.13. Mother attended a specialist domestic violence service having been referred by the police. She was assessed as "high risk", against the domestic violence Multi Agency Risk Assessment Conference (MARAC) checklist. The specialist domestic violence service contacted Housing Services. They informed them that mother had requested a management transfer. They also made a referral to Children and Young People's Service. This good practice was supportive of mother. The case was referred by the Independent Domestic Violence Advisor (IDVA), to the MARAC.

3.14. In March 2009, father attended court but the case was discontinued as the case papers could not be located. Father was released from custody. Police were not made aware of this until three weeks later. The officer in the case contacted the Crown Prosecution Service and convinced them that the case should be reinstated. A summons was issued.

3.15. Father appeared at court in April, for breach and a further alcohol treatment order was added to his suspended sentence order. He was remanded in custody until July 2009.

3.16. Mother was discussed in three successive MARAC meetings. In June 2009 a Child Protection Advisor attending the MARAC sent an e-mail to Children and Young People's Service staff and management suggesting that there were child protection concerns that should be acted upon. There is no evidence that any individual responded to these concerns. This was the first time the potential effects of domestic violence on the children had been highlighted.

The case was closed to MARAC in July 2009 because father was still in custody at that time. It was never referred back upon his release.

3.17. In the same month the Probation Service produced a pre-sentence report. They were unable to offer any alternative other than custody with a recommendation that whilst in custody father should address his alcohol problems and a psychiatric assessment should be completed. Despite this, the probation risk assessment was 'medium'.

3.18. Father was sentenced to 52 weeks imprisonment with 105 days on remand to count toward the sentence. The court recorded this wrongly as 26 weeks. The prison calculated father's sentence based on the inaccurate information and concluded that he was due for release the following day. He was released at the beginning of August.

3.19. A letter from the Court Clerk pointed out the error in the initial warrant. The amended warrant indicated a sentence of 52 weeks. A sentence of 52 weeks equals 364 days – or just less than one year. There was as a consequence no requirement for the Probation Service to be involved following his release. Father was duly re-arrested and returned to prison to complete his sentence.

3.20. Whilst in prison he was subject to intervention by the prison health care service. He was at one stage diagnosed as having a borderline personality disorder. At no stage was any agency informed.

3.21. Mother resumed contact with father while in prison. At the same time any meaningful contact with agencies that had been supporting her came to an end.

3.22. Father was released in October 2009. He was not subject to any licence conditions or supervision. A month later he self-presented to a hospital Emergency Reception Centre when drunk and abusive, but left before there could be any intervention. No other services were informed.

3.23. One month after this Mother was taken to hospital having been found apparently lifeless at her home address. She was pronounced dead on arrival at the hospital.

4 CONCLUSIONS/LESSONS LEARNED

4.1. This serious case review has been complex and far reaching. It has not only examined the actions of child-focused agencies but it has also had to consider the impact of

adult-focused services, including the criminal justice process, the prison and mental health services, both in the community and within the prison. The impact that these services had on father is inextricably linked to the risk posed to the children in this family. The review has identified a number of issues from which lessons can and must be learned.

Assessment of Family History

4.2. It is evident that most agencies knew little about either of the parent's childhood or early adult background. The only agencies who did become aware of father's background, and who gained some insight as to how this may have affected him, were the Mental Health and Probation Services. Unfortunately they did not share this insight with any other agency. The Mental Health Service - both the generic service and the prison mental healthcare service - failed to consider the children within the family when assessing father and his needs. Both they and the Probation Service remained adult focused.

4.3. Father's history was very significant. It provided a picture of an individual who was deeply disturbed probably, in part, due to his childhood experiences. This was very relevant information when considering his ability to form relationships or to be a protective parent. Because father's history, was never considered, his mental health problems were never identified or assessed by agencies other than by the Mental Health Service.

4.4. The failure of agencies to fully assess all males in a household has been highlighted in previous national serious case reviews. Brandon et al (June 2009) [1]*Understanding Serious Case Reviews and their Impact 'A Biennial Analysis of Serious Case Reviews 2005-07*' stated *"Assessments and support plans tended to focus on the mother's problems in caring for her children and paid little attention to the men in the household and the risks of harm they might pose to the children given histories of domestic violence or allegations of or convictions for sexual abuse. The failure to take account of men in assessments occurred sometimes even when good information was available'.*

Access to Information & Information Sharing

4.5. Information sharing is essential, but the quality of that information and access to it is dependant on effective recording systems within agencies. The Children and Young People's Service electronic recording system had limitations in that information did not automatically transfer across the records of children in the same family. It was up to the author of a given record to copy that record across into other family members' files but this was not consistently carried out - a particular problem when the information being entered on a file concerned the whole family rather than a specific child. The system does not facilitate the creation of a family record. This was identified in the Children and Young People's Service individual management review and is being addressed.

4.6. The original records of father's interaction with Mental Health Services, between 1988 and 1995, were held in paper files. An electronic database replaced these paper files in 2007, but these records were not automatically transferred onto the new system. Therefore health professionals did not have access to father's early life assessments and as the paper files were never subsequently requested or retrieved, significant information was never fully taken into account.

[1] Brandon et al (June 2009) Understanding Serious Case Reviews and their Impact 'A Biennial Analysis of Serious Case Reviews 2005-07'

4.7. Paper files and access to them was again highlighted as an issue when Health Visiting records were not transferred from a Primary Care Trust in another borough. It was not clear to the Review why the transfer did not take place but equally the records were never chased up. They have subsequently been located and found to contain information about domestic violence between mother and father, which should have informed health visitors' assessments.

4.8. Failure to access relevant information that could be stored in different parts of a system was also an issue in relation to GPs. Although GP records contained a history of significant domestic violence, this was hidden from immediate view and, due to the way the GP accessed the records, this information was not known by him.

4.9. Agency individual management reviews have made recommendations to address these concerns.

Information Sharing across Universal, Targeted and Specialist Services

4.10. In order for children to be effectively protected, good information sharing across the universal health service providers - General Practitioners, the Maternity Service, Health Visitors and School Nurse Service - is essential. The issue is no less significant for other universal providers such as schools and housing services. The level and quality of information provided between services, from pre-birth through to school, is an essential safeguarding tool.

4.11. This review identified that information sharing between the universal health services was not consistent. The mother's GP's record had an entry indicating that she was "At risk of violence in home" but this information was not picked up and highlighted to maternity services when she was referred to them upon becoming pregnant. The Health Visiting Service did become aware of some of the domestic violence concerns, but assessed them to be historic information stating that the '*parents were still together and the difficulties had settled down*'. This was a not an accurate picture and was totally reliant on information being supplied by mother.

4.12. Normally, if there is school involvement with children who are subject to a social work assessment, the social worker would communicate with the school. Because this did not happen at any assessment point in this case, the communication between health visitor and school nurse acquired a greater significance. Health visiting information was passed to the school nursing service in a blue folder denoting concern, but because the level of need was considered to be 'low' the school nurse filed the report without doing anything with it – hence the school remained unaware that there were any concerns.

4.13. It is of note that at that time domestic violence was not a category requiring an enhanced health visiting service. As a result of the Joint Area Review inspection (2008) this was changed and the use of the blue folder was extended to unresolved child protection concerns, including a history of domestic violence.

4.14. Conclusions that domestic abuse incidents are historic must be avoided as there can be long periods of time between incidents, and there will also be many incidents that go unreported. It should be the case that any indication of domestic abuse within a family should be relayed to the relevant school so that they at least have knowledge of the family history and can take it into consideration if they have concerns about a child.

4.15. Flaws in information sharing were also exposed in relation to housing staff and the specialist domestic violence service, in the main because the focus of their attention

tended to be the adult. Although there were examples of good practice, both services were guilty at times of accepting what mother told them at face value and not passing information to children's social care. Recognition of the impact of domestic violence on those children and need to do something about it was insufficiently strong; not least when the fact that father had been released from prison in October was known but not shared with social workers.

4.16. This review identified how the ability to access information is vital if effective assessments/judgments are to be made. A failure at any stage to highlight significant concerns has a knock-on effect. If this is not taking place, then communication and information sharing within the wider multi-agency system becomes flawed leading to some agencies, specifically schools in this case and then latterly social workers, not being aware of relevant information.

Referrals and Interventions

4.17. It was evidenced that when presented with domestic violence referrals or notifications the Children and Young People's Service failed to respond in line with procedures and thereby failed to fully support any of the children or mother. In October 2008, a child protection investigation should have been considered in line with the London Child Protection Procedures, because a child under 12 months old was present.

4.18. The initial assessments that were undertaken did not involve any agency other than social care. There was a perception held by some staff, that when undertaking initial assessments the social worker was, at that stage, not conducting child protection enquiries and therefore any contact with external agencies required parental consent. They also judged that information could not be shared with other agencies for an initial assessment because it may contravene Data Protection legislation. These inadequate assessments led to cases being closed with no further action being taken.

4.19. This was an issue discussed in Laming 2009 *The Protection of Children in England: A Progress Report (p41)*[2]
'Those who have local accountability for keeping children safe should ensure that all staff in every service, from frontline practitioners to legal advisors and managers in statutory services and, voluntary sector, understand the circumstances in which they may lawfully share information about both children and parents, and that it is in the public interest to prioritise the safety and welfare of children'

4.20. Their decision making was also influenced by the domestic violence risk assessment levels indicated on police notifications. The risk was identified as 'low,' but the risk that was being assessed was measuring the likelihood of physical harm to the children rather than the nature of any emotional impact that might result from exposure to domestic violence. The receiving social worker will not necessarily have known that. Each agency had different processes for assessing risk and different measures for risk levels.

4.21. The role of the Children and Young People's Service has been fully examined in this review and it must be placed in the context of the position of the organisation at that time. Significant and positive changes have taken place as a result of the Peter Connelly Serious Case Review, but what cannot be underestimated is the effect that the lack of a social work response had on other agencies.

[2] Laming 2009 *The Protection of Children in England: A Progress Report* TSO *(p41)*

4.22. As has previously been highlighted the universal health services failed to make good informed assessments which might have led to referral and interventions. Mother was pregnant and gave birth on a number of occasions, but these services, whilst concentrating on mother's clinical needs, failed to identify the issue of domestic violence and the risk to the children and mother's reaction to her situation.

4.23. Despite having concerns, agencies such as the police and the specialist domestic violence service failed to challenge the lack of response to their notifications and therefore tacitly accepted the implication that there was little risk to the children.

4.24. The overwhelming feeling this review leaves the reader with is that the children had no voice. No agency really worked with them; the work was all adult-focused. Even when, on the isolated occasion, an agency identified that the children may be suffering and submitted notifications or referrals they did not challenge a lack of action. This would indicate that agencies felt that their role was completed upon submission of the referral.

4.25. The interview with one of the children confirmed this view. Despite being exposed to domestic violence in the family home for a number of years, despite being the individual who often called the police when her mother was being attacked, she was never spoken too or asked how she felt. She believes that if she had been consulted she would have been able to say what she was feeling and what she and her siblings were being exposed to.

Domestic Violence

4.26. There is little evidence that the impact of domestic violence on children was fully considered by any agency. This appears to have been due to a number of generally held misconceptions. Firstly, the lack of any physical evidence that the children were affected. They showed no signs of any physical injuries or demonstrated any signs of abnormal/unusual behaviour, especially at school; and secondly the belief that mother was able to protect her children from risk, a situation that, in itself, may have placed more pressure on mother not to co-operate with the authorities in the fear that her children might be removed.

4.27. Understanding of the complexities of domestic violence such as the impact on women, why they might react in certain ways, why their vulnerability may compromise the choices they make and the long term impact on their children, was still at a basic level over the period reviewed.

4.28. The family members were able to provide some insight into what mother and the children were going through. The children were able to compartmentalise their life at home and their life at school. By doing this they were able to hide their home life from teachers. Mother achieved the same. This shows that the perception that the school had, that friends would have made them aware if anything was going on, is wrong. As a close family member revealed, even she was unaware of the extent of the violence being endured by mother and witnessed by the children.

4.29. The Multi Agency Risk Assessment Conference (MARAC) was in place as of 2008. Its intended function was set out in The Co-ordinated Action Against Domestic Abuse [3](CAADA) (2010) :
A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs)

[3] CAADA (2010) *Administration and Governance Template*

and other specialists from the statutory and voluntary sectors. After sharing all relevant information they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim. The MARAC will also make links with others to safeguard children and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety '

4.30. Whilst its main function is to support the adult victim the MARAC should be a vehicle through which other safeguarding processes can be linked. This includes the child protection process and processes such as Multi Agency Public Protection Arrangement (MAPPA) or adult protection. The process is reliant on appropriate referrals, information sharing risk assessment and planning.

4.31. It is evident from agency individual management reviews that the MARAC role and function within Haringey was not fully understood. If it had been functioning well it should have allowed for a full assessment of the risk father posed to the children and their mother and a multi agency plan would have been produced and implemented. There is no evidence that an effective plan was ever produced or followed up. The fact that even the MARAC had not recognised the need to consider the impact of release of father from prison is evidence of this.

4.32. The effectiveness of the MARAC was limited and, as the domestic homicide review highlighted, unless the police were directly responsible for an action then the minutes did not record the details of that action or information about its completion.

Role of Criminal Justice Agencies

4.33. There was significant involvement in this case from criminal justice agencies; specifically courts, probation and prisons. The children in the family were never fully considered by any of these agencies. Sentencing decisions, both in respect of father's initial early release and the later misconception that the 52 week sentence constituted a year when in fact it equated to only 364 days was very important. Its knock-on effect was to allow father, who was considered to be potentially dangerous, to be released without supervision as he had received a sentence of less than 12 months. This meant that he could not be considered as a category 2 Multi Agency Public Protection Arrangement (MAPPA) subject that would have increased the risk assessment process and monitoring.

4.34. Whilst it is accepted that the consequences of the sentencing decisions could not have been easily rectified, it was compounded by the lack of any effective information sharing between the prison and probation service. Neither the police nor children's social care were notified that father was to be released.

4.35. As father was not subject to a licensing arrangement any subsequent management of him as a MAPPA subject would sit with the police, not the Probation Service. Unless he has been identified as a MAPPA subject prior to being sentenced and a local police owner has been identified, then the only way father's risk could have been assessed and managed was if the local police had been informed of the risk he posed. This did not take place. The function of the prison service, the probation service and the police with regard to information sharing and the application of the MAPPA process need to be reviewed in light of this case.

Role of Mental Health Services

4.36. Mental health services, at various stages, not only had knowledge of father's very

difficult childhood and his history and mental condition, but they were also aware that he was father of a number of children. At no time did they assess the impact that he might have on those children. They were considering only the adult, their client, not the family he was part of. The 'Think Family' principle was not applied.

4.37. During his time in prison, father had significant involvement with the prison mental health team where he was diagnosed at one stage with a borderline personality disorder. This diagnosis was changed just prior to his release. As his condition was not diagnosed as 'severe' he did not meet the criteria for inclusion on the 'Care Programme Approach'. This would have required a health care professional to have considered the whole family and a programme of support which would have been continued upon father's release. Father had never registered with a GP. The prison mental health team thought, wrongly, that he could not be referred directly to a community mental health programme when he was released.

4.38. Father was therefore considered to be potentially dangerous but was expected, upon his release; to register himself with a GP and seek help - an expectation that he would self-administer his own support when all the evidence indicated that he had at no time previously had been able to achieve this. He was also an abuser of substances - both drugs and alcohol. The prison service mental health team recorded his treatment on the prison's internal recording system, but there was no requirement to record father's treatment on an external electronic system, so when father presented to the local hospital Emergency Reception Centre in late2009 the treatment he had received in prison was not known. None of the mental health providers considered it necessary to contact children's social care to make them aware of the potential danger father posed to other people.

Good Practice

4.39. The review has sought to highlight good practice where it existed. The joint working between housing staff and the specialist domestic violence service needs to be recognised as they were one of the few groups that by working together became engaged with mother and started to support her in her wish to detach herself from her situation.

Police officers also demonstrated good practice: specifically the officer who insisted that the Crown Prosecution Service proceed with a summons against father when they had previously discontinued the case having lost the file. They clearly recognised the potential danger he posed and took proactive action to ensure he remained in the system.

The examples of good practice in this case are unfortunately limited.

Subsequent Changes

4.40. The review did establish that important changes that have taken place in Haringey as a consequence of the Peter Connelly Serious Case Review. This has included the formation of the new First Response Multi Agency Assessment Team (FR MAT) and the development of a Risk Management Strategy by the Local Safeguarding Children Board. If this is fully embraced by all agencies, then many of the issues with regard to information sharing and effective initial risk assessments will be addressed.

4.41. This case does highlight the need for closer links with adult-focussed services in order to ensure the effective protection of children. This can be modelled by adult-focussed services re-thinking about the way in which they can achieve compliance with statutory duties under the Children Act 2004 and by closer co-operation between the Safeguarding Children and Adult Boards.

4.42. Whilst no child died or suffered serious physical injury they are likely to have suffered long term emotional harm. The death of their mother may not have been avoided but better multi agency working might have reduced the level of harm the children were exposed to. It is right to end with a child's view - that neither she nor her siblings were spoken to about what they were facing. The process that should have been protecting these vulnerable individuals failed to properly identify what was happening to them or what they needed.

SERIOUS CASE REVIEW RECOMMENDATIONS

The Haringey Local Safeguarding Children Board and Haringey Safeguarding Adult Board to:

1 Develop a joint protocol to underpin a joined up approach to safeguarding of both children and adults specifically in relation to domestic violence and mental health, taking into account:

- the role and remit of other partnership boards
- existing protocols and practice guidance

The Haringey Local Safeguarding Children Board and Haringey Safeguarding Adult Board to work with the Domestic Violence Partnership Board in Haringey to:

2 Review current training approach to domestic violence, to ensure that it is underpinned by core knowledge and understanding of issues such as:

- The long and short term impact of DV on children
- Co-dependency
- Work with male perpetrators and other men in the household
- Parental mental illness, including personality disorder

3 Scope a review of the Multi Agency Risk Assessment Conference (MARAC) to identify what work needs to be done by which Board to produce:

- a framework for a 'Think Family' approach that explicitly considers the needs of children
- the development of a clear, recorded meeting process that identifies actions, leads and timescales
- a system for monitoring and scrutiny that can evidence an understanding of process and function and require action to be taken to address any areas of weakness

4 Ensure that the information sharing issues highlighted by this review are specifically addressed by all agencies in their action planning.

5 Review the current service provision for people with personality disorder to recognize the point at which a parent with this diagnosis needs support and services so as to enhance the support provided to the children and families.

The Haringey Local Safeguarding Children Board to:

6 Embed systems to improve and monitor multi-agency assessment practice in line with the principles laid out in the LSCB Risk Management Strategy 2010 and Section 11 Children Act 2004.

7 Monitor the effectiveness of the First Response Multi Agency Team (FR MAT). Lessons learnt from this Serious Case Review to be used to inform and the strategy for development of the First Response team.

8 Ensure that staff from all agencies gives equal importance to the role of males involved with a family, resident or non resident, during their assessment processes. To be examined during audits.

National Issues
The Haringey Local Safeguarding Children Board and Haringey Adult Safeguarding Board to:

9 Bring to the attention of the Department of Health issues highlighted in this review, specifically the link between health provision for transient individuals, including released prisoners, and entry into community health services when these individuals are not registered with a general practitioner.

10 Bring the attention of the Ministry of Justice issues highlighted in this serious case review with regard to the implementation of the Multi Agency Public Protection Arrangements (MAPPA) process within the prison.

11 Bring to the attention of the London Safeguarding Children Board the need to review, in conjunction with the Metropolitan Police, the current Domestic Homicide Review Process operating across London. Consider the implementation of a multi-agency Domestic Homicide Review Process in line with the Home Office interim guidance, and identify how it can operate in conjunction with, and inform the serious case review process, be this for adults or children.

12 Bring to the attention of the London Safeguarding Children Board the need to review, in conjunction with the Metropolitan Police, the current MERLIN notification system to identify how and when safeguarding issues that do not reach a crime threshold should be made subject to police referrals rather than notifications under the current practice.