NEWHAM
SAFEGUARDING CHILDREN
PARTNERSHIP

Hounslow Safeguarding Children Partnership

and

Newham Safeguarding Children Partnership

Serious Case Review for Family K

Independent Reviewer – Fergus Smith

Overview Report – Keith Ibbetson

Published on 25th September 2020

Contents

	Page
1. Background and reasons for conducting the review	1
2. Brief narrative of family background and events	1
3. Learning and recommendations	3
• Learning point A	3
○ Recommendation 1	3
• Learning point B	4
○ Recommendation 2	4
○ Recommendation 3	4
• Learning point C	4
○ Recommendation 4	4
• Learning point D	4
○ Recommendation 5	5
• Learning point E	5
○ Recommendation 6	5

1. Background and reasons for conducting the review

1.1 In June 2018 an infant (referred to below as Child R) suffered severe knife injuries when his father attacked him and his mother. Child R's father subsequently pleaded guilty to the attempted murder of both Child R and the mother. At the time Child R's mother was living in Hounslow with her four children. Child R's father was awaiting sentence for a domestic assault on the mother committed in March 2018 at the address in Hounslow. This had never been his home address and at the time of the attack on Child R, his bail conditions barred him from contacting the mother or going to the family home.

1.2 The mother and her children had moved back to Hounslow in early 2018, having lived over the previous two years at a number of locations in London and the South-East. Child R's mother, the children, Child R's father and the father of the three older children in the family had been known to at least twenty organisations in four local authority areas including the police, Children's Social Care, schools, voluntary sector domestic abuse services, hospitals and community-based health services, as well as the National Probation Service and the Child and Family Court Advisory and Support Service (CAFCASS).

1.3 All members of this family are from Pakistani heritage; identifying as Muslim or practising Islam. The mother had moved to the UK from Europe and had the right to reside permanently here. She travelled regularly to see her family throughout the period under review. Child R now lives with his mother's extended family in Europe. The father of the three older children is a UK national and he now has responsibility for their care. The father of Child R was born in Pakistan and had a limited right of residence in the UK.

1.4 In July 2018 Hannah Miller, the Independent Chair of Hounslow's Safeguarding Children Board (now Partnership) decided that the criteria for undertaking a Serious Case Review (SCR) were met, taking account of the very serious injuries to Child R and his mother, the number of services that had been involved with the family and some initial concerns about the way in which agencies had worked together. It was clear that in hindsight that the level of risk to the children and their mother had been underestimated.

1.5 Although work on the review began immediately and its scope and approach were set in a proportionate way, delays to the review were caused by the large number of agencies and local partnerships involved and the difficulty in obtaining and verifying potentially relevant information. This mirrored the difficulties experienced by professionals working with the family before Child R was injured.

1.6 This summary report sets out the learning and recommendations of the review and has been prepared for publication in order to comply with the statutory guidance and transitional arrangements for safeguarding children boards and partnerships.[1]

2. Brief narrative of family background and events

2.1 The children's mother had an arranged marriage to a Pakistani man living in the UK. They had three children over a period of four years who are all now of secondary school age. Agency records give no indication of concerns about their care until 2016, when their mother made allegations of domestic abuse, including a very serious sexual allegation, against the father. These allegations

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722306/Working_Together-transitional_guidance.pdf

were subsequently retracted, and the mother later expressed her confidence in his ability to care for the children. Initially the family court granted the mother care of the children and an order enabling her to live in the family home.

2.2 The mother also said that she felt threatened by members of her own family, alleging that they might try to remove her children. This was recorded by the police as being possible 'honour-based violence', though no specific details were noted and there was no investigation. Despite her reported fears, the mother subsequently had numerous contacts with her family, travelling several times to see them with her children, causing no apparent difficulties for her. The alert in police records led officers to track her when she made travel arrangements to leave the UK, and on a number of occasions welfare checks were made (sometimes on her return to London).

2.3 During the period of separation, mother moved home on a number of occasions. Although initially the court ordered that the children should live with their mother, the arrangements for the children appear to have been fluid and not always in line with the intentions of the court. The reasons for this are not clear but no urgent concerns were ever raised about their care. Court welfare officers expressed concern about the veracity and inconsistency of the mother's accounts, which were never tested in court through a fact finding (which is a requirement of the relevant family court guidance).[2]

2.4 At around the time of her separation the mother from her first husband, she met the father of Child R and became pregnant. They married under Sharia law (Islamically), a status not recognised under UK law. She booked antenatal care at more than one hospital and during her pregnancy presented to a number of health trusts and women's organisations (in Hounslow, East London and elsewhere). She usually repeated the allegations of domestic abuse (by the father of the older children) and agencies suspected low level concerns about her mental health. The latter were not specific or serious and therefore were not judged to require further assessment or treatment. No agency obtained a comprehensive account or chronology of the children's history. Mother persistently denied any allegations of abuse from her new partner until much later in the review period.

2.5 Sharing of these concerns led to referrals to social care from a number of agencies, a pre-discharge planning meeting after the birth of Child R and the allocation of a social worker from the Local Authority in East London where the family (mother, the three older children, Child R and his father) planned to live. A single assessment was started though social work involvement was limited.

2.6 The older children attended primary school, who were alert to the children's needs and in liaison with the mother, facilitated contact with their father, which was positive for the children and was not deemed to have caused any difficulties.

2.7 In August 2017, the father of Child R assaulted the mother during a dispute about the contact that was taking place between the older children and their father. She had informed her family about this, who told her to stay in her Islamic marriage due to the shame of being divorced twice. There is no evidence that she told any professional about the assault until March 2018, when she reported that the abuse had continued from that point and had become worse

2.8 In December 2017, the mother told Child R's father that she was ending the relationship because she had found sexual videos of him with another woman. In response, she reported that he had threatened to kill Child R and attempted to persuade her to send him to be brought up in Pakistan. The police investigation highlighted inconsistencies in the mother's account and prosecution was

[2] 'Practice Direction 12J - Child Arrangements & Contact Orders: Domestic Abuse and Harm'. https://www.justice.gov.uk/courts/procedure-rules/family/practice_directions/pd_part_12j#21a

not pursued. Mother continued to seek separation from Child R's father, though when offered a refuge place she did not accept it because it was located outside London. It is not clear whether the couple remained in the same household after this point.

2.9 For this period, there is no record of action by the responsible Local Authority, Children Social Care service and the reasons for this could not be determined by the review. Information about the family was maintained and shared in the professional network through the actions of an Asian women's voluntary organisation who worked closely with the mother. The local Multi-Agency Risk Assessment Conference panel (MARAC) was notified of the most recent incident.

2.10 In early 2018 the mother found accommodation for the family and moved back to Hounslow. The previous Local Authority did not share information about the family moving, however the domestic abuse organisation working with the mother did and the Hounslow MARAC obtained information from its counterpart. Mother was given support to live in Hounslow by voluntary sector domestic violence services, stating her intention that she would not tell the father of Child R where she was living or have contact with him. Professionals accepted her view that this was adequate protection against further attacks by Child R's father.

2.11 In March 2018 he assaulted the mother after she gave him the address of where she and her children were living. She reported to professionals that this was on the pretext that he needed to collect his possessions, and that he 'snuck in' and she was too frightened to make him leave letting him stay overnight. At this point the police pursued a prosecution against him. Children's Social Care and a domestic abuse organisation both undertook an assessment and practical protective measures were put in place. The Hounslow MARAC panel noted that the Local Authority was undertaking a risk assessment and took no further action.

2.12 The Children's Social Care's assessment concluded that there was no risk to the children from Child R's father. After being convicted for the assault, but before sentencing, he stabbed the baby and his mother. This is understood to have been linked to the mother's refusal to undergo a paternity test, which the father had pressed for.

3. Learning and recommendations

Learning Point A - The need to focus on the children's daily lives and the emotional impact of domestic abuse

The focus of investigations and assessments was on the possibility of there being immediate risk of physical harm to the children, though in two instances, after the children had returned to live in Hounslow in 2018, that risk was not identified. Most agencies paid insufficient attention to the day to day experience of the children and the potential for emotional harm resulting from the instability caused by exposure to incidents of violence, repeatedly moving home and uncertainty caused by changing family composition.

Recommendation 1

The safeguarding partnership will recommend to member agencies that assessments of children's needs should always take account of the emotional impact of domestic abuse.

Learning Point B - Recognising the importance of families that move frequently

The frequent household moves over a relatively brief period of time caused difficulties for professionals. The mother approached different agencies (for example antenatal services) without always informing them that other services had already been involved. Although there were

exceptions, agencies rarely sought information from their counterparts in other areas, as a result of which the risk assessment could only be based on information provided by the mother and the current presentation. At several important points, information was not shared by agencies when they knew that a family had moved.

Recommendation 2

The safeguarding partnership should highlight the importance of compiling and sharing information that is crucial to the safe transfer of cases; case summaries and reviews, case closure documents, and chronologies setting out key events. Agencies must ensure that when a family leaves or arrives in an area their staff take all relevant steps to transfer and request information.

Recommendation 3

The safeguarding partnership should ensure through Learning and Development, that all agencies have arrangements in place to consider within assessment and supporting multi-agency procedures the child's experience and emotional impact, as well as the child's voice.

Learning Point C - Recognising the importance of previous episodes in assessment

Recommendation 4

The safeguarding partnership should ask member agencies and partnerships (including those who are the commissioners of services) to ensure that whenever possible, professional assessments of risk in relation to domestic abuse consider relevant history. For example, past accounts of abuse, including those with other partners, pervious services provided and their impact and the impact of abuse on the victim and children.

Learning Point D - The need for professionals to evaluate the veracity of accounts of abuse

The review highlighted the difficulty faced by professionals in deciding how to evaluate the allegations made by the mother. The records show that professional understanding of risks had been based exclusively on the accounts given by her, with no corroborative or supportive evidence until the final episode of abuse. In hindsight, it is clear that some allegations of abuse were retracted or not shared with professionals by the mother. There was little evidence that she followed up offers of support, often changing her opinion about the ability of the father to look after the three older children safely. At the time, professionals were either not aware of these inconsistencies or did not choose to understand them better within the context of the family function.

It is not the responsibility of the Serious Case Review to retrospectively judge whether the allegations made were true or not. However, the lack of a careful evaluation at the time may have contributed to professional views which underestimated the very serious risk posed by the father of Child R. Professionals need to recognise that victims of domestic abuse may not always give full, truthful or consistent accounts of what has happened and are most likely to understate its severity or impact. The reasons for this should not be hard to understand. Many victims find it difficult to trust professionals and wish to keep as much control as possible; they may take a particular view as to the best way to protect themselves and their children, which they may not feel that professionals understand or agree with. It is also the case that victims who fear losing their children may understate the impact of the abuse on them.

It is the responsibility of agencies to take all of these factors into account in evaluating allegations made, starting with a recognition that all allegations should be taken seriously and responded to respectfully. The police are legally charged with investigating allegations with an open mind. Social Care professionals must place a particular onus on understanding potential risks to children, which

should always include making an evaluation of how reliable and protective the alleged victim and those who are supporting her can be. Sometimes it will be right to advocate or take immediate measures to protect a woman making allegations, returning later to a more careful evaluation of the circumstances.

Recommendation 5

The safeguarding partnership should ensure that all agencies promote a culture and competence that enables staff to evaluate risks from domestic abuse in full, always taking them seriously and treating alleged victims with respect but in appropriate circumstances exploring how complete allegations are and whether they are valid.

Learning Point E - Assessments must take account of race, religion and other individual and family characteristics that shape its impact on victims

Assessment and management of risk, where there are allegations of domestic abuse need, to take account of specific factors of race, religion and family background – recognising that this will be a unique assessment because every family and individual has a different interpretation of these factors and individual needs. For example, in this case insufficient attention was paid to the characteristics and circumstances of Child R's father. As a (reported) overstayer, whose Islamic marriage had not secured his right to remain in the UK, his need to remain involved with his child, control his partner's behaviour by remaining in contact and establish his paternity were all of considerable significance, but were not properly recognised or assessed.

Similarly, the status of the mother as a potential victim of 'honour-based violence' were noted as an alert on her police record but never explored to enable the reality of any risk to be determined. Some other agencies were aware of this but there is no evidence of any professional asking either the police or the mother what it signified in practice. The subsequent decision to place the injured infant with this branch of the family, suggests that there was never a serious, current risk of honour-based violence, but in other instances this might be very significant.

Recommendation 6

All services dealing with domestic abuse allegations and assessments of risk to children must ensure that staff take full account of race, religion and other individual and family characteristics that may shape its impact.