

**\*\*STRICT EMBARGO UNTIL: 12:00 Thursday 21<sup>st</sup> July 2016\*\***

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## **Publication of Serious Case Review: Child R**

### **Independent Chair's Summary Statement, on behalf of Haringey Safeguarding Children Board (HSCB)**

In January 2015 the young boy referred to in this report as "Child R" was murdered, aged 6 months. In December 2015 the High Court found his father guilty of the murder. There had been limited contact with agencies during Child R's short lifetime.

The Local Safeguarding Children's Board (LSCB) is the partnership within Haringey of agencies who seek to keep children safe. Our collective role is to promote effective joint working, and to hold each agency to account. Following Child R's death, the Board commissioned an independent author to lead the process of reviewing the work of all agencies and seeking to identify learning. Agencies have engaged fully in the review, and have worked hard to agree on areas of learning. The review identified some occasions where agencies could have initiated assessments of the family, examining risks and identifying support needs. It does not identify a causal link between these occasions and his death in January 2015, which it concludes could not have been anticipated. But some significant learning has been identified and acted upon.

In particular, the review focused on two principal issues where practice could have been improved, although they did not directly lead to harm to Child R or his older sibling.

The first issue is the failure of agencies to undertake a risk assessment once information was available regarding the criminal background of the mother. In 2016 the family court judge praised Child R's mother for her care of her two children. However, in 2002 as a 17 year old she had been convicted in her country of origin of the murder of an adult; she had served 9 years of her sentence and then broken the terms of her parole to come to England. She had been served a European Arrest Warrant in January 2014 and bailed, whilst awaiting Extradition. This event should have resulted in a risk assessment of her ability safely to care for her child, and for Child R with whom she was pregnant at the time. Learning has been identified for the Police Extradition Unit, the courts and probation.

Another opportunity arose in July 2014, at the birth of Child R, when information about the mother's background should have resulted in the Multi Agency Safeguarding Hub (MASH) initiating a robust risk assessment. In early January 2015, fuller detail relating to the Mother's previous offence was made available, and should have resulted in further risk assessment. However, since it was the action of the father, not the mother, which led to Child R's death, it is uncertain that any such assessments would have resulted in a different outcome.

The second issue relates to actions which could have been taken to assure the safety of Child R's sibling. Child R suffered fatal injuries in late January 2015, and was in hospital over a weekend before he died. During that weekend, an aunt cared for Child R's older sibling from Friday night until Sunday morning, and there is no suggestion that the sibling was harmed in any way. However, given the possibility (later confirmed) of non-accidental injury, a more robust risk assessment should have been undertaken of the safety of the sibling over that weekend. Learning has been identified for the operation of services over weekends, with a need to improve the quality of multi-agency working.

All the agencies in Haringey involved with Child R have reviewed their own practice and are acting on lessons learnt. HSCB will monitor the delivery of those actions.

**Sir Paul Ennals Independent Chair Haringey Safeguarding Children Board**

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