Dudley Safeguarding People Partnership

MULTI AGENCY CHILD SAFEGUARDING REPORT

Child T

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Contents

1. Framework of the review 3
2. Scope 3
3. Summary of Facts 4
4. Other relevant facts 5
5. Methodology 5
6. Analysis 5
6.1 Domestic Violence and coercive control 5
6.2 Maternal mental health 9
6.3 Child T's poor school attendance 10
6.4 Engagement with other family members who may be considered protective factors 11
6.5 Evidence of professional disagreement and escalation 11
7. Evidence of good practice 12
8. Reflective Learning Workshop / Feedback Session: 12
9. Terms of reference 13
10. Conclusions and Recommendations 13

1. Framework of the review

1.1 Working Together to Safeguard Children 2018 contains the statutory guidance for undertaking Child Safeguarding Practice Reviews (CSPRs) when a serious child safeguarding cases has been reported. These are cases in which:

- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed

1.2 Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice.

1.3 Issues might appear to be the same in some child safeguarding cases but reasons for actions and behaviours may be different and so there may be different learning to be gained from similar cases. Decisions on whether to undertake reviews should be made transparently and the rationale communicated appropriately, including to families.

1.4 Some cases may not meet the definition of a 'serious child safeguarding case', but nevertheless raise issues of importance to the local area. That might, for example, include where there has been good practice, poor practice or where there have been 'near miss' events. Safeguarding partners may choose to undertake a local child safeguarding practice review or another form of review in these or other circumstances.

1.5 The aim of this review is to identify improvements that can be made to better safeguard children and to prevent, or reduce the risk, of recurrence of similar incidents.

1.6 The review will undertake a rigorous and objective analysis of what happened and why. It will consider whether there are systematic issues, and whether and how policy and practice need to change. It should be noted that the review is not being conducted to hold individuals, organisations or agencies to account as there are separate processes for this.

1.7 Dudley Safeguarding People Partnership (DSPP) is a joint overarching body, with the remit to monitor and improve safeguarding activity for children and adults. It brings together senior officers from the key agencies and agreed significant partners to ensure there is a focus on transformation by providing strong leadership and guidance to all of its partners, identifying the strategic priorities on a yearly basis and determining the desired outcomes in respect of safeguarding activity and practice. The DSPP has strategic oversight of the work across both the Safeguarding Children Partnership and the Safeguarding Adult Board, which in turn drives the work of the sub-groups to improve outcomes.

2. Scope

Subject/s of the review:

Child T- age 8

Mother R – age 34

Sibling 1 – sister – age 14

Sibling 2 – sister – age 13

Father to children - age 34

Mother's partner S – age 33

Timescale of the review from: May 2019 – January 2020. The time in which the couple were in a relationship including the significant event and sequelae.

3. Summary of Facts

3.1 Child T was living with his mother R and her new partner S since June 2019. His older sisters initially lived in the house but chose to move to their grandparents over the summer as they didn't like mother's new partner. Child T continued to have weekly contact with his father and paternal grandparents.

3.2 Concerns were raised that T's school attendance had declined and when school tried to investigate the child's mother was initially co-operative and her partner intimidated staff. A referral was made to MASH where probation information was shared but there was no strategy discussion and the case was referred to Early Help. It was following the referral into MASH that police made the visit to undertake the Claire's Law 'right to know' visit. Early Help services also tried to undertake an assessment, but mother's partner tore up mother's consent. Children's services began to assess but were also met with resistance.

3.3 In October, a visit was made to the home by West Midlands Police. During this meeting the previous history of offending was discussed including a risk assessment made by probation from June 2019 when probation involvement ended. This risk assessment specified that S posed a very high risk of harm to a known adult and a medium risk of harm to children. Child's T's mother was asked in front of S if she knew about this risk assessment and S's previous offending. She replied that she had but it later transpired that she had not and was therefore unaware of the previous convictions. She later stated that she had been coerced by S into that she was fully aware of his history.

3.4 Initially Child T's mother states that she made a Clare's Law application following the commencement of the relationship. Police records do not have any evidence of this however there is evidence of a Clare's Law Right to Know log. Police were under the misapprehension from the visit in October 2019 that the mother had already reviewed the probation risk assessment, as described above, so they felt there was nothing to add. It is noted that the relationship started after probation supervision ended, so probation would not have disclosed any information to T's mother.

3.5 In the early hours on a day in December 2019, Child T's mother escaped from the house having been physically assaulted, Child T had been injured as he tried to protect his mother.

3.6 Following this incident Child T's mother disclosed a six month history of repeated physical abuse, sexual abuse and sustained coercive control which included financial control, threats to kill, isolation from family, manipulation of medication, being humiliated and having no control over bathing or what she wore.

3.7 Child T had been kept off school, in part, to prevent him talking about the home situation, however when he was interviewed following the incident in December he revealed that his mother's partner had told him that he would hurt his mother and other family members if he told anyone about what was happening at home. Child T also revealed that he knew a lot about the controlling behaviour that his mother had experienced and reported that he had been assaulted and force fed by his mother's partner.

3.8 The children are currently subject to Child in Need plans, the perpetrator is currently serving a custodial sentence, Child T's mother has ended the relationship and the maternal grandparents are considered to be protective factors in the children's lives.

4. Other relevant facts

Nothing of relevance was identified during scoping or rapid review.

5. Methodology

5.1 Following the completion of the scoping and the rapid review meeting, a decision was made that whilst there were areas for learning from the case, the serious harm criteria had not been met and the case did not meet the threshold for an independently led CSPR. The members agreed that a multi-agency table top review would be the appropriate methodology to extract any further learning.

5.2 The table top review was held as per endorsement from the National Panel (NP) who agreed with the recommendations and recognised that:

"The rapid review set out clearly the details of the incident, your analysis, the learning and actions to take including your proposed multi-agency table-top review".

They requested that;

"One issue which we would however like you to consider is the issue of front-line practitioners working with aggressive and violent men and how best they can acknowledge that and be helped to manage any understandable anxieties they might have. It would, we think, be helpful to consider a process which allows this issues to be discussed within practitioner forums".

Chronologies: Proportionate chronologies were included in the scoping documentation.

6. Analysis

6.1 Domestic Violence and coercive control

6.1.1 The partner's aggressive and controlling behaviour was recognised by professionals. School particularly felt that his presence was very intimidating. He tore up mother's agreement to Early Help Services and it would appear that he was instigative in preventing Child T from having contact with his birth father. At the Initial Child Protection Conference following the incident it became apparent that both Child T and his mother had been threatened that they or other family members would be harmed if they disclosed the ongoing abuse to anyone.

6.1.2 During the police ABE interview, Child T disclosed that he had witnessed numerous incidents of assault against his mother and demonstrated that he recognised the control that her partner had on her. Child T's mother had experienced extensive coercive and financial control, threats to kill, manipulation of medication, torture, isolation and use of weapons.

6.1.3 Children's Social Care received a referral from Child T's primary school in October 2019, raising concerns in regards to his poor school attendance, his mother's deteriorating mental health and concerns around her relationship with her new partner. The school had undertaken a home visit where they felt intimidated and threatened by the partner. The school were unaware of the partner's previous history of significant domestic violence.

6.1.4 The probation services had statutory involvement with S, mother's partner during a 48 months sentence imposed for four offences, including an assault against an ex-partner. He was released on licence and recalled for an alleged domestic abuse incident against an ex-

partner. Probation did not support re-release whilst police under took an investigation about this alleged incident. Probation then supported re-release with a robust risk management plan to attempt to undertake some rehabilitative work before the end of his sentence. The Parole Board did not re-release, and he remained in prison until his sentence end date, meaning he was released with no licence conditions or probation oversight.

6.1.5 S was discussed at MAPPA on multiple occasions until July 2019 when statutory involved had ended. The panel did not know about the relationship with T's mother as S had not engaged with police since his release from prison, albeit there was no statutory requirement for him to do so and any engagement would have been on a voluntary basis. The MAPPA was held in the area which S previously resided, in accordance with MAPPA policy. Disclosure was considered at the meetings but not shared with the area in which mother and Child T resided as there was no evidence that was required. The relationship only became known to services when the school completed the referral in October 2019.

6.1.6 There is no standard practice to automatically disclose MAPPA information to a GP unless there is a specific reason. As such, the risk information was not shared with S's GP as a matter of course. As the relationship with T's mother was not known, information was not shared with agencies involved with her. Neither mother nor her children had been known to police prior to the significant incident and there is no evidence of domestic abuse in mother's previous relationship.

6.1.7 The expectation on all practitioners is that they recognise the indicators of domestic abuse, controlling and coercive behaviours and if indicated they are encouraged to complete the SafeLives risk assessment and refer appropriately to MARAC. Whilst there were no explicit signals that domestic abuse was a feature for this family until the significant assault in December, a number of covert signs did appear to be indicated within the scoping documents. Child T's primary school recognised that mother's partner demonstrated signs of aggression and felt intimidated by him during a home visit in October 2019. The school documented that he was abusive to staff and had two aggressive dogs. He stated, "if I let you in they will have you". This aggression towards staff raised concerns and staff home visits were withdrawn. There was consideration for the experiences of Child T living in this environment as a MARF was submitted to Children's Social Care. The case was transferred to Early Help services and the school were in contact with the family centre who also had concerns leading to a referral back to Children's Social Care.

6.1.8 At this point, the school were planning to refer Child T's case to the Education Investigation Service and were therefore also in contact with Child T's birth father who reported that he was no longer being allowed contact with the child. Mother and her partner became very angry and abusive when they became aware that father was in contact with the school. It was explained to them both that as father had parental responsibility, he had a right to receive information unless prohibited by court order. School reported that mother's partner was always swearing and shouting in the background when she was on the telephone to them, telling mother what to say. Father continued to have contact with the school on a weekly basis to determine his son's level of attendance.

Learning:

6.1.9 Whilst professionals recognised that mother's partner aggressive behaviour gave cause for concern, it would appear that professionals were often working in silos. The school were unaware of the partner's criminal and violent history despite the fact that he openly informed them had he had recently been released from prison. Police were under the impression that

mother was aware of his previous convictions for domestic abuse and information from MAPPA is not shared as a matter of course without specific purpose and the MAPPA was not aware of the relationship with mother at that time. This information would have supported a more holistic approach to be taken when the referral was made by the school in October, enabling professionals to build up a more thorough picture of the child and mother's lived experience.

6.1.10 The Home Office updated MAPPA guidance (2019) gives clarity around sharing information from MAPPA meetings providing that it is lawful, necessary and proportionate. The Data Protection Principles also dictate that the purpose of information sharing must be specified and the information shared must be accurate and up-to-date, stored securely, and not be retained any longer than necessary with each agency following its own policy. Each MAPPA Strategic Management Board (SMB) has an Information-Sharing Agreement between all Responsible Authorities and Duty to Co-operate (DTC) agencies (which include health). Information shared under MAPPA will usually meet the statutory purposes and administration of justice conditions and the safeguarding of children and of individuals at risk condition.

6.1.11 The management of risks posed by an offender to particularly vulnerable people, for example children and adults at risk, requires effective links between the lead agency and other agencies, including Local Authority Children or Adult Services. This is especially important in relation to licence conditions that are directly relevant to children or adults at risk and their families. It is noted in this case that S was released at sentence end date and was therefore not subject to licence conditions.

6.1.12 It is not clear from the guidance that CCG representatives should attend MAPPA meetings. The guidance refers to Health Authorities or Strategic Health Authorities, Primary Care Trusts or Local Health Boards being DTC agencies. Despite the guidance being updated in July 2019, these obsolete organisations have not been superseded. The document refers to CCGs in relation to their responsibility to provide after care services to offenders but not to their responsibilities of involvement with the MAPPA operational processes.

6.1.13 NHSE guidance issued in July 2020 states that input to MAPPA processes will be determined through local arrangements. There is no requirement for Designated Nurses to be involved but local arrangements could include CCG representation where commission of a service or placement is required, this does not necessarily require a member of the safeguarding team.

6.1.14 Dudley CCG have agreed that the Designated Nurses will attend MAPPA meetings in an attempt to scope the current information sharing processes and to determine how best information regarding MAPPA nominals can be shared with the primary care team in a lawful and proportionate manner.

6.1.15 Often professionals struggle to deal with aggressive parents as they often feel intimidated and worried that confrontation might impact negatively on the working relationship with the family. In extreme cases, professionals can experience fear from abuse, threats of violence and actual acts of violence. However, the child's welfare should remain paramount at all times and where professionals are too scared to confront the family, they must also consider what life is like for a child within the family.

6.1.16 When the police attended the home to undertake a Clare's Law disclosure under the function of 'right to know' (where police can proactively disclose information in prescribed circumstances) they saw the couple together and were given the impression by Child T's

mother and her partner that Child T's mother had seen her partner's probation risk assessment and was therefore aware of the history of domestic abuse. They considered that there was little more information that they could add and it was assumed that she was continuing the relationship despite being aware of his history of domestic abuse. It was apparent that the police officer also discussed S's criminal history with the couple. Both of these instances may have put Child T's mother at risk or at the very least, limited her ability to speak candidly about the potential threat posed by her partner.

6.1.17Mother later disclosed that she had been coerced into informing professionals that she had read the probation risk assessment by her partner which was untrue. The police representative acknowledged that this is not standard practice to undertake a disclosure with the offender present and will follow up with WMP to ensure that correct procedure is followed. The caveat to this is that police would not just leave the home if S was present as this may make him more suspicious and put his partner at risk of further assault or abuse.

6.1.18 Working with potentially hostile and violent families can place professionals under a great deal of stress and can have physical, emotional and psychological consequences. It can also limit what the professional/s can allow themselves to believe; make them feel responsible for allowing the violence to take place; lead to adaptive behaviour, which is unconsciously 'hostage-like' i.e. when faced with significant fears for their own safety, professionals may develop a 'hostage-like' response. This is characterised by accommodating, appeasing or identifying with the 'hostage-taker' to keep safe.

6.1.19 Each agency should have a supervisory system in place that is accessible to the professional and reflects practice needs. Supervision discussions should focus on any hostility being experienced by professionals or anticipated by them in working with families and should address the impact on the professional and the impact on the work with the family. Written guidance on how to manage hostile and aggressive parents should be available to staff.

6.1.20 Managers should encourage a culture of openness, where their professionals are aware of the support available within the team and aware of the welfare services available to them within their agency. Managers must ensure that staff members feel comfortable in asking for this support when they need it. This includes ensuring a culture that accepts no intimidation or bullying from service users or colleagues. A 'buddy' system within teams may be considered as a way of supporting professionals. Professionals must feel safe to admit their concerns knowing that these will be taken seriously and acted upon without reflecting negatively on their ability or professionalism[1].

6.1.21 The referral in October 2019 led to lateral checks being undertaken by multiple agencies in MASH, including probation. This revealed that mother's partner was assessed as having psychopathic tendencies, was assessed as presenting a very high of harm to partners, medium risk of harm to children and was previously a MAPPA level 2 nominal. he was considered to be as risk to adults and children and there would be serious concerns for anyone who entered a relationship with him. This should have resulted in a strategy discussion to ensure all information was shared and a plan put in place, however, as mother had consented to a CYPA, this was not felt to be necessary. The outcome was a transfer to Early Help services and the consent for this was subsequently torn up by mother's partner. This approach was considered by the panel to be too optimistic.

[1] https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/noncompliant/

6.1.22 From the time of the referral in October 2019 until the critical incident in December, no lateral checks had been completed by the Social Worker to inform the assessment. Given the concerns, in the interest of completing a timely assessment, greater efforts should have been made to obtain these lateral checks – as it was, there was a delay in over a month from the point of allocation to any professional information being gathered. There was also no Child in Need Plan or meeting held between 22/10/19 and the incident resulting in a missed opportunity for professionals to share information and any concerns.

6.2 Maternal mental health

6.2.1 Mother had suffered with anxiety and depression dating back to at least 2013. She was referred for primary care mental health services but failed to attend any appointments until July 2019 when she self-referred. A telephone consultation identified that she was having relationship and financial issues and that poor mental health had been a feature for some time. She reported that she had been prescribed medication by the GP but she was not concordant. She disclosed a history of suicidal ideation in the past but at the time of the call she had no existing ideation nor suicide plans and stated that her children remained a protective factor. At this point mother appeared to be focused on her previous relationship issues and there was no mention of a new partner.

6.2.2 She was offered support via group therapy however she declined as her preference was to access one to one counselling services. She agreed to self-refer to Relate and was discharged back to the care of her GP with advice to contact the GP directly should there be a marked deterioration in her mental health. There was no disclosure of domestic abuse at this point in fact when she attended the GP surgery prior to the referral she reported that her partner was supportive.

6.2.3 Mental health problems are a common consequence of experiencing domestic abuse both for adults and children. Having mental health issues can render a person more vulnerable to abuse. A significant proportion of people accessing mental health services have experienced abuse[2]. As mental health issues feature regularly in cases of domestic abuse, when attending the GP surgery with anxiety and depression there was a missed opportunity to enquire further about any potential issues or violence within the household.

Learning

6.2.4 With regards to mother's mental health issues there was no evidence that primary care professionals explored her home life. Since this time, the CCG have introduced the IRIS programme within primary care. IRIS is a national project which works with GPs to combat domestic abuse and make the most of their opportunities to reach vulnerable victims. The project offers training and advice for GPs and practice staff on how to recognise, enquire and record domestic abuse, and a dedicated support service for identified victims.

6.2.5 IRIS also includes an electronic prompt which provides a reminder of the dimensions of abuse and can be used to record the type of abuse the patient is experiencing. It is linked to 160 read codes (including mental health, alcohol and substance misuse issues) and provides a "pop up" template which acts as an aide-mémoire for asking about and recording any disclosed abuse. Had this have been in place at the time when Child T's mother attended the GP practice, it may have initiated a conversation about domestic abuse within the household.

[2] SafeLives (2019) Spotlight Report Safe and Well: Mental health and domestic abuse

6.3 Child T's poor school attendance

6.3.1 In February 2019, the school nurse met with school staff to discuss concerns around Child T's poor attendance (which at that time was 64%). The GP records noted that he was a regular attender with minor complaints and that mother tended to keep him off school for longer than necessary. There is no evidence that this was explored further, however it should be noted that the relationship between mother and her partner does not appear to have commenced until June 2019 and Child T's attendance was already causing concern.

6.3.2 Mother later disclosed that once in a relationship with her abusive partner, she tended to keep Child T off school as he was less likely to assault her if the child was present. This suggests that she was prioritising her needs over those of her child. In the circumstances this can be regarded as a survival instinct. The BMA Board of Science (2014) suggest that "what appears to an outsider to be a lack of response to living in an abusive relationship may in fact be a strategic, calculated 'assessment of what it takes […] to survive in the relationship and to protect [oneself] and any children.' Sufferers of domestic abuse live in fear of the next attack and it is a natural response to try to prevent it from happening or, if this is not possible, to reduce the severity of the attack"[3]

6.3.4 Throughout the rest of the year Child T continued to arrive late or miss school altogether and was also collected late on several occasions. On one occasion mother requested that the school staff saw Child T across the road (the family lived very close to the school) and she would receive him at the door as she couldn't leave the house due to her anxiety. There is a possibility that she had been victim of an assault and did not want school to see any injuries as the following day Child T was taken to school by mother's partner who was heard to say "if they say anything, tell them you're 8 years old and 'no comment'." On one occasion when mother and her partner collected Child T from school, staff witnessed bruising to the side of her face, which she tried to cover. The school contacted Children's Social Care who stated that the case was possibly being closed due to a lack of evidence of any safeguarding concerns. The older sibling's secondary school were unaware of any issues until after the assault on mother in December 2019.

Learning

6.3.5 It was clear from both the scoping documents and the multi-agency table top discussion that the primary school felt let down by Children's Social Care. They felt that they had raised concerns appropriately, particularly around mother's partner's aggressive behaviour and Child T's school attendance but that these had not been taken seriously. They remained unhappy with Children's Social Care's decision to either step down or close the case.

6.3.6 There is little evidence that Child T's poor school attendance was perceived as potentially indicative of issues at home. The School Nurse does not appear to have had any involvement with the family from February 2019 until after the assault in December.

6.3.7 Whilst the school documented that mother was seen with bruises, there were concerns around Child T's attendance and issues around mother being unable to leave the house due to anxiety there does not appear consideration of potential domestic abuse and coercive control. This information could have informed social care's intervention.

[3] BMA (2014) A report from the BMA Board of Science: Domestic abuse

6.4 Engagement with other family members who may be considered protective factors

6.4.1 There was little evidence that any meaningful engagement took place with Child T's birth father. His father contacted Children's Social Care in November, advising that mother had discontinued contact with Child T and this was perceived to be due to CSC involvement. There is no evidence that this was explored by the social worker. There is no further recorded contact with birth father until a Children in Need meeting was held at the beginning of December.

6.4.2 The older siblings had moved to live with their grandparents as they did not like their mother's partner but there appeared to be a lack of professional curiosity around the rationale for their aversion and the sibling's secondary school appeared to be unaware of the home situation until after the assault on their mother in December. There was no evidence of information sharing by social care prior to the significant incident which was an oversight in practice.

6.4.3 The school scoping makes it clear that Child T's mother was angry that they were in contact with his birth father regarding Child T's poor attendance. However Child T's father was not always very proactive in engaging with agencies. He attended the initial Child Protection conference following the assault but failed to engage with further meetings. He had previously reported that he wanted to be involved but that mother's partner was considered to be an obstructive element.

6.4.4 There is no evidence that the older siblings or grandparents were involved until after the assault on mother in December. Several scoping documents suggested that the older siblings moved to reside with their maternal grandparents as they did not like mother's partner. There is no evidence that this was explored and as the siblings later disclosed that they too had witnessed the abuse when residing with their mother and her partner, this was a missed opportunity to build up a holistic picture of what life was like for the children. However the CSC case notes noted that the older siblings were reported to be living with maternal grandmother due to breakdown of relationship at home with their mother.

6.4.5 It is also not clear which agencies were aware that the older siblings no longer lived in the family home and the reasons for this. The group felt that this should have been explored by the Social Worker during the period of involvement.

Learning

6.4.6 It was agreed that there was a missed opportunity to undertake a holistic assessment of the family and to determine if maternal grandparents and Child T's birth father were considered to be protective factors and could have supported the children throughout the Early Help/CIN process.

6.4.7 It was felt that agencies need to use professional curiosity when children choose not to reside within the family home. Had the older siblings have been spoken to alone they may have disclosed the domestic abuse that they had witnessed towards their mother. This would present the opportunity to consider a "Think Family" approach to assessments.

6.5 Evidence of professional disagreement and escalation

6.5.1 There is clear evidence that concerns from school were being articulated and recorded but no evidence that the DSPP Multi Agency Professional Resolution and Escalation protocol

for children and young people was utilised. It would appear that professionals felt that submitted a further MARF constituted escalation of a case.

Learning

6.5.2 The school appeared to be unaware of the updated protocol which would suggest that the DSPP have been unsuccessful in disseminating and promoting the process to all organisations.

6.5.3 In view of the fact that the DSPP relates to both children and adults, it would seem sensible to develop the protocol to reflect disagreement in cases of adults at risk to ensure that there are equitable resolution and escalation processes across the life course.

7. Evidence of good practice

- Both primary and secondary schools have been very pro-active in offering pastoral support to all three children following the significant incident.
- Safeguarding practice within ED was exemplary. All safeguarding actions were taken at the time of attendance. CP-IS was checked on admission to ED and it was recorded that there was no child care alert. The ED Safeguarding checklist had been completed and concerns documented. All family members are recorded and consideration was given to the older sibling's whereabouts and safety. Voice of the child is evident in the records and Child T's presentation is documented- both physical appearance and behaviours. An adult safeguarding referral was completed in relation to mother and a Multi-Agency Referral Form completed in respect of Child T. A telephone call was made to Emergency Duty Team prior to the written referral being submitted and a message left for them to contact the department. An incident was raised via DATIX and the Paediatric Liaison reviewed the child's attendance, forwarding information to the school nurse. Child T was admitted to the paediatric ward for a child protection examination and when mother self-discharged with Child T, police and social care were called to ensure that he was safeguarded. Information was shared at MARAC.

8. Reflective Learning Workshop / Feedback Session:

8.1 The report has been shared with the table top review members and factual errors corrected.

8.2 A written briefing regarding the case will be produced and shared across all agencies. A briefing session will also be arranged, however as the covid 19 pandemic continues, this may have to be completed using virtual means.

9. Terms of reference

Key Issues to be addressed by the Review:

1. How practitioners manage cases where they are faced with a violent partner?

2. Was there a missed opportunity to identify domestic abuse in the household?

3. Clare's Law interview: The couple were seen together. Is this standard practice?

4. Did practitioners recognise coercive and controlling behaviour?

5. If and how information regarding MAPPA nominals is shared with primary care.

6. Where SNs aware of concerns re poor attendance and did the child's poor school attendance pre-date the commencement of the relationship

7. Is there evidence of the escalation process being followed when concerns were raised by practitioners?

10. Conclusions and Recommendations

10.1 The rapid review panel agreed that whilst Child T (and to some degree the older two siblings) would have suffered emotional and physiological abuse as they had witnessed domestic abuse and controlling behaviour perpetrated against their mother, the referral didn't meet the criteria to undertake a Local CSPR as the serious harm criteria were not met. There had been no previous referrals to CSC and no evidence of any domestic abuse in mother's former relationships. There was no evidence from any agency that Child T's mother had disclosed any domestic abuse until the assault in December 2019.

10.2 The group acknowledged that the domestic abuse perpetrated against Child T's mother was significant and included assault with weapons, incarceration and humiliation. The final assault resulted in a number of injuries to her including fractured ribs and sternum and a broken nose, however the relationship was relatively short i.e. 6 months from start to finish. Therefore despite not meeting the threshold for a local CSPR, the group agreed that there was missed opportunities to protect Child T (and his mother) and as such a multi-agency table top review would be undertaken and any learning points and recommendations shared with practitioners across all agencies.

10.3 The table top review identified a number of learning points that have been collated into a multi-agency action plan, this will be monitored by the DSPP Learning and Improvement Sub Group. It is clear that professionals often find it difficult to manage families that present as hostile and aggressive and the group agreed that practice guidance would be a helpful method of improving confidence when attempting to manage these challenging situations. The DSPP members will also work with the business unit training co-ordinator to develop a training package and briefing for frontline staff.

10.4 There is no MAPPA process to automatically share risk information with generic agencies and no mechanism to record information about an individual on a shared system which can be checked by professionals. The relationship was not known to MAPPA at the time S was being discussed and therefore information was not disclosed. The Black Country CCGs are

currently working with the MAPPA co-ordinator to develop an equitable process to share proportionate information with the GP when an individual is considered to pose a risk to others. Had the Sandwell GP been informed of the risks posed then this would have been flagged on his records should he have subsequently registered with the mother's GP.

10.5 It was clear from the review that not all agencies were familiar with the DSPP Resolution and Escalation process which should be utilised when there are professional disagreements regarding the management of safeguarding cases. It is recommended that the DSPP work with its members to promote the use of the protocol across the partnership in order to encourage effective challenge to support effective safeguarding in order to promote the safety and wellbeing of individual children and young people.

10.6 In 2018, Dudley decided to develop a people's partnership with strategic safeguarding aims covering both adults and children. Going forward to reflect the Dudley "Think Family" approach, the current Resolution and Escalation process for children will be reviewed to include adults at risk.