Dudley Safeguarding People Partnership

LOCAL CHILD SAFEGUADING PRACTICE REVIEW REPORT

Children: Q and R

Date of significant incidents

December 2020

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Contents

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 Two cases were referred into the DSPP Learning and Improvement sub group in September 2020 for consideration to potentially undertake an identified learning review. Following the Rapid Review Meeting (RRM) for both cases, similar themes were identified in both cases. The Rapid Review panel initially considered undertaking a thematic review of both cases but the National Panel recognised that much of the work had already been completed and learning had already identified. Therefore this local report has been completed using the findings of the RRM and identified learning from both cases. Terms of reference for the review were identified at the RRM. The RRM highlighted recurrent themes in the safeguarding and promotion of the welfare of children and some concerns around the way that two or more organisations or agencies working together effectively to safeguard and promote the welfare of children.

2. Scope

It was agreed that the scoping period would begin from the beginning of 2018 to the date of the critical incidents. Any pertinent information outside of the identified scoping period would also be included.

3. Summary of Facts

Case 1 Child Q

Identity	Relationship to Child	Age	Ethnic Origin
Child Q	Subject child	4	Mixed-other mixed background
Adult A	Mother	22	Not recorded
Adult B	Father	21	Not recorded

Case 2 Child R

Identity	Relationship to Child	Age	Ethnic Origin
Child R	Subject child	7 weeks	Mixed-Black and White
Adult C	Mother	23	White and Black Caribbean
Adult D	Father	21	White and Black Caribbean
Child 2	Sibling	3	White and Black Caribbean
Child 3	Sibling	8	White and Black Caribbean

Child Q sustained a serious leg fracture whilst in the care of her Father. She articulated to the paediatrician that her father threw her onto a piece of furniture and broke her leg. The father has admitted to causing the injury but states that it was in play. The case is subject to an ongoing police investigation. Following the injury, father did not seek medical attention for the child who would have been in significant pain. The injury was identified by mother when father return Child Q back to her care the following day. The injury required surgical intervention and subsequent physiotherapy. At this time father cannot have contact with Child Q.

Child R. Parents have two children. Child R and a 3 year old. There is also an older sibling residing with maternal grandparents under a Child Assessment Order (CAO) as mother was very young when she had the baby. There was a positive assessment undertaken by Children's Social Care (CSC) during the pregnancy with her second child. There were no further contacts or referrals to CSC until the time of the critical incident. A referral was made from Russell's Hall Hospital in September 2020 stating that Child R had attended A&E with his parents and had a boggy swelling on his head. An X-ray confirmed a fracture to the skull. There was also several bruises noted around the child's eyes and leg. The explanation was that the child had accidentally fallen from a height of approximately 40 to 50 cm whilst father was changing his nappy. A child protection medical identified no internal injuries. Following the incident, father picked up the child who cried. He did not identify any obvious injuries and the child settled. Father called mother to inform her (mother was out taking Child 2 to nursery with paternal grandmother). Mother and father met up at the hospital. A CP medical was undertaken by hospital following the identification of the skull fracture and referral to CSC. An initial strategy discussion took place out of hours by EDT and included the involvement of a paediatrician. However there was a degree of disagreement around whether the mechanism described by father was consistent with the injury. A second strategy meeting was arranged for due to the professional disagreement regarding the mechanism of the injury and a joint S47 investigation was later agreed.

4. Other relevant facts

No other relevant facts were identified

5. Analysis

The serious harm criteria was discussed at length by the panel. Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical

health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where the impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred (WT 2018).

The burden of proof in child abuse cases is different to that of the criminal courts. In a criminal case the standard is "beyond all reasonable doubt" in order to secure a conviction. In cases of suspected child abuse the standard of "balance of probabilities" is applied. In a recent case (Re BR Proof of Facts), Mr Justice Peter Jackson stated that in cases of child abuse:

> "The standard of proof is the balance of probabilities: Is it more likely than not that the event occurred? Neither the seriousness of the allegation, nor the seriousness of the consequences, nor the inherent probabilities alters this."

Whilst both children suffered significant injuries, medical opinion concluded that both should recover from the injuries with no long term physical or mental impairment. It was helpful to have the attendance of a senior paediatrician at the panel to discuss the mechanism and potential impact of both injuries. Paediatric opinion was that both injuries were more likely to have had a non-accidental cause.

In both cases there appeared to be some professional disagreement around whether the injuries sustained by the children were compatible with the explanations offered by the parents. In the case of Child Q, the paediatrician was very clear at the strategy meeting that they felt that the explanation given by father would not have resulted in such a significant injury. There was evidence at the meeting that some professionals appeared to find it difficult to "think the unthinkable" and were somewhat complicit with the parental explanation. The decision in the case of Child R was subsequently challenged using the multi-agency escalation process which led to a S47 investigation being commenced.

There were also a number of other themes that were common to both cases. These include

Domestic abuse

Both cases featured recent and historic domestic abuse. In both cases several domestic abuse notifications had been received. One case had been discussed at MARAC but both of the victims (mothers to the children in both cases), were reluctant to disclose the extent of the abuse, declined support and minimised the level of abuse within their relationships. In one case the mother stated to the GP that "although her partner was abusive, he was company". This was considered to be quite typical of victims of domestic abuse who are often controlled to the point of acceptance (IRIS 2020).

Domestic abuse has been identified as one of the adverse childhood experiences (ACEs) that has long lasting impact on the health and wellbeing of children. Children can experience both short and long term cognitive, behavioural and emotional effects as a result of witnessing domestic abuse. Each child will respond differently to trauma with some demonstrating resilience and not exhibiting any negative effects. However many children may also feel angry, guilty, insecure, alone, frightened, powerless or confused. They may have ambivalent feelings towards both the abuser and the non-abusing parent.

Children's responses to the trauma of witnessing domestic abuse may vary according to a multitude of factors including, but not limited to, age, race, sex and stage of development. It is equally important to remember that these responses may also be caused by something other than witnessing domestic abuse (NSPCC 2019).

In August 2020, Women's Aid released the report: *A Perfect Storm – The impact of the Covid-19 pandemic on domestic abuse survivors and the services supporting them*. The report highlights that the covid pandemic and subsequent lockdown has had a negative impact on victims of domestic abuse.

Two-thirds of survivors identifying as currently experiencing abuse stated that their abuser had started using lockdown restrictions or the Covid-19 virus and its consequences as part of the abuse.

Lockdown restrictions and the fear of spreading the Covid-19 virus made it more difficult for women to seek support or leave their abuser during lockdown. Over three quarters of survivors of those living with an abuser said they felt they could not leave or get away because of the pandemic. (Women's Aid Survivor Survey 2020).

Children have also been impacted during the pandemic. Half of the survivors with children who were currently experiencing domestic abuse disclosed that their children had witnessed more abuse towards them, and over one third said their abuser had shown an increase in abusive behaviour directed towards their children. (Women's Aid Survivor Survey 2020).

Both of the cases involved injuries to children during the pandemic and both families were known to have had a history of domestic abuse.

Historic safeguarding concerns and CSC involvement

There had been historic safeguarding concerns in both cases. The mother of Child Q had been in care since the age of 4 and her stay put carers had raised concerns regarding her maturity and ability to care for her child. Her lifestyle was described as chaotic and the home conditions raised concerns. The child subsequently became subject of an Early Help plan in which mother was successfully supported to improve her parenting skills. In the case of Child R, mother had had a child placed with maternal grandmother as she was only 14 when she became pregnant. This child remains with her grandmother.

A number of referrals to Children's Social Care had been made by professionals in both cases but often did not meet the threshold for statutory intervention. At the Rapid Review meeting it became clear that not all agencies were in receipt of all of information required to inform their decision making and to undertake a holistic assessment of the family and child and to understand the child's lived experience.

There appeared to have been evidence of start over syndrome in both cases with historic concerns not always informing risk analysis and holistic assessment. Both mother's had experienced ACEs in their formative years which is known to often impact on parent's ability to safely parent their children.

Maternal mental health issue

In both cases, the mothers of the children had suffered from mental health issues. Both had previously been referred to CAMHS, and both suffered from depression and anxiety. Mental health assessments carried out seem to suggest that their mental wellbeing had been impacted by their experiences as children. The impact of ACEs on children going into adulthood is well documented and predict poor adult outcomes. Exposure to ACEs quadruples the risk of sexual risk-taking, mental health problems and problematic alcohol use and debilitating diseases. Over the past 20 years, ACE studies consistently confirm that the greater the number of ACEs experienced before the age of 18, the greater the chance of poor adult outcomes (Early Intervention Foundation 2020).

Decision making for ICPC

It is important that all professionals working with children and families understand the concept of significant harm and also what constitutes abuse and neglect in order that they may engage with the strategy meeting and offer a professional opinion. They should be able to gather and analyse information as part of an assessment of the child's needs.

The West Midlands Multi Agency Safeguarding procedures identify that strategy meetings should be multi-agency as far as possible and should involve all key professionals known to, or involved with, the child and family. Local authority children's social care, health and the police should always attend. Where the child is in hospital, the appropriate clinician should also be included.

The strategy meeting/discussion should:

- Decide whether, or how, section 47 enquiries should be pursued and produce a plan for carrying out the enquiries
- Agree an interim multi-agency plan to adequately safeguard the child or children during the period between the strategy meeting/discussion and the first conference.

The decision to proceed (or not) to ICPC in these cases appears to have been made unilaterally by CSC following the strategy discussion. There was little evidence of multi-agency decision making at the time and this was acknowledged in the scoping document provided by CSC for both cases.

Disguised compliance

Disguised and non-compliance was a feature in both cases. Cancelling appointments, DNA's, not answering calls from professionals, not registering with GP featured in the scoping documentation regarding both children. Disguised compliance involves parents and carers appearing to co-operate with professionals in order to allay concerns and stop professional engagement (NSPCC 2019).

Parents and carers may minimise concerns raised by practitioners or deny that there are any risks facing children. They may develop good relationships with some professionals whilst criticising or ignoring others which can divert attention away from parents' own behaviours. Parents and carers displaying disguised compliance may manipulate professionals and situations to avoid engagement or intervention and some parents and carers may say the right things or engage 'just enough' to satisfy practitioners.

This appears to be the case with both of these families. The mother of Child Q declined any support from domestic abuse services, police and both mothers engaged only intermittently with mental health support. Published case reviews highlight the importance of practitioners being able to recognise disguised compliance, establishing the facts and gathering evidence about what is actually happening in a child's life.

Professional curiosity

Professional curiosity refers to "seeing past the obvious" and is a combination of looking, listening, asking direct questions, checking out and reflecting on information received. It involves not taking a single source of information and accepting it at face value and testing out professional assumptions about different types of families.

Effective professional curiosity results in triangulating information from different sources to gain a better understanding of family functioning and the lived experience of the child which,

in turn, helps to make predictions about what is likely to happen in the future. In these cases it was clear that a number of professionals accepted what parents were saying.

At the strategy meeting for Child R, some professionals accepted the father's explanation for the injury despite a differing medical opinion. Studies demonstrate that often practitioners do not like to "think the unthinkable" and sometimes attempt to "fit" the injury to the explanation rather than to review the whole picture and review the case holistically. This suggests a 'bias' towards an optimistic interpretation of medical advice. It would appear that sometimes if paediatricians cannot definitively identify an injury as non-accidental, then an accidental cause if often accepted.

An SCIE analysis of SCR reports found several examples in which agencies such as social care and the police wrongly interpreted medical advice about cause of injury as being definitive, when in fact it was only one of a range of possibilities. For example, advice that an injury could be consistent with the parental explanation being interpreted as meaning that the injury did have an accidental cause.

The analysis within the SCR reports for these cases highlights a number of reasons for wrong interpretation of advice from health professionals, including:

- a general over-reliance on medical opinion to determine risk, rather than the weighing up of a range of types of evidence
- a 'clash' between social care and police pursuit of categorical explanations from medical professionals with a norm among medical professionals of giving differential diagnoses in which anything is possible until it is ruled out.

Professionals also accepted the fact that both mothers reported that they had separated from their partners following incidences of domestic abuse despite evidence to the contrary, as both women had become pregnant following the alleged separations.

Hidden men

Men play a very important role in children's lives and have a great influence on the children they care for. Despite this, they can be ignored by professionals who sometimes focus almost exclusively on the quality of care children receive from their mothers / female carers. Both of these cases highlighted the issue of hidden men. It was difficult to determine which men were involved in the care of the children, which men were being referred to within the agency records and if father was actually biological father or mother's partner. It was also unclear if the perpetrators of the domestic abuse directed to the children's mother were fathers to the children or mother's ex/current partner.

Professionals involved with men who are fathers (such as substance misuse workers, mental health and probation officers) tend not to share information about potential risks with other professionals supporting the children and partners of those men. This may be because they are unaware the men have contact with their children. Consequently, practitioners depend entirely on parents to share this information, which they may or may not do.

From the NSPCC Serious Case review analysis undertaken in 2015, two categories of 'hidden' men emerged:

- Men who posed a risk to the child which resulted in them suffering harm
- Men, for example, estranged fathers who were capable of protecting and nurturing the child but were overlooked by professionals.

Professionals sometimes rely too much on mothers to tell them about men involved in their children's lives. If mothers are putting their own needs first, they may not be honest about the risk these men pose to their children.

Professionals do not always talk enough to other people involved in a child's life, such as the mother's estranged partner(s), siblings, extended family and friends. This can result in them missing crucial information and failing to spot inconsistencies in the mother's account. Professionals can be reluctant to judge the decisions parents make about their personal and sexual relationships. However this is to ignore the risks that might be posed to children by men who are in short-term, casual relationships with the mothers (NSPCC 2015).

6. Terms of reference

Address the case specific terms of reference.

- The scoping period will be from the beginning of 2018 to the date of the critical incidents. Any pertinent information outside of the identified scoping period would also be included
- To identify the role played by the fathers of both children
- To review the multi-agency decision making process when agreeing to proceed to ICPC
- Did practitioners use professional curiosity when presented with evidence of neglect/abuse?
- Did practitioners recognise and act on disguised compliance from both families?
- Was the impact of maternal mental health issues on both mother's parenting ability recognised by practitioners?
- Were all involved practitioners aware of the history of domestic abuse?

7. Identified learning

- There was a lack of clarity around the males involved in the lives of the children
- The decision to proceed (or not) to Initial Child Protection Conference appears to have been made unilaterally by CSC
- Practitioners often have difficulties managing cases in which they face hostility and aggression from families
- Despite mother being seen with injuries, domestic abuse did not appear to have been considered or queried
- There was clearly some professional disagreement between medical and CSC practitioners regarding the causes of the injuries.

8. Conclusions and Recommendations

Both children sustained significant injuries which may or may not have long term effects on their health and development. Each of the families demonstrated a number of risk factors for abuse including maternal mental health issues and a history of domestic abuse, both of which can impact on parent's abilities to safely care for their children.

The decision to proceed to ICPC appears to have been made unilaterally and does not reflect the opinions of others attending the strategy meeting. In the spirit of partnership working, this needs to be addressed to ensure that equal gravitas is given to all agency judgements and opinions.

The mother's partner was very intimidating and sometimes threatening towards professionals involved in the case and it would appear that professionals sometimes struggle to deal with hostile family members and this may impact on their decision making and management of cases.

Recommendations to include single agency and any multi agency

1. The DSPP should ensure that decision making at strategy meetings includes all appropriate agencies
2. That the children's workforce feel confident and competent to recognise potential NAI in children
3. That the DSPP should consider the development of a practitioner forum to include medical and social care staff so that there is mutual understanding of each other's roles when managing cases of potential NAI
4. That the learning from this case is shared across the partnership