Hartlepool and Stockton-On-Tees Safeguarding Children Partnership

New Safeguarding Arrangements – Learning from reviews

March 2021

New Partnership Arrangements

- The updated Children and Social Work Act 2017 and Working Together 2018 set out some changes in relation to multi-agency safeguarding arrangements.
- The Hartlepool and Stockton-on-Tees Safeguarding Children Partnership went live in April 2019.
- From April 2019, the new Safeguarding Partnership has a duty to undertake Rapid Reviews of serious safeguarding incidents and determine whether a LCSPR needs to be undertaken.

Serious Safeguarding Incident Notifications and Rapid Reviews

- Since going live in early 2019, HSSCP have received ten Serious Incident Notifications and has conducted a Rapid Review for each of these notifications made.
- Of the ten Rapid Review undertaken, five have progressed to a Local Child Safeguarding Practice Review.
- One of these HSSCP LCSPR's has been part of a National thematic review on NAI under 1's.
- In addition, one SCR and one Learning Lessons Review transferred over into HSSCP from SLSCB.

Local Child Safeguarding Practice Reviews (LCSPR's)

- LCSPR's replace Serious Case Reviews
- Safeguarding Children Partnerships have 6 months to complete a LCSPR once a Rapid Review has confirmed that the criteria has been met for one to be undertaken.
- Safeguarding Partnerships have more flexibility as to the scale of the LCSPR
- HSSCP have undertaken five LCSPR's to date

Eve (SCR) Started prior to new arrangements

Context

- Eve was taken to hospital at age 2 with a significant head injury and extensive bruising. Eve was critically unwell and received extensive medical care and support. The injuries were subsequently found to have been non-accidental.

Background

- Mother had been previously assessed by adult social care and found to have limited mobility; requiring significant support. Mother provided with a package and employed PA's to support her.
- Mother sought advice about stomach pains from her GP and after a number of investigations, she was found to be 8 months pregnant (with Eve).
- Mother would spend considerable periods of time talking to professionals about her health conditions. This information was accepted at face value, recorded vaguely. Unclear what was mother's view or a professional opinion.
- Following the birth of Eve, the adults social worker referred to children's social care – CIN. Regular CIN meetings for next 19 months.

Need to think about:

1) Exploring a mother's circumstances when seeking ante-natal late in pregnancy
2) If you are working with adults whose behaviour concern you – seek advice
3) If you are supporting a disabled adult be aware of your role to support parents needs vs parenting on behalf of parent.
4) Need to ensure that role of PAs is clear for everyone working with the family
5) Be professionally curious - early signs of child neglect
6) Understanding and being aware of Fabricated and Induced Illness (FII)

Implementing Change:

- Concealed Pregnancy Procedure
- 'Working with Families who are Difficult to Engage' guidance
- Recording Standards – self-report
- Think Family Guidance – Child and Adult checklist
- Review of CIN processes (Stockton)
- New packs for PA which include a Whistleblowing Policy. DBS checks and Safeguarding training are now mandatory for all PAs who are working in households where there are children.
- Neglect Active learning sessions and briefings to relaunch the Neglect Statement of Intent and 6 question tool
- FII procedure to be reviewed / amended (awaiting publication of the FII guidance from the Royal College).

LOCAL CHILD SAFEGUARDING PRACTICE REVIEWS/ RAPID REVIEWS

TS (LCSPR)

Context

- TS was 5 years old when his mother attempted to murder him by strangulation. TS survived the incident. Mother had stated that she had wanted to end his suffering due to him having complex needs and autism.
- TS has an elder sibling (2 years older)

Background

- When TS was 4 weeks old, Mother attended local hospital stating that her baby wasn't moving his leg properly. Medical investigations quickly determined that TS had a broken femur and that the injury appeared non-accidental.
- Joint-parental responsibility was awarded by the Court between Mother and the LA.
- When TS was 2 years old, concerns were expressed by professionals around unusual behaviours presented by Mother. Fabricated or Induced Illness (FII) was suspected and multi-agency case conferences were convened to examine the facts. Ultimately, medical opinion was that the circumstances did not amount to a case of true FII.
- A year later, the Care Order granting joint-parental responsibility for the children was discharged and the court returned sole parental responsibility for TS and sibling to Mother.
- The following year, the decision was made to step-down the case and refer the family to Early Help.

Need to think about

- There was a **lack of professional challenge** in this case – if any worker have concerns that processes are not being followed or risks not taken seriously enough need to raise
- Need to ensure that information is shared between agencies – in this case the Finding of Fact against Mother by the court, this important fact was never communicated to Cleveland Police as no formal mechanism.
- Some practitioners were uncomfortable with the decisions of the court and the direction of the case. There was a lack of understanding around any mechanism to register their dissatisfaction with decisions made by the court or how they might provide challenge.
- Agencies took an **overly optimistic** view of Mother's parenting ability – supervision/ peer supervision/ agencies challenging each other
- Professionals managed incidents (such as the suspected case of FII) as a single issue of concern rather than applying a wider view and considering the escalating cumulative risk associated with the case. **Must consider cumulative picture**
- The decision to discharge the Care Order in December 2019 appears to have been made without all relevant material being considered. **Are we making decisions based on all the information?**
- Must ensure that all information is shared at step down and that there is an understand of risk and how this will be managed in Early Help
- Failures in the prompt exchange of relevant information between agencies is a feature of this case.

Alex (LCSPR)

Context

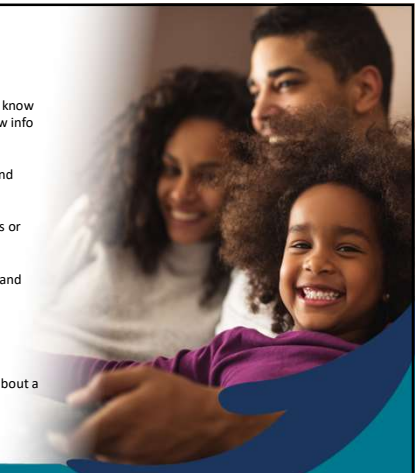
- Three month old Alex was taken to hospital twice in the same day; firstly following a reported choking episode and secondly with seizures. The baby was later diagnosed with a subdural haematoma (bleed on the brain) and a healing rib fracture, which were concluded as non-accidental injuries.

Background

- Parents and older sibling were already known to a number of agencies - early help support for financial difficulties /risk of homelessness. Single assessment following a domestic abuse incident.
- Single assessment - Mother said there had been unreported domestic abuse in their relationship in the past. She stated that he also sometimes struggled as Sibling could be difficult to feed, and that he had once 'force fed' Sibling.
- Outcome of assessment was case closed to CSC - parents stating did not wish for further support via CIN. Agreed Father would attend counselling sessions and work with Harbour. (This did not happen).
- Sibling taken to Urgent Care Centre/A & E on 17 occasions. On five of these occasions (6 months to 11 months old it was related to a head injury or a report that he had bumped his head. None of the attendances were considered a safeguarding concern
- When Alex was born the support being received by the family was largely universal and those involved had no concerns.

Need to think about:

1. Communication between agencies is critical.
2. Must make sure when a case is closed to Social Care that all agencies know what has been agreed so they can pick up if not as expected. Any new info must be shared across the system.
3. All workers should consider the cumulative impact of parental risks and vulnerabilities - in assessments and when working with a family.
4. Everyone needs to think about the cumulative impact of any incidents or concerns – supervision/ peer discussion/ info sharing.
5. GP information should be considered as part of a strategy discussion and additional information sought as part of the assessment.
6. Strategy discussions should always include consideration of whether siblings require a Child Protection Medical (Tees Procedure.)
7. You should always be alert to whether assumptions are being made about a family and whether any professional disagreements need resolving formally.



Emma (LCSPR)

Context

- 3 month old baby, Emma, was discovered not breathing by her mother and pronounced dead by paramedics. Emma died as a result of asphyxiation; caused by having been being propped up on a pillow in her pram and her head having fallen forwards, restricting her airways.

Background

- Between 2013 and 2017 there were four referrals for neglect
- Mum was previously a looked after child (trauma and abuse). Became pregnant at 16 – child was adopted due to neglect in 2010.
- At the time of Emma's death, Mother had three other children in her care; Sibling 3 and Sibling 2 from a previous relationship and Sibling 1.
- Father and Mother ended their relationship - number of domestic abuse incidents were recorded involving both parties (recent incidents)
- Mother taking medication for depression - GP's were concerned over an addiction to the use of Tramadol, Mother had taken this drug since 2007.
- The family previously supported via CP Plans (sexual abuse). At the time of death, the case was Child in Need and ready to step down into Early Help.
- Approx. 2 months prior to Emma's death, Mother attended hospital at 12 noon with Emma who had stopped breathing at 4am. Maternal grandmother performed 'rescue breaths' and the baby had resumed breathing. The hospital shared this information with CSC as they were concerned that Mother had delayed seeking medical attention.
- The last 2 physical visits to the house by professionals were 23rd and 25th April 2020. The health visitor conducted a planned visit on the 23rd and reported that the house was clean and the police did not identify any concerns on the 25th.
- Paramedics at the scene and police in attendance raised issues in relation to neglect.

Need to think about:

- **Over optimism** and over reliance on Mother's ability to parent and manage a partner who posed a risk for a sex offence and contact with 4 children.
- Lack of **professional curiosity** in assessing Mothers' behaviours and understanding the impact of childhood and historical adverse experiences (**cumulative vulnerability and risk**) and in particular Mother's ongoing relationship with her own mother.
- Recognising the impact and **role of the Father** and maternal grandmother in assessments.
- **Assessments** and multi- agency interventions should recognise and support all areas of risk, not a "headline" risk (sexual abuse)
- Missed opportunities in **identifying indicators of neglect – need to be constantly curious**
- **Safe Sleeping** arrangements for babies and how these are communicated with parents.
- **Information sharing and recording** – different agencies holding info which adds to risk and not sharing

Child M (LCSPR)

Context

- Child M lived with her mother, father and older sibling.
- 6 weeks of age - admitted to hospital following a choking incident. On examination she was seen to have two small bruises on her forehead. Further medical investigation identified a potentially life-threatening bleed on the brain, along with additional bruising to the thigh and a fractured humerus. The examining paediatrician concluded, in his professional opinion, the injuries had been caused by aggressive handling, commonly known as "shaken baby syndrome ".

Background

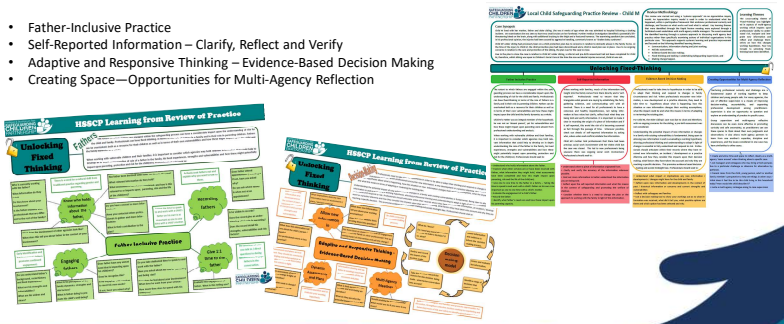
Child M's elder sibling had previously been on a child protection plan due to concerns in relation to domestic abuse in the family home. At the time of the injury to Child M, the child protection plan had been discontinued and a child in need plan was in place. Due to no ongoing concerns in relation to the care and protection of the sibling, the plan was for the case to close.

Due to the plan to close the case in relation to Child M's elder sibling, a referral and pre-birth assessment had not been completed for Child M, therefore, whilst sibling was open to Children's Social Care at the time the non-accidental injuries occurred, Child M was not.

Findings

The cross-cutting theme of '**Fixed-Thinking**' was highlighted in aspects of multi-agency working which impacts upon professionals' ability to understand risk, evaluate and integrate new information and reflect and challenge themselves on how this changes working hypotheses. Four key inroads to unlocking fixed-thinking have been identified.

- Father-Inclusive Practice
- Self-Reported Information – Clarify, Reflect and Verify
- Adaptive and Responsive Thinking – Evidence-Based Decision Making
- Creating Space—Opportunities for Multi-Agency Reflection



REVIEWS THAT HAVE SIMILAR THEMES FOR LEARNING

Child B (LCSPR)

Context
- Child B (12) was involved in a fatal accident and tragically passed away due to the injuries
- Although this specific incident could not have been predicted, 15 referrals to Children's Social Care had been made since 2009, 8 of which had led to single assessments being undertaken. (each concluded in no further action)
- The review was therefore instigated to identify points of learning from the involvement of agencies over a prolonged period of time.

Background
- Concerns had been raised over time in relation to anti-social behaviour and a lack of effective supervision of the children.
- Parents separated in 2018. Mum made allegations of domestic abuse. Mum moved away from the area at this point. A further single assessment was undertaken based on the previous pattern of referrals, and concluded with a referral for early help support.
- A Section 47 investigation in March 2019 into an allegation of alleged assault also concluded that the issues could be managed within early help.
- Early help support was provided in the period 2018-19 and was ongoing at the time of the fatal accident.

Child C (Learning Lessons Review)

Context
- Child C - 5 years of age. Taken to hospital due to severe vomiting and diarrhoea.
- She was diagnosed with toxic shock and sepsis caused by an infected wound on the back of her head as a result of a head lice infestation.
- Child C was taken to theatre where she underwent a skin graft to help repair the infected area, following which, treatment was continued in Intensive Care.

Background
- A number of referrals had been received to CSC in relation to substance misuse, parental mental ill-health / thoughts of suicide, care provided by grandmother and Domestic Abuse. One resulted in a social care assessment which closed following assessment. Another was referred to EH which closed due to refused consent. Another referral to CSC closed due to refused consent to an assessment.
- Child C was treated at A & E approximately 6 months prior to the serious incident due to a reaction to the solution used to treat head lice. Child C was taken to a number of GP appointments and was referred to a dermatologist; which parents engaged with.

L (Rapid Review)

Context
- L (6 years) parents took to Urgent Care after becoming unresponsive at home.
- After becoming increasingly unresponsive, he was taken to A&E (North Tees Hospital). Suffered convulsions and a seizure.
- Placed into an induced coma, intubated and transferred to Newcastle Royal Victoria Infirmary (RVI). The RVI diagnosed L as having Rotavirus; (common virus amongst that can run its course naturally with no major issues) However, the RVI reported that L had reached medical crisis due to his blood sugar levels having fallen so low and his sodium levels being high. Once treated and stabilised L made a rapid recovery (within 15 hours).
- L had been difficult to wake at around 10.30am. He was brought to Urgent Care by Parents at 1pm.
- L toxicology results were positive for cocaine

Background
L and elder sibling were subject to a CP plan under the category of neglect at the time of the incident. Concerns had been in relation to mum's mental ill-health, parents cocaine misuse, allegations of dad's drug dealing, alcohol use, poor presentation of the children, fluctuating home conditions, parents relationship – two incidents of domestic abuse and a previous period of separation, lack of collaborative parenting and parents failure to address the children's medical needs.

I (Rapid Review)

Context
I (aged one) who had been in the care of Father, had fallen into a large paddling pool in the back garden and had stopped breathing. A neighbour administered CPR and Police and ambulance attended. I was sedated and taken to hospital and was later discharged with no long-lasting impact.

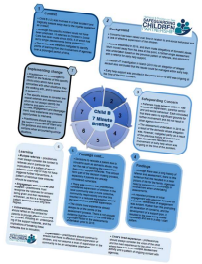
Background
- I has had ongoing Health Visiting (HV) support since birth, with visits outside of universal health pathway to support with feeding and developmental needs.
- I has delayed development and has had physiotherapy involvement to support this.
- RSPCA have had involvement with Father in relation to instances of animal cruelty.
- Previous referrals made in respect of Father's three eldest children to a previous relationship. The children were subject to Child Protection plans under the category of neglect between January 2013 and October 2013. CIN until 2016. Re-opened in February 2019 due to poor home conditions, however by this point in time Father was no-longer living with the family and had commenced the new relationship with I Mother.
- Father and I's Mother visited by Children's Social Care in early 2019 as part of assessment work carried out for Fathers eldest children. This is due to the children visiting Father and having overnight stays as part of contact arrangements. No concerns were raised in respect of home conditions of Fathers new property.

N (Rapid Review)

Context

- Safer referral from local property service which described hearing what sounded like the grabbing of a child, child whimpering. It also described an observed bruise on N's cheek and expressed concerns around suspicions that N was being left alone.
- Police attended the home. The home conditions were appalling with rubbish strewn all over, including numerous empty cider bottles. There was no food at all in the cupboard and a dead rat which had decomposed in one of the other cupboards. The smell was said to be so bad that some of the attending officers found it hard not to gag.
- N, aged 2 years, was observed by both the Police Officer and Duty Social Worker, to present as extremely grubby to the point that his clothes were crusted with dirt, urine and possibly faeces. N was not wearing a nappy and was not wearing any underwear. He was dressed in woolly tights, joggers and a t-shirt; all of which were extremely dirty and were seized by the Police for evidential purposes. N feet were noted to be extremely dirty from what would appear to have been walking around in bare feet on dirt and possibly faeces. The dirt was hard and engrained and his feet were also noted to be red, along with his hands, nose and ears. N was offered food, which he was observed to devour and it appeared that he had not eaten for some time.
- Further information was obtained from Maternal Uncle, who reported that Father had been neglecting N for some time. He stated that Mother had left N in the care of his father when he was 4-5 weeks of age and is believed to have returned to Poland - her whereabouts or contact details were not known.
- On 13th October 2020, in discussion with the Local Authority, Father confirmed the current home conditions had been like this for around 4 months. He stated that he did lock N in his bedroom for around 6 hours per day and that had been doing so for the last few months. He confirmed that he had left him home alone and only occasionally fed him.

Need to think about:



- **Assumptions** made across the system without checking them out
- **Reliance** on what other parts of system said or what is recorded
- **Recording** – reporting fact vs opinion vs self reporting
- **Cumulative risks –** Completion of **holistic assessments** incorporating wider family history and information **(Cumulative vulnerability)**
- **Multiple referrals** – you must always consider all information – referrals/ case closure etc.. A chronology will offer a understanding of the long term view. Need all agencies to share this long term info to give a richer picture
- **Engagement with services and support** – be alert to families saying they will engage with EH/ other agencies to avoid CIN and then not engaging. This is a recognised pattern associated with long term neglect.
- **Child's lived experience** – you must always consider the voice of the child and the lived experience for the child (critical when there are lots of assessments and no intervention) **What does a day in the life of child look like**

- **Over optimism** and the role of professionals in parenting neglected children
- ***Supervision of children*** – parents should be directly supervising must not assume a level of supervision in the community to be an acceptable alternative because it is seen as a community norm
- **Vulnerabilities** – reflect on the context for parents to be able provide effective parenting, including an understanding of the support networks. Would parenting be compromised if these networks were not in pace.
- **Challenging disengagement** / inconsistent engagement / disguised non-compliance
- **Language barrier**
- **Information-sharing** – particularly in relation to missed (not brought) appointments with different agencies
- Operating within **COVID**
- **Fathers and hidden males**
- Robustness of **transfer** across all services and sharing of information including across areas

Learning from Reviews