Local Child Safeguarding Practice Review

Child O

September 2021

Hartlepool & Stockton-on-Tees
SAFEGUARDING CHILDREN PARTNERSHIP

Case Synopsis

Nine year old Child O was assaulted by mother's partner and witnessed the assault of mother; who was stabbed multiple times in the attack. Child O suffered bruising and swelling and mother lacerations to her head and face. Both Child O and mother made a full recovery from their physical injuries but it will take time for both to recover from the emotional impact. 'Time' is the recommendation from CAMHS, a period of readjustment for Child O to allow a 'normalised as possible' process of healing to the distressing experience and following the life changes encountered.

Child O is an only child who lived with Mother before the incident. Child O's father has had no involvement since Child O was around 12 weeks old and there is no contact between them. Child O is currently living with maternal grandmother. Child O's maternal grandfather sadly died when Child O's mother was a child herself.

At the time of the incident, Child O was involved in a second period of Child Protection planning.

The first period was triggered by an incident whereby a male had been stabbed in Mother's home by another male – Child O had been present (upstairs). Concerns were also around Mother's drug use. A strategy meeting was undertaken followed by a single assessment under Section 47 of the Children Act 1989. The outcome of the single assessment and child protection enquiries was to proceed to Initial Child Protection Conference (ICPC). The multi-agency group of professionals who attended the ICPC agreed that Child O was at risk of significant harm and unanimously agreed that O should be made subject to a CP plan under the category of risk of neglect.

Two months after being made subject to a Child Protection plan, Child O became a 'child in our care' following being left home alone by Mother. Police received a report from a member of the public that mother was seen to be driving a car under the influence of alcohol and that a child had been left home alone. Police attended the home address and Child O was in the house alone. O was taken into Police Protection and was initially placed in foster care. Mother was subsequently arrested.

A Strategy discussion was held between the Emergency Duty Team and Cleveland Police followed by a Reconvened Strategy Meeting which included Children's Social Care, Health, Education and Police. A Legal Gateway meeting was also held which concluded that the Public Law Outline (PLO) needed to commence.

Child O remained in foster care for approximately one week whilst checks were carried out on grandmother. Maternal Grandmother was temporarily approved as a foster carer under Regulation 24 of the Care Planning, Placement and Case Review (England) Regulations 2010 and Child O moved to maternal grandmother's care. Because of being accommodated with grandmother as a child in our care, O's Child Protection plan was ended under 'dual protection' procedures.

A rehabilitation plan was developed in order for Child O to return to the care of Mother. A Safer Referral was received due to mother being brought into hospital by Police for driving whilst

intoxicated and crashing into wall. Child O had been in the process of being rehabilitated to the care of Mother and had been in her care at the time. O had been left with a friend by Mother, prior to the incident taking place. O was collected by grandmother and stayed with her until returning to Mothers sole care. The single assessment was completed which recommended that O be subject to a Child in Need Plan with an emphasis on supporting O to remain in the care of mother and calling on the familial support network. A further Legal Gateway Meeting was held. The meeting was informed that mother had made improvements and there was an agreement to remove Child O from the PLO.

The second period of Child Protection planning was triggered with a Strategy Meeting being convened. The Strategy Meeting was held due to two precipitating incidents in short succession. The first incident was following a report to the Police and Emergency Duty Team by mother's 'on/off' partner (perpetrator of the serious incident) alleging that mother was under the influence of cocaine and had left Child O home alone. The Police attended the family home following this allegation and noted that mother was not presenting as being under the influence of drugs and Child O was fast asleep in bed. Police also noted that Mother had sustained an injury/cut to her right eye. Mother's partner was not found in the house during a Police search of the property. Concerns were expressed in relation to the potential harm to mother as her partner was known to Police for assaulting his ex-girlfriend. Mother confirmed an on/off relationship with this partner who was believed to be from out of area for around 5 years. Mother confirmed that there had been no issues with him, that she saw him a few times a week and that their relationship was very casual. She stated that he had been staying at her house a few nights, an argument had occurred and that he had pushed her. Mother did not wish to receive support from Harbour or to support a police prosecution. The Police attended again a few days later to attempt to arrest mother's partner. He was found in the house and was arrested. The Strategy Meeting allowed for full Police information to be shared and to collate a plan moving forward. The Strategy Meeting decided that child protection enquiries needed to be carried out under Section 47 of the Children Act 1989. Concerns were substantiated and Child O was believed to be at continuing risk of significant harm. An ICPC was held and Child O was made subject to a second Child Protection Plan under the category of risk of Neglect. Mother was not in attendance at the ICPC, however had submitted her views via the Chair. Mother did not believe she had placed Child O at risk of harm and disputed the information held by Police. She denied there had been any form of domestic incident. She stated the injury to her eye was caused by a fall.

Contradictory information was received via a telephone call from a Probation Officer (for Mother's partner) advising that a sibling of Mother's partner had received a text message from mother stating that her partner had attacked her the previous evening and had split her cheekbone. Another strategy meeting was convened and further child protection enquiries were completed. Further legal advice was sought following the child protection enquiries concluding, however based on the information provided to the Legal Gateway Meeting, a decision was made that threshold was not met to re-start the PLO but to continue with the child protection plan.

Core group meetings and a MARAC (Multi-Agency Risk Assessment Conference) meeting took place. Safety was considered in place due to partner being on licence to probation in another part of the country. A referral was made for Mother to Harbour. The Review Child Protection Conference was held and Child O remained subject to a Child Protection Plan with specific instruction for Child O to

have no contact with mother's partner. A Claire's Law application was shared with mother following the MARAC meeting.

A notification from the Domestic Abuse Solutions Team was received on the release from custody of Mother's partner. Mother's partner had conditions not to enter the Cleveland area and was not permitted to contact mother, therefore it was felt by professionals at the time that appropriate safeguards were in place. Mother was also reporting that they were no-longer in contact. There is information available, however, to suggest that mother was remaining in contact with him, despite denying this to professionals. There was a specific incident a few weeks before the serious incident where it was thought that mother's partner (perpetrator) was with mother. A visit was undertaken however mother denied and this was taken at face value. This was not fully explored even though all those involved knew how much of a risk mother's partner posed.

The Rapid Review Findings

The initial Rapid Review found that there had been limited multi-agency involvement within the case with only Social Care and School being part of the Core Group of professionals in place to support the Child Protection plan. The substance misuse service was invited to a meeting but did not attend and once negative drug tests were submitted they closed their case. Health attended Child Protection conferences and the Child In Our Care review, however once the health assessment was undertaken and no health needs identified, they withdrew from the case (as per procedure).

NEAS (North East Ambulance Service) had information on their system which was of significance, in relation to mother's partner (perpetrator) using mother's address when contacting 111 for medication. If shared with the Core Group, this would have highlighted that there were significant risks to Child O and actions to safeguard could have been progressed. There is no current process to routinely share information from NEAS to social care, although in discussions as part of this review, it was identified that this information would be on the main health record held by the GP. However, in this case, as the perpetrator was not the child's parent, as his GP is located in another part of the country and therefore would not have had any knowledge of his link with Child O, it would not be realistic to expect this information to be shared by the GP with social care.

There was a MARAC meeting held which discussed this case, however, whilst NEAS feed information into MAPPA, they do not share information into MARAC. Whilst it was identified that the relevant information in relation to Mother's partner using her address would be on the health record held by the GP, there is no indication that this was considered within the MARAC process and the information recorded in the MARAC meeting minutes provided by the NHS is not explicit and does not mention that mother's address was given.

In light of the above, this Local Child Safeguarding Practice Review aimed to further examine the emerging learning, exploring how it translates across the wider system.

Review Methodology

This review was carried out using an Appreciative Inquiry model. An Appreciative Inquiry model is used in order to understand what has happened, within a participative framework that embraces professional curiosity and challenge, and focuses on what works well and what is valued. Key learning themes that were identified through the Rapid Review meeting were explored through a facilitated event undertaken with multi-agency middle managers. The event examined the identified learning through a systems approach to discussing multi agency best practice rather than specifically examining actions of individual organisations in this particular case. This approach supports systemic learning and practice improvement and focused on the following identified learning themes:

- **Communication, information sharing and joint working;**
- **Multi-Agency Planning, Oversight and Decision-Making; and**
- **Making change happen.**

Within these themes the review explored:

- **What communication, information-sharing and joint-working between other agencies could look like, particularly where the 'Team around' consists of only two agencies (such as Social Care and school)**
- **What best practice in information sharing looks like; where there is information in relation to adults. How the multi-agency system can ensure it knows all relevant information, in order to better understand risk and inform planning.**
- **How professionals ensure wider input, oversight and challenge, particularly where the plan or 'Team Around' consists of only two agencies (such as Social Care and school).**
- **How professionals ensure that oversight is not lost and that this is a more pro-active role.**
- **How agencies (including schools and social care) feed in wider / local knowledge to help build and maintain a fuller picture.**

Systemic Learning and Practice Improvement

Multi-Agency Meetings

Where the core group / 'team around' consists of only two agencies (such as Social Care and school), it is essential that information is also considered from wider agencies. Whilst this does not need to be a physical presence at the meeting itself, information should be collected, shared and considered collectively alongside all other information; to form a bigger picture of risk and need. It is important to consider which agencies may hold relevant information that could help to develop a more in depth understanding, particularly where there are suspicions, as in Child O's case, that the true circumstances are being disguised by parent(s). Evidence is key. The best way to gather the evidence needed is by actively seeking information from other agencies which may help to fill in the gaps or unknowns to form the bigger picture. Having a dedicated section on the meeting agenda for other agency information may prompt multi-agency professionals to consider what is not known and

where / how they could find out more to inform their planning and decision-making **[Recommendation 1]**. It may also assist in prompting questioning around which other agency may need inviting, for example, Probation - where there is an adult open to them who poses a risk to the child / family. Where there are no unmet health needs identified for the child, the multi-agency meetings should consider whether health input may be needed in respect of mother or other relevant adults (mother's partner).

The Initial Child Protection Conference is key in identifying which agencies are required to be part of the Core Group for the child / family and also set out what the expectations are of the core group by making recommendations on how organisations and agencies work together to safeguard the child in future.

For Child O, health (0-19) were initially included within the core group and a health assessment was undertaken; which identified no unmet health needs. However, the review recognised that, whilst a child may not have any *identified* physical health needs, given what is known about Adverse Childhood Experiences (ACEs) it is reasonable to assume that the impact of the trauma experienced by the child will likely manifest at a later date, despite not being immediately obvious at the time **[Recommendation 2]**.

It was recognised that the 0-19 service may not be the most suitable agency to deliver intervention in relation to ACEs / trauma experienced. The 0-19 service do not have the resource to remain as part of the core group for all cases which have potential emotional health needs (ACEs) and it is currently the expectation that the Core Group monitor any physical and emotional health needs and bring the most appropriate health professionals back in where needed. This review recommends that HSSCP consider how best to fill the 'gap' in provision for children who have no identified physical health needs but have experienced trauma / Adverse Childhood Experiences – in order that emotional intervention can be considered as part of their care plan **[Recommendation 3].**

Professionals involved in the Core Group need to remain mindful that other agencies may be able to contribute to the progression of the care plan and may need to become members of the Core Group to assist with this. Harbour's domestic abuse service is an example. In Child O's case, his mother had declined Harbour's support. Harbour are able to work with children who have experienced domestic abuse even when their parent(s) don't want to access this support themselves **[Recommendation 4]**. It was unclear in this review whether the Core Group had considered a referral for Child O to Harbour in O's own right.

Review conferences should revisit Core Group membership and reflect upon any barriers to progress. Where it is identified that there are unknowns or suspicions that cannot be evidenced, it should set out how and where further information could be sought in order to make informed and evidence-based decisions.

In Child O's case, the Core Group could have been more rigorous in their analysis of the worry and suspicion that O's mother was having contact with her partner and consider whether there were any other avenues they could explore to evidence their concerns.

As well as existing multi-agency meetings, the Core Group / Team Around the child / Review Conference should consider other opportunities for multi-agencies to reflect upon and analyse new information. This is particularly important where the membership of the multi-agency meetings are small, where the case is 'stuck', where there are barriers in understanding what life is really like for the child or there are unanswered questions or unknowns which are preventing a full understanding of the level of risk. Group supervision meetings or complex case discussions can be convened with wider multi-agency partners to examine the information known collectively **[Recommendation 5]**. Alternatively, and depending on the level of concern, if any service are raising concerns, where there is suspicion that the child is experiencing significant harm or where an agency is challenging the progress being made, a new strategy meeting could be held to pull together all new relevant information from other agencies so that it can be fully considered as a whole.

Pathways of Communication and Information-sharing

The review has highlighted issues relating to how information can be effectively shared between agencies and professionals particularly when they are not an active member of the Core Group.

There are natural intersections within the child protection process for agencies and professionals to come together to share information and to decide on action that is needed to safeguard a child:

- Strategy Meeting
- Initial Child Protection Conference
- Review Child Protection Conference

Outside of these three intersections, there is the Section 47 Enquiry and the Core Group Meetings.

In the case of Child O, we have already noted that there were only two active agencies within the Core Group; Children's Social Care and Child O's school. The review has highlighted that when agencies are actively engaged in a Core Group, there is ample opportunity to effectively share information. When the involved agencies are not satisfied with each other's actions this can be addressed via professional challenge which is explored in the next section of this report.

This review has spent time focusing on how agencies and professionals who are not actively involved in the Core Group could more effectively share information with the Core Group and the review concluded that there are two approaches that need to be developed:

- Core Group actively seeking information from other agencies and professionals
- Non-Core Group agencies and professionals actively providing information to the Core Group

The review recognised that neither of these approaches can be passive, the key term is 'actively'. The review also recognised that when an agency or professional is asked for information to support the protection of a child, there should not be any unnecessary barriers to prevent this being shared in a timely manner.

The question that then arises is this:

- How do Core Group members know which agencies and professionals to actively seek information from?

- How do non-Core Group agencies and professionals know about children where they might hold information that will help to progress the child protection plan?

In Child O's case, there was suspicion from the Core Group that mother was not being honest and that her partner was having more contact with her and Child O than she was admitting. Where there is un-evidenced or insufficiently evidenced suspicion, the Core Group needs to take an investigative approach, practice 'respectful uncertainty' applying critical evaluation to any information received and to use their professional curiosity to enquire deeper.

An issue that the review was unable to resolve and which was relevant to Child O's case is how the Core Group would necessarily know that another agency may have relevant information or how an agency with information would know that there may be linked child protection concerns. For example, NEAS via 111 was aware that mother's partner was requesting medication when he was in the Stockton area. In this case, it would not be reasonable for the Core Group to seek this information as it is very specific – the Core Group would have had to combine their suspicion that mother's partner was in the area along with knowledge that he was prescribed medication and to have been inquisitive enough to suspect that he may have needed to renew his prescription. In this example, the information sharing pathway would more sensibly come from the NHS to the Core Group as the NHS was the holder of the information however, this is also not straight forward as in this case, the person posing the risk was not a parent so his health record would have had to flag Child O – an unrelated child who he should not have been having contact with. The current Child Protection Information Sharing (CP-IS) system would not have captured this link.

The review heard that information sharing from GPs is inconsistent and in most cases, it does not happen outside of Initial or Review Child Protection Conferences. GPs need to have a pathway to share relevant information with the Core Group when they become aware of concerns about adults who are linked to a child who is subject to a Child Protection Plan. To do this effectively, they need to have a mechanism to flag linked children on adult records **[Recommendation 6]**. In Child O's case, there was a CP flag on his own GP record via the CP-IS but this did not extend to either his mother's GP record or mother's partner's GP record as the CP-IS system is based on the child's own NHS number.

The most relevant safeguarding information in Child O's case was shared via the MARAC rather than the Core Group. The review highlighted that the professionals contributing to the MARAC are not always those directly involved with the family. Schools do not routinely know which of their children are linked to domestic abuse victims and perpetrators who are discussed at MARAC and some schools are not aware that they can refer to MARAC. This review recommends that when a child is linked to a MARAC discussion, schools need to be informed so that they can contribute to the MARAC information sharing and discussion **[Recommendation 7]**.

This review recommends increased training and publicity to professionals and agencies so that they are fully aware of all groups involved in protecting children including MARAC and MAPPA, how they can contribute to these forums and how information can be shared back to the Core Group to assist with the task of protecting children **[Recommendation 8]**. SAFE Lives are currently completing a review of MARAC in the Cleveland Police area and this review should consider the recommendations from this LSCPR.

A Single Point of Contact (SPOC) within Children's Services could help develop effective information sharing pathways so that agencies such as Probation, Mental Health Services and Substance Misuse

Services can provide information that can be shared with Social Workers and Designated Safeguarding Leads in schools **[Recommendation 9]**.

My Sisters Place / IRIS (a 1 year pilot currently underway in Middlesbrough) currently feed information into MARAC and Core Groups using a funded central point of contact, a designated role which enables consistent information sharing. This is a development that could be further considered within Stockton and Hartlepool **[Recommendation 10]**.

The review recognised that there is a gap in information sharing on active Children's Social Care cases when new referrals or information is provided. As these new referrals are not screened within the Children's Hub, as procedure is to pass them directly to the allocated Social Worker, the Children's Hub's designated education professional does not receive the information to share with the child's school. The review recommends that Social Workers are reminded of the need to share new information of concern with schools as a matter of course **[Recommendation 11]**.

Another issue identified within the review was in relation to the flagging of Child in Need cases with agencies. There is more scope for missed opportunities to share information in relation to Children in Need as there is not the same framework as for those children with child protection concerns. A robust flagging process would highlight to agencies and professionals when they are working with Children In Need **[Recommendation 12]**.

The development of the Vulnerable Children Database in Stockton will help with the process of flagging as schools in Stockton will be able to access this database to see which of their pupils have child in need or child protection plans or those children who are in the care of the Local Authority.

Professional Challenge

Although School Designated Safeguarding Leads and head teachers have been briefed about professional challenge this needs to be highlighted more. At Safeguarding Forum there may be a need to explicitly pull off procedures from Tees Procedures 17. Professional Challenge and Resolution of Professional Disagreement (teescpp.org.uk) **[Recommendation 13]**. Lists for social care contacts need to be updated and shared at least annually. In addition to this, sharing of good practice should include examples of successful escalation and professional challenge.

When challenging it is important to be clear as to what the precise nature of the challenge is and what the expected outcome is. This can then be measured against. It would also benefit from the inclusion of a timescale for the response to these challenges before escalating further. In many cases these challenges can have an early resolution but where local knowledge is incomplete professional curiosity should be used to delve deeper.

There is a need for all agencies involved with named children to be responsive to appropriate professional challenge. When there is poor or no response this should be logged so that systems preventing the release of potentially crucial information can be challenged further (pending a bigger picture of failure to respond appropriately).

When a professional challenge leads to a group discussion then roles need to be identified and supervision clearly indicated. When the case appears to be stuck then professional curiosity and a wider multi-agency approach must be utilised.

Family Involvement

Child O did not participate in the review due to their age and as there were ongoing family Court proceedings.

Child O's mother was approached when the review was commencing so that she was aware of what was happening and why. Following the draft report being produced, one of the lead reviewers met with Child O's mother alongside Child O's social worker to share the findings from the review and to seek her views so that they could be reflected within this final version of the report.

Child O's mother was very clear from the outset that she did not want anything that she said to be misconstrued or that she was trying to minimise anything that has happened to O.

Child O's mother has had opportunity since the events which led to this review took place to reflect and she feels that the therapeutic support she has been engaging in has given her a different perspective. She reflects that "I wish I had someone like the 'me now', sitting on my shoulder telling the 'me then' what I should have been doing". She believes that "accepting that you were wrong is the most difficult thing" and also believes that without the therapeutic intervention she has had, "I wouldn't be able to have these discussions".

Her reflection to professionals working with children and families in general is "you do need the support of the parent otherwise you won't get anywhere". When reflecting on the intervention at the time, Child O's mother now believes that professionals should have been "softer" but also "more persistent" and that "it is all about relationships". She thinks that persistence might have been the only thing that could have encouraged her to behave and think differently at the time but she isn't really sure whether this would have prevented what happened. She did know that people were there to help but that "it is really hard to be told when you have done something wrong".

Child O's mother reflected on one dilemma that she can now recognise. She thinks that she should have been 'forced' to engage with the domestic abuse service but she also recognises that people can't be 'forced' to do these things. She now sees, having worked with 1-1 support from domestic abuse services that "I was being controlled and manipulated. I was made to feel worthless" and that the domestic abuse service has "been a massive sounding board for me to understand what was happening to me and my child".

Child O's mother also has specific feedback for those professionals who were working with her and her child at the time. She believes that everyone involved were doing what they could but she thinks that clearer language needs to be used with families so they can understand the severity of a situation **[Recommendation 14]**. She reflected on when information was being shared via Claire's Law (the Domestic Violence Disclosure Scheme). She learned about her partner's domestic abuse history but noted the number of incidents that had 'No further Action or NFA' or that there were 'charges pending'. She felt that a clearer explanation of what these terms meant might have been beneficial and that just because an allegation had an official outcome of 'no further action', it does not mean that it did not happen. She also reflected a similar view in relation to MARAC; "I didn't really know what MARAC meant", and that people need to know that when something is being discussed at a MARAC "it is a big red flag, I know now that if someone is being discussed at a MARAC, they are so very dangerous, you don't get on a MARAC for nothing, even if there have been lots of things with 'no further action'.

Child O's mother ended our discussion by describing her child as "an amazing kid" and "I wish I could turn back time for O".

Summary

The learning from this review demonstrates the importance of **active** information sharing and the need to look not only at the information on the identified child and parent but also the significant adults around the child.

Most of all, the learning is underpinned by a need to remember the lived experience of children and ensure that this is at the heart of our practice. This includes the need for schools (who usually have the most consistent communication with the child and family) to be at the forefront of discussions with the child and that those attending any meetings related to the child have had recent and relevant conversations with them.

Recommendations

The review has made 14 recommendations that HSSCP consider the need to/for and these recommendations are grouped into four thematic areas:

Immediate improvements

- **[Recommendation 1]** Having a dedicated section on multi-agency meeting (Core Group / Team Around) agendas for other agency information - to prompt multi-agency professionals to consider what is not known and where / how they could find out more to inform their planning and decision-making

Information sharing

- **[Recommendation 6]** A pathway for GP's to share relevant information with the Core Group when they become aware of concerns linked to a child who is subject to a Child Protection Plan.
- **[Recommendation 7]** Raise, as part of the MARAC review underway, that schools need to be informed when a child is linked to a MARAC discussion, so that they can contribute to the MARAC information sharing and discussion.
- **[Recommendation 9]** A Single Point of Contact (SPOC) within Children's Services to help develop effective information sharing pathways so that agencies such as Probation, Mental Health Services and Substance Misuse Services can provide information that can be shared with Social Workers and Designated Safeguarding Leads in schools.
- **[Recommendation 10]** The My Sisters Place / IRIS pilot (which currently feeds information into MARAC and Core Groups using a funded central point of contact in Middlesbrough) to be replicated / rolled out within Stockton and Hartlepool.
- **[Recommendation 11]** Social Workers to be reminded of the need to share new information of concern with schools as a matter of course.

Practice improvements / reminders / refreshers and training

- **[Recommendation 2]** Professionals to be reminded that where a child had suffered trauma / ACEs, it should be assumed that there are health needs (even where none are immediately identified at the time)
- **[Recommendation 4]** Professionals to be reminded that children can be referred for Harbour support even if their parent(s) don't want to engage in Harbour support themselves, subject to parental consent
- **[Recommendation 5]**Professionals should be reminded that group supervision and complex case discussions can be convened
- **[Recommendation 8]** Increase training and publicity to professionals and agencies so that they are fully aware of all groups involved in protecting children including MARAC and MAPPA, how they can contribute to these forums and how information can be shared back to the Core Group to assist with the task of protecting children.
- **[Recommendation 13]** Plan into the Safeguarding in Education Forums time to go through specific procedures (such as the Professional Challenge, Escalation and Dispute resolution procedure).
- **[Recommendation 14]** Professionals should be reminded of the need to use clear understandable language, avoid professional jargon and acronyms and to take the time explain complex issues as well as allowing families time to reflect and then question at a later date, information that has been shared with them.

Further investigation and scrutiny of

- **[Recommendation 3]** How best to fill the 'gap' in provision for children who have no identified physical health needs but have experienced trauma / Adverse Childhood Experiences (ACEs) – in order that emotional intervention can be considered as part of their care plan
- **[Recommendation 12]** A robust flagging process for Children In Need