Local Child Safeguarding Practice Review
Child Q

Contents

Executive Summary

1. Background

1.1 A Rapid Review commenced following **serious incident notification** submitted by Stockton Borough Council in June 2021 in relation to Child Q who suffered serious harm caused by neglect. Child Q was admitted to A & E Department at University Hospital of North Tees in April 2021 following several concerns including appearing to be severely underweight following a welfare visit by Social Care and the Police.

1.2 The Family (Mother, Father, Child Q and siblings) have been known to Children's Services since 2011 and came across to the UK as asylum seekers fleeing death threats and persecution in Pakistan. Child Q is a 14-month-old Asian ethnic minority child who has been on a child protection plan under the category of neglect from being an unborn baby. Child Q has older siblings who are currently subject to an Interim Care Order and another sibling on a supervision order.

1.3 Child Q is currently in foster care having faced severe malnourishment. Mother was reported to have eaten only milk and honey during the pregnancy and beyond impacting significantly on the growth and development of Child Q resulting in serious health issues.

1.4 Mother is currently under investigation by Cleveland Police for neglect and following a short stay in hospital under observation, has now been transferred to a mental health specialist Hospital under mental health assessment and care.

1.5 Parents were religiously divorced sometime in early 2017 but both were residing in the family home.

2. Purpose and Scope of the Review

2.1 The Rapid Review identified several areas where further consideration of practice learning is required. Hartlepool and Stockton Safeguarding Children Partnership Executive, in line with the views of those participating in the Rapid Review, considered that there remains a significant amount of information that remains unknown about the lived experiences of the children in this family and the effectiveness of partners to safeguard and promote the welfare of Child Q.

2.2 The Rapid Review recommended a Local Child Safeguarding Practice Review to inform professional curiosity, risk assessments and having a fuller understanding of the relationship and dynamics of the family and/or nature of abuse between parents, and the impact on the child(ren), with a focus upon two key areas:

- **Safeguarding children where there is non-engagement with services**
- **The impact of cultural and religious considerations.**

2.3 The Local Child Safeguarding Practice review was undertaken from November 2021 to February 2022 following the HSSCP Rapid Review and meets the criteria for relevant government guidance: *"A serious incident is where abuse or neglect of the child is either known or suspected and the child has died or has been seriously harmed"* **(16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017))**.

3. Methodology

3.1 A blended approach has been adopted providing a safe space for practitioners to share learning and identify good practice, strengths, and opportunities through focus group events, providing opportunities for reflective practice and problem solving. Recall and Learning workshops have enabled a broader range of views from Managers and decision makers to be captured and understood.

3.2 The Reviewers had several key questions that informed the discussion with frontline practitioners and decision makers as part of the information gathering stage to: enhance understanding, encourage professional curiosity, challenge, and adopt a solution focused approach. These included:

- What actually took place?
- What was supposed to take place?
- Why is there a difference - barriers, gaps, one off?
- What is the learning and what should be done about this?

4. Family Engagement

4.1 Engagement with the family has not taken place due to several risks that have needed to be managed regarding the health - both physical and mental, and the wellbeing of family members. Reviewers have worked with existing agencies and information regarding the welfare of family members and after careful consideration, following a risk-based approach, agreed that contact could negatively impact the mental health of family members. A number of approaches were made to the Father, as it was considered safe to do so using a number of mediums both in English and Urdu - but to date, no contact has been made by the Father.

5. Summary Key Findings

5.1 Layers of complexity and intersectionality alongside restrictions from the pandemic made it difficult for the professionals to navigate, circumvent and address concerns leading to them feeling stuck at times.

5.2 Professionals struggled to identify accumulative risk around domestic abuse, lack of engagement, honour-based abuse (HBA), disguised compliance of Father, mental and physical ill health and the lack of historical and contextual reference to trauma made it difficult for the case to be escalated at an earlier date.

5.3 Turnover of professionals at times resulted in reduced consistency for the family and impacted upon engagement and connection with them.

5.4 Inconsistent signs of safety ratings gave mixed messages to decision makers.

5.5 Lack of awareness of abuse within BME families led to indicators around this not being picked up and referred on to specialist support.

5.6 Gender split within the household was not unpicked enough, which might have led to a deeper insight into family dynamics.

5.7 Disguised compliance of Father – he was the only lens that was on offer to see the family and therefore, the Mother and the other female members of the household's rights, responsibilities, and entitlements were not explored enough.

5.8 Front line professionals presented as passionate, experienced, and skilled with a strong membership of the core group who shared information in and out of meetings, but at times reported feeling frustrated, not heard, and stuck.

5.9 Attempts were made to fully engage the parents via holding core group meetings in the family home, local venues, using translators and consulting with a local Iman.

5.10 Description of Mother and how she presented was not considered to be part of a trauma response to the historic disclosure of domestic and sexual violence, which was not referred on to a specialist agency.

5.11 Cultural sensitivity blocked and led to lower standards of care and safeguarding, Inter-agency communication and management oversight; failure to fully understand a family's race, culture, ethnicity, impinged on professional's ability to provide effective help to the parents and children.

6. Recommendations

6.1 Getting the balance right between support and challenge when working with parents can be difficult, it is a complex balance which requires skilled practitioners, reflective practice, effective supervision, and professional challenge within and between agencies. The following recommendations are key to improving future practice and case management.

6.2 Training which specifically provides triggers and recognises disguised compliance, domestic and honour-based abuse (HBA), trauma, culture and faith and how to professionally challenge and scrutinise using professional curiosity with mechanisms that test and ensure that the training is being embedded into practice.

6.3 Multi agency supervisions - when dealing with complex cases; identify through training which supports supervision encouraging professional curiosity which can assist professionals to determine key facts and base decisions on more than a risk assessment or historic judgement; a contextual and intelligence-led approach can provide justifications for tailored actions.

6.4 Implementing a programme of champions/specialist around certain fields such as HBA and/or complex cases.

6.5 Improve understanding of vulnerabilities within a whole family approach within BME and diverse groups by taking an intersectionality approach to protect and support individuals within a family unit.

6.6 Increase understanding and awareness of cultural harms, HBA triggers and implement a specific multi-agency pathway/process within agencies and as part of a multi-agency framework.

6.7 Review decision making protocols and documents including how risks are accounted for and weighed up, and the value of professional frontline opinion where trends and patterns are emerging.

6.8 Review escalation procedure where police intervention is required through a multi-agency/professional “quick check-in” meeting.

6.9 Performance review at the end of multi-agency meetings encouraging reflective practice, professional challenge, and key learning areas to be identified.

6.10 Implement complex case guidance; this is currently being reviewed by the Tees Procedures Group.

6.11 Conduct equality impact assessments where appropriate and relevant ensure procedures and policies support equality of opportunity.

6.12 Review processes to include referral to specialist agencies to undertake pieces of work such as engagement with family members to better understand the lived experience, and to provide guidance and support to professionals.

6.13 Align practices with new domestic abuse model currently being explored by a HSSCP Task and Finish Group.

6.14 Conference Chairs to be the point of contact for professionals wanting to challenge progress and to also set up mid-way review meetings to help prevent drift.

The review highlighted the challenges professionals face within a complex case with multiple barriers and risk, compounded with the multi-agency management of such a case. In doing so, one of the key barriers to engaging with the family included the role of the one communicator; namely the Father who became the provider of information. He led professionals to the risks posed by Mother, all of which were compounded by the struggle to provide a culturally sensitive setting which stifled professional challenge and curiosity with gaps in gaining a real understanding of the dynamics and BME characteristics of the family which subsequently led to the abuse of Child Q, the other children and Mother.

7. Introduction

7.1 This independent review is commissioned by The Hartlepool and Stockton-On-Tees Safeguarding Children Partnership (HSSCP) with two of the area's specialist charities, the reviewers, namely A Way Out and The Halo Project, selected for the combined delivery practitioner support and expertise of children's safeguarding and violence and abuse in Black and Minoritised communities. Led in partnership by:

- Sarah McManus CEO of A Way Out, part of the Child Sexual Abuse Transformation Partnership, delivers targeted support to boys and girls in primary and secondary schools across Cleveland; wrap around support for families and specialist support for girls and women around sexual exploitation and abuse.

- Yasmin Khan CEO and Founder of HALO; Government Advisor in Wales around violence against women, domestic abuse, and sexual violence. Leads pioneering work and programmes to support victims and survivors of Forced Marriage and Honour Based Abuse in the North-East along with campaigns for system change.

7.2 This review was undertaken from November 2021 to February 2022 following HSSCP Rapid Review and meets the criteria for relevant government guidance: *"A serious incident is where abuse or neglect of the child is either known or suspected and the child has died or has been seriously harmed"* **(16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017))**.

- The Family have been known to Children's Services since 2011 and although this review highlights the most recent interventions relating to Child Q it has been necessary to understand the multi-agency interventions from this earlier date; see 8. Abridged - *"Summary of Timeline and Background".*

- Child Q is a 14-month-old Asian ethnic minority child who has been on a child protection plan under the category of neglect from being an unborn baby. Child Q's older siblings are currently subject to an Interim Care Order and one sibling on a supervision order.

- Child Q is currently in foster care having faced severe malnourishment. Mother was reported to have eaten only milk and honey during the pregnancy and thereafter impacting significantly on the growth and development of Child Q resulting in serious health issues.

- Mother is currently under investigation by Cleveland Police for Neglect and following a short stay in hospital under observation, has now been transferred to a mental health specialist Hospital under mental health assessment and care.

- Parents were religiously divorced sometime in early 2017 but both were residing in the family home.

8. Abridged Summary of Family, The Timeline and Background

- South Asian - Fled death threats and persecution in Pakistan. Came to UK as asylum seekers in 2011. Both parents educated professionals in Pakistan.
- Father
- Mother
- Religiously divorced in early 2017 but still resided together in family home.
- Child Q
- Older siblings

Parents sought asylum in UK in 2010, fleeing death threats and persecution in Pakistan. The family came to the attention of Children's Social Care in 2011 seeking their right to remain, which was granted to Father and the children only. Mother was not contacted directly, and Father stated she would not sign the paperwork.

8.1. There were no assessments carried out to explore domestic abuse, coercive control, or honour-based abuse. However, Father self-referred himself to the service in August 2019, stating he was the victim of emotional abuse and control. The Lead Practitioner contacted Father who agreed to a full assessment; however, he did not attend and subsequently asked for his case to be closed.

8.2. In 2017 the Father reported Mother to the Police for concerning behaviours towards the children in August, Early Help were involved but closed the case in October 2017 as mother was reluctant and would not engage.

8.3. Case was reopened in November 2017 following concerns in relation to mother's mental health from the children's school, which resulted in the children being made subject to child protection plans for the first time under the categories of emotional and physical abuse.

8.4. Mother's mental health was questioned and reported by the Father, she was admitted to hospital in December 2017, the Consultant Psychiatrist found no evidence of psychosis or depression. Mother did however report her husband was abusive, so she stayed in one room in the home. Liaison between services and Social Care was positive as too was sharing of information and analysis of risk. No action was taken regarding domestic abuse disclosure following discharge.

8.5. In August 2018, Police attended the family home following an anonymous contact reporting that a child could be heard screaming; access was initially refused but eventually gained. This information was not shared with Children's Social Care or the wider partnership network, no referrals were made. Child Protection Planning continued until September 2018 until the plan was removed, the case subsequently closed due to small differences being made and it was felt Father was now meeting the needs of children and therefore referred back to Early Help.

8.6. A further anonymous contact to the Police was received in April 2019 reporting similar concerns of a child screaming. Mother refused to engage and is described as “aggressive”. This information was shared with Children’s Social Care and a Public Protection Notification was submitted.

8.7. In May 2019, Father had approached housing in relation to a sole tenancy. At this time, Father reported that he and Mother were separated and religiously divorced. Father informed Housing Provider of Mother’s immigration status, stating she did not have leave to remain. He also informed she would be returning to Pakistan and that the children would be remaining in his care. Sole tenancy was granted to Father in July 2019 - it does not appear that the Mother had been spoken to directly regarding her rights or entitlements going forward. Mother remained in the property where her condition deteriorated until she was removed and taken to hospital in late 2021.

8.8. In September 2019, a GPs home visit established Mother was pregnant and a SAFER referral was made. Perinatal Mental Health referral was made by the midwife. A home visit was undertaken, and the perinatal assessment was attempted, however Mother refused to take part.

8.9. Throughout the remainder of the pregnancy, three formal Mental Health Act assessments were requested by the Crisis Team. However, all of them reached the same conclusion - that there was no evidence to support detention under the Mental Health Act. Mother was not willing to work with mental health services, and she was also reluctant to engage with midwifery. Father reported Mother was not happy about the pregnancy.

8.10. Strategy meeting held 11 November 2019 escalating concerns relating to the unborn child and siblings and agreed S47 enquiries and recommended escalating risk to Initial Child Protection Conference (ICPC) and to hold a legal meeting.

8.11. Single assessment completed 30 November 2019. ICPC December 2019 siblings became subject to a CP plan under the category of emotional abuse and unborn child under neglect.

8.12. Legal Gateway Panel meeting in December 2019 concluded there was insufficient evidence to reach threshold to initiate court proceedings or Public Law Outline (PLO). Non-engagement continued to be a reoccurring concern as well as the condition of the home and the well-being of siblings.

8.13. A MARAC referral was submitted in February 2020 by Stockton crisis team due to Mother having historically reported (during her time at Hospital) 17 years of physical and sexual abuse. This referral was declined due to a lack of information for high risk of harm.

8.14. Child Q born in February 2020; intermittent engagement follows with continued concerns for Child Q and siblings, isolation, and voice of child unknown.

9. Serious Incident and Rapid Review

9.1. A Rapid Review commenced following **serious incident notification** submitted by Stockton Borough Council in June 2021 in relation to Child Q who suffered serious harm caused by neglect. Child Q was admitted to A & E Department at University Hospital of North Tees in April 2021 following several concerns including appearing to be severely underweight following a welfare visit by Social Care and the Police.

9.2. A child protection medical found the following concerns

- Failure to thrive
- Severe Vitamin D deficiency
- Advanced Rickets
- Severe metabolic bone disease with multiple fractures
- Iron-deficiency anaemia
- Dropping from weight of 25th Centile at birth to 0.4th centile
  In addition, Child Q had food allergies to milk, dairy, egg, wheat, peanuts, and hazelnuts; global developmental delay; and no immunisation had been received with no registration with a GP.

10. Multi-Agency Involvement

10.1. Agency involvement with the family commenced in 2011 when the family sought asylum. Restarted engagement in 2017 where a Child Protection Plan was initiated for the older siblings and where agencies were intermittingly involved throughout this period to date. Several partner agencies involved were all consulted as part of the Rapid Review. A Chronology document was also produced summarising in detail the involvement by each agency and outlining specific actions taken.

11. Rapid Review

11.1. Recommendations from the Rapid Review summarised the following which initiated the LCSPR: “It is clear we do not know nor have explored the lived experience and lives of the children; we do not understand the family dynamics and the roles and responsibilities of parents. The family culture has not been factored into professional’s engagement in understanding expectations. In my opinion due to the history and complexities of this family, this case would benefit from further exploration in the form of a Local Child Safeguarding Practice Review.”

12. Rapid Review Key findings

12.1. The two key areas arising from the Rapid Review were:

A. Safeguarding children where there is non-engagement with services

B. The impact of cultural and religious considerations

12.2. The Rapid Review requested a review into two specific areas to inform professional curiosity, risk assessments and having a fuller understanding of the relationship and dynamics of the family and/or nature of abuse between parents and the impact on the child(ren). Some of the considerations included:

- Over-reliance of father to provide information and highlight concerns to professionals and how this impacted professional judgement and decision making.
- Over-optimism demonstrated whenever slight improvements or engagement was made, some assumptions were made of the older children seemingly okay and professionals assuming “baby must be okay” (from a health / neglect perspective).
- How professionals deal with refused consent / lack of engagement and how to escalate in complex cases.
- Consideration to Culture and religious beliefs – the perception held in some religions regarding sexual abuse within marriage. Professionals’ confidence in asking direct questions and in challenging religious beliefs where there are potential risks to the health and well-being of children.
- Potential missed opportunities for Information-sharing and making referrals to support agencies.
- Identifying concerns in silo rather than looking holistically / considering cumulative risk and decisions made without all information available.
- Acceptance / challenge – The threshold for care proceedings not being met and how professional challenges can be supported and encouraged.
- Case management of complex cases; considering the guidance of such cases and/or seeking expertise from specialist providers specifically for Black and minoritised (BME) communities with multiple vulnerabilities.
- Domestic Abuse awareness and risk management – asking domestic abuse questions, recognising the risks and indicators especially surrounding cultural issues and abuse within BME communities.

13. Local Children’s Safeguarding Practice Review

Methodology

A blended approach has been adopted providing a safe space for practitioners to share learning and identify good practice, strengths, and opportunities through focus group events highlighting learning and solutions. Recall and Learning workshops have enabled a broader range of views from Managers and decision makers to be captured and understood.

13.1 Reflective practice was encouraged following the events and workshops which enabled partner agencies to share their evaluation outside of structured meetings via emails and telephone calls. The Lead Reviewers also consulted a range of professionals directly themselves to help deepen understanding and expand opportunity for further involvement from practitioners. In total, 21 frontline practitioners took part in two focus groups with a further 17 Managers and decision makers at both the Learning and Recall events.

13.2 To gain a broader insight to lessons learnt, academic and desktop research of reviews has also been considered to explore best practice in similar cases and to ascertain themes and key areas of improvement.

In addition, the chronology report and information provided by each agency alongside the Rapid Review Report helped to shape the context, delivery and decision making around the case.

The Reviewers had several key questions that informed the discussion with frontline practitioners and decision makers as part of the information gathering stage through two focus groups, the main areas explored were:

- What actually took place?
- What was supposed to take place?
- Why is there a difference - barriers, gaps, one off?
- What is the learning and what should be done about this?

13.3 To enable a greater understanding and identify what more could be done, the latter part covered the key areas such as the reasons why specific decisions were made, how individual agencies responded to non-engagement and whether there were gaps within a multi-agency setting, systems and processes.

13.4 The focus groups and workshop provided opportunities for challenge, reflection, and analysis so that learning could be identified and safeguarding practices strengthened, thereby reducing the risk of future harm to children and families. Participants were asked to share good practice and identity what worked well, prompting balanced opportunities.

13.5 A discussion briefing paper was produced and shared with the Hartlepool and Stockton.

13.6 Safeguarding Children's Partnership Executive ahead of the draft report to stimulate discussion, ownership, and challenge. As leaders of the charitable sector, The Lead Reviewers were keen to capture critical thinking of the members around wider system change linked to initial findings and recommendations.

13.7 Governance and scrutiny were provided through a (1) joint practitioner, (2) Manager's accuracy event reviewing the first draft of the report and (3) Hartlepool and Stockton Safeguarding Children's Partnership Executive.

13.8 Key to the review was the need to capture the voices and lived experience of the family members, particularly the Mother and the children. Following analysis of the case drawn from the chronology and the practitioner discussions, several tailored engagement tools and options were offered by the Reviewers, tailored to family members. Consideration was given to timescales and the emotional position of family members. The engagement methods included a therapeutic and empowering approach e.g., using reflective journals, arts and craft targeted activities to enable the voice of the child to be safely and creatively articulated and heard, enabling freedom of expression by the individual.

14. Family Engagement

14.1 Engagement with the family has not taken place due to several risks that have needed to be managed regarding the health - both physical and mental, and the wellbeing of family members. Reviewers have worked through existing information provided by agencies for the welfare of family members and after careful consideration, it felt imperative the on-going risks to further introduce yet more professionals could have a negative impact. Some of the risks included:

14.2 Family members have agency fatigue and hold much mistrust.

14.3 Timescales to conduct the review do not support building trust to enable meaningful engagement.

14.4 Mother is currently in hospital she has been under constant 24/7 care and fed by a tube. As her physical condition has improved slightly, she has now been moved to stay at Roseberry Park, for her mental health. Professionals are keen that her physical and mental health care is not disrupted at the present time.

14.5 One sibling has just started a programme of counselling which professionals are keen to protect as further interventions could disrupt attendance and engagement with much needed support.

14.6 Family dynamics are still not fully understood by agencies although the evidence does suggest domestic and sexual abuse / coercive controlling behaviour displayed by Father.

14.7 A number of letters have been sent both in English and Urdu to the Father along with a number of telephone calls and texts introducing the Safeguarding Practice Review, its purpose and an open offer for involvement to contribute to the findings and help shape services going forward. To date no response has been received.

14.8 The offer around future engagement from Reviewers has been extended following the review so that the findings and understanding can be enriched and enhanced once family members are able to engage as part of the partnership's commitment to continuous improvement.

15 Summary of Review Findings

15.1 The case has many different layers of complexity relating to culture and religion, mental ill health, indicators around domestic and sexual abuse, along with the long-term impact this has had on the children; potential historic trauma experienced in Pakistan which has not been documented exasperated by the lack of engagement and questions around domestic abuse around paternity of Child Q. Whilst there is recognition of challenges caused by the pandemic, there is a shared understanding and recognition by professionals that the level of complexity undoubtedly made it difficult for them to navigate, circumvent and to address some of these concerns.

15.2 Professionals and agencies struggled to identify the accumulative risks of this complex case which could have led to an earlier escalation and/or outcome. The challenges presented throughout this case caused by non-engagement with the family led to the barriers professionals faced. The contextual and historical trauma were not reflected in the initial assessments - such information is important and should have been clearly articulated within a multi-agency safety plan. This may have provided an understanding of the family dynamics and some of the cultural attributes which were important in terms of specific trauma within BME communities.

15.3 Frontline practitioners referred to some of the difficulties around escalation as “battling to be heard, feeling stuck, not knowing what else they can do, and feeling isolated as the core group”.

15.4 Services describe “significant abuse” taking place, “hidden abuse”, “dad disguised compliance” and dad as a “ringmaster isolating services”. Children were described as more withdrawn when Father was present at meetings. The actions instigated by agencies with regards to concerns raised regarding the behaviour of the Father do not seem to reflect the belief held by professionals.

15.5 Although Indicators and a disclosure of domestic abuse was made, there was a lack of awareness of abuse within BME families which led to honour-based abuse, and specific referral pathways for taking the necessary action or making a referral to a specialist agency. In most domestic abuse including honour-based abuse, this is generally perpetrated by men against women and the Home Office provides guidance on safeguarding the children who, through being in households / relationships, are aware of or targeted as part of the violence.

15.6 There is reference to a “one chance rule” to be applied in cases of honour-based abuse whereby professionals must act on the one opportunity victims have to seek help.

15.7 Lack of clarity for how the impact of disguised compliance by dad has been accounted for, assessed, and understood in terms of risk.

15.8 Escalation procedures needed to be in place taking account of the number of times Police were involved and had to gain access to the property for Social Care. This could then have been part of the Child Protection Plan leading to legal advice possibly being sought at an earlier stage, which may have led to a different outcome.

15.9 In the four years since 2017 leading to the serious incident arising in 2021, the case has been handled by different individuals in the same agency (example of this is seen via the number of social workers involved with this case) highlighting the lack of continuity with the family, impact on relationships, engagement, and trust. New professionals have had to revisit the entire case which has led to delayed actions and a lack of understanding of the whole-systems approach required for such a complex case.

15.10 Evidence of good practice with a range of services consistently attending Core Group meetings, sharing information in and outside of the meetings, supporting one another demonstrating strong partnership working.

15.11 Evidence demonstrated in part where strong multi-agency collaboration was present involving the midwife, health and social care sharing information to inform agreed safety planning. This led to some questioning surrounding the Father and mother regarding the pregnancy and whether it was planned.

15.12 Frontline practitioners presented as passionate, experienced and skilled at their jobs but also expressed their frustration at feeling stuck, not heard, when it came to trying to escalate the case and did not know what else they could do.

15.13 Inconsistent ratings around the Signs of Safety between professionals was raised providing mixed messages to decision makers. Some agencies consistently scored between 2-3 on the Signs of Safety but struggled to understand how this had not then met with the threshold criteria for further action.

15.14 Conference meeting membership was not consistent starting at 12 members reducing to 4 partner agencies, so current intelligence information was not always shared to enable better informed decisions to be made and actions taken. There was evidence of a Core Group meeting being cancelled at short notice and some drift between meetings between February and end of April 2020.

15.15 One Core Group meeting did question and challenge Adult Mental Health services as to their position around the Mother having capacity to consent.

15.16 Variances with supervision and management support for frontline practitioners left some professionals feeling isolated and anxious about the case However, evidence of good practice from the Conference Chair who held a reflective practice meeting with professionals enabling further exploration and challenged decisions regarding the level of progress achieved to date.

16. Safeguarding children where there is non-engagement with services

16.1 Agencies described Mother as “difficult”, “challenging”, “aggressive” which went on to inform a collective understanding as to who she was and underpinned the challenge around engaging with her. Little analysis was evident or shared around “why” she might present in this way; link to previous disclosure of domestic abuse in 2017 or how this could be a trauma response to harm she was experiencing or had experienced.

16.2 Father was “the voice” for the entire household; his opinion and lens was the one given to professionals to see the family through. Lack of the voice and lived experience of other family members affected engagement and services being able to better understand family dynamics and thus tailor delivery and interventions accordingly. It is unclear as to what challenge and professional curiosity around a single point of contact was explored linked to the rights, entitlements and equality, diversity, and inclusion around the lack of a female insight into the household. Connections have started to be made and engagement increased since two of the siblings were placed into foster care.

16.3 Where engagement was difficult and challenging, services seemed stuck as to what else they could do and other options available - hence more of the same happened with little progress being made leading to drift and delay for the children.

Other options around using a specialist voluntary sector organisation to establish connection and engagement do not appear to have been explored. It must be noted, an area of good practice developing within the School where A attended through a key worker has started to show positive engagement and trust. There is potential for this developing and moving forward, real opportunities to better understand the family dynamics and the contextual setting of the family's entry into the UK, highlighting any trauma and/or abuse which may have occurred.

16.4 Non engagement with services does not appear to have been unpicked asking not "what else can I do?" but rather "why does it look like this?" and making links to indicators and historic reports of domestic abuse, cultural factors, who is best placed to engage and meet the need of family members and looking at trauma.

16.5 Good practice was noted where engagement had been encouraged around attendance at Core group meetings where venues had been changed to accommodate access, such as offering to hold them in the family home, use of translators, written communication in Urdu and consulting with a local Iman. In addition, some direct work was undertaken with the children which was not mentioned in the Rapid Review.

17. The impact of cultural and religious considerations

17.1 Police response whilst it seems disproportionate (using an armed response vehicle to gain access to the family home) was to enable safe access. Obvious key domestic abuse indicators were not acted upon, despite two similar complaints being made to them about a child screaming for hours and little consideration around potential honour-based abuse and prevention. Evidenced by lack of information sharing and referrals being made.

17.2 Reports that females were in the darkened bedroom with Mother, whilst males opened the door to agencies or often the ones who engaged with professionals. No evidence of this gender balance was unpicked to explore what this meant for the females of the family. Designated Social Worker did enquire why the girls were left upstairs in the dark whilst the boys were downstairs but there does not appear any further assessment around this.

17.3 Assumed view of the family was through the father's lens only as he engaged, the remaining family did not. It is his views that formed the views about his wife, and he informed how she was presenting and the family dynamics. Father's compliance and engagement was sporadic at times; evidenced by him leaving the family following expressing concern about how his wife was coping and presenting. Lack of knowledge around specific cultures and religions can affect professional confidence to challenge harmful parenting practices.

17.4 A lack of awareness of cultural and religious practices and how these should be applied within the safeguarding and protection procedures and practices. Professionals wanted to respect the family's cultural and religious practices but the desire to be culturally sensitive can result in accepting lower standards of care. This is evidenced via the malnutrition of Child Q and concerns about mother being pregnant just before she was admitted to hospital when she was unable to bear her own weight when coming out of bed and was so very frail.

This has been highlighted in many serious case reviews (see Alexis Jay review of sexual exploitation in Rotherham) where the safeguarding of the child should be the paramount overriding concern, yet the fear around cultural sensitivity is one that professionals struggle with.

17.5 Misunderstanding between culture and religion both used and blurred together in some agency reporting. Ethnicity, culture, and faith should all be considered when looking at family relationships.

17.6 Professionals demonstrated wanting to be culturally sensitive yet lacked the confidence to challenge parents when raising culture to distract attention from a focus on the child. Culture then becomes prioritised above safeguarding practices and is driven by the fear of getting this wrong.

17.7 The case has been driven by what Father has reported, however no question of his accountability appears to have been considered, nor is he subject to Police action / prosecution given he was one of two parents residing in the home, had joint parental responsibility and was the most vocal member of the household.

18. Themed Recommendations

18.1 **Decision makers should review** how risks are weighted and value professional frontline opinion and intelligence, including belief, where trends and patterns are evolving to support actions which follow. The importance of robust multi-disciplinary sharing of historical information, taking account of the views of partner agencies, was essential to ensure the child's care plan was well co-ordinated and appropriate supports identified and put in place.

18.2 **A review of procedures and policies** to include referrals to specialist agencies around domestic abuse, engagement, and other issues to ensure different routes and pathways are taken to help safely progress a case, strengthen safeguarding practices and understanding. Referrals could be made to a specialist for them to take on elements of that work or to provide advice and guidance to enable professionals some specialist provision to lean into, increasing awareness around the intersectionality of similar cases.

18.3 **Increasing professional accountability as a multi-agency group**, if progress is not being made, specifically exploring as to why a PLO has not been considered and how this is communicated to partner agencies. Key explorative questions evaluating the performance, effectiveness and progress of the group should be in place at the end of each meeting reaffirming the purpose and outcomes to achieve. This would provide an opportunity for multi-agency reflection, encourage challenge and evaluation identifying when other support/advice or guidance is needed.

18.4 **Broader assessment to take account of race, religion and abuse and family characteristics**.

18.5 **Refresh, "Think Family Approach"** to encourage a holistic consideration of the whole family when assessing need and planning care packages which will take into consideration domestic abuse, mental health, culture enabling tools and goals to be set and informed by these factors.

18.6 Adopt and align to **Complex Case Guidance** already being developed across the Tees following a previous review.

18.7 **Review decision making protocols** to strengthen and support professional challenge

19. Learning and Development Recommendations

19.1 The combined chronology and significant events present opportunities for improvements and learning, both for individual agencies and as a collective partnership through a multi-agency evaluation of the risks. A common thread in any review is the training and learning we can embed to make the necessary changes. The HSCCP requires assurances that the risks are managed effectively, and professionals can competently protect families with complex needs. The following key areas will provide a platform to improve the gaps identified throughout this review:

19.2 Peer to peer support to instil confidence to frontline practitioners where professional challenge is necessary, structure as to how and when as well as disguised compliance, the voice of the child and engagement.

19.3 Case and management supervision to explore and encourage professional curiosity requiring intelligence, as well as information to enhance a better understanding which helps to inform core group discussions with partner agencies.

19.4 Raising awareness around culture and domestic abuse and illegal cultural harms needs to be prioritised understanding the indicators and signs and how to respond to concerns. This should be interactive, practical based, sharing tools and strategies to address as frontline practitioners and illustrated with practice examples and case studies to help inform learning and understanding.

19.5 Training around trauma and how this can manifest, impact on the brain when experienced compound trauma, along with techniques to stabilise. Trauma informed approach and responses can also help encourage engagement and thus inform and strengthen safeguarding practices.

19.6 Asset based practices encouraged looking at good practice and sharing across agencies to strengthen what is working well, adopting an appreciative enquiry approach outside of safeguarding practice reviews.

19.7 Develop multi-agency supervisions in complex cases such as this to join up work, sharing of information and strengthen collaborative working and partnership understanding. Consider external clinical supervision sessions at a multi-agency level to support a culture of challenge and professional curiosity whilst supporting practitioners and providing positive tools to do this.

19.8 Develop a programme of champions and ambassadors who will lead as specialists in certain fields such as HBA cascading learning, supporting professional challenge and curiosity to help embed understanding, creating a shift in approach.

19.9 Link into the new approach and model being developed and reviewed by the Domestic Abuse Task and Finish group which would support an evidence base for action and provide tools and guidance around the complexities and intersectionality of domestic abuse cases.

20. Process and Review Recommendations

20.1 Review of safeguarding practices to ensure that safeguarding is prioritised above culture using toolkits to support staff to do this.

20.2 Review how information is shared to streamline this between professionals making it more timely, efficient, and effective; this could be a training need around professional responsibilities as information sharing is clear in child protection.

20.3 Signs of safety ratings to be reaffirmed, giving examples of what this looks like to illustrate and ensure that this is rolled out to all and can be consistently applied.

20.4 Review the role of the Child Protection Conference Chair as a point of reference for any professional concerned about the progress of the CP plan and the challenge that the Chair can exercise to support escalation. Look to the Chair setting midway review meetings between Core Group meetings to monitor and prevent drift.

20.5 Capture the Child's voice and experience / whole family view / wider family linkages / family circumstances history, when appropriate, making use the voluntary sector or specialist agencies to help support and enable this, recognising that as non-statutory agencies engagement can be more readily embraced by families experiencing multiple disadvantages.

21. Good Practice Recommendations

21.1 There is a danger in such a highly charged and emotional case such as this, that with the crude application of hindsight any genuine and more honest learning will be lost. Reliance on hindsight can wrongly infer that wrong personal or professional judgments were made rather than looking at what was known at the time and analyse how and why information was being processed by all the relevant people (family and professionals) and the reasons behind this.

21.2 The review highlighted the difficulty faced by professionals in deciding how to evaluate the allegations made by the father. The records show that professional understanding of risks had been based largely on the accounts given by him, with no corroborative or supportive evidence until the most recent episodes of abuse to Child Q. The following areas for improvement are supported by the recommendations in **section 6** and are intended to provide a broader, thematic approach for the safeguarding partnership, however they can also be applied to individual authorities including health trusts, police, education, children and adult social care and relevant public bodies involved with safeguarding responsibilities.

21.3 The safeguarding partnership should ensure through learning and development, that all agencies have arrangements in place to consider within assessment and supporting multiagency procedures the child's experience and emotional impact, as well as the child's voice.

21.4 The safeguarding partnership should ask member agencies and partnerships (including those who are the commissioners of services) to ensure that whenever possible, professional assessments of risk in relation to domestic abuse consider relevant history. For example, past accounts of abuse, including those with other partners, pervious services provided and their impact, and the impact of abuse on the victim and children.

21.5 Assessments must take account of race, religion and other individual and family characteristics that shape its impact on victims' assessment and management of risk, where there are allegations of domestic abuse within BME communities; need to take account of specific factors of race, religion, and family background. This will be a unique assessment because every family and individual have a different interpretation of these factors and individual needs. For example, in this case insufficient attention was paid to the characteristics and circumstances of the family.

21.6 It is recommended that training around improving professional curiosity and embedding this as part of day-to-day delivery with the mechanisms to test and ensure that this is the case needs to take place.

21.7 If there is a lack of experience within multi-disciplinary teams of abuse within BME communities, the specialism and expertise should be sourced. Similarly, their needs to be a review of the tools, interventions and pathways around Honour Based Abuse (HBA) separate to domestic abuse as referenced in Home Office guidance and associated protocols.

21.8. Training, along with toolkits to support and improve understanding and delivery around honour-based violence enabling indicators and questions to be asked to inform safeguarding practices and decision making are recommended.

21.9 This review identified the need to train and raise awareness of professionals around culture and faith and how this can practically be used when completing child, adult and family assessments. Lack of knowledge may result in professionals adopting a reactive and punitive approach when confronted with cultural or religious values. Practices which put a particular ethnic group at a disadvantage in comparison to their white counterparts fails to meet Public Services Equality Duty (Equality Act 2010), furthermore leads to institutional and systematic failures to protect Black and minoritised communities.

21.10 When working with families where a lead communicator is apparent to the level the Father became, staff need to be made aware that research and practice evidence demonstrate that the level of manipulation by one parent can be considerable, and their subsequent actions must be rigorous to a point of not automatically trusting the information provided. Analysis of the potential risks and assessments of the children and Mother involved need to be subject to additional scrutiny in such complex cases.

22. Practice recommendation

All services dealing with domestic abuse allegations and assessments of risk must ensure that staff take full account of race, religion and other individual and family characteristics that may shape its impact. A specific honour- based abuse risk assessment and multi-agency referral pathway should be developed with risks and harm training to enable professionals to understand the triggers and thereby the relevant interventions and support.

23. Practice recommendation

The safeguarding partnership should providence due regard that all agencies promote a culture and competence that enables staff to evaluate risks from domestic abuse, lack of engagement, disguised compliance in full, always taking them seriously and treating alleged victims with respect but in appropriate circumstances, exploring how complete allegations are and whether they are valid.

24. Practice recommendation

The safeguarding partnership should highlight the importance of compiling and sharing intelligence and information which is crucial to building a whole systems approach to supporting cases where non-engagement is experienced.

Assessments for children and all the adults within the family is essential as part of any chronology setting out key risks and challenges. Agencies must ensure appropriate tools and culturally specific interventions are available such as the use of arts and craft, journals to promote an environment which is trauma-informed and explores in different ways how information can be obtained.

25. Practice recommendation

Ensure that all local multi-agency pre-birth risk assessment tools and protocols and information sharing comply with child protection procedures and local guidance, and that staff are aware of, and trained, in using these.

26. Practice recommendation

Protecting children from extremist behaviour during pre-natal assessments and multi-agency responses requires careful assessment and working collaboratively across agencies as, initially, concerns may be inconclusive and protecting a child or young person against a potential risk can be dependent on a wider range of factors. Sharing information effectively and keeping the child in focus should be the main aim of any interventions and services.

Increased awareness of extremism behaviour and professional cultural competency can be enhanced by training, tools, and specialist roles/lead professionals.

27. Monitoring and Evaluation

27.1 Learning and good practice recommendations should form part of an implementation plan around the LCSPR for Child Q. Milestones and review periods should be established to assess progress, impact and difference ensuring that the changes identified do take place, become embedded and shift the culture and approach, thus strengthening safeguarding practices for future families and children. Managers in all agencies should ensure staff supervision of complex cases, risk assessments are critically evaluated, and hypotheses are tested.

27.2 The partnership should agree how they will measure the impact and distance travelled and report upon this incrementally ensuring that above becomes part of everyday practice in general.

27.3 Critical thinking and challenge, reviews frequently highlight ‘over optimism’ and a lack of ‘professional curiosity’. Practitioners should be confident in using the authority of their role to promote ‘support and challenge’ relationships between themselves and children and young people. Critical thinking can provide a framework for practitioners to analyse and reassess their work with children and families.

Appendices and References

Appendix 1, Terms of Reference Decision making

HSSCP Executive members took the role of a governance group for the review and dedicated governance group meetings were scheduled at regular intervals throughout the independent review period. The Executive issued terms of reference, agreed actions, and monitored progress. A governance meeting gave final sign off to the review.

Terms of reference

A focussed review which was to explore two key learning themes identified from the Rapid Review already undertaken; **Safeguarding children where there is nonengagement with services** and **the impact of cultural and religious considerations.** The independent reviewer(s) appointed undertook an examination of agency chronology information. Following this, two **focus groups** were to be undertaken with frontline practitioners; one for each of the key themes identified. A facilitated **learning event** was then held with wider representation from across the partnership; the aim of which was to explore how identified learning translates across the safeguarding system. A **recall event** was then undertaken to examine the draft report, prior to its submission to the HSSCP executive for final consideration.

Practitioner involvement

Frontline practitioners from the following agencies that were involved with the case were identified to be part of the two **focus groups**:

- Harrogate and District NHS Foundation Trust – 0-19 Service, Health Visiting
- Stockton Borough Council - Children's Social Care
- Stockton Borough Council - Early Help
- Stockton Borough Council – IRO Service
- School
- Hartlepool and Stockton-On-Tees Children's Hub
- North Tees and Hartlepool NHS Foundation Trust
- Tees, Esk and Wear Valley NHS Foundation Trust
- NHS Tees Valley Clinical Commissioning Group
- Cleveland Police
- Harbour Support Services

The **learning event and recall event** included representation from managers / strategic leads from the focus group agencies, with the addition of:

- Housing (Thirteen)
- Hartlepool Borough Council 0-19 Service – Health Visiting
- Hartlepool Borough Council - Children Social Care
- Hartlepool Borough Council – Early Help
- HSSCP Engine Room

Scope of the Review Themes

Safeguarding children where there is non-engagement with services

What was known /understood in relation to the father and family dynamics (in relation to DA / power and control / non-engagement)? What were the gaps in professionals' knowledge and understanding? What were the barriers to:

- Engagement with services?
- Family engagement in conference / core group?
- Engaging with the siblings/undertaking direct work? ➢ Was lack of engagement questioned or accepted?

What information could / should have been shared when the case was escalated (concerns re non-engagement) and legal advice sought / when referral was made to MARAC?

Processes were followed but were largely ineffectual. Do we understand why

The impact of cultural and religious considerations

What was known / understood in relation to the father and family dynamics (in relation to culture / religion impacting upon dynamics and the lived experiences of the child(ren))?

Was culture / religion a barrier? How? Was culture perceived to be a rationale for parental behaviour? Did professional understanding of / fear of culture or religion impact upon professionals' ability to challenge? Were professionals involved aware of these barriers?

How did the core group understand family dynamics / cultural beliefs and challenge?

Meetings with Family/ Significant Others

HSSCP required the reviewers and a representative from the HSSCP to make contact with the family to introduce themselves and explain the review process, so they were given the opportunity to input their views into the review.

Appendix 2 Summaries and Sources of other reference for the Review

Published case reviews highlight that professional sometimes lack the knowledge and confidence to work with families from different cultures and religions. A lack of understanding of the religions and cultural context of families can lead to professionals overlooking situations that may put family members at risk; whilst the desire to be culturally-sensitive can result in professionals accepting lower standards of care. The learning from these reviews highlights that professional need to take into account families' cultural and religious context when undertaking assessments and offering support. The rights and needs of the child need to remain the focus of interventions at all times, regardless of this context. Professional misconceptions, lack of confidence and lack of knowledge. Many professionals lack knowledge about specific cultures and religions and do not feel confident in challenging harmful parenting practices. Professionals want to be respectful of families' cultural and religious practices but the desire to be culturally sensitive can result in professionals accepting lower standards of care (NSPCC Briefing 2014).

Annual review of Local Child Safeguarding Practice Reviews (LCSPRs) and Rapid Reviews 2020

The Child Safeguarding Practice Review Panel commissioned the University of Birmingham and University of East Anglia to undertake a review of case reviews. The review highlights learning from the published LCSPRs as well as unpublished advice from the Panel to local child safeguarding partnerships to support local safeguarding partners and the Panel in their work to improve child protection practice.

Several themes emerged from the analysis of the reviews, including:

- opportunities to be curious
- inter-agency communication and sharing
- knowledge and application of policies and procedures and training
- working with families during the coronavirus pandemic
- peer-on-peer abuse
- young people's gender and sexual identities child trafficking

Overall NSPCC review found that domestic abuse was featured in 42% of all serious incidents. Working with families where engagement is reluctant and sporadic Reviews often refer to a 'lack of engagement' by vulnerable families, including missed appointments, cancelled home visits and refusals of offers of support. It is important to understand the underlying issues, such as unresolved adverse childhood experiences, socio-economic pressures or difficulties engaging with large numbers of professionals, that give rise to reluctant or sporadic engagement from families. Relationship-based practice and motivational interviewing can help practitioners develop connections with families and maintain a balance between being directive, supportive and non-judgmental. *(source: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984770/Annual_review_of_LCSPRs_and_rapid_reviews.pdf)*