7 Minute Briefing – Child Q

1.Context

Child Q was 14 months old when he was admitted to A&E department, University Hospital of North Tees (UHNT) in April 2021, due to concerns raised by Social Care and the Police following a welfare visit that Child Q was severely underweight. He was subsequently assessed by health as being severely malnourished, his mother having followed a diet of milk and honey both during her pregnancy with Child Q and beyond impacting significantly on the growth and development of Child Q. Child Q was reported to have severe Vitamin D deficiency, advanced rickets, severe metabolic bone disease with multiple fractures and iron deficiency anaemia. Upon discharge from hospital Child Q was placed in foster care subject of S.20 (Children Act 1989). CP medicals were undertaken on Child Q's older siblings at this time and no health concerns were identified. The Local Authority issued immediate care proceedings in relation to all of the children.

2. Background

The family 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 (and siblings) are of Asian ethnic minority descent. At the time of this incident Child Q was subject of a child protection plan (CPP) under the category of neglect, made when Child Q was an unborn baby. Child Q's older siblings were also subject of a CPP under the same category.

Between 2017 and 2019 the CHUB triaged and responded to three referrals in respect of the family:

- August 2017 (referred by the Police) – Father sought advice around mothers increasingly reclusive behaviour. Outcome: Referred to Early Help (Help and Support). Daily visits offered to support the family; children were seen in school. Mother refused to engage. Father was deemed to be a protective factor. Consent to continue to work with the family was refused and case therefore closed.

- November 2017 (referred by school) Concerns raised around mother's mental health and impact of this on the children. Outcome: Referred to Childrens social care for a Single Assessment. Child Q's siblings were made subject to their first Child Protection Plan. This remained until September 2018 when the plan was removed due to positive changes within the family. At this time father refused consent for the case to step down into Help and Support and the case was subsequently closed. Mother had a short impatient admission to Roseberry Park Hospital in December 2017 due to concerns around her mental health. During this period mother alleged that she was a victim of Domestic Abuse. Upon discharge, mother refused to engage with any follow up support from the crises team.

- September 2019 (referred by family GP) concerns raised around mother's significant mental health issues. Mothers' pregnancy with Child Q was confirmed by the GP. Concerns that mother was self-neglecting and had not booked with the midwifery service. Outcome: Referred to Children's Social Care for a further single assessment. Case was still active at the time of this incident. Due to a lack of engagement Child Q and his siblings were made subject of a CPP initially under the category of neglect. This was later changed to emotional abuse in February

2020. (This was the siblings second CPP). Throughout this period concerns were shared by professionals around a lack of any meaningful engagement by parents who agreed to only limited access to the children. Mother refused to allow any health professional to examine Child Q and he did not receive any immunisations. Case was escalated into the Public Law outline process (PLO) with a view to apply for a child assessment order if engagement by parents did not improve. Slight improvement meant that the case was not escalated.

- In October 2019 concerns were again raised by professionals in relation to mothers' mental health. She had become increasingly reclusive, had not left the house for three years and was aggressive in nature. During this period three mental health Act assessments were completed with them all reaching the same conclusion – there was no evidence to support detention under the Mental Health Act and mother was not willing to voluntarily work with mental health services.

- In August 2018 police attended the family home following an anonymous call that a child could be heard crying for approximately 20-30 minutes. Police attended; mother initially refused to answer the door. Armed Response assisted with entry. No concerns shared by the police.

- In April 2019 a further anonymous call was made to the police raising concerns around a child screaming in the home. Mother refused to engage with Officers and locked herself in the bathroom. Information shared with the CHUB.

- In August 2019 police attended the home following a report of an altercation between mother and the children's uncle. Father reported that this aggressive behaviour was normal for mother. This incident was not reported to the CHUB.

- In February 2020 a MARAC referral was made by Stockton Mental Health Crisis team due to mother disclosing fifteen years of physical and sexual abuse. Referral declined due to minimal information submitted on the referral form.

- In March 2020 Police assistance was requested to support the Social Worker to enter the family home in order to undertake a statutory CP visit. Child Q seen, and no concerns raised.

- In April 2020 Police Assistance was again requested to support the Social Worker to enter the family home. Mother had barricaded herself into the bedroom with Child Q and refused to allow any professional to examine the child. It was obvious to professionals in attendance that Child Q presented as very underweight and malnourished. Police Protection was taken and Child Q was removed from mother's care and taken to A&E UHNT.

3. Findings

- Recognition that this case had many different layers of complexity relating to culture and religion, mental ill health, indicators around Domestic and Sexual abuse and potential historic trauma experienced in Pakistan
- Lack of acknowledgement or full understanding of the impact of the above on the children
- Challenges brought about as a direct result of the pandemic and lockdown restrictions. Not all partners were undertaking home visits or having direct contact

- There was an over reliance on father to provide information and highlight concerns to professionals
- There was an over optimism demonstrated whenever slight improvements or engagement was made
- Evidence that assumptions were made of the older siblings being 'Okay' and professionals therefore assuming Child Q 'must be Okay'
- Professionals being at a loss of how to proceed when consent is refused/there is a lack of engagement and how to escalate in complex cases
- A lack of consideration/full understanding of the cultural and religious beliefs and professionals lack of confidence in challenging beliefs where there are potential safeguarding concerns
- Potential missed opportunities for information sharing and making referrals to agencies for specific support
- Decisions being made without full information being known
- Lack of holistic assessments to inform understanding around cumulative risks
- Acceptance/challenge – The threshold for care proceedings not being met and how professional challenge can be supported and encouraged.
- The need for expertise in managing complex cases involving Black and minoritized (BME) families with multiple vulnerabilities
- Lack of Domestic Abuse awareness and risk management – asking Domestic Abuse questions, recognising the risks and indicators especially surrounding cultural issues and abuse within BME communities.

A Local Child Safeguarding Practice Review has been undertaken and the report now published. An action plan is in the process of being developed.

4. Learning

- Over optimism
- Lack of professional challenge – particularly in relation to the decision not to initiate care proceedings
- Lack of professional curiosity
- Poor information sharing
- Cumulative vulnerabilities were not considered
- Assessments were not holistic in nature
- Lack of understanding around the impact of religious and cultural issues
- Difficulties and need for specialist support when dealing with complex cases
- What to do when cases are 'stuck' or engagement from families is poor.

5. Recommendations

- Staff to receive training which specifically triggers and recognises disguised compliance, domestic and honour-based abuse (HBA), trauma, culture and faith
- Multi agency supervisions to be introduced when dealing with complex cases
- Implementation of a programme of champions/specialists around certain fields such as HBA
- Improve understanding around vulnerabilities using a whole family approach with BME and diverse groups

- Training to be offered to staff to improve understanding and awareness of cultural harms, HBA triggers
- Implementation of specific multi-agency pathway/process within agencies
- Review decision making and escalation protocols/processes
- Implement complex case guidance
- Conduct equality impact assessments where appropriate and ensure policies and procedures support quality of opportunity
- Review current processes - to include referral to specialist agencies to undertake specific pieces of family work
- Align practices with the refreshed Domestic Abuse Model
- Child Protection Conference Chairs to be the point of contact for professionals wanting to challenge progress of cases/practice.

6. Progress

- An action plan is currently being developed by the HSSCP Engine room members
- Complex case guidance is currently being reviewed by the Tees Procedures Group.
- Refreshed Domestic Abuse model currently being explored by an HSSCP task and finish group.

7. Key messages

- Professional challenge
- Disguised compliance
- Professional curiosity
- Missed opportunities
- Concerns being considered in ‘silo’ rather than cumulatively
- Over reliance on one communicator (father)
- Impact of cultural and religious considerations
- HBA/trauma and impact on families/mother
- Safeguarding when there is non-compliance from families.