Local Child Safeguarding Practice Review
Child Roo

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1. Introduction

1.1 This Local Child Safeguarding Practice Review (LCSPR) was commissioned by Hartlepool and Stockton-on-Tees, Safeguarding Children Partnership (HSSCP) to consider the multi-agency safeguarding responses in relation to death of Child Roo. The HSSCP noted, that the cause of death remains unknown at this time. The HSSCP agreed that the case highlighted improvements were needed and there was evidence of recurrent themes, to safeguard and promote the welfare of children; additionally, that the case highlighted concern regarding two or more agencies working together effectively, to safeguard and promote the welfare of children. In view of the emerging recurrent themes, the HSSCP Executive recommended that the TOR for the LCSPR focus on identifying the barriers to improving practice and outcomes for the child/ren, as well as the lived experience of the child and his two siblings.

2. Review Methodology

2.1 This review was carried out using an Appreciative Inquiry model. An Appreciative Inquiry model is used to understand what has happened, within a participative framework that embraces professional curiosity and challenge and focuses on what works well and emergent ways forward.

2.2 Key learning themes that were identified through the Rapid Review process were explored through facilitated events undertaken with multi-agency practitioners, managers, and strategic leaders. The events examined the identified learning through a systems approach to discussing multi agency best practice rather than specifically examining actions of individual organisations in this case. This approach supports systemic learning and practice improvement and focused on the following identified learning themes:

- Cumulative Impact of Neglect – Recording and Evidencing.
- Evidence of Domestic Abuse without disclosure – recognising behaviour as evidence.
- Recognition of signs and symptoms in young children of abuse and neglect; particularly in those with extremes in violent behaviour (‘adultification’).
- Learning Disability / Learning Difficulty – professional’s understanding of impact.
- Clarity of explanation between medics and non-medics to support collective understanding for all.
- Management of Bruising in Non-Mobile Babies – Adhering to the procedure.
- How race, culture and ethnicity impacts decision making by professionals.
- Fathers.

These themes formed a framework in which to analyse the findings, enquire and develop an understanding of what was happening and what it meant in the circumstances for Child Roo.

2.3 To support analysis and identification of learning the key principles highlighted in the Child-safeguarding-practice-review-panel-annual-report-2022-to-2023 have been adopted. This included looking at the "why", having clear recommendations, setting out how they will impact on practice and identifying how they will be evaluated.

3. Timeline and Case Overview

3.1 The timeline considered as part of this review is as follows:

2018 - 2021

March 2018: Family move to Tees Valley, request made to transfer CIN not accepted therefore CIN plan closed

June 2020: Nursery call HV worries child 1 appears unkempt

March 2021: Safer referral for UBB (child 2) by CMW, referral for EHA

October 2021: Child 1 had 16 teeth removed

December 2021: Safer referral from GP - Child 2 missed immunisations.

Anger issues reported by teachers of Child 1 - recognised as probable learnt behaviour - referral for EHA (no feedback from earlier EH referral)

Possible learning difficulty for mother known

2022

March: Safer referral by 0 -19 service, fathers' cannabis use and poor mental health. Father games all day and night and in between he smokes cannabis. He shouts and belittles me in front of the children. Child 1 is not bothered by his behaviour and Child 2 covers their ears.

Safer referral from school, regarding Child 1 behaviour

Referral to CAMHS by HV for Child 1.

May: Strategy meeting following home visit by SW, appalling home conditions. SW left home as did not feel safe due to father aggression.

Criminal standard for neglect not met as property had been cleaned prior to police and CSC return visit.

Child 1 disclosure " my dad smacks me" allegation withdrawn later and no evidence from child protection medical.

CPP commenced for Child 1 and 2 - neglect

August: Child 1 abusive to HV, F*** off, threatening to kill her and heard to go in cutlery draw.

September: Referral for PAMS assessment for Mother declined as cognitive assessment will be completed by SW.

Referral to CSC by CMW for UBB Roo.

Father arrested common assault, and assault beating emergency worker.

October: Unplanned home visit, home conditions deteriorating, seen to have improved at next visit.

School reporting decline in child 1 school attendance, poor home conditions when visited.

November: Discussion with parents in home visit consideration would be give to alternative care for children if improvements are not sustained.

Home visit by SW and HV. Home conditions appalling, Child 2 nappy overflowing with faeces coming down his leg. Child 1 sleeping on the landing as father sleeping in their bed.

PAMS request for Mother not appropriate as not in court arena. Cognitive assessment to be considered.

Father re-referred to CGL declined support said he wanted to focus on his mental health. Father later has appointment with Nurse Practitioner about long standing mental health. Medication prescribed, review Jan 2023.

December: ICPC for UBB Roo – CPP commenced for neglect. Minimal change for the children noted.

Baby Roo born at 30+6 weeks.

Teacher raised concerns about child 1's behaviour - this is probably " learnt behaviour".

2023

January: RCPC CPP continues for neglect.

Baby Roo discharged from hospital.

Safe sleep and ICON discussed.

Routine enquiry about DA not asked as father present

February: Safe sleep and ICON discussed.

Routine enquiry about DA not asked as

father present.

Invite to learning disability annual review sent out

March: Child 1 suspended for 2 days from school, for being verbally abusive and a physical assault against a teacher.

Routine enquiry by HV, mother denied any domestic abuse and reported that when father was in a bad mood she allowed him to come out of it himself.

March: Unannounced visit to family home by SW. Father looked stressed. SW was refused entry to house and kept on the doorstep. Allowed SW access next day, father calmer, happier and home conditions had improved.

Child 1 permanently excluded from school.

April: Child 1 CAMHS assessment, father attempted to contact mother multiple times and she reported unable to go anywhere with father contacting her.

Referral to CSC by Paediatric Therapies missed appointments

May: Roo admitted to children's ward because of faltering growth.

Mother disclosed domestic abuse perpetrated by father to CAMHS during appointment. Adult safeguarding completed.

Telephone call to GP by father send questionnaire to complete for anxiety, depression. Not completed or returned.

June: Roo seen at home with a bruise above his eyebrow by HV and Community Neonatal Nurse. Named SW not available, spoke to duty SW and mother reported duty SW reviewed photographs and accepted mothers' explanation; sibling had thrown a toy.

Father has threatened to burn the house down.

MARAC referral submitted.

CT scan of head "small collections observed on Roo's brain possibly subdural haematomas.

Safety plan put in place mother care of children supervised legal advice sought.

MARAC meeting held.

Referral to Harbour, request for Clare Law and Non molestation order discussed.

July: Care proceedings initiated.

Non accidental injury confirmed as most likely cause of subdural haematomas.

Interim care order requested; child guardian instructed children solicitor to apply to court for urgent court hearing as not listed until 14.08.2023 recommending court oversight was needed.

ICO granted and children to remain in care of mother supervised by family friend. Exclusion Order granted in respect of father to not enter mother's property with power of arrest.

August 2023: Sudden unexplained death of Roo

3.2 Context

3.2.1 Seven month old Roo died whilst sleeping in his cot at home, where he was living with his mother and two siblings. Roo and his siblings were subjects of interim care orders at the time of his death. The court had agreed that Roo and his siblings should live at home with their mother and that her care of them should be supervised by a family friend. In accordance with this plan, the family friend was living in the home and present at the time of Roo's death. An exclusion order was in place to prohibit Roo's father attending the home address.

3.2.2 Roo was born prematurely (30 weeks) and spent the first 4 weeks of his life in hospital. An ultrasound of his head done routinely due to his prematurity showed a small bleed on his brain. This bleed was typical of those seen in premature babies and was unlikely to cause any problems clinically. At age 5 months, Roo was admitted to hospital with poor weight gain. It was noted that his head was large in circumference and therefore an ultrasound scan was booked as an outpatient. The ultrasound took place four weeks later. This showed evidence of subdural collections. These were subjected to further exploration and a second opinion from a specialist hospital. The conclusion was that these were bleeds on the brain and were not due to Roo's prematurity. While these exploratory investigations were ongoing, the Local Authority implemented a safety plan whereby a family friend supervised mother's care of the children in the family home.

3.2.3 Medics confirmed that the cause of the two bleeds in the brain was more than likely inflicted injury and the Local Authority issued care proceedings, with a plan to place the children outside of mother's care with a family member. The Guardian challenged the plan. An interim care order was agreed but with the children remaining in mother's care, subject to the supervision and safety plan which had already been in place. Father had been living outside of the family home for approximately 2 months. An exclusion order was granted with the interim care orders to prohibit him from attending the address. Roo died 1 week later.

3.3 Historical Involvement

3.3.1 The family first moved to Teesside when Roo's sibling 1 was aged 1 year, 5 years prior to Roo's birth. Mother had been previously receiving support from Children's Social Care in another part of the country prior to relocating. This previous involvement included when her first born child from a previous relationship was adopted from her care and, then when sibling 1 had been assessed as a Child in Need. The Child in Need plan was due to Domestic Abuse within the relationship. A referral was made from the original host Local Authority to the new Local Authority when the family were moving but the receiving Local Authority did not accept the transfer and the family closed to the host children's social care when they moved.

3.3.2 The Family lived in their initial Teesside Local Authority until Roo's eldest sibling was 3 years of age. The family had been accessing universal services during this time. Shortly after moving from their initial Teesside Local Authority to their current Local Authority, a referral was made by Midwifery services prior to Roo's second sibling's birth. The referral was prompted by Mother disclosing to the Midwife that she has had a previous child adopted from her care, that she has a learning disability and concerns regarding her family support network. The outcome of the Single Assessment was for the family to be supported by Family Hubs. However, the family chose not engage with the support that was proposed.

3.4 Involvement with the Family Pre-Birth

3.4.1 The following year a referral for support was made by sibling 1's school due to concerns around her escalating behaviour following an incident during which she had thrown a bike at Mother on the school grounds, saying 'I want to kill all my teachers' whilst trying to hit a teacher and also due to sibling 2's physical presentation, i.e. dirty clothes and dirty face.

3.4.2 An unannounced visit was undertaken by Children's Social Care. There was a smell of Cannabis and smoke within the home. Home conditions were deemed to be extremely poor. Parents were advised that significant changes needed to be made and that a further joint visit with Police would be completed that same day as the home was not suitable. An urgent Strategy meeting followed later that day. Significant changes had been made to the home at the second visit and therefore it was agreed the children could remain.

3.4.3 Two days later Child 1 disclosed to staff at school that her father had hit her "all over her body". A further Strategy meeting was held and joint visit agreed. However, due to no Police being immediately available, Children's Services visited alone. Child 1 did not repeat the same disclosure she had with school but did report that she had been hit by her dad on the top of her arm. Due to the timing, a child protection medical could not be undertaken that evening. Therefore, a safety plan was implemented with Mother and both children stayed with their maternal grandfather for the evening. A medical was undertaken the following day and Child 1 was observed to have two small bruises on her hip. The Paediatric consultant confirmed that these were likely to be accidental and typical of a child of her age. A safety plan was then implemented with parents to advise that Father would not use physical chastisement and Mother would discipline Child 1.

3.4.4 At the reconvened Strategy meeting professionals expressed significant concern in respect of the cleanliness of the home, Child 1's behaviours and parents' ability to manage the behaviours effectively. Concerns remained in respect of Father's drug use. Therefore, child protection enquires concluded there was a risk of significant harm and an initial child protection conference was convened. The outcome of initial child protection conference (ICPC) was for the children to be made subject to child protection plans under the category of neglect. This was 6 months prior to Roo's birth.

3.4.5 Mother and Father had reported that they were no longer in a relationship but that they remained living together and were co-parenting the children. However, shortly after the ICPC, Mother disclosed her pregnancy with Roo. A referral was made for Roo as an unborn baby. A Strategy meeting took place for Roo and a pre-birth social work assessment was completed leading to an ICPC where Roo was made subject to child protection plan under the category of neglect, prior to birth alongside his siblings.

3.5 Post-Birth Involvement

3.5.1 Roo was born prematurely (30 weeks) and spent the first 4 weeks of his life in hospital. He had no significant complications. A routine ultrasound scan showed a small bleed around the ventricles in the brain; this is quite common in premature babies and does not usually cause any significant problems; it is unrelated to any further bleeds. The family continued to be supported via the child protection plan with regular core group meetings taking place.

3.5.2 A home visit took place from Paediatric Therapies. Roo was seen in his Moses basket fully swaddled, and his face completely covered. Mother had explained that the swaddling was just holding his dummy in place. Sibling 1 was seen to be pulling the swaddling up over Roo's nose and was

positioning toys around his face. Mother also advised that Father was no longer living in the property due to Sibling 1 lashing out at him but he resided nearby and was still involved.

3.5.3 Following a home visit by the Community Neonatal Nurse and concerns around Roo's low weight / faltering growth (drop of 2 centiles), he was admitted to the Children's Ward, where he remained for monitoring for 2 nights. Investigations were arranged as an outpatient for an ultrasound of his head, echocardiogram and further follow up. A subsequent home visit carried out by the Health Visitor in which Roo's weight was observed to have decreased again since his previous growth monitoring.

3.5.4 Sibling 1 was receiving support from Child Adolescent Mental Health Services (CAMHS) due to concerns about her aggression and violent behaviour. During an initial appointment Mother disclosed domestic abuse perpetrated by Father. Abuse disclosed included demanding food and money, verbal aggression and throwing items. Father refused to care for the children when Mother was with her dying father. Mother reported to feel overwhelmed as she did when her eldest daughter was adopted. A referral to adult social care followed.

3.5.5 In a joint visit by the Health Visitor and Neonatal Nurse a bruise was noted above Roo's eyebrow. Mother's explanation was that Sibling 2 had thrown a toy which had hit Roo. A discussion was held between the Health Visitor and Neonatal Nurse in relation to the bruising in non-mobile babies' pathway, however, the Neonatal Nurse and the Duty Social Worker agreed that the toy was a likely cause of the bruise and a plausible explanation. A child protection medical was therefore not instigated.

3.5.6 At this time Mother was reporting threats to burn down the house from Father which resulted in a multi-agency risk assessment conference (MARAC) referral being made. Then, during a routine ultrasound on Roo's head, small 'collections' were observed on Roo's brain, thought to be possible small subdural bleeds. A computed tomography (CT) scan showed two bleeds at the front of Roo's brain: a larger one on the right and a smaller one on the left. The outcome of the child protection medical was suspicious of head trauma but inconclusive. CT scans were sent to another hospital for a second opinion. Safety planning was addressed by the Local Authority with a family friend to remain in the home to provide continuous supervision until further information was obtained. A Strategy meeting was held and section 47 enquiries commenced which concluded that legal advice was to be sought. The Local Authority issued care proceedings, with a plan to place the children outside of mother's care with a family member. The Guardian challenged the plan and agreed an interim care order but with the children to remain in their Mother's care, subject to the supervision and safety plan which was already in place. Roo died 1 week later.

4. Involvement of Parents with the Review

4.1 Involvement

- Both parents received letters inviting them to participate in the local child safeguarding practice review (LCSPR) and the family Social Worker advised a telephone call to mother as father was not engaging.
- Following a telephone call to mother a face to face meeting was arranged to explain the LCSPR process and seek her views on the services she and her child received.
- Mother engaged fully with the process and reported she understood the purpose of the review.
- Mother said that she wished Children's Social Care had appointed someone external to supervise her care of the children and she does not think the family friend should have been

appointed. She raised worries about the assessments completed suggesting her relative had had her children removed from her care some years previously and had significant mental health issues which she did not know about at that time. This disclosure from Mother has been shared with Children's Social Care to review.

- Mother also when asked about fathers' involvement in the plan said that the plan was all about her and all he had to do was "stop smoking".
- Mother did say that she thought the plan could have been made clearer at times and with 3 small children the timetable about cleaning were not achievable and she could only do certain tasks once they were in bed.
- When asked about positive aspects of the services involved, she reported the CAMHS worker helped her to understand she was a victim of domestic abuse and explained how child 1 behaviour was attributed to protecting her because of what she had witnessed. She also was pleased about the Education, Health and Care Plan (EHCP) that she believes has helped child 1.
- To support consideration of ethnicity, race, and culture this was discussed. Mother reported she identified the children as "African mixed race". She reported the children father was also" African mixed race and this did not feature in the children's upbringing as "I brought them up".
- She did not believe the children were treated any differently to others because of their mixed race.

4.2 Recommendation

Recommendation 1
Stockton Children Social Care Where family members or friends are proposed to supervise a parent's care of their child(ren), Children's Social Care's assessment of them must include checks with every Local Authority the person(s) has previously lived in. Any subsequent family safety plan must clearly set out the expectations of the supervisor and the level of supervision being provided.

5. Thematic Analysis and Key Learning

5.1 Cumulative Impact of Neglect – Recording and Evidencing

5.1.1 The Children were subject to Child Protection plans under the category of neglect for just over a year at the time of Roo's death.

5.1.2 **What happened and why?**

- Roo and his siblings had been known to services throughout their lives. Sibling 1 had been assessed as being a Child in Need initially, and numerous referrals had been made to Children's Social Care in different Local Authorities depending on where the family were living at the time, with neglect being the main theme.
- Both parents had been known to Children's Social Care, with the father being adopted at the age of 2, and both parents identified themselves as having adverse childhood experiences (ACES).

- Child 1 and 2 were made subject to a child protection plan under the category of neglect in May 2022, and Roo was also included in the child protection plan as an unborn baby in December 2022.

5.1.3 **Concerns identified during the period of Child Protection**

Concerns
• Poor home conditions to the extent of the Social Worker and Police on one occasion considering police protection.
• Children presenting as dirty.
• Historical involvement led to the mother's eldest child being adopted.
• Child 1's behaviour and parents struggling to manage this.
• Child 1 had made allegations of physical harm by the Father.
• Cannabis in the family home, being used by the Father.
• Concerns relating to father's mental health.
• Both parents had ACE's.
• Domestic Abuse perpetrated by the father.
• Roo faltering growth.
• Both parents had a reported learning need.
• Roo had subdural bleeds.
• Roo sustained a bruise on the side of his head.

5.1.4 The concerns that led to the child protection plan persisted despite brief periods of positive change that were not sustained. The child protection plan did not progress sufficiently during this period. Professionals have reflected on the CPP and have recognised that for the plans to be effective, they must be dynamic, owned and produced with the core group members and the family, and time-specific. Mother has reported feeling overwhelmed by the child protection plan. Parents struggling to meet the expectations within plans can then be framed as neglect, rather than as evidence of parents feeling that the demands of them from some agencies are overwhelming This issue was most seen in terms of expectations on mothers. Child-safeguarding-practice-review-panel-annual-report-2022-to-2023 .

5.1.5 As the concerns for Roo and his siblings continued, core group members shared their professional concerns with the Social Worker. It was suggested by Core Group members on several occasions that the legal threshold to issue care proceedings had been met. The Social Worker discussed this with their manager, who disagreed. There was no further discussion or escalation. Though it is recognised that the legal framework responsibilities lay within Children's Social Care, further multi-agency case discussion using the principles of reflective supervision could have been considered. Where neglect is chronic or where challenges around thresholds exist, multi-agency reflective supervision should always be considered. McGregor and Devaney (2020) highlight the role of those providing supervision in emphasising the value of reflecting on chronic neglect cases and given the role of supervision in bringing a more objective perspective and reflection on complex cases, it is suggested that supervision is an important conduit to escalation.

5.1.6 Though professionals were concerned about the welfare of the children and the effectiveness of the CPP no complex case discussion or formal effective escalation took place. This ongoing issue

identified in LCSPR continues not to be embedded in practice Child-safeguarding-practice-review-panel-annual-report-2022-to-2023 highlights the need for 'creating an inclusive culture where professional challenge is promoted'. There needs to be effective leadership and culture within organisations to support critical thinking and professional challenge.

5.1.7 Each agency held relevant information regarding the children and both parents. During the practitioner event this was explored (see Appendix B). It became apparent that there was information that was known, partially known and not known to differing core group members. The cumulative impact of this information over time was not fully analysed to consider the impact on the children. A multi-agency chronology is a tool which could have been effectively used to evidence chronic neglect and see the patterns of behaviour.

5.1.8 Recommendation

Recommendation 2
HSSCP should update the multi-agency training programme to ensure it includes: • Legal processes within child protection arena • Complex case discussions • Effective multi agency care planning • Multi-agency chronologies • Escalation
Impact on the Child
Neglect is more likely to be managed at the correct level of interventions and practitioners will have the skills and knowledge to escalate and challenge decision making.
Measuring Success
HSSCP consider a multi-agency audit focusing on neglect to include. • Effective multi agency care planning • Use of multi- agency chronologies • Complex case discussions • Evidence of multi- agency consideration of legal threshold • Evidence of escalation and challenge by professionals

5.2 Evidence of Domestic Abuse without Disclosure – Recognising Behaviour as Evidence.

5.2.1 There were signs and indicators of Domestic Abuse during involvement with the family which was only formally disclosed after one year of Child Protection planning.

5.2.2 **What Happened and Why?**

- Domestic abuse was the reason a request was made for transfer of the child in need (CIN) plan when child 1 moved into a neighbouring local authority in 2018 from Kent. This was declined by the receiving Local Authority and the CIN plan ended.
- Domestic abuse was asked at various points but not always routinely asked because father was present and child-safeguarding-practice-review-panel-annual-report-2022-to-2023 recognises this as a challenge nationally. Furthermore, documentation reported routine enquiry was made but there was no narrative regarding the content of the conversation.

- Child 1 anger issues were identified in 2021 when she began nursery and it was recognised as learnt behaviour but there was no association with this to domestic abuse and no evidence of taking this "opportunity to be curious" Annual review of LCSPRs and rapid reviews March 2021.
- Child 1's behaviour escalated over time and mother began to disclose how father became angry when gaming and child 1 did not react and had normalised this behaviour but child 2 covered their ears and he belittled her in front of the children. The Social Worker also left the home address once during a visit because of father's aggressive behaviour, and they did not feel safe.
- Domestic abuse was effectively named and addressed by the Child Adolescent Mental Health Worker (CAMHW) who begun work with Child 1 twelve months after the child protection plan begun.
- A limited understanding about domestic abuse by professionals has been identified as the reason for not taking the opportunity to identify and respond and similarly this has been highlighted in the Child-safeguarding-practice-review-panel-annual-report-2022-to-2023 .

5.2.3 Recommendation

Recommendation 3
All-age single and multi-agency training to be updated to reflect the learning from this case offer to ensure it includes: • Recognising domestic abuse without a direct disclosure. • Asking about domestic abuse using an enquiring approach and document the detail about what was asked and the response.
Impact on the Child
Improved identification of domestic abuse will improve care planning for children and parents/carers.
Measuring Success
Audit- training compliance, referral rates to Harbour, staff survey, service user feedback.

5.3 Recognition of signs and symptoms in young children of abuse and neglect; particularly in those with extremes in violent behaviour / 'adultification'

5.3.1 Child 1 displayed adult behaviours and language. The behaviour was seen through a lens of risk (to school peers, siblings and adults) and response was around managing behaviours (reward systems, routines).

5.3.2 **What happened and why?**

- The language used to describe Child 1's behaviour at times did not reflect that these were signs of her suffering abuse and neglect. Whether 'adultification' was a factor has been considered. Davis and Marsh (2020) define adultification as: 'The concept of adultification is when notions of innocence and vulnerability are not afforded to certain children. This is determined by people and institutions who hold power over them. When adultification occurs outside of the home it is always founded within discrimination and bias'. This was not recognised as a feature during this review however it was recognised that Child 1's behaviours were not considered through the lens of abuse and neglect.

- Child 1, at the age of 4 years, displayed aggressive behaviours and used threatening language based on what she had seen and heard. The behaviours were seen through the eyes of risk to her school peers, siblings and adults. The plan to manage these behaviours did not recognise the broader context of Child 1's lived experience and did not recognise what her externalising behaviours were telling professionals. Children's behaviour is a means of communicating their lived experience; they learn what they see. Professionals working with children need to interpret and understand this behaviour to ensure plans reflect the child's needs in the broadest context and not just the behaviour in isolation.

- Many CSPRs evidence the need for a greater emphasis on the child's voice, encompassing what the child is verbally telling us and their actions and behaviours. A working hypothesis can be a tool for making sense of what a child is telling us, recognising that children can display externalising and internalising behaviours as a form of communication. The word hypothesis originates in ancient Greek and means a proposed explanation for a phenomenon (Wikipedia - online dictionary). In modern-day usage, a hypothesis is a provisional idea or explanation that must be evaluated or tested. The idea needs to be either confirmed or disproved. The hypothesis should be 'falsifiable', which means it is possible for it to be shown to be false, usually by observation. Even if confirmed, the hypothesis is not necessarily proven but remains provisional. Hypothesising is a core activity within social work assessment. Holland (2004) states: "The cornerstone of analysis in assessment work might be seen as the process of building hypotheses for understanding a family situation and developing these until they include a plan for the way forward."

- The impact that domestic abuse can have on children's behaviours can include, some of which were displayed by Child 1:
  - low self-esteem and difficulties with forming healthy relationships.
  - changes in mood and atmosphere
  - reduction in school attainment, risk of exclusion from school
  - inconsistent regulation of emotions, including becoming distressed, upset, or angry
  - becoming aggressive or internalising their distress and becoming withdrawn

- Child 1 was excluded from school at the age of 5 years due to externalising behaviours, which were in part indicative of her suffering abuse and neglect. Child 1 has since been diagnosed with Autism Spectrum Disorder. It was a single-agency decision taken by school to exclude Child 1. When Child 1 was excluded from school, this potentially increased the risk of abuse and neglect to all the children.

5.3.3 Recommendations

Recommendation 4
Update single and multi-agency training programme to ensure it includes: • An overview of normal child development • The impact of neglect and abuse on early brain development to support recognition of behaviours as signs of abuse/ neglect. • Support and understanding of the child lived experience and a working hypothesis.
Impact on the Child

Better understanding of the child and what their behaviour may indicate. In turn, this improves the assessment, analysis of the child's developmental needs and their outcomes. Practitioners would spot signs & indicators of abuse and neglect earlier, leading to improved care planning and interventions to support the concerns.
Measuring Success
Training evaluation and evidence of practitioner learning.

Recommendation 5
The Partnership should engage with Education to consider collaborative working to reduce the risk of a child being excluded as a result of childhood trauma.
Impact on the Child
Children will be supported with their trauma and supported to remain in school.
Measuring Success
Fewer permanent exclusions.

5.4 Learning Disability / Learning Difficulty – professional's understanding of impact

5.4.1 Mother was known to have a learning difficulty. More could have been understood regarding the impact of this.

5.4.2 **What happened and why?**

- When the family moved into Tees Valley in March 2018 it was shared that mother had a possible learning disability and later in March 2022 it was recorded, she had said an assessment had been undertaken and she "has a mind of a 7 year old" but she felt she had overcome this and was effectively raising her children and managing a home.
- The GP practice reported in the initial child protection conference report there was a learning disability code on Mother's electronic medical record from the previous practice, but no further information was recorded.
- A parenting assessment manual software (PAMS) assessment was requested in September 2022 and declined. Advice was a cognitive assessment may be appropriate. This was refused by Local Authority resource panel as it was felt it would not add anything to child protection planning. A referral to Adult Social Care was advised for consideration but did not take place.
- Reference to modifications to support mother with parenting when giving advice was evidenced by both health and social care undertaking pieces of work and there was evidence of a positive impact whilst professionals remained engaged with the family.
- Unequivocally learning disability/ difficulty were recognised and efforts were put in place by the professional working with the family to address this but a referral to adult social care for assessment was not considered until she was recognised as a victim of domestic abuse. Similarly the child-safeguarding-practice-review-panel-annual-report-2022-to-2023 recognised the importance of addressing parental vulnerabilities when working with families.

5.4.3 Recommendation

Recommendation 6
Current single and multi-agency training for safeguarding children/safeguarding adults is reviewed to ensure the training includes: • Impact of learning needs/disability on parenting capacity • Referral pathways into adult social care are included. Obtaining consent for a referral into adult social care when there is an indication of a learning need/difficulty.
Impact on the Child
Recognition of learning disability/difficulty would improve understanding of parenting capacity and care planning.
Measuring Success
Audit: • Review of children records, learning disability/ difficulty is recorded appropriately on parent and child records. • Evidence of assessment, and this is reflected in the plan and intervention provided. • Review of referrals into adult social care for parent/carer. • Service user feedback.

5.5 Clarity of explanation between medics and non-medics to support collective understanding for all.

5.5.1 It was believed by professionals working with the family at the time that the toy was a possible cause of the bleed on the brain Roo suffered. However, medical professionals within the Rapid Review following Roo's death explained that a toy would not be able to cause this. When Roo was admitted to hospital in May due to faltering growth this was not seen through a possible safeguarding lens.

5.5.2 **What happened and why?**

- There was a lack of understanding as to whether the bleeds on the brain should have been picked up earlier. Medical professionals attending the Rapid Review explained that a large head circumference can indicate subdural bleeds. The Rapid Review Panel felt that a clearer explanation of this should take place between professionals.
- There was a lack of understanding regarding the potential cause for the subdural bleed, with Children's Social Care under the impression that the toy which had caused a bruise on the side of Roo's head in June could potentially be the cause. It was only following Roo's death in August that Children's Social Care became clear that the toy could not be the cause.
- There was a misunderstanding regarding the medical information presented, and professionals did not seek clarity on understanding this.
- Medical professionals thought they were clear in communication that the most likely cause of bleeds on brain was inflicted injury. The medical report states "in absence of satisfactory explanation of the bleeds then inflicted head injury must be considered" The medical professionals felt this statement was clear, however it did not rule out or mention the unlikelihood of the toy and bruise on Roo's forehead being a cause of the bleed. The police and social care interpreted that the accident involving the toy was still a possibility in the cause of the bleeds. However more clarity in medical report of likely type of inflicted injury i.e significant and not a plastic toy thrown by sibling, would have helped Non health

professionals in the case assess risk. A toy being thrown at child's forehead would not usually cause subdural bleeds, it is not clear that social care and police were sighted on the seriousness of implications of the bleeding on the brain and of this being feature of abusive head trauma.

- Roo's faltering growth and large head was considered via a medical model and not holistically considering possible abuse or neglect. Subsequently Roo did not have an ultrasound of his head until 4 weeks after his large head was noted by medics. There was no discharge meeting when Roo was discharged from the children's ward and therefore no opportunity for multiagency consideration of the risks and possible causes.

5.5.3 Recommendations

Recommendation 7
Designated Doctor to deliver multi agency training, on understanding child protection medical reports to support risk assessment and multi-agency decision making.
Recommendation 8
Designated professionals ensure child protection medical reports use laymen terms and provide the HSSCP with a glossary as part of Tees Procedures.
Impact on the Child
Better and safer outcomes for children outcomes for children undergoing an child protection medical.
Measuring Success
Audit: • Child protection medical reports • Practitioner survey

5.6 Management of Bruising in Non-Mobile Babies – Adhering to the procedure

5.6.1 The Tees Bruising in Non-Mobile Babies procedure states that:
"because of the difficulty in excluding non-accidental injury in immobile infants' practitioners should seek advice from a consultant paediatrician via Children's Social Care in all cases. An immobile child with bruising needs to be seen the same day by a Paediatrician The practitioner should inform social care so they can commence child protection discussions e.g., Strategy Discussions and if required Section 47 Enquiries. It is the responsibility of Children's Social Care in conjunction with the local acute or community paediatric department to decide whether the circumstances of the case and the explanation for the injury are consistent with an innocent cause or not. "

5.6.2 **What happened and why?**

- The bruise was first observed on Roo in June 2023 and the explanation given by Mother was the sibling had thrown a toy. This was accepted by healthcare professionals and the Social Worker. There was no referral for a child protection medical. Sentinel injuries are visible, poorly explained small injuries such as a bruise or mouth injury in pre-cruising infants, often from abuse. Sentinel Injuries often precede serious abuse; 30% of abusively head injured babies had prior sentinel injuries (Sheets 2013) and 25% of battered babies had prior sentinel injuries (Sheets 2013). Sentinel Injuries are subtle abusive injuries. When recognised and responded

to, escalation of abuse to fractures, head trauma and infant homicide might be prevented. In a study, 50% of babies with just a bruise who were evaluated for abuse had other serious injuries (Harper et al 2014).

- The toy may have caused the bruise on Roo's forehead, but this would not, in usual circumstances, cause bleeds on the brain. A paediatric child protection assessment would have addressed any vulnerabilities and risk of further accidental and non-accidental injuries. In this case, as the head was large at the time, this would have instigated an urgent CT scan, which would have picked up bleeds on the brain earlier.
- It was suggested that professionals were looking for a plausible explanation rather than following the policy and not taking the opportunity to be "curious and ask the second question" Annual review of LCSPRs and rapid reviews March 2021. All babies with bruising need to be seen by a paediatrician.

5.6.3 Recommendation

Recommendation 9
All professionals follow the "Bruising on non-mobile babies' procedure which is currently being updated. HSSCP should: a) Give consideration to reviewing the title of the procedure so it is more explicit as to the instruction / expectation b) Ensure the updated version is communicated and understood to all professionals with consideration for multi-agency stimulation training.
Impact on the Child
All children would be assessed by the correct professional and safeguarded. Sentinel injuries would be action appropriately.
Measuring Success
Audit • Compliance with Bruising on Non Mobile Babies Procedure. • Staff feedback survey.

5.7 How race, culture and ethnicity impacts decision making by professionals.

5.7.1 The children were of mixed race. Their race was noted in records as white-British, white-Asian and also white and black African.

5.7.2 **What happened and why?**

- It was recognised that ethnicity was recorded differently within the chronology. This was not discussed at the rapid review but was part of the practitioner event. Practitioners did not identify race, culture and ethnicity had an impact on the children and there was no specific identified learning.
- Speaking with the mother, she described the children's ethnicity as African mixed race and the father as African mixed race also. The mother does not believe race, ethnicity, or culture to be influential in their parenting, nor does she believe it impacted decision-making by professionals.
- Race, culture and ethnicity were not part of the assessment of the children and parents. The Child-safeguarding-practice-review-panel-annual-report-2022-to-2023 states that 'it is

important that, safeguarding partners and other stakeholders continue to develop and enhance our understanding about the impact of race, racism, ethnicity and culture on both the lives of children and families and how agencies, individually and together, design and deliver services to help and protect children'.

5.7.3 Recommendation

Recommendation 10
HSSCP consider a briefing raising awareness about how race, culture and ethnicity may impact on the lived experience of the child and is part of assessments.
Impact on the Child
Race, culture, and ethnicity would be understood by professionals working with the children and family and any impact this had on protecting children.
Measuring Success
An audit of multi-agency records to ensure race, culture and ethnicity are accurately recorded and reflected in assessment and plans.

5.8 Fathers

5.8.1 A lot of expectations are placed on Mothers in terms of both parenting and in protecting children from harm. Father was a perpetrator of abuse in this case. Mother had a learning difficulty and was a victim of abuse. The majority of actions and expectations within the Child Protection Plan were on Mother. Abusive Fathers are not always held to account for their parenting choices or for how they are disrupting family functioning.

5.8.2 **What happened and why?**

- The child protection plan appeared to focus heavily on Mother achieving the actions and to keep the children safe i.e., Child 1 made a disclosure of physical abuse/ chastisement perpetrated by Father, which was later retracted, and the safety plan was mother would discipline her. It did not reflect an equal balance between both parents to achieve the actions. There was no exploration of why Father had chastised her.
- There was a lack of responsibility placed upon the father as the perpetrator of domestic abuse to change his behaviours. The child protection plan focused heavily on mother keeping the children safe and removing the father from the family home once domestic abuse had been recognised. Father's behaviour was not addressed. This has been identified in reviews whereby there is an over-reliance on one parent to mitigate the risks to their children often being the mother (child-safeguarding-practice-review-panel-annual-report-2022-to-2023.)
- There was a lack of understanding about the impact of substance misuse on the father's parenting or the wider family. Engagement was offered twice with drug and alcohol services and refused. This was not explored any further. Similarly the child-safeguarding-practice-review-panel-annual-report-2022-to-2023 highlighted challenging engagement and having the skills to respond to this did not always occur.
- The assessments recorded did not reflect the impact of the father's adverse childhood experiences (ACE's) or consider the impact they would have on his parenting capacity, child-safeguarding-practice-review-panel-annual-report-2022-to-2023 suggests this is a reoccurring theme in assessments and demonstrates a lack of consideration of the "think family agenda".

5.8.3 Recommendations

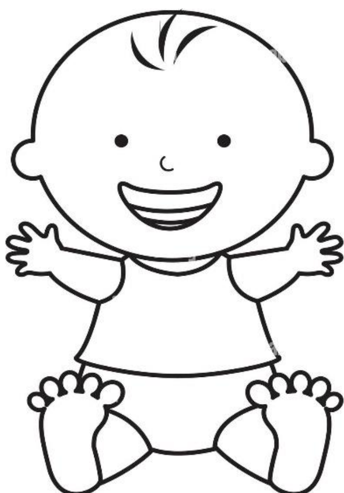
Recommendation 11
Fathers are held to account for their behaviour and the impact of family functioning, parenting capacity, and any risks to their children. Consideration to be given to adopting the Safe and Together model.
Impact on the Child
Improved understanding of father parenting capacity and family functioning which would support appropriate care planning and decision making for the child.
Measuring Success
Audits evidencing: • Fathers' involvement in assessments, planning and review meetings. • Fathers being held to account

5.9 The Child's Lived Experience

5.9.1

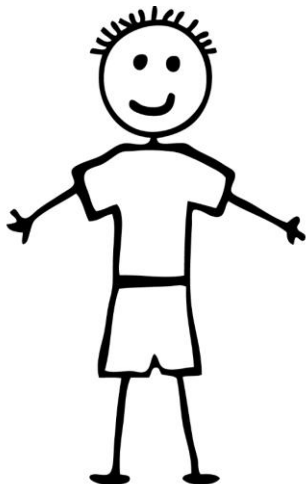
- The practitioner event considered what life was like for each child in the family; set against their experience and developmental age.
- The feedback from the event was consistent across all participants and very powerful.
- The child's lived experience was known but it was not reflected in the care plans and did not appear to influence practice.
- It was evident child 2's lived experience was overshadowed by the needs of their siblings.

5.9.2 **Baby Roo**



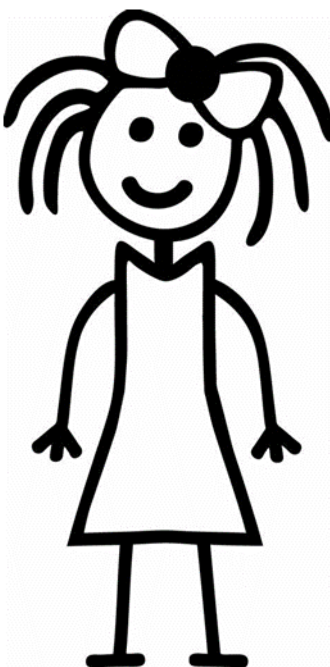
I feel hurt and I am always left alone.
I am not thriving.
No one comes when I cry.
No one plays with me.
Basic needs but no nurture.
My sibling is very protective of me.
I struggle to hold the weight of my head and sometimes bump it on the floor.
I was hit on the head and now it is sore.
Am I unwell, my head hurts?

5.9.3 **Child 2**



- I'm copying my sibling's behaviour.
- I throw things.
- I'm dirty.
- I'm unsafe.
- Loads of people to my Mum about my brother and sister but no one wants to talk about me.
- Losing my voice.
- Maybe I can get attention if I am like my sister.
- Have I done something wrong? Where is my Daddy?

5.9.4 **Child 1**



- I always get excluded from school.
- Nobody wants me.
- I'm scared.
- I need to protect and control.
- I want to hurt people/ things/ animals.
- I'm curious and I want to know.
- It's my job to keep my Mum and brothers safe.
- When I'm away at school I'm worried about them, my dad comes to the house and I don't know what's happening.
- I'm worried things keep changing and no one wants to play with me at school.
- People keep telling me to stop doing things but I don't understanding what they mean.
- I don't trust anyone except my Mum.
- All about me.
- I get angry when Dad comes round.
- I like to play with mini beasts and watch them die

5.9.5 Recommendations

Recommendation 12
HSSCP evaluate the child's lived experience in multi-agency assessment and care planning using the child's language, reflecting their developmental stage, and recognising all children equally.

Impact on the Child
All children would be seen heard and listened to.
Measuring Success
Audits - review of care plans.

5.10 Good Practice

- There has been good communication and information sharing between professionals.
- Child protection meetings were well attended.
- Mental Health Service made an adult referral for the mother in a timely manner.
- Mental Health Service changed appointments to face to face and arranged transport, so mother had a safe space to make a disclosure of domestic abuse.

6. Summary and Recommendations

6.1 This practice review has explored nine identified learning themes leading to eleven recommendations for the partnership to consider and one single-agency recommendation.

6.2 Neglect was a significant theme threaded throughout the review. Learning has been identified which is not new to HSSCP; highlighting the challenges of effectively making sustained changes which positively impact children. The child-safeguarding-practice-review-panel-annual-report-2022-to-2023 highlighted "perennial learning is not easily resolved though policy, procedural change, training or supervision and suggests it is extremely complex. The solution suggested is accepting the uncertainty and fluidity of human beings and concentrating efforts on making sense of why certain practice issues repeatedly surface."

Repeated learning which have been themes in this and other LCSPR and should be seen as routine practice are:

- Child's lived experience
- Effectiveness of care planning
- Assessment and understanding of learning disability/difficulty
- Opportunities to be professionally curious
- The role of fathers
- Lack of adherence to the 'Bruising in Non-Mobile Babies' policy

As such, this report does not only include recommendations for HSSCP but also focuses on the impact on the child and how success can be measured following those recommendations. This reflects making sense of why repeated practices keep resurfacing and supports the key principles of learning highlighted in Child-safeguarding-practice-review-panel-annual-report-2022-to-2023 .

6.3 Neglect has been a feature in all HSSCP rapid reviews undertaken since 2019. HSSCP have neglect as a key priority within their business plan 2022-2024. Both the child's lived experience and assessing and intervening with neglect are key areas of focus in relation to neglect.

6.4 Summary of Recommendations

Stockton Children Social Care

1. Where family members or friends are proposed to supervise a parent's care of their child(ren), Children's Social Care's assessment of them must include checks with every Local Authority the person(s) has previously lived in. Any subsequent family safety plan must clearly set out the expectations of the supervisor and the level of supervision being provided.

Cumulative Impact of Neglect – Recording and Evidencing

2. HSSCP should update the multi-agency training programme to ensure it includes::
    - Legal processes within child protection arena
    - Complex case discussions
    - Effective multi agency care planning
    - Multi-agency chronologies
    - Escalation

Evidence of Domestic Abuse without disclosure – recognising behaviour as evidence

3. All-age single and multi-agency training to be updated to reflect the learning from this case to ensure it includes:
    - Recognising domestic abuse without a direct disclosure.
    - Asking about domestic abuse using an enquiring approach and document the detail about what was asked and the response.

Recognition of signs and symptoms in young children of abuse and neglect; particularly in those with extremes in violent behaviour / 'adultification'

4. Update single and multi-agency training programme to ensure it includes:
    - An overview of normal child development
    - The impact of neglect and abuse on early brain development to support recognition of behaviours as signs of abuse/ neglect.
    - Support and understanding of the child lived experience and a working hypothesis.
5. The Partnership should engage with Education to consider collaborative working to reduce the risk of a child being excluded as a result of childhood trauma.

Learning Disability / Learning Difficulty – professional's understanding of impact

6. Current single and multi-agency training for safeguarding children/safeguarding adults is reviewed to ensure the training includes:
    - Impact of learning needs/disability on parenting capacity
    - Referral pathways into adult social care are included.
    - Obtaining consent for a referral into adult social care when there is an indication of a learning need/difficulty

Clarity of explanation between medics and non-medics to support collective understanding for all

7. Designated Doctor to deliver multi agency training, on understanding child protection medical reports to support risk assessment and multi-agency decision making.
8. Designated professionals ensure child protection medical reports use laymen terms and provide the HSSCP with a glossary as part of Tees Procedures.

Management of Bruising in Non-Mobile Babies – Adhering to the procedure

9. All professionals follow the "Bruising on non-mobile babies' procedure which is currently being updated. HSSCP should:
   a) Give consideration to reviewing the title of the procedure so it is more explicit as to the instruction / expectation
   b) Ensure the updated version is communicated and understood to all professionals with consideration for multi-agency stimulation training.

How race, culture and ethnicity impacts decision making by professionals

10. HSSCP consider a briefing raising awareness about how race, culture and ethnicity may impact on the lived experience of the child and is part of assessments.

Fathers

11. Fathers are held to account for their behaviour and the impact of family functioning, parenting capacity, and any risks to their children. Consideration to be given to adopting the Safe and Together model.

The Child's lived experience

12. HSSCP evaluate the child's lived experience in multi-agency assessment and care planning using the child's language, reflecting their developmental stage, and recognising all children equally.

APPENDIX

A. Glossary

ACES	Adverse childhood experiences
CMW	Community Midwife
CAMHS	Child and Adolescent Mental Health Services
CPP	child protection plan
CSC	Children Social Care
CGL	Change, grow, live
CIN	Child in need
CT scan	Computed Tomography
DA	Domestic Abuse
EH	Early help
EHA	Early help assessment
HSSCP	Hartlepool and Stockton Safeguarding Children Partnership
HV	Health Visitor
ICON	Infant crying is ok, comfort helps, its ok to put your baby down, never shake your baby
ICPC	Initial child protection case conference
LCSPR	Local child safeguarding practice review
MARAC	Multi agency risk assessment conference
PAMS	Parenting assessment manual software
RCPC	Review child protection case conference
SW	Social Worker
UBB	Unborn baby

B. Information Visual Created by Practitioners as part of the Learning Event